Board of Directors (Part 1) - 10/06/2025

Tue 10 June 2025, 09:30 - 15:20

MS Teams

Agenda

09:30 - 09:55
25 min

1. Staff and Patient Story

09:55 - 10:00
5 min

2. Formalities

- 1a DRAFT Agenda DCH BoD Part 1 June 2025 - DCS.pdf (4 pages)
- BOD Declarations of Interest 2025-26.pdf (1 pages)
- 1b Draft Minutes BOD Part 1 08 04 2025.pdf (22 pages)
- 1c Action Log BoD PART 1 June 2025.pdf (1 pages)

10:00 - 10:05
5 min

3. Chair's Comments

10:05 - 10:15
10 min

4. CEO Report

- 4. CEO Report June 2025 Final.pdf (7 pages)

10:15 - 10:25
10 min

5. Board Assurance Framework

- 5a DCH Board Assurance Framework Q4 Board June 25.pdf (3 pages)
- 5b Appendix A BAF DCH Board Q4 June 25.pdf (13 pages)

10:25 - 10:35
10 min

6. Corporate Risk Register

- 6a Front Sheet Risk Register May 25.pdf (4 pages)
- 6b Corporate risk register May 25 v1.pdf (35 pages)

10:35 - 10:55
20 min

7. Shared Services

- 7a Shared Services FBC DCH Board June 2025.pdf (10 pages)
- 7ai Dorset Shared Services - FBC - June 2025 V2.2 (1).pdf (70 pages)
- 7b. Shared Services annexes.pdf (475 pages)

10:55 - 11:05
10 min

8. Quality Committee Assurance Report

- Assurance Report QCIC 27 May 2025 - CL DD.pdf (5 pages)

11:05 - 11:15
10 min

9. Maternity Safety Report

- 8.2a front sheet Maternity Neonatal Report May with April data 2025.pdf (2 pages)
- 8.2b Maternity safety report May 2025 - QC.pdf (21 pages)

11:15 - 11:25
10 min

10. Learning from Deaths Q4

- 8.3 DCH 24-25 Q4 Learning from Deaths Report.pdf (18 pages)

11:25 - 11:35
10 min

11. Patient Safety Incidence Response Plan (PSIRP)

- 8.4a PSIRP Front Sheet Board.pdf (2 pages)
- 8.4b PSIRP March 2025 v2.pdf (37 pages)

11:35 - 11:45
10 min

12. Safe Staffing Mid-Point Review

- 8.5a Front Sheet Safe Staffing Workforce Report DCH May 2025.pdf (2 pages)
- 8.5b Bi-Annual Safe Staffing Report 20242025 v4 (002).pdf (11 pages)

11:45 - 11:55
10 min

Coffee Break

11:55 - 12:05
10 min

13. Finance and Performance Committee Assurance Report

- 9.1 FPC May 25 Assurance Report.pdf (5 pages)

12:05 - 12:15
10 min

14. Balance Scorecard

- 9.2 Board Balanced scorecard report Junw 25 meeting (Apr data).pdf (12 pages)

12:15 - 12:25
10 min

15. Finance Report

- 9.3a Front Sheet DCH FPC M1.pdf (2 pages)
- 9.3aii DCH Finance Report M1 2526.pdf (12 pages)

12:25 - 12:35
10 min

16. Update on Finance and Operational Plan 2025/26

12:35 - 12:45
10 min

17. People and Culture Committee Assurance Report

- PCC May 25 Assurance Report - Joint - MB.pdf (4 pages)

12:45 - 12:55
10 min

18. Joint Strategy Enabling Plans – People Plan

- 10.2ai DHC DCH Board meetings Joint People Plan front sheet June 2025.pdf (2 pages)
- 10.2aii Joint People Plan Final for Board June 2025.pdf (12 pages)

12:55 - 13:05

19. Guardian of Safe Work Report incl. Annual Report

10 min

- 10.3a GoSW_FRONT PAGE 2425 Annual.pdf (2 pages)
- 10.3b GoSW_MAINPAPER 2425 Annual.pdf (7 pages)
- 10.3c GoSW_APPENDICES_2425_Annual.pdf (4 pages)

13:05 - 13:15 10 min

20. Questions from the Public – morning session

13:15 - 14:00 45 min

Lunch

14:00 - 14:10 10 min

21. Freedom to Speak Up Report incl. Annual Report

- 10.5 FTSU Annual Report April 2025 Board.pdf (10 pages)

14:10 - 14:20 10 min

22. Strategy, Transformation and Partnership Committee Assurance Report

- 11.1 STPCIC Assurance Report May 2025 V2.pdf (4 pages)

14:20 - 14:30 10 min

23. SIRO Annual Report

- 11.2a Front Sheet SIRO annual report 2024.25.pdf (1 pages)
- 11.2b SIRO Annual report 2024-25.pdf (4 pages)

14:30 - 14:40 10 min

24. Audit Committee Assurance Report

- Assurance Report DCH Audit Committee 02 June 2025 SP.pdf (3 pages)

14:40 - 14:55 15 min

25. Governance Report

- 12.2a DCH Governance Report.pdf (8 pages)
- 12.2b DCH Committee Terms of Reference.pdf (29 pages)

14:55 - 15:05 10 min

26. Charitable Funds Committee Assurance Report

- 12.4 Assurance Report - DCH Charitable Funds Committee (20.5.25).pdf (2 pages)

15:05 - 15:05 0 min

27. ICB Board Report

- 13.1 ICB Board Report to Partners Part One 060325.pdf (1 pages)

15:05 - 15:05 0 min

28. DCH SubCo Ltd Q4 Performance Report

- 13.2a DCH SubCo performance report Front Sheet.pdf (2 pages)
- 13.2b DCH SubCo Performance Report Apr 2025.pdf (6 pages)

15:05 - 15:05
0 min

29. DCH SubCo Terms of Reference

- 13.3a DCH SubCo Terms of Reference.pdf (2 pages)
- 13.3b. 2025 05 Draft ToR SubCo Board.pdf (4 pages)

15:05 - 15:05
0 min

30. Estates Compliance Report

- 13.4 Estates and Facilities Compliance Paper May 2025 (Joint).pdf (28 pages)

15:05 - 15:05
0 min

31. Health and Safety (including fire and water) compliance report

- 13.5 DCH Health Safety Compliance Report.pdf (12 pages)

15:05 - 15:15
10 min

32. Questions from the Public – afternoon session

15:15 - 15:15
0 min

33. AOB

Meeting of the Board of Directors (Part 1) of Dorset County Hospital NHS Foundation Trust
Tuesday 10th June 2025 at 9.30am to 3.20pm
Board Room, Trust Headquarters, Dorset County Hospital, Dorchester and via MS Teams

AGENDA

Ref	Item	Format	Lead	Purpose	Timings
1.	**Staff and Patient Story**	Presentation	Dawn Dawson	Information	9.30-9.55
2.	**FORMALITIES** to declare the meeting open.	Verbal	David Clayton-Smith Trust Chair	Information	9.55-10.00
	a) Apologies for Absence	Verbal	David Clayton-Smith	Information	
	b) Conflicts of Interests	Verbal	David Clayton-Smith	Information	
	c) Minutes of the Meeting dated 08 April 2025	Enclosure	David Clayton-Smith	Approve	
	d) Matters Arising: Action Log	Enclosure	David Clayton-Smith	Approve	
3.	**Chair's Comments**	Verbal	David Clayton-Smith	Information	10.00-10.05
4.	**CEO Report**	Enclosure	Matthew Bryant	Information	10.05-10.15
5.	**Board Assurance Framework** (June Audit Committee)	Enclosure	Jenny Horrabin	Assurance	10.15-10.25
6.	**Corporate Risk Register** (June Audit Committee)	Enclosure	Dawn Dawson	Assurance	10.25-10.35
7.	**Shared Services**	Enclosure	Nick Johnson	Approval	10.35-10.55
8.	**Quality**				
8.1.	**Quality Committee Assurance Report**	Enclosure	Claire Lehman	Assurance	10.55-11.05
8.2.	**Maternity Safety Report** (May QC)	Enclosure	Dawn Dawson (Jo Hartley)	Assurance	11.05-11.15
8.3.	**Learning from Deaths Q4** (May QC)	Enclosure	Rachel Wharton	Approval	11.15-11.25
8.4.	**Patient Safety Incidence Response Plan (PSIRP)** (April QC)	Enclosure	Dawn Dawson	Approval	11.25-11.35
8.5.	**Safe Staffing Mid-Point Review** (May QC)	Enclosure	Dawn Dawson	Approval	11.35-11.45
Coffee Break 11.45-11.55					
9.	**Finance and Performance**				
9.1.	**Finance and Performance Committee Assurance Report**	Enclosure	Dave Underwood	Assurance	11.55-12.05

9.2.	**Balanced Scorecard**	Enclosure	Anita Thomas Executives	Assurance	12.05-12.15
9.3.	**Finance Report** (May FPC)	Enclosure	Chris Hearn	Assurance	12.15-12.25
9.4.	**Update on Finance and Operational Plan 2025/26**	Verbal	Chris Hearn Anita Thomas	Information	12.25-12.35
10.	**People and Culture**				
10.1.	**People and Culture Committee Assurance Report**	Enclosure	Margaret Blankson	Assurance	12.35-12.45
10.2.	**Joint Strategy Enabling Plans – People Plan** (May PCC)	Enclosure	Nicola Plumb	Approval	12.45-12.55
10.3.	**Guardian of Safe Work Report incl. Annual Report** (May PCC)	Enclosure	Rachel Wharton (Jill McCormick)	Assurance	12.55-1.05
10.4.	**Questions from the Public – morning session**	Verbal	David Clayton-Smith		1.05-1.15
	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				
LUNCH 1.15-2.00 **Board members are invited to attend the opening of the sensory garden during their lunch break.**					
10.5.	**Freedom to Speak Up Report incl. Annual Report** (May PCC)	Enclosure	Nicola Plumb (Lynn Patterson)	Assurance	2.00-2.10
11.	**Strategy, Transformation and Partnership**				
11.1.	**Strategy, Transformation and Partnership Committee Assurance Report**	Enclosure	David Clayton-Smith	Assurance	2.10-2.20
11.2.	**SIRO annual report** (May STPC)	Enclosure	Chris Hearn	Assurance	2.20-2.30
12.	**Audit Committee and Governance**				
12.1.	**Audit Committee Assurance Report**	Enclosure	Stuart Parsons	Assurance	2.30-2.40
12.2.	**Governance Report:** • Fit and Proper Persons Compliance • Code of Governance • Provider Licence • Leadership Competency Framework • Committee Annual Reports, Effectiveness Reviews and TORs	Enclosure	Jenny Horrabin	Approval Assurance	2.40-2.55

12.3.	**Charitable Funds Committee Assurance Report**	Enclosure	Dave Underwood	Assurance	2.55-3.05
13.	**CONSENT SECTION**				-
	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.				
13.1.	**ICB Board Report**	Enclosure	David Clayton-Smith	Information	
13.2.	**DCH SubCo Ltd Q4 Performance Report** (March FPC)	Enclosure	Nick Johnson	Information	
13.3.	**DCH SubCo Terms of Reference** (March FPC)	Enclosure	Nick Johnson	Approval	
13.4.	**Estates Compliance Report** (May FPC)	Enclosure	Chris Hearn	Assurance	
13.5.	**Health and Safety (including fire and water) compliance report** (May FPC)	Enclosure	Chris Hearn	Assurance	
14.	**Questions from the Public – afternoon session**	Verbal	David Clayton-Smith		3.05-3.15
	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				
15.	**Any Other Business** Nil notified	Verbal	David Clayton-Smith	Information	3.15
16.	**Date and Time of Next Meeting**				
	The next part one (public) Board of Directors' meeting of **Dorset County Hospital NHS Foundation Trust** will take place at **9.30am** on **Tuesday 12th August 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 and Operational Plan Update
- Shared Services – Annex 11
- One Dorset Provider Collaborative Board Minutes
- Case for the Extension of the Stroke HASU
- Keyworker Housing Unilateral Undertaking

- Generator Critical Infrastructure Funding Release
- Satellite Haemodialysis Contract for Yeovil – Novation Update

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NHS Foundation Trust

Dorset County Hospital NHS Foundation Trust Register of Interests - Board of Directors

Date of Publication: **24/04/2025**

Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
David Clayton-Smith	Joint Chair	Role is a joint role with Dorset HealthCare NHS Foundation Trust	11/03/2025	10/03/2026	
Matthew Bryant	Joint Chief Executive Officer	Role is a joint role with Dorset HealthCare NHS Foundation Trust Member of Dorset Integrated Care Board (Mental Health Partner Representative).	28/02/2025	27/02/2026	
Dawn Dawson	Joint Chief Nursing Officer	Role is a joint executive role with Dorset HealthCare NHS Foundation Trust • Son is a sales representative for Stryker IVS South & Southwest • Daughter is Associate Director of People & Transformation in NHS Somerset • Daughter in law is Assistant Divisional Management Accountant at Royal Devon and Exeter NHS Foundation Trust • Son in law is a registered nurse degree apprentice in Dorset Healthcare	27/02/2025	26/02/2026	
Chris Hearn	Joint Chief Finance Officer	Role is a joint role with Dorset HealthCare NHS Foundation Trust	04/03/2025	03/03/2026	
Frances West	Joint Non-Executive Director	Role is a joint role with Dorset HealthCare NHS Foundation Trust Non-Executive Director - Westward Housing Group	11/03/2025	10/03/2026	
Jenny Horrabin	Joint Director of Corporate Affairs	Role is a joint role with Dorset HealthCare NHS Foundation Trust Trustee – Coventry Sports Foundation Independent Audit Committee Member - Citizen Housing	24/02/2025	23/02/2026	
Nick Johnson	Deputy CEO Joint Chief Strategy, Transformation and Parternships Officer	•Board member of DHC •Board member of DCH •Director for DCH Subco Ltd •Director for Dorset Estates Partnership LLP •Board Memmber for Health Innovation Wessex Ltd Partner is an employee of Skills for Care.	27/02/2025	26/02/2026	
Nicola Plumb	Joint Chief People Officer	Role is a joint role with Dorset HealthCare NHS Foundation Trust	17/04/2025	16/04/2026	
Anita Thomas	Chief Operation Officer	Nil	25/03/2025	24/03/2026	
Margaret Blankson	NED	Nil	04/03/2025	03/03/2026	
Eiri Jones	Deputy Chair	Non Executive Director (SID) Salisbury NHS Foundation Trust.	16/04/2025	15/04/2026	
Claire Lehman	NED	Non executive directorships – Southwest Ambulance FT (since July 2024); Great Western Hospital FT (April 2023-April 2025). Advocacy for Parkinson's disease, including but not restricted to Cure Parkinson;s, Parkinson's UK, Critical Path for Parkinson's/	25/03/2025	24/03/2026	
Stuart Parsons	NED	Nil	27/02/2025	26/02/2026	
Stephen Tilton	NED	Director and Chairman of DCH SubCo Ltd.	05/04/2025	04/04/2026	
Dave Underwood	Senior Independent Director (NED)	Joint NED at DCH and DHC Chair of Royal British Legion Club West Hill Ltd Registered IP23677R on the FCA Mutuals Public Register Policy Board member of the SW Business Council - The economic partnership for the South West of the UK Member of the University of Exeter Digital Advisory Network	25/03/2025	24/03/2026	
Rachel Wharton	Chief Medical Officer	Nil	03/02/2025	02/02/2025	

Minutes of a public (Part 1) meeting of the Board of Directors of Dorset County Hospital NHS Foundation Trust held at 9.30am on 8th April 2025 at Board Room, Trust Headquarters, Dorset County Hospital and via MS Teams videoconferencing.

Present:		
David Clayton-Smith	DCS	Joint Trust Chair (Chair)
Matthew Bryant	MBr	Joint Chief Executive
Dawn Dawson	DD	Joint Chief Nursing Officer
Chris Hearn	CH	Joint Chief Finance Officer
Jenny Horrabin	JeH	Joint Director of Corporate Affairs
Nick Johnson	NJ	Deputy Chief Executive and Joint Chief Strategy, Transformation and Partnership Officer (via videoconference)
Eiri Jones	EJ	Joint Non-Executive Director (Deputy Chair)
Claire Lehman	CL	Non-Executive Director
Nicola Plumb	NP	Joint Chief People Officer
Anita Thomas	AT	Chief Operating Officer
Stephen Tilton	ST	Non-Executive Director
David Underwood	DU	Joint Non-Executive Director
Frances West	FW	Joint Non-Executive Director (via videoconference)
Rachel Wharton	RW	Chief Medical Officer
In Attendance:		
Abi Baker	AB	Corporate Governance Manager (Minutes)
Henry Bull	HB	Corporate Affairs Apprentice (Observing)
Mandy Ford	MF	Joint Deputy Director of Corporate Affairs (via videoconference)
Jo Hartley	JHa	Head of Midwifery (item BoD25/009)
Jo Howarth	JoH	Director of Nursing (Acute Care) (item BoD25/001)
Paul Kirby	PK	Patient Story (item BoD25/001)
Caryn Mitchell	CM	Interpreter (item BoD25/001)
Hannah Robinson	HR	Head of Patient Experience (item BoD25/001)
Neil Tomlin	NT	Maternity Advisor (item BoD25/009)
Members of the Public:		
Alan Clark	AC	Governor (via videoconference)
Kathryn Harrison	KH	Lead Governor (via videoconference)
Jean-Pierre Lambert	JPL	Governor (via videoconference)
Carol Manton	CMa	Governor (via videoconference)
Apologies:		
Margaret Blankson	MBl	Non-Executive Director
Stuart Parsons	SP	Non-Executive Director

BoD25/001	**Patient Story**	
Baker Abi 05/06/2025 15:15:16	JoH introduced the patient story, outlining that it arose from a complaint from a patient, Samantha, who was profoundly deaf, her experience attending the emergency department (ED) during out of hours, and how the trust failed to meet her communication needs. On reviewing the complaint response JoH was concerned that the trust was not doing enough to understand the needs of the deaf community, so she met with Sam and CM as interpreter to hear about Sam's experience. As a result of that a conversation café was arranged where patients could share their experiences in small groups with staff, and this was where JoH met PK.	

	PK was a local resident and user of hospital services and had been invited to the meeting today to share his experience. Afterwards HR would share the actions and learning opportunities arising from the conversation café. Throughout the meeting PK used British Sign Language (BSL) and CM spoke for him as his interpreter. PK outlined that he would like to explain his story. CM stopped interpreting and PK communicated to the meeting in BSL for a few minutes. CM resumed interpreting and asked on PK's behalf if attendees understood what he had said, thereby reflecting his experience when communicating with non-deaf people. PK thanked the chair and board for inviting him to the meeting. PK outlined the story of his friend who recently attended hospital with stomach pain. An interpreter was not provided on arrival, so they communicated by writing to begin with. The friend asked for an interpreter to be booked and waited to be seen. When he was seen by clinicians there was no interpreter present. Blood was taken for a test but as they were not able to communicate the friend did not know what this for. The friend was desperate and in pain so was given medication; he did not know what the medication was but took it because he was in pain. He had a scan and found issues were found with his pancreas. The friend asked the clinician what this meant, and the clinician wrote down 'cancer'. They explained in writing that he would need to come back and receive palliative care. The friend was confused, did not understand and asked for further explanation and for an interpreter. PK described that as his friends cancer spread his mental health deteriorated and his rights disappeared. He needed end of life care and did not have access to an interpreter. If this was the service for cancer care, PK wondered what the service would be like for other medical needs and stressed the importance of meeting the communication needs of deaf people so that they could access their own care. PK said that he was not scared of dying but was scared of being ill and of losing his communication. JoH reflected on the stories heard at the conversation café, including the assumptions made about deaf people, and that each individuals experience was unique. It was important not to make assumptions based on our own communication needs. HR shared a presentation detailing the key findings, recommendations and actions from the conversation café, highlighting the below key points: • Attendance from staff across the trust, including from education, procurement, patient experience. MBr also attended the session. Five patient representatives attended from the deaf community with two interpreters, including CM. • The session had no agenda but was an opportunity solely to listen to the experience of those patients. • One of the key findings was the importance of having the right interpreter present, and that whilst digital solutions were useful in an emergency, they were not a substitute for an in-person interpreter.	

- Recommendations included staff training and awareness, but it was recognised that training for all staff was not the right solution, staff champions, and a digital translation and interpretation service across the Dorset system.
- Most important was how to improve BSL services, ensuring interpreters were available and ensuring that the patients needs were put first
- The recurring theme around funding issues and who pays of it. There were plans to create a central budget from which interpreters could be booked.
- Potential for a 15-steps challenge with members of the deaf community. This could focus on the new ED build to ensure that the trust got this right before the service opened.

There was a discussion around people who lose their ability to speak and hear due to dementia, what could be done to support them. PK noted that he did work to support deaf dementia patients.

The board discussed the procurement process for booking interpreters and how digital solutions were useful but were not as effective as in-person interpretation. It was important that patients did not need to bring their own booked interpreter or use family members, noting the information governance issues and inappropriateness of this. PK understood that finances were tough, particularly at present, but reflected that the cost of an interpreter was preferable to any cost that might be incurred from a complaint or litigation. He added that he had mental capacity and rights, but that without an interpreter these were lost.

FW suggested teaching staff the BSL alphabet as a quick and easy way to improve communication with deaf patients, although recognised that this was not a substitute for making BSL interpreters accessible. JoH noted that communication packs including visual aids were available in every department, primarily for patients with learning disabilities, but staff often did not use these when communicating with deaf patients. The conversation café evidenced that there was no substitute for access to BSL interpretation and that it was important the interpreter was trained to the right level for medico-legal discussions. The board heard an example of a serious mis-interpretation due to the interpreter not being trained to a high enough level. PK described the importance and nuance of translating meaning, not just words, between English and BSL.

DU reflected that when appointments were booked for the future it was possible to arrange an interpreter in advance, but asked how to ensure interpreters were available in emergency situations, such as ED attendance. JoH described that in Sams's case her family had phoned ahead to say an interpreter would be required. There were out of hours processes for arranging interpreters at short notice, but staff needed to be made more aware of this and the process needed to be easy to navigate.

DD thanked PK for sharing his story today. Whilst it was not possible to identify solutions today board members would certainly continue to think about this outside of the meeting. In light of her joint role, DD considered how the same issues might appear at Dorset HealthCare (DHC), particularly for patients with mental health needs and how best the two

	trusts could support people within the deaf community who needed to access healthcare. MBr thanked PK for attending and felt privileged to have been able to attend the conversation café. He had been impressed by the high standards for communication, how articulate the patients had been in sharing their experience, and how patient they were in working with the trust to get this right. MBr described the issue as a shortcoming of the service and noted the need to improve access to interpreters during emergency and unplanned care. He further reflected on the value of the conversation café approach and the work of JoH and HR to use this with other patient communities. The board meeting would discuss many different topics today, but getting matters such as this right was fundamentally why the hospital was here. Finally, PK reflected that mistakes happen, but it was important to learn from them and prevent them from happening again. Board members thanked PK and CM for joining the meeting and for the valuable discussions. PK, CM, HR, and JoH left the meeting.	
	Resolved that: the Patient Story be received for information.	
BoD25/002	**Formalities**	
	The Chair declared the meeting open and quorate and welcomed governors to the meeting. Apologies for absence were received from Margaret Blankson and Stuart Parsons. The Chair extended a welcome to RW for whom this was her first meeting as Chief Medical Officer (CMO).	
BoD25/003	**Conflicts of Interest**	
	There were no conflicts of interest declared in the business to be transacted on the agenda.	
BoD25/004	**Minutes of the Meeting held on the 11 February 2025**	
	The Minutes of the meeting dated 11 February 2025 were approved as an accurate reflection of the meeting, although noted that they were quite lengthy and could be more compressed.	
	Resolved: that the minutes of the meeting held on 11 February 2025 were approved.	
BoD25/005	**Matters Arising: Action Log**	
Baker,Abi 05/06/2025 15:15:16	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. BoD24/214: CH updated that the key reasons for the discrepancies related to the phasing of efficiencies over the year. It was known that the trust would not deliver the full £14.4m cost improvement plan (CIP) for 2024/25	

	so the reason for the overspend on substantive staff was that the budget was removed to some extent during planning, but the saving had not materialised in the expenditure run rate. CH would speak to SP outside of the meeting to provide him with an update on this matter. EJ noted two matters arising from the last meeting. Firstly, she remained concerned about safe staffing as headroom had not been increased and the risk that this could have on patient safety. Secondly, EJ was concerned that quality impact assessments (QIA) were not being completed in a timely manner and were instead being completed after a decision had been made, for example with decommissioning by the Integrated Care Board (ICB). DD noted that the matter of decommissioning and related QIAs were the responsibility of the ICB, not of the trust. The Trust had established a new, robust QIA process which was currently being finalised, and any internal schemes would go through this new process. This matter would be further discussed under the update on finance and operational plan agenda item. BoD24/164: the action related to the triangulation of escalation reports raised by resident doctors with risk data. DD noted that it was difficult to track this information retrospectively, and so instead she and RW had considered how this could be tracked prospectively to ensure that risks were identified, mapped and linked to safe staffing information. RW added that from April the guardian of safe work would review all immediate safety concerns and where she felt there was a patient risk she would create and link a datix report. This would align with the process of 'red flags' within safe staffing for nursing. MBr further suggested that this further linked with particular themes or issues described in the guardian's quarterly report. This was felt to be good evidence of the trust being well-led. RW would give an update to action BoD24/156 within the learning from deaths agenda item.	
	Resolved: that updates to the action log be noted with approval given for the removal of completed items.	
BoD25/006	**Chair's Comments**	
Baker Abi 05/06/2025 15:15:16	DCS reflected on the amount that had happened since the last board meeting, particularly in relation to national changes with the ICB and NHS England (NHSE) and noted that the resource constraints were very real. The trust had held an extraordinary board meeting to consider the system's financial and operational submission for 2025/26 and a further extraordinary meeting would be held at the end April to approve the trust's own submission. Since the last meeting DCS had continued to visit departments across the trust and a board-to-board-to-board meeting with DHC and University Hospitals Dorset (UHD) had taken place. DCS reflected that the meeting had developed quite far since the last meeting in February 2024. The financial situation might test the positive relationships being fostered, but DCS was encouraged by the focus on delivering the best care possible for the residents and patients across Dorset. DCS had also attended a workshop of the three councils of governors from each of the three providers in the system which had also proved to be very positive. He	

	noted the importance of engaging with members and the public as the trust and NHS met the challenges it was facing.	
	Resolved: that the Chair's comments be received for information.	
BoD25/007	**CEO Update**	
	MBr welcomed RW to her first board meeting in her substantive role as CMO and noted the contribution of Alastair Hutchison over the past seven years as CMO. Updating the meeting, MBr highlighted the following key points for the Board: • The appointment of Rachel Small (RS) as Chief Operating Officer for DHC. RS had been in the interim role for some time prior to this. • The appointment of Beverly Bryant (BB) as joint chief digital information officer across DCH, DHC and UHD. At DCH NJ would retain responsibility for the digital agenda at executive level. • Jenni Douglas-Todd had now stepped down as chair of the ICB, with Rob Whiteman in post as acting chair. The appointment process to replace Rob Whiteman as chair of UHD was ongoing. MBr reflected on the scale of the recently announced national changes and the impact these will have on colleagues within NHS Dorset, other ICBs and NHSE. Nonetheless, the direction of travel was clear in terms of amalgamating NHSE and the Department of Health and Social Care and the need for ICBs to rapidly reduce costs by the end of quarter three of this year. The impact of this would be discussed throughout the meeting in various agenda items. ICBs had also been given a clear task to reduce corporate costs by 50% by the end of quarter three. Further detail about this had been received by trusts yesterday, and included detail about how trusts would be judged within the performance framework. All trusts would need to work within these constructs and adapt to the new processes within the NHS. MBr further highlighted: • Receipt of the new board member appraisal guidance. The trust had adopted much of this last year so was in a good position to meet the new requirements. • Positive discussions at the board-to-board-to-board meeting with an emphasis on needing to work together both in relation to corporate services, to achieve the shared goals relating to population health, and in relation both vertical and horizontal integration. • DD continued to work with colleagues in the BCP place (Bournemouth, Christchurch and Poole) regarding integration, and RW was leading the acute service agenda with counterparts at UHD. It was important to keep a focus on collaboration in order to make the most difference for the population of Dorset. • Receipt of the staff survey results. These would be discussed in more detail later in the meeting but indicated positive and negative areas for the trust. The trust had an improved response rate and an improving score in relation to the rate of staff recommending the	

	trust as a place to work. The trust was third highest in the southwest region for this metric. • The emergency department entrance move had taken place. This was the first step in a complex process to deliver the new emergency department build by 2027. There had been some concerns about the move, but it had proved positive and had resulted in improved flow in ED. DU agreed with the need to give BB additional time to develop the digital enabling plan for the joint strategy to encompass system working. However, he noted that this needed to be tightly coordinated as the other enabling plans all had significant dependencies on digital components. Any delay to those digital components would need to be communicated effectively and in a timely way. DCS agreed, and noted that the Strategy, Transformation and Partnership Committee in Common had discussed the need to monitor those interdependencies.	
	Resolved: that the CEO Update be received for information.	
BoD25/008	**Quality Committee Assurance Report**	
	CL spoke to the previously circulated assurance reports from the Quality Committee meetings held on 25 February and 25 March. She drew the Board's attention to the below matters: • Decision by the ICB to decommission some services, which may have implications for DCH patients. DD and RW were involved in ongoing conversations with the ICB in relation to this. On this point DCS asked for further detail about the concern and how the trust was addressing it. DD noted the potential impact on patients that received care at DCH. She described that decommissioning was new for the system and so there was some learning around how to do this well and safely and to ensure that patients had alternative mechanisms to get the care they needed if a service was no longer going to exist. DD was working with the ICB to understand further detail about the decommissioning. CL referenced EJ's earlier comment about QIAs being undertaken prior to any decommissioning decision being made. CL continued to highlight: • Positive service update from the Acute Hospital at Home service • Receipt of an update from ophthalmology in February regarding the process to address lost to follow up, with a further update in March. The committee sought assurance that the cause of the issue in ophthalmology is no longer a concern, and that there were process in place to identify patients affected and any harm they may have come to. The committee further sought assurance that the potential of lost to follow up was not a concern in any other specialities, and this was not the case. • Approval of Quality Committee in Common terms of reference • Approval Strategy Enabling Plans – Clinical and Quality Plan Noting the service report from Acute Hospital at Home, FW asked if the board could receive an overview of work going on in the trust that supported the national change of focus from hospital to community. DD	

	described that she and AT were looking at vertical integration, around shifting the focus within services from being internally focused to being externally focused and could provide an update on this work in the coming months. MBr suggested that this be presented at a Board Development Session after the publication of the 10-year plan (expected in May). The session could take stock of the trust's ongoing work that support the 10-year plan, and the areas of the plan that the trust needed to focus on.	**JH**
	Resolved: that the Quality Committee Assurance Report be received for assurance.	
BoD25/009	**Maternity Safety Report**	
	JHa and NT joined the meeting for this item. The report was taken as read and board members were invited to ask questions. EJ highlighted that it had been reported at the last board meeting that the trust was compliant with all ten Maternity Incentive Scheme (MIS) standards. However, the trust had subsequently been challenged on this position and EJ sought an update. DD updated that following submission of the MIS data there had been a query around the completeness of the perinatal mortality data. This had been reviewed by the maternity team and a comprehensive response with supporting evidence was provided, and confirmation had recently been received that this additional information was accepted and that the trust was compliant with all MIS standards. As NED maternity safety champion, it was EJ's responsibility to highlight any concerns to the board. EJ undertook regular walkarounds to the maternity service and reflected that even when it was busy staff across all professional groups were welcoming and there was evidence of good practice in the service. EJ did however note that a concern had been raised from a governor observer of Quality Committee around post caesarean-section care, particularly at night, so she was intending to undertake an out of hours walkaround with DD. EJ further highlighted to board the risk relating to the three old neonatal ventilators on the unit which had reached the end of their contracted service lifetime. DD updated that the service was looking to replace one ventilator at a time. It was noted that the trust did not regularly have ventilated babies on the unit, but the ventilators were needed in emergencies or whilst awaiting transport to another unit. The board heard that the trust had challenges in staffing the special care baby unit (SCBU) but that temporary workforce was utilised to ensure safe staffing, whilst recognising that the trust was trying to reduce temporary workforce usage. This was not an unusual issue for small units and EJ suggested that there may be an opportunity to share skills and workforce across the system. DD undertook to liaise with UHD about the potential for joint work in this area. MBr reflected that the use of agency staff in SCBU was appropriate to ensure safe care was provided. He further brought to the board's attention the change an anticipated change in focus for boards to be able to make appropriate decisions based on safety assessments, instead of automatically following guidance from national bodies. This was not the	**DD**

	case yet, but was something the board should be aware of moving forward. As and when this developed it would be for Quality Committee to consider safety implications.	
	Resolved: that the Maternity Safety Report be received for assurance.	
BoD25/010	**Learning from Death Q3**	
	RW took the report as read, highlighting: • The positive position that the Summary Hospital-level Mortality Indicators (SHMI) remained static • There was a plan in place to address the backlog of structured judgement reviews (SJRs) and to share learning from those reviews In relation to action BoD24/156 regarding mis-triage to ward RW outlined that the trust was an outlier as it had a higher than usual number of patients be discharged directly to home from intensive care, which triggered as a mis-triage. RW confirmed that those patients were discharged appropriately but that the process of discharging from intensive care straight to home was seen as a reflection of a lack of beds in the hospital. The discharge decisions were safe for the patients but were not the usual convention for discharging. AT added that management was very aware of this issue and that it often increased in winter with increased acuity in the hospital. AT regularly raised the issue at system meetings. MBr suggested that the future care programme would support addressing the issue. The action was closed.	
	Resolved: that the Learning from Deaths Q3 be received for approval.	
BoD25/011	**Quality Committee in Common Proposal**	
	DD outlined that a working group had been in place for some time to develop the Quality Committee in Common, a draft workplan for the coming year had been created with aligned reporting where possible. The two trusts were now in a position to go live with the Quality Committee in Common with an informal meeting planned for April. The terms of reference had been reviewed by both trust's Quality Committees and also the Strategy, Transformation and Partnership Committee in Common. The proposal and terms of reference were presented today for approval. JH highlighted the below key points for clarity: • Health inequalities currently sat in Strategy, Transformation and Partnership Committee in Common, but it was now recommended that this be moved to Quality Committee in Common • The Patient and Carer Race Equality Framework would move from Strategy, Transformation and Partnership Committee in Common to Quality Committee in Common • The membership outlined in each trust's terms of reference included individuals from the other trust. This would be updated to trust specific and joint roles only, as each term of reference was trust specific.	

	DU requested that committee chair meetings be reinstated, as they offered good opportunity for the chairs to discuss and cross reference matters with each other. The board noted that the concerns discussed earlier in the meeting regarding QIAs for decommissioning services had been escalated to the ICB by both DD and MBr to their counterparts. During the development of a Quality Committee in Common it was considered that a Mental Health Legislation Assurance Committee in Common could also be developed. As a mental health trust DHC already had a Mental Health Legislation Assurance Committee, and whilst DCH was not a mental health trust it still had mental health responsibilities. The detail of the proposed Mental Health Legislation Assurance Committee in Common was being developed and returned to board at a later date for final approval. MBr reflected that this was a good idea. He asked that as the plans were being developed consideration be given to what the committee offered to DCH, as a non-mental health trust. From a DHC point of view, thought should be given to how the same input was being given to UHD to ensure that mental health standards were being championed across the system. DD undertook to explore the latter point. The board approved the Quality Committee in Common proposal and terms of reference, subject to the minor changes outlined by JH.	**JH**
	Resolved: that the Quality Committee in Common Proposal be approved, subject to the minor changes outlined by JH.	
BoD25/012	**Finance and Performance Committee Assurance Report**	
	DU spoke to the previously circulated assurance report from the Finance and Performance Committee in Common meeting held on 24 March. He drew the Board's attention to the below matters: • Review of the financial and operation plans in the face of the challenges being seen across the NHS. The plans were recommended for approval, and an extraordinary Board meeting later that day approved the plans. • The focus on those plans, inside and outside of the meeting, means that the committee was not able to focus on performance metrics in the way it usually would. As such DU requested that the board give extra focus to the next agenda item. • A number of approvals were made by the committee, as outlined in the assurance report The board discussed where the funding for the approvals detailed in the was coming from, noting the constrained financial environment. In relation to the renal dialysis unit refurbishment, AT outlined that the funding was identified as part of the trust's capital spend for the coming year, but an application for additional funding had been made as well. DU provided assurance that the source of each business cases funding was explored in the committee. In relation to the new hospital programme generator CH noted that the board had received a paper several months ago with a list of schemes that would require approval, and this was the first of those. EJ sought assurance that items reviewed early in the financial year were not	

	given priority over items later in the year, once funding had been allocated. CH noted the robust processes through Capital Planning and Space Utilisation Group (CPSUG) and Medical Devices Committee and the work to link QIAs with business cases moving forward. AT added that capital demands were discussed in divisional triumvirate meetings to ensure that spend was apportioned appropriately.	
	Resolved: that the Finance and Performance Committee Assurance Report be received for assurance.	
BoD25/013	**Balance Scorecard (incl. elective tiering)**	
	In relation to the scorecard overview, AT highlight that 12 indicators were showing 'fail' or 'special cause variation', compared to 11 for the reporting month of December 2024. This additional metric related to mandatory training. Work was ongoing to rationalise mandatory training requirements in recognition that there had been an increase over time. Reporting data for the 2025/26 would include targets for all metrics. AT noted predominantly positive performance for the reporting month (February 2025), highlight the following key points in relation to the performance elements of the report: • Difficulty consistently meeting the threshold for the 31 days cancer performance target, but strong performance within the south west. At the end of March, the trust was less than 1% away from meeting the target. • Improvements across theatres, diagnostics and referral to treatment (RTT), with further work to improve performance • The trust ended 2024/25 with one patient remaining on the >65 week waiting list. This individual had very specific prosthetic requirements and had an appointment booked in April. • The trust met the trajectory for echoes, for which AT praised the team • A deterioration in endoscopy partly due to staffing and an increase in cancer referrals • AT reflected that the waiting list had reduced in size since the beginning of the year, contrary to what the dashboard indicated. This was against a background of 7% increase in referrals • The trust ended the year by meeting ED standards, children and young people trajectories, and reducing >52 week waiting list size to 48 patients who were primarily in oral maxillofacial, and ear, nose and throat specialities. The trust also met the faster diagnosis and 62-day standards at the end of the year. • This position set the trust in good stead for the coming year. Asked about the sustainability of these performance metrics, AT outlined that a full capacity and demand review had been undertaken regarding RTT performance which had informed how elective recovery funding (ERF) was used. AT further noted the continuing discussions with the ICB about the increasing demand and the expectation on the ICB to reduce demands offered some hope for the trust continuing to meet performance metrics. The move of the ED front door had also proved positive and helped to improve performance in the service. AT noted that UHD moving	

	their ED further east may have an impact on the trust, but she was otherwise confident the trust would meet its targets for the coming year. MBr reflected that there was always more that could be improved but the reason to focus on these elements was to make sure services were right for patients. The trust should celebrate the operational performance, and thanks were extended to all the teams involved recognising that this only happened through hard work. EJ extended additional thanks to AT. DD added the following key points in relation to quality performance: • The trust ended 2024/25 slightly above trajectory for C. difficile. This was a national trend, and a national incident response had been set up to understand the increase. • PURPOSE T, an evidence-based assessment tool for reducing pressure ulcers, had been rolled out in all but two wards • A new early resolution complaints process was in place and being well received. Only 14 complaints from the old process remained open. • 98.2% of people who responded to the friends and family test (FFT) would recommend the trust as a place to receive care • Work to resolve concerns with the timeliness of electronic discharge summaries continued • The trust continued to reduce off-framework agency usage, although this was still used in highly specialised areas such as ED, SCBU and children's ward. NP highlighted the following key points regarding people performance: • Concerns regarding essential skills compliance, as outlined by AT, with a great deal of focus and various workstreams ongoing to address this • Vacancy rate stood at 3.1%, compared to more than 10% two years ago • Low and stable turnover figure (9.3%), compared to 11.5% two years ago • Continued reduction in agency usage • Answers to questions regarding appraisals in the staff survey indicated a higher appraisal rate than the dashboard showed. This would be investigated further.	
	Resolved: that the Balance Scorecard (incl. elective tiering) be received for assurance.	
BoD25/014	**Finance Report**	
Baker Abi 05/06/2025 15:15:16	CH provided an update on the trust's financial position at month 11, recognising that although we were now in the new financial year the year-end position was currently being finalised. Of note, CH highlighted: • Month 11 ended in a surplus of £1m, £600,000 away from the planned surplus of £1.6m • Year to date to the trust had delivered a £9.4m deficit, being £8m away from the original plan. However, this position was in line with the trust's revised trajectory plan. • Key drivers of the position were as previously reported:	

	○ Operational pressures with 55 no criteria to reside patients at the end of month 11 leading to increased staff costs and escalated beds ○ Inflationary pressures especially relating to energy prices ○ Increase in drug expenditure in line with the national picture • At month 11 the trust had delivered £7.2m of its £14.4m CIP target. It was anticipated that the trust would end 2024/25 delivering £8.3m CIP. Whilst this was a shortfall against the target, it should be recognised that in previous years the trust had delivered £4m in savings. The hard work of colleagues across the trust was commended, but it was recognised that there was further to go in identifying and delivering efficiencies. • Significant improvement in year in the reduction of agency spend. At month 11 year the trust had spent £6.1m year to date, compared to £12.6m at the same point last year. • The trust ended month 11 with £11.8m cash, partly due to receipt of ERF, cash management and timing of payments in month, as well as additional system support. • The trust was anticipating delivery of the trajectory plan of a breakeven position. Additionally, the system was in receipt of an additional £13m of national support. Given the cash risk in DCH that funding would flow to the trust, which means that the trust should end the year delivering a £13m surplus. No questions were asked relating to the month 11 finance report, and discussions moved on to the financial and operational plan update.	
	Resolved: that the Finance Report be received for assurance.	
BoD25/015	**Update on Finance and Operational Plan 2025/26**	
Baker Abi 05/06/2025 15:15:16	CH outlined that the previously circulated paper had been presented to Finance and Performance Committee in Common and an extraordinary Board meeting on 27th March, where it had received approval. He summarised the key financial elements of the paper: • The proposed plan submission for the Dorset system is a breakeven position. Significant work had taken place by all parties to develop this plan. • Within that plan the trust had a forecast deficit of £12.8m. Further work was ongoing to finalise the plans for system partners and these would be submitted at the end of April. • A number of key assumptions were made in the development of the system plan, including reinstatement of £18.4m non-recurrent provider support funding from the ICB to DCH, and a total CIP target of 8% or £26m (comprising 5% efficiency target plus 3% reinstatement of non-recurrent efficient delivery). • A proportion of the CIP requirement for 2025/26 had already been identified, including 10% corporate efficiencies in line with the national agenda to reduce corporate cost growth. The additional 3% of CIP would need to be found through transformational schemes. A full update would be provided ahead of the final plan submission at the end of April. • Assuming no investments to be made other than where required for safety and quality, supported by QIAs. There would be investments	

in ophthalmology, registered nurse degree associates and in the skill mix on SCBU.
- CH highlighted the risk to cash in this plan, even with the receipt of additional cash at the end of 2024/25. A key piece of work in the coming weeks was reaching agreement with the system around the approach to potential cash deficits.

AT further highlighted the key operational performance elements:
- A shift away from finite numbers in the performance expectations
- 6% improvement in overall waiting times, and 5% improvement in first outpatient appointment waiting time.
- Overall reduction in 52 week-waits to less than 1% of the total waiting list
- The trust was in a good position to meet these due to its performance at present
- 75% target for 62-day standard for cancer, and 80% for the faster diagnosis standard. The trust met the 62-day standard in March, but focus would need to be maintained on this over the coming year given the growth in cancer referrals.
- The trust may be given a stretch target for ED to support wider system performance
- The trust would need to make effective use of ERF to meet efficiency targets in light of increasing demand.

AT did not anticipate the performance requirements changing unless the trust was given stretch targets to support system outcomes.

In relation to the workforce elements of the plan NP highlighted that workforce figures continue to be finalised, following the publication of the papers, and there was a planned reduction of approximately 232 whole time equivalent (WTE). The trust was applying all of the must-do actions regarding reduction in temporary staffing and returning to 2022 levels for corporate service costs and was also looking at WTE reduction requirements whilst triangulating workforce to operational requirements.

Over the coming weeks there would be further work with the system to de-risk the plan as much as possible. The system position would remain a breakeven plan and the plans of partners within the system would be finalised and workforce would be triangulated as outlined by NP. CH noted that there were different metrics around reducing corporate costs and these would be understood and finalised within the plan. Extraordinary meetings of the Finance and Performance Committee and Board would be held at the end of April to review and approve the plan.

DCS reflected on the interdependencies between the various elements of the plan, and these needed to be kept track of through committees. He further stressed the importance of making progress to meet the plan in the beginning of the year.

MBr considered the context for the financial position, stressing the gravity of the situation for the whole of the NHS as well as the broader context of public finances and the wider economic situation. The most recent national message regarding corporate services was to remove 50% of growth since

	2018/19. Across the country systems would be placed in to one of three segments, which would determine the level of help and support they received from the centre. The trust's had an 8% CIP target for 2025/26, but the system had a target of 11.6%, which was at the upper end of the national range. This and the system's financial record would be considered in setting the rating for the system. Executives would continue to keep board members closely sighted on developments in this regard, ahead of the extraordinary meetings at the end of April. The meeting heard about the additional weight being given this year to the assurance statements tied to the plan, which board members were required to approve. Board members should pay close attention to these statements and executives would ensure that the right level of detail and assurance was provided so that they could be appropriately signed off.	
	Resolved: that the Update on Finance and Operational Plan 2025/26 be received for assurance.	
BoD25/016	**People and Culture Committee Assurance Report**	
	FW spoke to the previously circulated assurance report, drawing the Board's attention to the below matters: • Staff survey, gender pay gap and equality, diversity and inclusion reports were all received and were presented to the board today • The people enabling plan required further work and would be returned to the informal committee meeting in April for further discussion and the May formal meeting for approval. • The mutually agreed resignation scheme (MARS) did not garner as much traction as intended. It was felt that this might have been due to messaging around the number of applications that would be accepted limiting people from applying. Consideration was being given to the merit of running another scheme.	
	Resolved: that the People and Culture Committee Assurance Report be received for assurance.	
BoD25/017	**Gender Pay Gap Report**	
	NP outlined that the report considered the pay disparity between men and women for equal work as well as social elements such as more women typically being in lower paid roles and for longer periods of time. It was also worth noting that the report was a statutory requirement, but did not consider other genders or pronouns outside of the binary male/female. Paragraph 2.7 of the report showed gender profile by pay band and showed where there was a pay gap. NP noted that the pay gaps in the lower bandings were typically in favour of women, whilst in the higher bands they were in favour of men. This indicated that men were being paid more than women in more senior roles., despite men making up 25% of the total workforce. The trust gender pay gap had improved significantly compared to last year, as detailed on p183 of the papers. NP highlighted that the trust would continue to encourage flexible working, supporting people in their career development, providing advice regarding	

	appointment to senior roles and continue to monitor how the board performed in this regard. In relation to paragraph 3.1 bullet point four, CL noted a point of semantics, that women did not always choose to be in lowed paid roles but might be there by circumstance. More broadly she asked how the trust was acting to redress the balance in higher paid bands. NP noted that when recruiting to senior roles the trust needed to take ensure there was diversity of experience and views and the need to focus on succession planning. Additional HR colleagues tried to support recruitment activity and to advise colleagues at the point of appointment, particularly around managing any requests for higher pay. MBr reflected on the positive progress made compared to last year's report and that the focus of the discussions today was right. It was expected that in future years the trust would be required to provide similar pay data for other protected characteristics, and these would likely lead to further focus on recruitment practices, enhanced support for senior leaders and ensuring a diverse pipeline of staff. MBr noted that the data around board members was incorrect as it showed 0 female members and 3 male members. This should be corrected prior to publication. Further to this, succession planning for board members was being further consideration. The board approved the report, subject to the correction of data regarding board members.	**NP**
	Resolved: that the Gender Pay Gap Report be approved, subject to the correction of data regarding board members.	
BoD25/018	**NHS Staff Survey Results**	
	Reflecting on the great amount of detail in the report, NP highlighted the following key points: • Increase in response rate by 5.4% • Page 190 of the papers detailed staff engagement levels for the trust, which remained above the benchmark average score, and that the trust was above average in each question relating to staff engagement • People's views of line managers had improved, with the results showing a more positive experience with line managers. However, this had not translated in to the same level of improvement around patient care, which was felt to be reflective of the demands on colleagues. • The trust had scored below average in relation to morale. The reason for these scores was believed to be work pressures. • Work continued to improve sexual safety within the workplace, noting the results detailed within the report • Whilst the trust was performing better than the sector average in relation to diversity and equality, 8.4% of respondents had experienced discrimination at work in the last 12 months. This rate was not reflected in employee relation cases, so staff were being encouraged to speak about discrimination.	

	Broadly, the results indicated that staff had a more positive view of their employment but were struggling with the demands put upon them. NP noted the significant improvements in work-life balance in recent years. However, it was key for the board to focus on the experience of minority staff groups. CL highlighted the increase in bullying and harassment from staff and patients, experienced by members of staff with a disability and from ethnic minority groups, and asked what actions could be taken to address this. Secondly, she wondered if there was anything that could be done to improve the number of people who felt they were able to make improvements happen in their area of work. EJ reflected on the impact that being able to participate in quality and continuous improvement projects had on staff. She further commended the improvement in scores relating to managers but raised concern with the pressures that staff were feeling. DD noted that only approximately 50% of staff had completed the survey, meaning that half the workforce had not. Whilst it was important to consider the overall figures, the granular, team-level detail was also important. MBr recommended that NP, working with People and Culture Committee in Common, reflected on the challenge of response rate and focussed the board's attention on it. This was particularly important given the current national position and feeling around the NHS, and that staff may feel they are not able to make a difference. Ensuring that staff were able to make a difference within the trust would need to be an area of continued focus.	**NP**
	Resolved: that the NHS Staff Survey Results be received for assurance.	
BoD25/019	**Equality, Diversity and Inclusion Annual Report**	
	NP took the report as read and reflected on the amount of work that had been done to improve equality, diversity and inclusion (EDI) within the trust. This included a dedicated EDI lead, conscious inclusion leadership training, additional support for staff networks, work to improve sexual safety, and a new anonymous reporting system. Board members noted that some of the information within the report was a year in arrears compared to the current data. For example, the gender pay gap information in the EDI report related to 2023 but the 2024 gender pay gap report had just been compiled and reviewed. NP reflected that the EDI report was compiled prior to the current years gender pay gap information being collated.	
	Resolved: that the Equality, Diversity and Inclusion Annual Report be approved.	
BoD25/020	**Strategy, Transformation and Partnership Committee Assurance Report**	
	DCS drew the board's attention to the following key areas of the report: • Capacity within the STP team to support the delivery of long term change, transformation and improvement is a constraint.	

	• Primary care partnership working (DHC with Royal Manor Health Care) recognised as extremely positive and embodies collaborative working and service transformation. It was noted that the report referred to DCH in this section but that this should read DHC; this would be corrected on file. • Key working housing joint strategy for DCH and DHC will be critical in recruiting and retaining staff. • The DCH Digital recovery plan is making good progress, but challenges remain. • The committee also heard a positive presentation about the work of the frailty team Board members noted the importance of ensuring cross referrals to People and Culture Committee in Common as required in relation to the key worker housing.	
	Resolved: that the Strategy, Transformation and Partnership Committee Assurance Report be received for assurance.	
BoD25/021	**Digital Recovery Plan**	
	NJ spoke to he previously circulated report, noting the risks relating to digital that had been identified some time ago and the subsequent paper presented to Strategy, Transformation and Partnership Committee in Common relating to capacity and capability of the digital team. It had been recognised that there was not the capacity required to deliver all that needed to be done. A joint chief digital information officer role had been created across the three Dorset provider trusts (DCH, DHC, and UHD) to offer shared leadership in this space and to maximise the resources, skills and experience of the teams across the three organisations as efficiently as possible. It was also recognised that some recovery work was needed in DCH because of the immediate risks being faced. Since then the team had developed a recovery plan, which the paper presented today summarised. NJ noted there were five key elements to the plan, with actions being taken in all areas, as detailed in the paper. The teams continued to make good progress, with recovery meetings in place every two weeks and it was expected that the new joint chief digital information officer would ensure better grip and control over the recovery. Noting the implications of the work, NJ highlighted that a prioritisation process had been undertaken, and the digital teams would not be able to deliver all that they were currently trying to deliver. This would lead to decisions about what systems could be supported. The most important systems were clinical and safety systems. Secondly, the team would need to recruit in to established roles to be able to fill some significant gaps, in order to address some priorities. This was within the context of needing to make 10% efficiency savings. NJ reflected that it was important for the board to recognise that the trust would not be able to respond to some national asks that may materialise. Furthermore, there were teams across the trust that were reliant on the digital team to deliver on efficiencies, but the digital teams would not be able to support on this. NJ summarised that	

	this was the position and reflective of the strategic approach to funding digital services within the NHS. DU reflected on the need to maintain a consistent set of decisions made, particularly in relation to prioritisation of digital resources, noting that without digital support some projects may not be able continue at all and may not deliver their intended benefits. It was important to track these interdependencies. The board discussed the action around clinical safety officer resource. It would be important to balance this with ensuring that clinical staff were not unduly taken away from their clinical work. It was further noted that there were a number of clinical systems for which there was no mandatory clinical safety resource. NJ described that a triage-based approach was being used to ensure that the biggest systems with the biggest potential for patient risks were addressed first. This work was already underway and NJ was comfortable that there was good clinical safety reviews and supports in place for those biggest systems. It was now smaller systems that were being reviewed for clinical safety officers. It was important that where teams used a clinical system there was someone responsible with subject matter expertise provided by the digital team. This had not been robust in the past but would need to be moving forward. NJ further described the iterative approach to the prioritisation process and that this would need to flex as new requirements came in. There would need to be a clear and consistent process to be able to prioritise the demands. The board reflected on the need to reduce resource in the service by 10% and the way in which the federation could support clinical safety officer numbers. MBr finally reflected on the need for teams across the trusts to take some ownership of the digital functions within their teams, in the same way that savings were made by teams across the trust and not just the finance team. The board would need to continue to focus on this area pragmatically as new and changing priorities emerged.	
	Resolved: that the Digital Recovery Plan be received for assurance.	
BoD25/022	**Audit Committee Assurance Report**	
	CH provided an overview of the meeting, in SP's absence. CH highlighted: • Recommendation that the accounts are prepared on a Going Concern position • Approval of Financial Statements (Review of Accounting Policies Areas of Estimation) • Recommendation for the approval of the Standing Orders for the Board • Receipt of the internal audit plan for the coming year • Presentation of the value for money risk assessment by KPMG. No risks of significant weakness identified in relation to governance or improving economy, efficiency and effectiveness, but a risk of significant weakness identified in relation to financial sustainability. • Approval of the conflicts of interest policy	

	• Discussion around the freedom to speak up and whistleblowing arrangements noting assurance around the arrangements in place for staff to raise concerns From discussions with SP, DCS understood that he was assured that all items were progressing as intended. ST added that the auditors had been complimentary of the work of the accounts department under CH's leadership, and who had good assurance of the work of the team.	
	Resolved: that the Audit Committee Assurance Report be received for assurance.	
BoD25/023	**Going Concern Statement**	
	CH referred to the previously circulated paper which recommended preparing the accounts on a going concern basis. The board approved the statement.	
	Resolved: that the Going Concern Statement be approved.	
BoD25/024	**Charitable Funds Committee Assurance Report**	
	DU outlined the following key points from the meeting: • At month 11 the charity had achieved income to date of £528,000 • Major legacy receipt still pending, now expected in 2025/26. Approximately £800,000 was expected to be received, with £500,00 of that being diverted to the ED/CrCU capital appeal • The capital appeal stood at £546,000 • Consideration was being given to setting up a fund to encourage innovation in the delivery of care to patients. • Receipt of a legacy, totalling £33,000 MBr asked for the trust and the charity to work together to consider strategic objectives moving forward, particularly in relation to the innovation fund. Finally, DU drew the board's attention to a fundraising event he was completing in support of the ED/CrCU appeal.	
	Resolved: that the Charitable Funds Committee Assurance Report be received for assurance.	
BoD25/025	**Constitution Review (including Standing Orders)**	
	JH outlined that a review of the constitutions of both DCH and DHC had been undertaken in order to ensure the documents were aligned and up to date with national guidance. This was a sizeable piece of work which the Council of Governors were involved in. The new constitution was an entirely new structure and not based on either trusts existing constitutions. Changes compared to the previous version of the constitutions were highlighted for ease of reading. The main change related to the trust's constitutional boundaries as the current boundaries resulted in a number	

	of vacancies in some governor seats, with other seats having too many governor candidates. The board were asked to approve a number of matters today. Firstly, the normal process would be for the constitution to be presented to the Audit Committee, then Board, then Council of Governors. However, because of the timing of recent meetings, it had first been to the Council of Governors, then Audit Committee and Board. The board were asked to support the reversal of the usual process. Secondly, there was not a sufficient number of governors in post for a quorum to approve the standing orders of the Board of Directors. The board was asked to approve the constitution and standing orders today, subject to final approval from the Council of Governors once new governors had been elected or appointed. Thirdly, the board were asked to agree that future Council of Governors meetings consider the organisations from which governors could be appointed. KH echoed her support for the recommendations and the governors involvement in the work to date. She hoped that the changes to the constitutional boundaries would offer the opportunity for more people to become governors. DCS thanked KH and governors for their involvement in the work and the Board approved the recommendations.	
	Resolved: that the Constitution Review (including Standing Orders) be approved.	
	CONSENT SECTION	
	The following items were taken without discussion. No questions had been previously raised by Board members prior to the meeting.	
BoD25/026	**ICB Board Report**	
	Resolved: that the ICB Board Report be received for information.	
BoD25/027	**Equality, Diversity and Inclusion Annual Report**	
	Resolved: that the Equality, Diversity and Inclusion Annual Report be approved.	
BoD25/028	**Guardian of Safe Work Report**	
	Resolved: that the Guardian of Safe Work Report be approved.	
BoD25/029	**Joint Strategy Enabling Plans**	
	Resolved: that the Joint Strategy Enabling Plans be approved.	
BoD25/030	**DCH SubCo Ltd Q3 Performance Report**	
	Resolved: that the DCH SubCo Ltd Q3 Performance Report be received for information.	

BoD25/031	**Questions from the Public**	
	Reflecting on the impact of decisions to decommission services by the ICB, JPL sought assurance that adequate resources would be available to the affected patients. DD advised that the trust had not received notification that any services at DCH would be affected, but rather it was community services that would be affected. For those services transition plans were being developed to ensure the patients received appropriate care and support. MBr added that whilst the trust would do everything it could to advocate for patients, it was ultimately not in the trust's control as the trust was not the commissioners of the system. KH noted that the Prince of Wales School taught sign language to all students and wondered if any best practice could be learned from them. DD would look in to this.	**DD**
BoD25/032	**Any Other Business**	
	Nil.	
BoD25/033	**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 10th June 2025** in the **Board Room, Trust Headquarters, Dorset County Hospital, Dorchester** and via **MS Teams.**	
BoD25/034	**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.	

BoD Action Tracker, Part 1 - 2025/26

Minute Reference & Name	Date of Meeting	Topic	Action	Lead	Deadline	Response	Status
BoD25/008 / Quality Committee Assurance Report	08/04/2025	Vertical integration Board Development Session	Board Development Session to be arranged re DD and AT's vertical integration work e.g. use of acute hospital at home and the move from hospital to community. To take place following publication of 10-year plan	JH	After May	Board Development session included in 25-26 programme	Complete
BoD25/009 / Maternity Safety Report	08/04/2025	SCBU workforce	DD to explore options for sharing SCBU workforce and skills with UHD, to support safe staffing levels	DD	10/06/2025	Since the last Board meeting the temporary closure of services at Yeovil District Hospital has resulted in a changed context with additional activity in DCH. Posts have been approved and jobs going to advert.	Complete
BoD25/011 / Quality Committee in Common Proposal	08/04/2025	Committee chair meetings	Committee chair meetings to be reinstated	JH	10/06/2025	Bi-monthly meetings being arranged from June 2025	Complete
BoD25/017 / Gender Pay Gap Report	08/04/2025	Board gender composition	Data around board member gender to be reviewed and corrected prior to publication.	NP	10/06/2025	Update awaited	Open - Due
BoD25/031 / Questions from the Public	08/04/2025	Sign language	DD to liaise with the Prince of Wales School to learn any best practice from them, regarding teaching students sign language as standard	DD	10/06/2025	Contact has been made with Prince of Wales School to request a meeting to share best practice guides. Dorset-wide Procurement for Translation services is being commissioned with learning from DCH being considered as part of this.	Complete

Actions to other Committees								
Minute Reference & Name	Date of Meeting	Topic	Action	Lead	Deadline	Response	Status	Committee referred to
BoD24/100/ CEO Update	09/10/2024	Ridgeway Ward Redesign	An investment review of the ridgeway ward redesign to be returned to Board.	CH	12/08/2025	The review of ridgeway ward would be returned to Board once it has been reported to Finance and Performance Committee.	Open - Not yet due	FPC

Dorset County Hospital
Dorset HealthCare

Report to	DCH and DHC Board of Directors	
Date of Meeting	DCH – 10 June 2025 / DHC 11 June 2025	
Report Title	Chief Executive Officers Report	
Prepared By	Jonquil Williams, Corporate Business Manager and jenny Horrabin Joint Director of Corporate Affairs	
Approved by Accountable Executive	Matthew Bryant, Chief Executive Officer	
Previously Considered By	N/A	
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	Relates to all strategic risks	
Financial	No specific implications arising from the report	
Statutory & Regulatory	Update on ICB cluster	
Equality, Diversity & Inclusion	Update on community events	
Co-production & Partnership	Update on system working	

Executive Summary

This report provides and overview of key national and local developments:

- The Model ICB and ICB Clustering Arrangements
- Elective Referrals
- Consultation on NHS Performance Assessment Framework
- NHS Pay Awards 2025/267 and VSM Pay Framework
- Electronic Health Record
- Agency Expenditure
- Shared Services in Dorset
- Maternity Service Changes
- Board Updates
- New patient experience and community involvement hub at Dorset County Hospital
- Community events around Dorset for Mental Health Awareness Week
- New wellness room and garden opens at Bridport Community Hospital

Recommendation

Members are requested to receive the report for information.

Chief Executive Officer's Report – June 2025

1 National updates

1.1 The Model ICB and ICB Clustering Arrangements

The NHS England Chief Executive wrote to NHS leaders on 1 April highlighting the critical role ICBs (Integrated Care Boards) will play in the future system architecture, alongside the need for all ICBs to reduce their running costs by approximately 50%. The letter undertook to issue a model to inform ICB redesign and support the development of plans to deliver the running cost reduction.

The 'Model ICB Blueprint' has subsequently been published Model Integrated Care Board – Blueprint v1.0. The document sets out the core functions of the Model ICB, as shown diagrammatically below.

The represents a shift in relationships with the ICB and the NHS England (NHSE) Regional Team which we are now seeing through our meetings with ICB and NHSE colleagues. We expect this to continue evolving over the coming months and as an executive team we will ensure that we are well placed to respond to the changing roles and responsibilities. In particular, we have seen a move to strengthening of the arrangements for ICB contract review meetings and reporting processes which will commence from June 2025. This will involve a move away from informal touchpoint meetings, which have largely focussed on operational delivery, to a more formal structured approach to contract review and management.

Alongside this ICB mergers that are planned to take effect from the start of the 2026-27 financial year should be agreed by the end of September 2025 to ensure there is enough time to implement the transition of "digital and data and finance" functions. The majority of remaining mergers should have been agreed by September 2026 before coming into force in April 2027. However, it is understood that some ICBs may be allowed to merge after April 2027 if it is deemed in the best interests of their area.

Dorset Integrated Care Board (ICB) is considering a clustering arrangement with Bath and North East Somerset, Swindon and Wiltshire ICBs. This area would match a proposed reform in local government in which Dorset, Somerset and Wiltshire will be grouped together as a devolved strategic authority.

1.2 Elective Referrals

On 16 May 2025, Glen Burley, NHS Transformation Executive Team – Financial Reset and Accountability Director, wrote to all ICBs to set out expectations around elective care demand management. The letter stated that '*at a national level, we need to see overall demand to elective care fall to 0.2% (from an expectation of 1.8% with no mitigations, and 1,5% if we were simply projecting demographic growth alone)*'. Dorset ICB Referral to Treatment (RTT) demand growth for 2024/25 (M1-M11YTD) was 3.5%. We are considering the implications of this for DCH and will work closely with ICB colleagues on referral management.

Within the National performance and Assessment Framework (NPAF) there is a single indicator on elective care for ICB's – percentage growth in waiting list size. This emphasises the importance of the accountability for demand management at commissioner-level. It is expected that NHSE will review performance at system level against this metric throughout the year., assessing how effective demand management interventions are at this level.

1.3 Consultation on NHS Performance Assessment Framework

The NHSE consultation on the new NHS Performance Assessment Framework closed on 12 May 2025. The draft framework can be found at NHS England » Draft NHS Performance Assessment Framework.

Under the proposal NHS England will use the assessment process to measure delivery against an agreed set of measures and identify where improvement is required. This will determine a 'segment' for each organisation. The appropriate response to secure improvement is then informed by the organisation's capability assessment. The approach to capability assessment is currently being finalised but the proposal is to align the NHSE approach with the CQC.

Every ICB and provider will be allocated a segment. This indicates its level of delivery from 1 (high performing) to 4 (low performing) and informs its support or intervention needs. A diagnostic will be performed on all segment 4 organisations to identify those with the most intense support needs, these organisations will enter the recovery support programme and allocated a segment of 5.

Whilst we await the outcome of the consultation and publication of the new NHS Performance Assessment Framework, as an executive team were are considering our reporting and oversight against the draft metrics and will be reporting this into the Finance and Performance Committee.

1.4 **NHS Pay Awards 2025/267 and VSM Pay Framework**

The Health and Social Care Secretary has accepted the recommendations of the independent pay review bodies to confirm pay awards for 2025-26 for doctors, nurses, dentists, and other NHS staff. Further details can be found at NHS Pay: everything you need to know about the 2025 pay award – Department of Health and Social Care Media Centre.

This pay award follow publication of the new Very Senior Manager (VSM) pay framework which was published on 15 May 2025 very senior managers (VSM) pay framework. The framework has been jointly produced by NHS England (NHSE) and the Department of Health and Social Care (DHSC) and replaces all previous guidance. The framework states that it seeks to strengthen the link between reward and performance outcomes, increase transparency and offer flexibility to attract talented candidates to the most challenging roles. The new framework and the implications for DCH and DHC will be considered via the respective trusts Remuneration Committees.

1.5 Electronic Health Record

The Dorset and Somerset Outline Business Case (OBC) for the Electronic Health Record (EHR) has been approved by National EPR Investment Board (EPRIB). The Business Case will now progress to the next stage of approval

In addition, a new opportunity to develop an additional OBC for additional funding for DHC has arisen. This would allow us to bring DHC back into scope if successful.

1.6 Agency Expenditure

On 30 May 2025 Jim Mackey, NHS England CEO, wrote to all NHS Trusts to recognise the significant reduction that has been observed across the NHS agency spending in recent years. The letter reiterates the message, as set out in the NHS Planning Guidance, that trusts must reduce their spending on agency staffing by at least 30% in the next financial year (2025/26), with a longer-term aim of eliminating agency use altogether by the end of the Government's term of office. A DHSC/NHSE Delivery group has been established to monitor progress and ensure robust action is being taken to ensure compliance with the required reduction. The letter also encourages trusts to consider whether working with NHS Professionals to use their national bank offer.

To ensure that we share best practice and focus on the most efficient use of our resources Dorset County Hospital and Dorset Healthcare already share a temporary staffing lead across both organisations. Over 2024/25 both Trusts demonstrated a significant reduction in agency spend with an end of year position.

During 2025/26 our focus on reducing spend on temporary staffing continues with an ambition to reduce spend on temporary staffing further. Plans to minimise the use of temporary medical staffing in Dorset Healthcare is underway with an International Medical Graduate scheme designed to bring in international recruits to vacant posts and reduce reliance on locum staffing. Additionally, work in Dorset Healthcare nears completion to understand the benefits of using the national bank (provided by NHS Professionals) for hard

to fill shifts in nursing, midwifery and allied health professional. Scoping the potential benefit for utilising the national bank in Dorset County Hospital has just commenced.

2 Dorset Updates

2.1 Shared Services in Dorset

Work is progressing to develop a proposal for shared estates, facilities management and procurement services for Dorset County Hospital, Dorset HealthCare and University Hospitals Dorset. The preferred option is to run these services through a wholly owned subsidiary company (SubCo) model into which staff would transfer, retaining their NHS terms and conditions, pension arrangements and union representation.

In May we held engagement events with colleagues across all three trusts to share information, listen to concerns and answer questions. We understand the issues staff are raising about this potential change, and we have reiterated that these are highly valued colleagues who will continue to work closely with all three trusts and make an important contribution to providing safe and effective patient care.

The full business case is included in the papers and if approved the programme will progress to the next phase, with a proposed transfer date in the autumn.

2.2 Maternity Service Changes

On 19 May Maternity services at Yeovil District Hospital (YDH) were temporarily closed for up to six months. Therefore, some women from who would have fallen under the care of YDH have been transferred to the care of Dorset County Hospital.

The maternity team at Dorset County Hospital have worked closely with those at YDH to ensure the smooth transition of care. Oversight is provided through the Quality Committee.

2.3 Board Updates

In the autumn Nick Johnson, Joint Chief Strategy, Transformation and Partnerships Officer, we will be leaving DCH and DHC to undertake a new role as Managing Director at Salisbury NHS Foundation Trust. Due to the challenging financial situation, we face we won't be making an immediate re-appointment. I would like to give huge congratulations to Nick on his success and thank him for all his continued work for our trusts. He has made a huge contribution in his time with us over the past nine years.

From May 2025 Claire Lehman has been appointed as a Non-Executive Director at DHC. Claire is already a NED at DCH and this marks our fourth appointment to a joint NED role. Clare will chair the new formed Quality Committee in Common across DCH and DHC.

2.4 New patient experience and community involvement hub at Dorset County Hospital

A new patient experience and community involvement hub has opened at DCH. The HIVE (Health and Wellbeing, Information, Volunteering and Engagement) will offer a welcoming space for patients and families to provide feedback about their experience, raise any concerns, and be signposted to various support services available in Dorset.

Overseen by the Patient Experience team, The HIVE will offer a space to promote hospital initiatives, such as the volunteer service, and be a used by local organisations for drop-in information events. Examples of planned activity include carer support information, armed forces community engagement, Trust Governor surgeries and membership recruitment, NHS Dorset events and Dorset Council digital champion sessions.

The DCH Charity will also be using the space as a 'front facing door' to the community to promote and encourage fundraising activity. The HIVE was officially opened by well-known journalist and author Kate Adie.

2.5 Community events around Dorset for Mental Health Awareness Week

In recognition of this year's Mental Health Awareness Week (12-18 May), Access Wellbeing invited people to events held across Dorset to showcase the support available in local communities.

Access Wellbeing is a pioneering partnership between the voluntary sector and NHS, offering people easier access to mental health and wellbeing support within their communities.

The first Access Wellbeing hub opened its doors in January 2024 and, since then, its hubs and drop-in services have received more 6,600 visits from people seeking help with mental health issues or guidance about matters which can affect their wellbeing, such as finances, work or housing.

Events that took place during Mental Health Awareness Week included:

- Weymouth – Community Front Room, Weymouth
- Lyme Regis – The Waffle House, Lyme Regis
- Bridport – The Harmony Centre, Bridport
- Poole – Access Wellbeing Poole hub
- Sturminster Newton – The Vale Family Hub, Sturminster Newton

The events provided an opportunity for those in the community to find out about what local support is available to them, both through Access Wellbeing and partner organisations.

Access Wellbeing hubs and drop-in spaces are managed by five charity partners – BCHA, The Lantern Trust, Help & Care, Dorset Mind and Harmony – in contract with Dorset HealthCare University NHS Foundation Trust.

2.6 New wellness room and garden opens at Bridport Community Hospital

Thanks to the generous support of NHS Charities Together, Bridport Hospital League of Friends and donations from the public, a new wellness room and garden has been created at Bridport Community Hospital.

The initiative, which raised an impressive £29,000, provides a much-needed space for staff at the Dorset HealthCare-run site to step away from their duties and take moments for reflection and relaxation.

Once an old mortuary, the new wellness room has undergone a remarkable transformation, led by Elmwood Property Services Ltd and staff volunteers who dedicated their time, equipment and plants to bring the space to life.

Report to	Trust Board	
Date of Meeting	10 June 2025	
Report Title	Board Assurance Framework – Quarter 4	
Prepared By	Jenny Horrabin, Joint Director of Corporate Affairs	
Approved by Accountable Executive	Jenny Horrabin, Joint Director of Corporate Affairs	
Previously Considered By	Assigned risks considered by Committees w/c 26 May 2025 and full BAF considered by Audit Committee 2 June 2025	
Action Required	**Approval**	No
	Assurance	Yes
	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	These are the risks from the BAF assigned to this Committee	
Financial	No financial implications arising from the BAF	
Statutory & Regulatory	There is a regulatory requirement to have a BAF in place	
Equality, Diversity & Inclusion	There are no specific EDI implications arising from this report	
Co-production & Partnership	We will consider system risks and alignment to the system BAF as part of the development of the BAF.	

Executive Summary

1. Overview

The Joint Strategy 'Working together, improving lives' was approved at the DCH and DHC Boards on 31 July 2024 and 7 August 2024 respectively. Alongside the development of the Joint Strategy work on developing the Joint Principal Risks to achieving the Joint Strategic Objectives continued and these were approved by the DHC and DCH Boards on the same dates.

Each Trust has a joint set of strategic risks and the template and review process are the same, as described below. However, the BAF is separate for each organisation as the controls and assurances and risk scores are different between DCH and DHC. Appendix One to this report is the DHC BAF for Quarter 4 2024/25.

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

2. Review Process

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

- Each risk has an unmitigated, mitigated (as at April 2025) and target score using the 5x5 scoring matrix previously reported. The unmitigated score is the level of risk before any mitigating actions

are taken. The mitigated score is the level of risk with the controls and assurance in place and the implementation of the identified actions.

- Controls and assurances are identified in terms of:
  - Priority Strategies and Plans
  - Risk controls and Plans
  - Oversight Governance and Engagement
- Each assurance has been assessed as Positive / Neutral / Negative. Where there is a gap in control or assurance this has been categorised as 'neutral'.
- Each of the three categories above have an overall assessment based on the controls and assurances in place as Red / Amber / Green. Where there is an assessment of Amber or Red there will be a corresponding action to improve the level of control and/or assurance.
- Each action is marked as:
  - On Plan (Green)
  - Behind Schedule' (Amber)
  - Significantly behind schedule (Red)
  - Complete (Grey)
- Each risk has been assigned to an Executive Lead who has signed off the BAF for their assigned risk.
- The BAF was reviewed and agreed by the Joint Executive Management Team.
- Each risk has been reviewed by the responsible Committee during w/c 26 May 2025. The BAF was then reviewed by the Audit Committee on 2 June 2025. There were no updates provided from these reviews.

3. Further Developments

Below is an update of further developments planned for the Board Assurance Framework in Quarter 1 of 25/26.

- **Key metrics will be assigned to each risk** – this was delayed to quarter 4 as awaiting approval of metric against strategic objectives, which will then be cross referenced to the BAF. However, this work is still in progress and therefore it is planned that we will move ahead with assigning key metrics to the strategic risks, and then review this against the strategy metrics when agreed. This approach was supported by the Audit Committee.
- **Risk appetite review -** Whilst we have a joint set of strategic risks, DCH and DHC have different statements of their risk appetites. The risk management framework and the risk appetite form part of the organisation's internal control and corporate governance arrangements. The risk appetite statement sets out how the organisation balances threats and opportunities in pursuit of achieving its objectives. Understanding and setting a clear risk appetite is essential to achieving an effective risk management framework. It also assists the organisation to have a consistent approach in responding to risks. A report setting out our proposed approach and timeline to reviewing the risk appetite across both organisations was presented to the DCH and DHC Audit Committees in June 25 and the approach was endorsed by both Committees. A survey will be provided to all Board members. We will the collate the results of this survey and present the results at a facilitated discussion at a Board Development Session, with the aim that we will arrive at a collective view of the risk appetite across DCH and DHC. Following agreement at Board, the risk appetite component will be added to the risk management frameworks and communicated across the organisation. Following agreement at Board, the risk appetite component will be added to the risk management frameworks and communicated across the organisation
- **Review of Strategic Risks for 2025/26** - Whilst the strategic risks are, by their very nature, long term it is good practice to undertake an annual review to confirm the strategic risks, as articulated in the BAF, have the right focus. A review of the BAF risks for 25/26 will be undertaken alongside the review of risk appetite and within the same timeframe.

The timeline for this is as per below:

Process	Date
Present process for Risk Appetite Review to DCH and DHC Audit Committees for endorsement	May /June 2025 - COMPLETE
Undertake survey of all Board Members	June 2025
Collate results of Survey and present to respective Senior Leadership Groups for review and comment	June/ July 2025
Facilitated Board Development Session	July 2025
Present finalised risk appetite statement and refreshed strategic risks to Board for approval	August 2025

4. Quarter Three Board Assurance Framework

Risk Scores

- The highest scoring risk identified within the assurance framework (based on the mitigated risk score) is SR3: Workforce Capacity; SR6: Finance and SR9: Digital Infrastructure and SR5: Estates (each with a score of 15 or more).
- The risk score in respect of SR7: Collaboration has been increased to 9 (from 6) – whilst there is strong collaboration with local providers the current climate and level of structural change in the NHS is creating uncertainty.
- Reference is made under several of the risks to the creation of a wholly owned-subsidiary. This will be considered further in the Q1 review as the plans develop.
- All other risk scores remain unchanged.

Actions

- Gaps in controls and assurance are identified across all strategic risks and clear actions to address these have been identified. Where an action has not been achieved by the due date this is marked on the actions plan as 'Behind Schedule' and a revised date has been added.
- Eight out of ten risks have at least one action that is behind schedule, with revised dates agreed. In some instances, this is a second date revision. The completion of actions will be an area of focus during quarter 1. This has also been highlighted in the individual BAF reports to Committees.
- One of the 14 delayed actions: One relates to national timetables and six of the delayed agreed actions relate to SR9 Digital and SR10 Cyber Security - A new Chief Digital Officer has been appointed from April 2025 (across UHD, DCH and DHC) and the postponements are to allow time to allow the new postholder to consider our strategic approach and consider the relative priorities.

Recommendation
Members are requested to: • Receive assurance on the process in place to review the Board Assurance Framework • Review and scrutinise the risks and identify any areas where further assurance is required

Dorset County Hospital
NHS Foundation Trust

Dorset County Hospital NHS Foundation Trust
Board Assurance Framework
Quarter 4 - April 2025

Dorset County Hospital NHS Foundation Trust

Board Assurance Framework Overview - Quarter 4 April 2025	Strategic Objectives				Responsibility		Score				
Strategic Risks	Care	Communities	Colleagues	Sustainability	Committee	Executive	Unmitigated Score	Mitigated Q2 Score	Mitigated Q3 Score	Mitigated Q4 Score	Target Score
SR1: Safety and Quality If we are not able to deliver the fundamental standards of care in all of our services we will not be providing consistently safe, effective and compassionate care	X				**Quality Governance**	Chief Nursing Officer	**16**	12	12	12	**12**
SR2: Culture If we do not achieve a culture of compassion and empowerment and engagement, we will not have a motivated workforce with the required capacity and skills to improve patient outcomes and deliver safe care.	X		X		**People and Culture**	Chief People Officer	**15**	**12**	**12**	**12**	**6**
SR3: Workforce Capacity If we are not able to recruit and retain the required number of staff with the right skills we will not be able to deliver high quality and safe sustainable services within our resources	X		X		**People and Culture**	Chief People Officer	**15**	**15**	**15**	**15**	**9**
SR4: Capacity and Demand If we do not meet current and expected demand and achieve local and national measures and targets within available resources we may face regulatory action and patients outcomes will be adversely affected	X	X		X	**Finance and Performance**	Chief Operating Officer	**16**	**9**	**9**	**9**	**6**
SR5: Estates If we do not have an estate that is fit for purpose and economically and environmentally viable we will be unable to provide the right places for our staff to deliver high quality services to the communities that we serve	X		X	X	**Finance and Performance**	Chief Finance Officer	**16**	12	16	16	**9**
SR6: Finance If we do not deliver on our financial plans, including the required level of savings, then and this will adversely impact our ability to provide safe sustainable services, and will impact upon the overall ICS position				X	**Finance and Performance**	Chief Finance Officer	**20**	16	20	20	**12**
SR7: Collaboration If we do not have effective and positive partnerships within the ICS then we will not be able to shape decisions and deliver the transformation required.		X		X	**Strategy, Transformation & Partnerships**	Chief Strategy Transformation and Partnerships Officer	**12**	**9**	**6**	**9**	**6**
SR8: Transformation and Improvement If we do not seek and respond to the views of our communities to co-produce and continuously improve and transform our services, we will not contribute to the reduction of health inequalities within our communities.	X	X		X	**Strategy, Transformation & Partnerships**	Chief Strategy Transformation and Partnerships Officer	**16**	**12**	**12**	**12**	**6**
SR9: Digital Infrastructure If we do not advance our digital and technological capabilities, including achieving our EHR ambitions, we will not deliver the innovative and sustainable services and the delivery of safe services could be compromised.		X		X	**Strategy, Transformation & Partnerships**	Chief Strategy Transformation and Partnerships Officer	**20**	**12**	**16**	**16**	**6**
SR10 Cyber security If we do not take sufficient steps to ensure our cyber security arrangements are maintained and up to date then we are at increased risk of a cyber security incidents	X			X	**Strategy, Transformation & Partnerships**	Chief Strategy Transformation and Partnerships Officer	**15**	12	12	12	**9**

Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care	**SR1: Safety and Quality** **If we are not able to deliver the fundamental standards of care in all of our services we will not be providing consistently safe, effective and compassionate care**	Quality Committee

Executive Lead: Chief Nursing Officer

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

Rationale for Score: Score unchanged but potential increased risk due to level of CIP and required workforce reductions. Continued use of agency staff to maintain safe levels; increased acuity and dependency of patients

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	Outcome of assurance	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Quality Priorities 24/25 (each have a subject matter expert owner)	Board approved 24/25 - Quality priorities on track and reported in Quality Account - annual position and 25/26 priorities out for consultation	Positive	Green
PSIRF Response Plan	Board approved PSIRF Response Plan, updates to Quality Committee (QC) - approved April 25	Positive	
Contractual obligations 24_25	KPI monitoring and Quality Dashboard	Positive	
Maternity Incentive Scheme (MIS)	Maternity Report, Quality Committee, LMNS oversight and reporting, MIS End Point Review Outcome - Compliance; Internal Audit Report	Positive	
Risk Controls and Plans			
Quality Priority Improvement Plan (inc agreed standards and measurement)	Quarterly Quality Priorities Report to QC (progress against KPIs)	Positive	Amber
Patient Experience Metrics and Improvement Plans	Patient Experience monthly, quarterly and Annual Complaints Report (inc local surveys and metrics), Friends and Family Test National Surveys, Patient Story to Board, 15 Steps Challenge; Complaints Policy in line with PHSO standards	Neutral	
PSIRF implemented to improve patient safety and Patient Safety Incident Response Plan	PSIRF Operational and Exec Huddles, Patient Safety Committee oversight of Patient Incidentr response Plan and Quality priorities - to be embedded and ongoing development and review	Neutral	
Quality Governance Committee Framework	Quality Reports and Dashboards; EQIA SOP approved - process in place and to be embedded	Neutral	
Oversight Arrangements for Governance & Engagement			
Quality Committee	Assurance Reports to Board, Quality Assurance Group in place. Quality Committee in Common from Q1 25/26. Scope confirmed and transition plan in place	Positive	Amber
Patient Safety Committee	Patient Safety Incidents Report and Assurance Reporting to Quality Committee	Positive	
PSIRF Implementation Group	Patient Safety Incidents oversight to Patient Safety Committee	Positive	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
PSIRF Response Plan to refreshed and reviewed for 24/25 - underway with Patient Safety Lead and DDON Complete	Jhow	~~Dec 24~~ Mar 25	Complete
Completion of CQC self assessments and actions plans - Under review following recent CQC changes. Target date moved to Sept 25	Jhow	~~Mar 25~~ Sept 25	Behind Schedule
Strengthen trriangulation and oversight of finance and workforce metrics and impact on safety and quality	Jhow	Jul-25	On Plan
Embed EQIA process and commence panels	Jhow	May-25	On Plan

Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care Colleagues	**SR2: Culture** **If we do not achieve a culture of compassion and empowerment and engagement, we will not have a motivated workforce with the required capacity and skills to improve patient outcomes and deliver safe care.**	People and Culture

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

Rationale for Score

No change in score - good progress made in key areas. 2024 Staff Survey Results and Joint People Plan will be a key enabling Plan to set out our priorities for next three years

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Joint Inclusion & Belonging Strategy	Board approved Joint Inclusion and Belonging Strategy and Plan Cultural maturity assessment - internal audit - provided positive assurance	Positive	Amber
Leadership and Management Development Programme	Staff survey - 46% response rate 2024 (increase on previous year) /Pulse Survey / FTSU Quarterly Report / Employment Relations Report in Workforce Dashboard	Positive	
EDS in place	EDS 2 developed - reported to PCC and STP CiCs Jan 25	Neutral	
Programme of staff engagement activity	Further assurance required to formalise programme and measure effectiveness	Neutral	
Joint Workforce Wellbeing Plan	Plan approved Dec 24, Delivery Action Plan to report to PCC	Positive	
People Plan DCH/DHC in place	WRES & WDES/EDS2/Gender Pay Gap / Staff Survey / Pulse Survey / Workforce report to PCC on progress against key metrics - Year one deliverables reviewed at PCC informal April 25	Neutral	
Risk Controls and Plans			
Freedom to Speak Up Policy	Freedom to Speak Up bi-annual and annual reports; Sexual Safety Action Plan	Neutral	Amber
Joint Inclusion and Belonging Action Plan	Reprioritisation of priorities and timeframes reported to PCC; Concious inclusion and respect and resolution training launched	Positive	
EDS2 Action Plan	Action Plan to P&C and STP CiC Jan 25	Positive	
Oversight Arrangements for Governance & Engagement			
People & Culture Committee in Common (DCH & DHC)	Assurance / Escalation Report to Board; underlying governance established and reporting in place	Positive	Green
Equality and Inclusion Group Health and Wellbeing Steering Group	Assurance Reports to People and Culture Committee	Positive	
Staff Networks, Executives now aligned to networks	Annual EDI Report and Minutes to be reported to PCC from Sept 24; execs assigned	Neutral	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Establishing the Culture and Inclusion Reference Group - not yet established to commence for 25/26 - Stakeholder workshop held 24/4/25 to refine TOR. To be taken to the PC CiC in May for sign off	NP	~~Nov 24~~ ~~Apr 25~~ Jun 25	Behind Schedule
Joint People Plan to be developed (aligned to Joint Strategy and ICS People Plan) - High level agreement at PC CiC for four strategic objectives, final plan to go back to People Committee in May	NP	~~Mar 25~~ May 25	Behind Schedule
Staff engagement capacity and plan to be considered as part of People Team Collaboration (DCH/DHC)	NP	Sep-25	On Plan
Staff reporting anonymised system - policy and system to be lauched May 25 - Embed and review and report back to PCC Oct 25	NP	Oct-25	On Plan

Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care Colleagues	**SR3: Workforce Capacity** **If we are not able to recruit and retain the required number of staff with the right skills we will not be able to deliver high quality and safe sustainable services within our resources**	People and Culture

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

Rationale for Score

Score unchanged. WTE reductions- WTE controls & QIA mitigate impact on delivery of safe services. Await publication of national planning guidance and results of NHS review which to inform planning. Sub Co will impact on workforce and HR on programme board

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
DCH People Strategy to 2025 Dorset ICS People Plan and NHS Long Term Workforce Plan	Workforce Metrics in Integrated Performance Report / Staff Survey and Pulse Surveys / Internal Audit Report - Recruitment High level agreement at PC CiC for four strategic objectives, final plan to go back to People Committee in May 25.	Positive	Amber
Workforce Planning framework	Workforce Metrics in Balanced Scorecard - other assurance reporting to be developed	Neutral	
Apprenticeship & Widening Participation Programme	Regular report from Education Team to People and Culture Committee	Positive	
People Promise Retention Exemplar Programme	Progress to NHSE and Board - closure report to PCC May 25	Positive	
Risk Controls and Plans			
Annual Workforce Plan and Priorities - New Joint People Plan developed together with a new joint delviery framewor	Workforce Metrics Report to People and Culture Committee on progress against key metrics / Safer Staffing Report to Board / Annual Workforce Safeguards Declaration	Positive	Amber
Learning Needs Analysis	Annual Education Quality Self-Assessment / Learning Needs Analysis	Positive	
Whole Time Equivalent Reduction Plan	Reporting to DCH Recovery Group and ICB and NHSE - Off plan in year for WTE reductions for 24/25 and revised plan in place for 25/26. Control and QIA provide assurance that safe services not impacts	Neutral	
Oversight Arrangements for Governance & Engagement			
People & Culture Committee	Assurance / Escalation Report to Board; underlying governance established and reporting in place	Positive	Green
Workforce Programme System Groups (Recruitment, Widening Participation) with recruitment considered at Provider Collaborative	Escalation Report to ICB People Committee (reports to ICB)	Positive	
Safer Staffing Review	Staff Staffing Report to Board, Annual Review approved Dec 24. Developing Workforce Safegards Report March 25	Positive	
Recruitment Control Panel	Weekly Reporting to Executives (system reporting ceased Jan 25)	Positive	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Joint People Plan to be developed (aligned to Joint Strategy and ICS People Plan) - Complete approved and year one deliverables in place	EH	Mar-25	Complete
More clarity on system implementation long term workforce plan - will respond in line national and regional direction - NHS long term workforce plan is superceded by new 10-year Health Plan for England. It is expected to be launched Spring 25 - postpone to Aug 25	NP	~~Dec 24~~ Aug 25	Behind Schedule
Roll out of recruitment training for managers with focus on diversity and inclusion - Complete	EH	Mar-25	Complete
Develop Talent Management and Succession Planning Approach - Included in Year One People Plan Deliverables and collaborative approach with DHC	EH	Jun-25	On Plan

Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care Communities Sustainability	**SR4: Capacity and Demand** **If we do not meet current and expected demand and achieve local and national measures and targets within available resources we may face regulatory action and patients outcomes will be adversely affected**	Finance and Performance

Executive Lead

Chief Operating Officer

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

Rationale for Score

No change in score. We continue to respond to demand and have plans in place to manage this. System challenges remain which impact on our position. In tiering for elective but good progress observed.

Controls *What we have in place to support delivery of the objective*	**Assurance** *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	**Assessment** *(See assessment guidance)*
Priority Programmes and Strategies			
Patient Flow Program (Internal to DCH with partners)	Regular updates against key plans and outcomes via F&P reporting	Positive	Green
UEC Review (Newton - Future Care) with System partners	Board Development Session Nov 24 and Approved Partnership Agreement Dec 24; Board Development session May 25	Positive	
Operational Plan 24/25 (in accordance with national planning guidance and inc Elective Recovery Fund - ERF)	Reported to F&P and Board (including risks to achievement of plan). Underpinning governance shared with FPCIC and agreed	Positive	
Risk Controls and Plans			
Elective Recovery activities	Work underpinning is within Divisional Performance and F&P reports / regional oversight of recovery - is in development but no formal Tiering indicated (Q1) - Tiering triggered if off Operational Plan in the key focus areas	Positive	Amber
UEC Improvement Plan	Work underpinning is within Divisional Performance and F&P reports - and underpinned by both Divsional Improvement Plans and Patient Flow Program	Positive	
Performance Management Framework (and resulting deep dive reviews)	Performance Report to F&P and Board and Deep Dives / Internal Audit Reports	Neutral	
Seasonal surge plan	Surge plan reported to F&P with monitoring via Performance Report, Winter Plan approved	Positive	
Oversight Arrangements for Governance & Engagement			
Finance and Performance Committee	Performance Report to F&P and Assurance Report to Board	Neutral	Amber
System Planned Care Delivery Group /Elective Performance Management Group (EPMG) /Productivity weekly meetings	Performance Report to F&P and Board	Positive	
UEC System meetings - weekly/monthly/Qtrly and Seasonal Surge Planning	Surge plan reported to F&P with monitoring via Performance Report	Positive	
Divisional Performance Meetings	Performance Report to F&P and Board and Deep Dives	Positive	
UEC (Newton) Governance framework agreed and in place	Performance Report to F&P and Board and Deep Dives	Positive	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Use of Performance Management Framework to increase oversight where performance identified for improvement - year end review of performance	AT	May-25	On Plan
Cold debrief on seasonal surge plan in Q4 - Complete	AT	Mar-25	Complete
Response to planning guidance to be prepared when available and in accordance with national timescales - Complete and reported to F&P and Board - Draft and Final submissions	AT	Mar-25	Complete
Complete review of Integrated Corporate Dashboard for 25/26 reporting - In progress following final plan submission on 28 April 25 and will report in accordance with timeline (April data to May F&P)	AT	Ap 25	On Plan

Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care Colleagues Sustainability	**SR5: Estates** **If we do not have an estate that is fit for purpose and economically and environmentally viable we will be unable to provide the right places for our staff to deliver high quality services to the communities that we serve**	Finance and Performance

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

Rationale for Score

No change. Work completed to identify gaps in compliance and ensure mitigating plans are in place and can be evidenced. Additional funding received for priority areas. Sub Co plans in development

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
New Hospital Programme	NHP Business Case, programme approved and build progressing	Positive	Amber
Joint Estates Strategy to be developed - not yet in place	Not yet in place - Six facets survey in progress which will inform strategy	Neutral	
Establishment of a wholly owned subsidiary to incorporate estates and facilities	OBC approved by Board Apr 25. Programme Board in place. Due diligence to be undertaken	Neutral	
Capital Programme	Monitoring to Finance and Performance Committee - Internal capital programme with prioritised schemes ranked across digital, estates and medical devices overseen by CAPSUG - cap prog within envelope 24/25 and strong plan for 25/26 with successful bids achieved inc £6m	Positive	
Risk Controls and Plans			
Estates compliance functions	Compliance reports in estates Function and reported to compliance groups - working to identify gaps and mitigations. Reporting in place on progress and commissioning external PAM assessment - Report to F&P May 25	Neutral	Amber
Fire safety compliance	Further assurance required on fire safety - review completed to assess gaps and issues and plans in place and ongoing - to F&P May 25	Neutral	
Backlog maintenance plan	On track and reported to Capital Investment Meeting - increased funding due to successful bid	Positive	
Oversight Arrangements for Governance & Engagement			
Finance and Transformation (Performance) Committee for estates planning and compliance and Strategy Transformation and Partnerships Committee for transformation (from Sept 24)	Assurance Reports to Board	Positive	Amber
Capital Investment Meeting	QIA of capital schemes now in place	Positive	
Estates related compliance groups in place (water, fire, health and safety)	Compliance reports on estates and health and safety from Nov 24 to F&P	Positive	
New Hospital Programme Board	Programme approved, NHP Programme Board report to STP & NHSE	Positive	
Shared Services Programme Board	Reports to Our Dorset Provider Collaborative - reporting to be confirmed	Neutral	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Develop Joint Estates Strategy - propose date change to Nov 25 as the enabler for Estates Strategy is a Six Facet Survey in progress	CH	~~Jul 25~~ Nov 25	Behind Schedule
Implement mitigating actions on fire and develop a five year plan for fire compartmentalisation - to F&P May 25 - Complete	DM	May-25	Complete
Estates compliance - End of Q4 expect to be assured that fully understand level of compliance and gaps that require mitigation - Complete report to F&P May 25	DM	Apr-25	Complete
QIA process for capital investments to be strengthened - confirmed process in place	DM	Mar-25	Complete
Completion of all required governance and due diligence in respect of wholly owned subsidiary	NJ	Aug-25	On Plan

Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Sustainability	**SR6: Finance** **If we do not deliver on our financial plans, including the required level of savings, then and this will adversely impact our ability to provide safe sustainable services, and will impact upon the overall ICS position**	Finance and Performance

Executive Lead: Chief Finance Officer

Risk Score	Consequence	x	Likelihood	=	Score
Unmitigated	4	x	5	=	20
Mitigated	5	x	4	=	20
Target	4	x	3	=	12

Rationale for Score: 24/25 Q4 RAFOT position achieved - NHSE non rec funding made to system allocated to DCH to support cash position. Risk score inc following 25/26 plan submission and F&P discussion Apr 25. CIP target - significant risk to full delivery at M1. Cash risk impact if efficiencies not delivered.

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Operational plan 2024/25 break even delivery (in year risk adjusted forecast outrun with agreed trajectory at system level) Operational Plan 2025/26 deficit plan of £9.8m within Dorset system overall break even plan requirement	Oversight via Finance Reporting to Finance & Performance Committee and Senior Leadership Group and Trust Board, plus bi-weekly Delivery Group to be re-established to support Trust delivery	Neutral	Amber
2025/26 8.6% CIP target of £29m required in full to meet £9.8m deficit plan, 30% agency reduction, 20% bank reduction, internal 10% Corporate target stretch, 232 WTE reduction of which 85 WTE support services recovery to Apr 22 levels	Oversight via Finance Reporting to Finance & Performance Committee and Senior Leadership Group and Trust Board, plus bi-weekly Delivery Group to be re-established to support Trust delivery	Neutral	
Medium Term Financial Plan - underlying position recovery and improve future sustainability inc cash focus	Medium Term Financial Plan to Finance and Performance Committee. Revenue request rejected by NHSE / DHSC Dec 24 & Jan 25 and exploring system collaboration. Daily cash report to CEO from Dec 24	Negative	
Risk Controls and Plans			
Operational workbook completion supported by Transformation & Finance with EQIA process updates - Trust CIP Tracker master for recording, CFO led support review meetings with all areas	Value Delivery Board Executive SRO oversight and Recovery Group from Oct 24 , reporting to Finance & Performance Committee accountability frameworks,bi-weekly Delivery/Recovery group to be re-established	Neutral	Amber
Regular budget meetings, enhanced budget manager training, recovery plans required for all overspending areas, linked to Productivity saving opportunities	Finance Reporting to Divisional Performance Meetings, Finance and Performance Committee & Trust Board	Neutral	
System wide working & development - System Investment Group revised ToR being finalised with reduction in £ thresholds	Reports to System Investment Group plus regular NHSE regional engagement / Oversight Framework rating and mirrored internal reporting via SLG/FPC/Board	Negative	
Oversight Arrangements for Governance & Engagement			
Finance and Performance Committee	Escalation Reports to Board, Finance Report to Committee and Board	Positive	Amber
Updated Delivery/Recovery Group to be re-established to prevent deterioration in financial position and workforce controls and support delivery of plans	Governance review underway to clarify governance led by DCEO	Neutral	
Value Delivery Board (VDB) - CFO Chair & Executive SROs in place per identified themed area, EQIA process being enhanced	Internal audit report HFMA checklist assessment and CIP process audit conducted, new EQIA panel being constructed overseen by CNO with reporting to Quality Committee	Neutral	
System wide working - Medium Term Financial Plan Group CEO Escalation meeting	Financial oversight reports internally and System ICB	Positive	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Re-establish internal Delivery/Recovery group - CIP, WTE and Prodcutivity key focus areas with relevant stakeholder leads	NJ/CH	Apr 25	On Plan
Enhanced of EQIA Process -process in place - embed EQIA process and commence panels	NJ	~~Nov 24~~ ~~Apr 25~~ May 25	On Plan
system mitigation re medium term cash sustainability - in development - delays noting national planning re-submission dates	CH	~~Mar 25~~ May 25	Behind Schedule

Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Communities Sustainability	**SR7: Collaboration** **If we do not have effective and positive partnerships within the ICS then we will not be able to shape decisions and deliver the transformation required.**	Strategy, Transformation & Partnerships

Executive Lead

Chief Strategy Transformation and Partnerships Officer

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

Rationale for Score

Increased likelihood score. Scale and pace of change in NHS at a national level (including change at ICB and NHSE level) is creating a higher degree of uncertainty whilst also driving more provider collaboration. Sub Co plans in development

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	Outcome of assurance	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Joint Forward Plan, supports NHS system focus on the same priorities. National Long Term Plan awaited	ICB-led Provider Relationship meetings to March 25 (to be replaced with NHSE), ICB Membership	Positive	Amber
Our Dorset Provider Collaborative	Our Dorset Provider Collaborative(PC) Board / PC Report to Board / NED PC Oversight Group in place from Nov 24/ B2B2B March 25 / Joint CDIO appointed April 25 / Wholly owned subsidiary being developed across 3 Dorset providers	Neutral	
One Transformation Approach	One Transformation Approach - Flagship Programme reporting to Joint Transformation and Improvement Board (JTIB) and Finance and Transformation to Aug 24. To STP Committee from Sept 24. 25/26 Transformation work plan to JTIB and STP CiC May 25	Positive	
Risk Controls and Plans			
Compliance with NHS Provider Licence and Code of Governance re duty to collaborate	Provider Licence and Code of Governance Compliance Report to Audit Committee annually reported to Audit Committee May 25	Positive	Amber
Five pillars from Joint forward plan - alignment of all programmes (pending review subject to release of National Long Term Plan)	Joint Strategy aligned to Joint Forward Plan-from November 24 forms part of prioritisation process via JTIB, further work required to understand ICB monitoring of ICB pillars and our role in that	Neutral	
Portfolios of change - INT / MH / Sustainable services / working together / operational redesign	Reporting to JTIB and to STP Committee from September 2024	Positive	
Oversight Arrangements for Governance & Engagement			
ICB and ICP Membership	Chair member of ICP, CEO member of ICB - updates and minutes to Board bi-monthly	Positive	Green
Finance and Transformation Committee to Aug 24 and Strategy, Transformation and Partnership Committee - from Sept 2024	Escalation Reports to Board	Positive	
Working Together Portfolio Board and Working Together Committee in Common then replaced by STP CiC from Sept 24	Escalation Reports from Working Together CIC to Board - to Aug 24 and STP from Sept 24. Review of Working Together Programme to STP CiC May 25	Positive	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Capital planning investment to be aligned to strategic objectives	PL	May-25	On Plan
Completion of all required governance and due diligence in respect of wholly owned subsidiary	NJ	Aug-25	On Plan

Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care Communities Sustainability	**SR8: Transformation and Improvement** **If we do not seek and respond to the views of our communities to co-produce and continuously improve and transform our services, we will not contribute to the reduction of health inequalities within our communities.**	Strategy, Transformation & Partnerships

Executive Lead

Chief Strategy Transformation and Partnerships Officer

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

Rationale for Score

Score unchanged, progress continues, some complexities to developing meaningful plans identified impacting delivery timeframes. Approaches between DCH/DHC different and further engagement required to align.

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	*Assessment (See assessment guidance)*
Priority Programmes and Strategies			
Joint Strategy	Approved Strategy. Metrics being developed and review at STP CiC May 25	Neutral	Amber
One Transformation Approach	One Transformation Approach - Flagship Programme reporting to Joint Transformation and Improvement Board (JTIB) and Finance and Transformation to Aug 24. To STP Committee from Sept 24. 25/26 Transformation work plan to JTIB and STP CiC May 25	Positive	
New Hospital Programme	Programme approved, NHP Programme Board report to STP Committee & NHSE	Positive	
Electronic Health Record (EHR) Programme (Outline Business Case - OBC)	DCH Board approved OBC (updated Dec 24). Further approvals by NHSE / Cabinet Office	Neutral	
Risk Controls and Plans			
Strategy Implementation Plan and enabling plans; Clinical & Quality, People, Digital, Finance and Infrastructure	Approved plan in place - assurance to be via bi-annual delivery reports, strategy dashboard to STP Committee- not yet in place. Enabling Plans approved April 25 (Digital delayed to enable new joint CDIO to review and input)	Positive	Amber
Five pillars from Joint forward plan - aligned of all programmes (pending review subject to release of National Long Term Plan)	Joint Strategy aligned to Joint Forward Plan-from November 24 forms part of prioritisation process via JTIB, further work required to understand ICB monitoring of ICB pillars and our role in that	Neutral	
Joint Improvement Framework approach	Approved Joint Improvement Framework approach - to be implemented. Continued momentum and celebration of improvement taking place alongside programme	Neutral	
Oversight Arrangements for Governance & Engagement			
Portfolio Boards - Flagships, Integrated Neighbourhood Teams and Working Together Portfolio Boards	Transformation Reports	Positive	Green
Joint Transformation Improvement Board	One Transformation Highlight Reports	Positive	
Working Together Committee in Common (to Aug 24) and STP Committee from Sept 24	Escalation Reports to Board	Positive	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Joint Strategy - Develop the Strategy Dashboard (including metrics to measure reduction in health inequalities) - measures approved but further work to align metrics to strategic objectives and agree form of reporting - executive engagement during Jan 25 to progress. To report to STP May 25 for 'proof of conecpt' and implementation to follow	PL	~~Nov 24~~ ~~Mar 25~~ Sept 25	Behind Schedule
Joint Improvement Framework. Develop the outline plan until Mar 25. 'Discover' stage 1/4 complete. Next stage (2) is 'Define' - Learning is longer timeline required for meaningful engagement. Define to be completed by June 25. Stages 3+4 dependent on outcome of 'Define' stage - on plan for agreed revised timetable	PL	~~Oct 24~~ June 25	On Plan
Joint Strategy. Produce and get approval for the Enabling Plans - Timeline to be reviewed as some risks to achieving this timetable due to need to allow sufficient time for meaningful engagement - Complete, plans approved April 25 (exception is digital - included as action in SR9 Digital)	PL	Mar-25	Complete

Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Communities Sustainability	**SR9: Digital Infrastructure** **If we do not advance our digital and technological capabilities, including achieving our EHR ambitions, we will not deliver the innovative and sustainable services and the delivery of safe services could be compromised.**	Strategy, Transformation & Partnerships

Executive Lead	Risk Score	Consequence	x	Likelihood	=	Score
Chief Strategy Transformation and Partnerships Officer	Unmitigated	5	x	4	=	20
	Mitigated	4	x	4	=	16
	Target	3	x	2	=	6

Rationale for Score

Score increased following Jan 25 Committee review - reflects number of underlying risks in this area. Strategy and roadmap will determine future state which will seek to mitigate risks with legacy infrastructure. Joint CDIO appointed and enabling plan being developed

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Joint digital strategy DCH/DHC	NHSE Digital Maturity Assessment (DMA), NHSE What Good Looks Like (WGLL)	Neutral	Amber
EHR Programme (OBC)	DCH Board approved OBC - Further approval Dec 24. Dorset and Somerset OBC approved by National EPR Investment Board (EPRIB). A new opportunity to develop an additional OBC for funding for DHC has arisen which would allow us to bring DHC back in to scope if successful	Neutral	
Risk Controls and Plans			
Digital risks monitored and reported	Monthly Report to Digital Transformation and Assurance Group (DTAG)	Neutral	Amber
Data Security & Protection Toolkit	Submission via Finance and Performance Committee and audited by BDO, reviewed by SIRO	Positive	
Oversight Arrangements for Governance & Engagement			
Strategy Transformation and Partnerships Committee - From Sept 2024	TOR approved - Reporting to Board commenced October 2024	Positive	Green
EHR Programme Board and EHR Advisory Group	EHR Report into Board	Positive	
DCH Digital Transformation & Assurance Group	Monthly reporting includes risks, cyber, projects	Positive	
Joint Digital Services Leadership Group DCH & DHC	Governance and reporting to be developed	Positive	
Information Governance Group (also covers cyber)	Bi-monthly report to Finance and Performance Committee, STP from Sept 24	Positive	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Joint digital strategy to be developed and submitted for Board approval - postponed to Sept 25 as new joint CDIO in post from April 25	BB	~~Mar 25~~ Sept 25	Behind Schedule
NHSE Review of outline business case (OBC) followed by EPR Investment Board/Cabinet Office - EPRIB approval received May 25	EHR Prog	~~Oct 24~~ ~~Jan 25~~ May 25	Complete
Implementation of Federated Data Platform (NHSE Mandate)	BB	Mar-26	On Plan
Development of infrastructure roadmap to support joint digital strategy - postponed to Dec 25 as new joint CDIO in post from April 25	BB	~~Mar 25~~ Dec 25	Behind Schedule

Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care Sustainability	**SR10 Cyber security** **If we do not take sufficient steps to ensure our cyber security arrangements are maintained and up to date then we are at increased risk of a cyber security incidents**	Strategy, Transformation & Partnerships

Executive Lead

Chief Strategy Transformation and Partnerships Officer

Risk Score	Consequence	x	Likelihood	=	Score
Unmitigated	3	x	5	=	15
Mitigated	3	x	4	=	12
Target	3	x	3	=	9

Rationale for Score

No change in score - continue to understand and mitigate threat landscape. Joint CDIO appointed from April 25 who will review the position and prioritise key actions

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

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Joint ICB-led cyber security strategy being developed - postponed to July 25 as new joint CDIO in post from April 25	SB	~~Nov 24~~ Jan 25	Behind Schedule
Implement multifactor authentication (MFA) for all staff (in progress) - postponed to July 25 as new joint CDIO in post from April 25	SB	~~Nov 24~~ Feb 25	Behind Schedule
Development of Infrastructure roadmap to support joint digital strategy - postponed to July 25 as new joint CDIO in post from April 25	SB	~~Mar 25~~ Jul 25	Behind Schedule
Joint digital strategy (includes cyber) to be developed and submitted for Board approval - postponed to July 25 as new joint CDIO in post from April 25	SD	~~Mar 25~~ Jul 25	Behind Schedule

ASSURANCE ASSESSMENT

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

RISK SCORING MATRIX

		LIKELIHOOD SCORE				
		1	2	3	4	5
CONSEQUENCE SCORE		**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic		5	10	15	20	25
4 Major		4	8	12	16	20
3 Moderate		3	6	9	12	15
2 Minor		2	4	6	8	10
1 Negligible		1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

0 - 3	Very low risk
4 - 6	Low risk
8 -12	Moderate risk
15 - 25	High risk

Report to	Board of Directors, Part 1	
Date of Meeting	10th June 2025	
Report Title	Corporate Risk Register – Quarter 4 2024/25	
Prepared By	Laura Sellick, Risk team	
Approved by Accountable Executive	Dawn Dawson, Chief Nursing Officer	
Previously Considered By	Risk and Audit Committee 02/06/2025	
Action Required	**Approval**	No
	Assurance	Yes
	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 & Quality SR2 Culture SR3 Workforce capacity SR4 Capacity & demand SR5 Estates SR6 Finance SR7 Collaboration SR8 Transformation & Improvement SR9 Digital Infrastructure SR10 Cyber security	
Financial	Activity and performance will impact on financial sustainability.	
Statutory & Regulatory	This will impact on all CQC Key Lines of Enquiry if risk is not appropriately reported, recorded, mitigated and managed in line with the Risk Appetite.	
Equality, Diversity & Inclusion	Nil specific	
Co-production & Partnership	Nil specific	

Executive Summary

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

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

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

Following the implementation of the revised Risk Management Framework (2023), each Board sub-Committee receives the Corporate Risk Register report with the specific risks assigned to them.

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

As defined in the Framework, any risk register items scored 15 or above will be reported in totality to the Audit Committee, with the sub-committees receiving reports relevant to their area of responsibility. Any risk register item scoring 15 or above will automatically be escalated to the Corporate Risk register.

Recommendation

The Board is recommended to:

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

1 Executive Summary- Overview of Risks

1.1. **1 new opened risk scoring 20 and above, added last quarter**.

Inability to undertake necessary clinical systems upgrades
Risk 2133 opened 27/03/25

1.2. **5 new opened risks scoring 15-19 added last quarter**

1.3. Lack of Inpatient capacity impacting patient flow in Recovery and Theatre utilisation
Risk 2126 opened 07/03/25

1.4. Lack of visibility regarding future funding/finance roadmap makes it difficult to procure and maintain continuity of security
Risk 2070 opened 19/02/25

1.5. Lack of networking segmentation
Risk 2072 opened 19/02/25

1.6. Risk to sustainability of Maternity & Neonatal Digital Service
Risk 2044 opened 19/02/25

1.7. Theatre Staffing Sustainability
Risk 1556 added on 20/03/25
Further details can be found in appendix 2.
This risk was closed on 3/2/25 by Service Manager for Theatre and reopened by Senior Sister for Theatre on 20/3/25. Risk reopened due to significant staffing issues and lack of progress with delays in recruitment and financial sign-off for posts available. Risk details have been updated, and establishment has been reviewed with Divisional Head of Nursing to highlight the shortfalls.

2. Main narrative

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

2.2. The Board sub-committees receive quarterly Corporate Risk Register reports to ensure that the risks that are relevant to those Committees are being managed effectively, and that the risks are being shared across the organisation.

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

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

- inform the planning of audit activity (Audit Committee)
- inform financial decision making and budget setting (Finance and Performance Committee)
- inform quality and governance decisions (Quality Committee)
- inform workforce; human resources; training and development decisions (People and Culture Committee)
- inform the strategy, transformation and partnership decisions (Strategy, Transformation and Partnership Committee)

2.5. Audit committee Risk Register detail (appendix 2)
2.6. Managed and closed risks for last quarter (appendix 3)

3. Conclusion

3.1. Risks continue to be regularly reviewed and have been aligned with the revised Risk Management Framework and are linked to the Board Assurance Framework. Mitigations are in place for all identified risk items and actions are in place. The Risk team will continue to support the Divisions, enabling and educating them to update and own their risks.

4. Recommendations

4.1. The Board is recommended to:

- review the current Risk Register for **assurance**; and
- note the high-risk areas.
- consider overall risks to strategic objectives and BAF.
- request any further assurances.

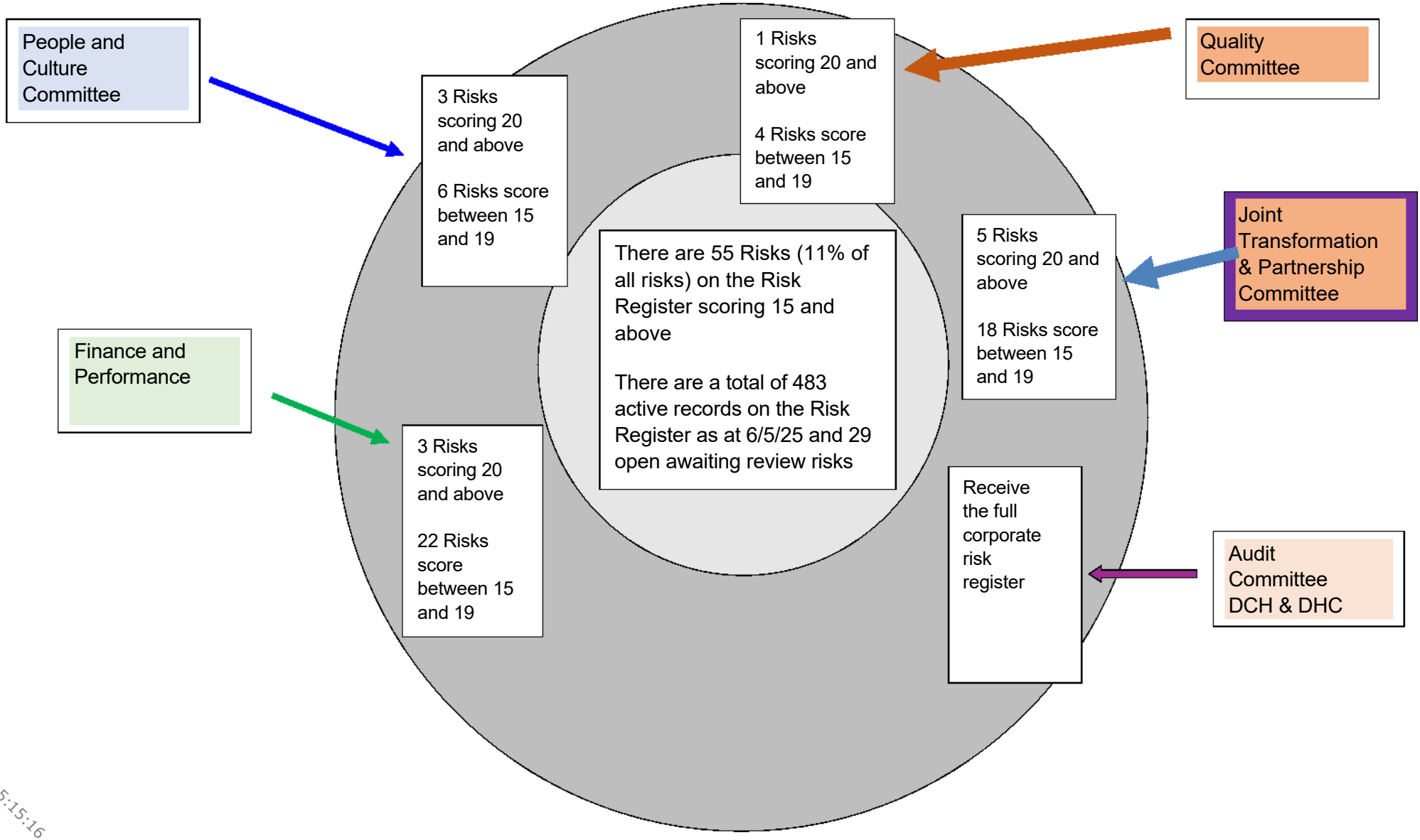
Name and Title of Author: Laura Sellick
Date 23/05/25

5. Appendices

5.1. Appendix 1 • Heat Map
5.2. Appendix 2 • Corporate Risk Register items
5.3. Appendix 3 • Closed Risks

Appendix 1

Corporate Risk Register – Risk scoring for Primary Reporting Committees on 6/5/25

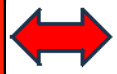


Active Risk Register 20 or above

Approval status	ID	Title	Review date	Opened	Care Groups	Service of responsibility	Risk level (initial)		Risk level (current)	Risk level (Target)	Type of Risk
Active	1877	Clinical digital Safety - DCB0160 assurance debt	08/04/2025	29/04/2024	Director of Strategy and Business Development	Clinical IT Systems	12		20	8	Strategy, Transformation and Partnerships
Active	1152	Current Digital Staffing levels present risk to both operational and strategic activities	08/04/2025	14/09/2021	Chief Information Officer	Digital Technology and Infrastructure (DTI)	16		20	9	People and Culture Committee, Digital Systems Risk

Active	**2152**	**End of Support wireless access points in use within the corporate wireless network**	**01/06/2025**	**01/05/2025**	**Chief Information Officer**	**Digital Technology and Infrastructure (DTI)**	**20**		**20**	**1**	Strategy, Transformation and Partnerships
Active	**2157**	**Inability to fund the replacement of medical devices from capital**	**02/06/2025**	**02/05/2025**	**Pharmacy, Pathology and Medical Physics (A4)**	**Across all specialties**	**16**		**20**	**4**	Finance and Performance Committee

Active	2133	Inability to undertake necessary clinical systems upgrades	02/05/2025	27/03/2025	Chief Information Officer	Clinical IT Systems	20		20	8	Strategy, Transformation and Partnerships
Active	876	Maternity Staffing	07/07/2025	21/09/2021	Family Services (B4)	Maternity Service	12		20	4	People and Culture Committee

Active	1881	Neonatal Nursing staffing	12/06/2025	01/05/2024	Family Services (B4)	Special Care Baby Unit (SCBU)	**16**		**20**	**6**	People and Culture Committee
Active	1862	Neurophysiology EMG equipment	16/06/2025	23/04/2024	Radiology & Neurophysiology (B3b)	Neurophysiology Service	**12**		**20**	**2**	Finance and Performance Committee, Medical Devices Group
Active	2153	Out of support Core Network Infrastructure	01/06/2025	01/05/2025	Chief Information Officer	Digital Technology and Infrastructure (DTI)	**20**		**20**	**1**	Strategy, Transformation and Partnerships

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Active	472	Patient Safety Concerns and Increased Risk of Adverse Outcomes Due to Prolonged Wait Times in Community Paediatrics	28/05/2025	10/09/2018	Family Services (B4)	Paediatrics Service	15		20	10	Finance and Performance Committee
Active	1906	Total Intravenous Anaesthetic Pumps Required	16/06/2025	11/06/2024	Theatres, Anaesthetics, Critical Care & Decontamination (B3a)	Theatre Service	15		20	4	Quality Committee

Active	1913	TPP SystmOne - EPR core unit	08/04/2025	03/07/2024	Chief Information Officer	Clinical IT Systems	**15**		**20**	**4**	Strategy, Transformation and Partnerships

Active Risk Register 15 or above

Approval status	ID	Title	Review date	Opened	Care Groups	Service of responsibility	Risk level (initial)		Risk level (current)	Risk level (Target)	Type of Risk
Active	1752	2003 Servers Out of Support Since 2010	01/06/2025	01/11/2023	Chief Information Officer	Digital Technology and Infrastructure (DTI)	16		16	4	Strategy, Transformation and Partnerships
Active	1735	2008 Servers Out of Support Since January 2020	01/06/2025	01/01/2020	Chief Information Officer	Digital Technology and Infrastructure (DTI)	16		16	4	Strategy, Transformation and Partnerships
Active	1745	2012 Servers Out of Support Since October 2023	01/06/2025	16/10/2023	Chief Information Officer	Digital Technology and Infrastructure (DTI)	16		16	3	Strategy, Transformation and Partnerships
Active	1903	Age of Washers in EDU	06/06/2025	06/06/2024	Theatres, Anaesthetics, Critical Care & Decontamination (B3a)	Decontamination Service	16		16	2	Finance and Performance Committee

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Active	1611	Blood results for Renal Patients from Somerset Foundation Trust are not added to eMed (Renal System) as there is no interface	23/05/2025	13/02/2023	Vascular and Metabolic (A1)	Renal Service	9		15	1	Strategy, Transformation and Partnerships
Active	2137	Careflow Printing & Re-Scanning	30/05/2025	04/04/2025	Chief Information Officer	Clinical IT Systems	16		16	6	Strategy, Transformation and Partnerships
Active	641	Clinical Coding	08/04/2025	17/05/2019	Chief Information Officer	Clinical Coding	20		15	3	Strategy, Transformation and Partnerships
Active	1932	CPAP Service Space at Vespasian House to be rescinded, no permanent location identified, short term arrangement from 01/04/25	23/05/2025	10/08/2024	Integrated and Holistic Care (A2)	Respiratory Service	12		16	4	Finance and Performance Committee
Active	1650	DCH Patients who have access to their GP records can now see documents for DCH before they have been contacted/seen by the Trust	08/04/2025	18/05/2023	Chief Information Officer	Clinical IT Systems	12		16	12	Strategy, Transformation and Partnerships

Active	1530	Digital Systems with Pharmacy Aseptic Suite	19/05/2025	18/10/2022	Pharmacy, Pathology and Medical Physics (A4)	Pharmacy Service	9		16	3	Finance and Performance Committee, Medicine Safety Committee
Active	1919	Electronic Health Record - Insufficient Digital Resource to support EHR readiness and implementation	08/04/2025	12/07/2024	Chief Information Officer	Digital Technology and Infrastructure (DTI)	16		16	12	Strategy, Transformation and Partnerships
Active	1815	Electronic Health Record, risk of not receiving FD Funding	08/04/2025	02/02/2024	Chief Information Officer	Digital Technology and Infrastructure (DTI)	16		16	12	Strategy, Transformation and Partnerships
Active	1122	Failure to comply with Freedom of Information Legislation	30/11/2024	12/07/2021	Chief Executive	Corporate Services	15		16	4	Strategy, Transformation and Partnerships
Active	1886	financial sustainability 24/25	30/09/2024	09/05/2024	Chief Finance Officer	Finance	16		16	6	Finance and Performance Committee
Active	1896	Fire Team Response to emergencies	17/09/2024	24/05/2024	Chief Finance Officer	Fire Safety	16		16	2	Finance and Performance Committee, Health, Safety, Fire and Security Group
Active	1781	Glaucoma FOWL Long Waiters	06/06/2025	04/01/2024	Head & Neck, Specialist Medicine and Outpatients (B2)	Ophthalmology Service	20		16	6	Finance and Performance Committee, Patient Safety Group, Clinical Effectiveness Group
Active	2161	HICCS Endoscopy system nearing end of life	13/06/2025	13/05/2025	Surgery & Gastroenterology (B1b)	Endoscopy Service	16		16	4	Strategy, Transformation and Partnerships

Active	2003	Histopathology Biomedical Scientist Workload Capacity	09/05/2025	08/11/2024	Pharmacy, Pathology and Medical Physics (A4)	Histopathology Service	16		16	8	Finance and Performance Committee
Active	2144	Home Enteral Nutrition (HEN) Service Risk - Growing demand, insufficient staff & supply chain for enteral and SIP feed supplies	13/05/2025	15/04/2025	Integrated and Holistic Care (A2)	Dietetics and Nutrition Service	16		16	6	Finance and Performance Committee
Active	1912	ICE - unsent EDS (Electronic Discharge Summary) issues	08/04/2025	03/07/2024	Chief Nursing Officer	Clinical IT Systems	20		15	12	Strategy, Transformation and Partnerships
Active	2138	Inadequate stock of orthopaedic implants Baker,Abi 05/06/2025 15:15:16	23/06/2025	07/04/2025	Theatres, Anaesthetics, Critical Care & Decontamination (B3a)	Theatre Service	12		15	4	Strategy, Transformation and Partnerships

Active	1207	Insufficient HD capacity across all sites - increase in demand does not meet our capacity	23/05/2025	07/02/2022	Vascular and Metabolic (A1)	Renal Service	16		16		Finance and Performance Committee
Active	2007	Lack of Adequate Support for Digital Systems in a 24/7 Acute Trust	08/04/2025	19/11/2024	Chief Information Officer	Clinical IT Systems	12		16	8	Strategy, Transformation and Partnerships
Active	1981	Lack of Assurance from Fortrus to meet clinical safety processes	08/05/2025	23/09/2024	Chief Information Officer	Clinical IT Systems	16		16	6	Strategy, Transformation and Partnerships
Active	2126	Lack of Inpatient capacity impacting patient flow in Recovery and Theatre utilisation	23/06/2025	17/03/2025	Theatres, Anaesthetics, Critical Care & Decontamination (B3a)	Theatre Service	12		15	12	Finance and Performance Committee
Active	1635	Lack of Isolation Facilities on Prince of Wales ward	23/05/2025	02/05/2023	Vascular and Metabolic (A1)	Renal Service	16		16	4	Finance and Performance Committee
Active	2072	Lack of networking segmentation	01/06/2025	19/02/2025	Chief Information Officer	Digital Technology and Infrastructure (DTI)	20		15	6	Strategy, Transformation and Partnerships

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Active	1655	Lack of Service Provision for Avoidant/Restrictive Food Intake Disorder	19/05/2025	24/05/2023	Family Services (B4)	Paediatrics Service	12		15	4	Quality Committee
Active	2070	Lack of visibility regarding future funding/finance roadmap makes it difficult to procure and maintain continuity of security	03/07/2025	19/02/2025	Chief Information Officer	Digital Technology and Infrastructure (DTI)	16		16	1	Strategy, Transformation and Partnerships
Active	1780	Macular FOWL Long Waiters	14/05/2025	04/01/2024	Head & Neck, Specialist Medicine and Outpatients (B2)	Ophthalmology Service	20		16	6	Finance and Performance Committee, Patient Safety Group, Clinical Effectiveness Group
Active	839	MDT representation in Specialist Paediatric Epilepsy Service	09/06/2025	11/12/2019	Family Services (B4)	Paediatrics Service	2		16	2	People and Culture Committee
Active	659	Medicines Supply Challenges	02/07/2025	20/11/2018	Pharmacy, Pathology and Medical Physics (A4)	Pharmacy Service	20		16	6	Quality Committee
Active	1675	Medtronic Valleylab FX Diathermy Machines	23/06/2025	13/06/2023	Theatres, Anaesthetics, Critical Care & Decontamination (B3a)	Theatre Service	12		16	6	Finance and Performance Committee

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Active	1629	Move of Hampshire Trust to a Sectra PACS	14/07/2025	21/04/2023	Chief Operating Officer		16		16	9	Finance and Performance Committee
Active	1852	Neurophysiology Workforce levels not meeting Demand	16/06/2025	27/03/2024	Radiology & Neurophysiology (B3b)	Neurophysiology Service	12		15	3	People and Culture Committee
Active	1466	NHP - Inability to support and finance 'growing our own' skilled staff	10/06/2025	02/08/2022	Chief Finance Officer	Strategic Estates	16		16	9	Finance and Performance Committee
Active	1770	No electronic capture and referral process for treating tobacco dependency in the acute sector	08/04/2025	05/12/2023	Chief Information Officer	Clinical IT Systems	15		15	6	Strategy, Transformation and Partnerships

Active	1663	No Height and Weight Room - Children Centre	09/06/2025	02/06/2023	Family Services (B4)	Paediatrics Service	15		15	5	Finance and Performance Committee
Active	1957	Ophthalmology Lost to Follow Up Patients	09/06/2025	04/09/2024	Head & Neck, Specialist Medicine and Outpatients (B2)	Ophthalmology Service	20		16	4	Quality Committee
Active	1502	Pharmacy Aseptic Unit - High risk to patient safety	09/06/2025	08/09/2022	Pharmacy, Pathology and Medical Physics (A4)	Pharmacy Service	20		16	8	Quality Committee, Medicine Safety Committee
Active	1837	Pharmacy Aseptic Unit staffing not resilient	09/06/2025	27/02/2024	Pharmacy, Pathology and Medical Physics (A4)	Pharmacy Service	12		16		People and Culture Committee, Medicine Safety Committee
Active	2044	Risk to sustainability of Maternity & Neonatal Digital Service	17/06/2025	14/01/2025	Family Services (B4)	Maternity Service	12		15	4	Finance and Performance Committee
Active	1664	Skill Mix within -Paediatric Outpatient Department - No Registered or Lead Nurse	09/06/2025	05/06/2023	Family Services (B4)	Paediatrics Service	12		15	6	People and Culture Committee

Active	1168	System revenue affordability pressures	10/06/2025	11/11/2021	Chief Finance Officer	Strategic Estates	16		16	8	Finance and Performance Committee
Active	1221	Tackling the backlog of elective care	31/03/2025	09/03/2022	Chief Operating Officer	Central Appointments	20		16	8	Finance and Performance Committee, Clinical Effectiveness Group
Active	1556	Theatre Staffing Sustainability	23/06/2025	20/03/2025	Theatres, Anaesthetics, Critical Care & Decontamination (B3a)	Theatre Service	16		15	6	People and Culture Committee, Clinical Effectiveness Group

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Active	1843	There is insufficient capacity for consultant led clinics in Haematology for current demand levels	23/05/2025	06/03/2024	Integrated and Holistic Care (A2)	Haematology Service (blood sciences)	16		16	2	Finance and Performance Committee, Patient Safety Group
Active	1272	Trust Integration Engine	08/04/2025	20/05/2022	Chief Information Officer	Clinical IT Systems	20		16	9	People and Culture Committee, Patient Safety Group, Digital Systems Risk, Clinical Effectiveness Group
Active	1909	Unauthorised Battery Disposal	18/09/2024	18/06/2024	Chief Finance Officer	Fire Safety	9		16	3	Finance and Performance Committee, Estates and Facilities Governance and Compliance
Active	1891	Windows 11 upgrade at risk due to lack of hardware resource	03/05/2025	17/05/2024	Chief Information Officer	Digital Technology and Infrastructure (DTI)	6		16	16	Finance and Performance Committee

Closed and Managed Risk Register (short)

Approval status	ID	Title	Review date	Opened	Care Groups	Service of responsibility	Risk level (initial)	Risk level (current)	Risk level (Target)	Type of Risk
Managed / Tolerated within Risk appetite	1738	2ww Cancer Capacity for PMB - Gynaecology	06/01/2025	04/10/2023	Family Services (B4)	Gynaecology Service	12	9	4	Finance and Performance Committee, Clinical Effectiveness Group
[redacted]	890	Ambient Temperature control of medicines in clinical areas	11/02/2025	26/04/2017	Pharmacy, Pathology and Medical Physics (A4)	Pharmacy Service	15	6	2	Quality Committee, Medicine Safety Committee

	799	Blood Sciences Biomedical Scientist Workload Capacity	22/04/2024	07/11/2019	Pharmacy, Pathology and Medical Physics (A4)	Pathology Service	16	6	6	Finance and Performance Committee
Managed / Tolerated within Risk appetite	836	Children's Community Nursing Staffing	10/01/2025	04/03/2020	Family Services (B4)	Paediatric Community Nurses	4	9	4	People and Culture Committee, Quality Committee

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Managed / Tolerated within Risk appetite	1617	Clinical USB devices are being blocked by SOPHOS (EEG)	03/01/2025	28/02/2023	Anaesthetics & Radiology (B3) (inactive Sep 23)	Digital Technology and Infrastructure (DTI)	15	1	4	Finance and Performance Committee, Digital Systems Risk
Managed / Tolerated within Risk appetite	1999	Community Paediatrics - Service Continuity Risk	12/01/2025	31/10/2024	Family Services (B4)	Paediatrics Service	12	12	1	
Managed / Tolerated within Risk appetite	2058	Contractors creating electrical and trip risk	05/03/2025	05/02/2025	Chief Finance Officer	Estates Department	12	12	2	

Managed / Tolerated within Risk appetite	1464	CT1 Scanner Reliability	04/08/2025	28/07/2022	Radiology & Neurophysiology (B3b)	Radiology Service (DCH)	12	6	6	Quality Committee
	1819	Disparity in the provision of Powered Wheelchairs to Paediatric Patients	13/01/2025	08/02/2024	Family Services (B4)	Children's therapy service	16	16	6	Quality Committee
	1874	East Wing Patient Alarm System not Audible in Ultrasound	22/04/2025	29/04/2024	Radiology & Neurophysiology (B3b)	Radiology Service (DCH)	4	4	2	

[redacted]	532	ED Estate	01/12/2021	26/03/2019	Unscheduled Care (A3)	Emergency (ED) Services	12	8	8	

Managed / Tolerated within Risk appetite	1257	EEG HL7 Connectivity Unreliable	22/04/2025	11/05/2022	Radiology & Neurophysiology (B3b)	Neurophysiology Service	15	3	1	Finance and Performance Committee, Quality Committee

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	1497	Emergency Buzzers Not Heard Consistently Throughout the Maternity Unit		02/09/2022	Chief Finance Officer	Estates Department	12	9	6	Finance and Performance Committee
Managed / Tolerated within Risk appetite	1975	Exceeding Paediatric Cardiology Outpatient Waiting Times	23/12/2024	11/09/2024	Family Services (B4)	Paediatrics Service	12	9	2	Finance and Performance Committee

[redacted]	1606	Facing the Future standards for acute paediatric cover	02/04/2025	08/02/2023	Family Services (B4)	Paediatrics Service	10	10	3	People and Culture Committee
Managed / Tolerated within Risk appetite	1609	Impact of boundary moves when UHD paeds services move to Bournemouth	23/12/2024	08/02/2023	Family Services (B4)	Paediatrics Service	9	8		
Managed / Tolerated within Risk appetite	1989	Inability to provide adequate staffing for safe dialysis & patient care at RBH	17/10/2024	10/10/2024	Vascular and Metabolic (A1)	Renal Service	9	16	4	People and Culture Committee

[redacted]	1879	Instability in the supply of fluid bags of all sizes	13/02/2025	30/04/2024	Pharmacy, Pathology and Medical Physics (A4)	Pharmacy Service	16	6	12	Quality Committee, Medicine Safety Committee

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Managed / Tolerated within Risk appetite	1917	Introduction of Right Care, Right Person	01/04/2025	12/07/2024	Chief Operating Officer		12	9	6	Finance and Performance Committee, Patient Safety Group, Mental Health Steering Group, System Risk - sits with ICB or other
Managed / Tolerated within Risk appetite	1978	Issues with the audit log in WinPath	18/11/2024	18/09/2024	Pharmacy, Pathology and Medical Physics (A4)	Pathology Service	6	3	3	

[redacted]	1939	Lack of Dietician Availability to Support Monthly Food Allergy Clinic	20/01/2025	10/08/2024	Family Services (B4)	Paediatrics Service	9	9	2	
Managed / Tolerated within Risk appetite	1983	Lack of Office Space - Children's Centre	10/02/2025	26/09/2024	Family Services (B4)	Paediatrics Service	9	16	1	
Managed / Tolerated within Risk appetite	1991	Lack Of On-Framework Agency To Provide Orthodontic Nursing Cover	21/04/2025	11/10/2024	Head & Neck, Specialist Medicine and Outpatients (B2)	Orthodontics Service	16	6	6	

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Managed / Tolerated within Risk appetite	1804	Loss of socket power supply to HTL	13/01/2025	22/01/2024	Pharmacy, Pathology and Medical (A4)	Hospital Transfusion Blood sciences	20	4	4	Finance and Performance Committee, Patient Safety Group, Digital Systems Risk

[redacted]	1561	Maintaining Business As Usual During Construction Phase of NHP	12/08/2024	12/12/2022	Chief Finance Officer	Strategic Estates	16	12	9	Finance and Performance Committee

Managed / Tolerated within Risk appetite	1539	Medical and Nursing Agency Costs	05/11/2024	04/11/2022	Unscheduled Care (A3)	Emergency (ED) Services	15	9	6	Finance and Performance Committee, People and Culture Committee
[redacted]	1977	National Shortage of permacol mesh - Impact on Lap VMR surgery breeches	20/01/2025	16/09/2024	Surgery & Gastroenterology (B1b)	Colorectal Service	12	12	4	

	1554	National Shortage of Stock - Supply Chain Problems	10/02/2025	23/11/2022	Theatres, Anaesthetics, Critical Care & Decontaminati o n (B3a)	Theatre Service	15	16	3	Finance and Performance Committee, Clinical Effectiveness Group
	2034	Neurophysiology EMG server old and requires upgrade	03/04/2025	03/01/2025	Radiology & Neurophysiolog y (B3b)	Neurophysiolog y Service	9	9	3	
	2048	Otology drill replacement	10/03/2025	21/01/2025	Theatres, Anaesthetics, Critical Care & Decontaminati o n (B3a)	Theatre Service	16	16	4	
	1608	Paediatric consultant job planning and rota cover	28/02/2025	08/02/2023	Family Services (B4)	Paediatrics Service	15	9	1	People and Culture Committee
	1870	Patient Call Bells in East Wing not Sounding Throughout the Department	22/04/2025	26/04/2024	Radiology & Neurophysiolog y (B3b)	Radiology Service (DCH)	4	4	4	

	1996	Pre Assessment Room Availability	03/03/2025	25/10/2024	Theatres, Anaesthetics, Critical Care & Decontaminatio n (B3a)	Pre-assessment Service (SAL)	12	9	4	Finance and Performance Committee
	1516	Radiology Reports not being reviewed	14/02/2025	26/09/2022	Medical Director	Radiology Service (DCH)	20	6	4	Clinical Effectiveness Group, Quality Committee
Managed / Tolerated within Risk appetite	1760	Reconfiguration of Microbiology workstreams across Dorset	05/08/2024	16/11/2023	Pharmacy, Pathology and Medical Physics (A4)	Pathology Service	9	6	4	People and Culture Committee
	765	Reduced Theatre Capacity & Longer Waiting Lists due to Closure of Weymouth DSU	17/02/2025	08/08/2019	Theatres, Anaesthetics, Critical Care & Decontaminatio n (B3a)	Theatre Service	15	9	4	Finance and Performance Committee, Clinical Effectiveness Group

	1898	resuscitaires for labour ward	05/03/2025	28/05/2024	Family Services (B4)	Maternity Service	9	2	1	Quality Committee, Patient Safety Group
	1162	Risk of 'on the day' Cancellations with Over Night Opening of Day Surgery	24/02/2025	01/10/2021	Theatres, Anaesthetics, Critical Care & Decontaminati o n (B3a)	Theatre Service	15	6	6	Quality Committee
Managed / Tolerated within Risk appetite	1851	Server Upgrade (Neurophysiology server)	02/12/2024	27/03/2024	Radiology & Neurophysiolog y (B3b)	Neurophysiolog y Service	9	1	1	Finance and Performance Committee, Digital Systems Risk
Managed / Tolerated within Risk appetite	1844	Sodium Valproate MHRA alert - risk to unborn child	13/02/2025	06/03/2024	Pharmacy, Pathology and Medical Physics (A4)	Pharmacy Service	9	9	3	Quality Committee, Medicine Safety Committee, System Risk - sits with ICB or other

	1741	Sterile Service Non-conformance Audits and Logs not Updated	14/05/2025	09/10/2023	Theatres, Anaesthetics, Critical Care & Decontaminati o n (B3a)	Decontaminati o n Service	4	4	4	
	1578	Triage and the use of BSOTS (Birmingham Symptom Specific Obstetric Triage System)	04/03/2025	15/01/2023	Family Services (B4)	Maternity Service	15	2	4	Quality Committee, Digital Systems Risk

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Report to	Board of Directors	
Date of Meeting	10 June 2025 (DCH) 11 June 2025 (DHC)	
Report Title	Shared Services for NHS in Dorset	
Prepared By	Richard Renaut – Chief Strategy & Transformation Officer University Hospitals Dorset, working on behalf of One Dorset Provider Collaborative	
Approved by Accountable Executive	Nick Johnson, Chief Strategy, Transformation and Partnerships Officer, and Chris Hearn, Chief Finance Officer.	
Previously Considered By	24th March 2025 – DCH/DHC Finance and Performance Committee - endorsed/approved the paper and the FBC 14th March 2025 Informal DCH/DHC/UHD Board to Board to Board – proposals endorsed 29th January 2025 Our Dorset Provider Collaborative Leadership Board - FBC approved and recommended that Trust Boards approve	
Action Required	**Approval**	YES
	Assurance	No
	Information	No

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care		No
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR6 Finance. If we do not deliver on our financial plans, including the required level of savings, then this will adversely impact our ability to provide safe sustainable services, and will impact upon the overall ICS position.	
Financial	The FBC presents the largest single opportunity to deliver significant financial savings, on a project which doesn't directly impact upon patient care.	
Statutory & Regulatory	Third party consultancies are required to support the transformation. Approval is required from NHSI for this appointment.	
Equality, Diversity & Inclusion	An Equality Impact Assessment will be undertaken during the proposed TUPE process.	
Co-production & Partnership	The delivery of shared services is a priority of the Our Dorset Provider Collaborative, and this FBC has been developed between the DCH, DHC and UHD.	

Executive Summary

1.1 The need to improve NHS services, live within our means, and offer a good place to work for staff is increasingly difficult to achieve. This proposal addresses do all of three. The NHS FT Boards in Dorset have been working through the provider collaborative to identify opportunities for

improvement and Estates, Facilities and Procurement (EFMP) offer significant benefits from coming together. The attached Full Business Case sets out the options and a Preferred Way Forward (PWF).

1.2 Importantly, this:

- Protects pay, terms, conditions and pensions.
- Keeps services 100% owned by the local NHS.
- Generates upto £58m of procurement savings, over the next 5 years.
- Creates the scale and resilience for these services to flourish.
- Provides many other benefits themed under 10 headings.

1.3 The proposal is to set up NHS-owned subsidiaries, with an operating company (OpCo) to provide the EFMP services. Each Trust would have a property company (PropCo) to ensure assets remain under each Trust. This arrangement allows greater freedom and transparency to better serve the Trusts, and potentially other customers.

1.4 The subsidiary model has worked well for many other NHS Trusts and public bodies and is recommended by NHSE. Learning has been taken from 10+ years NHS experience of these, including where they have not performed as expected. This learning has been incorporated into the February 2024 NHSE guidance on setting up wholly NHS-owned subsidiaries. This guidance and learning has informed the Dorset proposal.

1.5 The initial Board discussion of the FBC has been followed by work over April and May. This included updating the FBC and supporting information, engagement of staff and stakeholders, and workstreams developing more detailed plans. This has led to this point in June, where the Board is asked make a series of decisions on whether to progress to the next stage of the process.

1.6 In line with the guidance, the Board is asked to self-certify readiness for progressing to formal staff consultation (under TUPE) and to prepare for the set-up phase. The self-cert is attached as part of the FBC annexes. NHSE will also provide feedback following their assessment of the case.

1.7 In addition, a report is attached on the staff and stakeholder feedback following the April–May engagement work. The Board is asked to consider this information alongside the updated Full Business Case (FBC) and appendices.

1.8 There is then a list of ten decisions for the Board to take to progress the project. These are listed below. It should be noted the three Boards are all considering this case in June, and all three would be required to agree to proceed with the collaborative proposal, that is the Preferred Way Forward.

1.9 The Boards will then receive an update in September and make a go/no go decision on whether to proceed to go live.

1.10 The list of decisions required are:

(1) To approve the updated FBC & recommended option, including changes as a result of the engagement, such as the “triple lock” and a 25-year contract duration for greater certainty.
(2) To self-certify against the NHSE checklist, as readiness to progress to the next stage.
(3) To agree the OpCo Shadow Board’s Terms of Reference. Then to agree the names of FT shareholder directors onto the Shadow Board. This creates the oversight and a programme Board to move to set up & delivery of the subsidiaries.
(4) To agree the PropCo Shadow Board for each Trust subsidiary, that lease and managed the Trust building and equipment assets and provide the Operated Healthcare Services. Agreement.
(5) To decide whether to include sterile services within the scope of services (now or in 2026).

(6) To agree completion of the preparations in June, for starting formal staff consultation (TUPE) for July and August.
(7) To agree a target go-live date of 1st November 2025, subject to the outcome of the TUPE consultation, & NHSE feedback.
(8) To approve the process for naming of the companies and ensuring that the organisational development and culture remains aligned with NHS values.
(9) To work with the NHS Business Services Authority to see if further re-assurance can be given on NHS pensions, beyond the certainty of ministerial direction that NHS Pensions will be available to all subsidiary staff.
(10) To set up the legal entity, to allow preparatory work to be undertaken, and initial steps for the permanent subsidiary Boards set up.
(11) Other issues for preparation – OpCo Board, Reserve Matters and FBC development.

2.0 Background
2.1 Updated Full Business Case (FBC) following engagement.

2.2 Dorset's three NHS Foundation Trusts, working through the Dorset Provider Collaborative, have identified significant benefits from Estates, Facilities Management, and Procurement (EFMP) were to operate as a shared service. The attached Full Business Case follows HM Treasury and NHSE guidance on this subject.

2.3 The case has been updated from the April version. The Boards all agreed a shared Preferred Way Forward (PWF) at that point. This has been worked up and the FBC strengthen, especially in relation to the Management Chapter, covering governance and self-certification requirements. Feedback from the engagement over April and May has also been used to strengthen key aspects, especially the assurance over pay and NHS ownership being retained.

2.4 NHSE have been asked to assess the case and give feedback. This is expected in early June. In simple terms, the NHSE feedback will be to proceed, with any recommendations, or for NHSE to request more information and/or undertake a more detailed review. How long this might take is not pre-determined. This may affect the target go live date, and an update will be given at the Board meeting.

2.5 Whilst Trusts co-operating and sharing support services is very much national policy direction, this is the first ICS multi-Trust subsidiary. Therefore, the timeline has been extended a month to allow more time for questions about the proposal from regulators and stakeholders. This also allows a longer period for the set up phase. This makes the target start date 1st November 2025. This timeline will remain under regular review and is subject to preparations being completed and successfully passing a go/no go Boards decision, targeted for September.

2.6 The preferred way forward has been the focus of the stakeholder engagement and communications. This is because whilst the other options are listed, they all score less well, and some such as outsourcing, would cause staff distress, which is avoidable.
2.7 The staff engagement has been with hundreds of staff, in formal and informal settings. Details and results of the engagement are written up and reported in the annex of the FBC. Pre-meets held with unions and the managers of the services also occurred.

2.8 Unison and other unions have declared they are opposed in principle to subsidiaries. There have been disagreements on issues of substance and process, summarized in the correspondence with Unison's Head of Health. Local MPs have also raised issues. These have all been taken seriously and detailed replies given.

2.9 Throughout the engagement, the Trusts' agreed principles have been clearly and consistently communicated. These are:

1. Protecting Agenda for Change pay, terms & conditions, and thus staying aligned with future national updates for current & future staff.
2. Protecting pensions for all current & future staff
3. Keeping ownership in the public sector.

2.10 Despite this, many staff had heard these were at risk, therefore, much of the engagement Q&As have focused on providing assurance. This has meant less time has been given to the opportunities that the proposal brings. This should be re-balanced in the next stage of the engagement work.

2.11 As a result of the engagement, and need for staff assurances, two substantive changes are proposed:

- A "Triple Lock" on pay, pension & NHS ownership
- A 25-year contract.

2.12 The “Triple Lock” is three measures that go far beyond the TUPE legal protection on pay and conditions. The first protection is NHS FT Directors will sit on the OpCo Board and have reserve powers to block any change to pay, terms or pensions for existing or new staff. Secondly, the contract between each FT and the subsidiary will have a requirement that staff working have to be employed on NHS national pay, terms and conditions, with the right to the NHS pension.

2.13 Thirdly, the company articles, in effect its rules, will have the requirement for staff to all work on NHS Terms and conditions, access to NHS pension etc. Therefore, there is no prospect of the company “going rogue” and being able to do anything different.

2.14 The Triple Lock also applies to ownership having to remain 100% within the NHS.

2.15 The second concern raised, and with a suggested solution, is whether the contract could be 25 years. This is longer than the originally proposed ten. This allows longer for the company to be established, and fits with the contract length many other subsidiaries have been set up with.

2.16 Of particular note, the fear of being outsourced is then effectively “locked out.” This is something that is stronger than the status quo, where outsourcing could occur any year, especially if the wider Dorset Trusts entered into financial turnaround and the scale savings of outsourcing became impossible to resist. In those circumstances, there would be no triple lock on pay, pension, and public ownership would be lost.

2.17 The engagement stage has been more divisive and undoubtedly some staff have been deeply affected. The national context of job losses in the NHS, and in neighbouring Trusts has heightened anxiety. With this stark backdrop the Board’s principles around protecting staff and public ownership still left many staff wanting greater assurance. This is why the triple lock and longevity proposals are recommended as substantial changes following the engagement.

3 Self-certification to progress the business case.

3.1 Attached are the 42 specific areas that the NHSE guidance expects Boards to consider, prior to establishing a subsidiary.

3.2 Each has been assessed and met for this stage of the project, with a small number requiring work that is only possible a later stage. The NHSE review panel will also consider the evidence and strengthened FBC, against the 42 checks, and provide feedback, as part of its process.

3.3 Professional advice has been sought where legal or accounting opinion is required. A tax opinion has also been shared with NHSE.

3.4 This is a self-certification, as FTs are the responsible legal entities with the competency to establish subsidiaries. Therefore, the Board is asked to give due consideration to the self-assessment. This includes having had a detailed walk-through and scrutiny prior to the Board meeting.

4 Operating Company Shadow Board (OpCo)

4.1 It is good practice to establish a Shadow Board, to provide oversight and assurance of the "go-live" process, and to provide continuity from Day One.

4.2 The Terms of Reference are attached for approval. In essence, the Shadow Board will be the programme Board for everything that the FT Boards can delegate. The final go/no go decision will remain for each Trust Board to make. The Shadow Board will allow the speed and co-ordination required to match the programme and timeline.

4.3 The membership of the Shadow Board is drawn from two sources:

1. Shareholder non-executives, drawn from the 3 FTs.
2. Shadow executives (MD, FD, Directors of Estates & Facilities, Procurement, and major capital).

4.4 The proposed shareholder non-executives are as per the annex, which includes profiles of the individuals. They have been selected to provide a range of skills & experience and representation from each Trust. The shadow chair is proposed as a 7th member. This would be the UHD Strategy and Transformation Officer.

4.5 The shadow executives will be working on an interim or secondment basis. The process to identify these would be via expressions of interest from staff working within the Dorset provider collaborative area, and then interview by shareholder non-executives.

5 Property Company Shadow Boards (PropCos)

5.1 As part of the proposal each Trust will have a Property Company dedicated to ensure the OHFA (Operated Healthcare Facility Agreement) is delivered, and to manage the assets. This will be fully consolidated within the Trust group structure.

5.2 The shadow Board membership is expected to be far more focused, with just the CFO, a FT NED and one independent non-executive director. It is recommended to recruit the independent NED now on a 12-month contract, which ensures continuity and a minimal project cost.

5.3 The Board is asked to support these next steps in establishing the Shadow Prop Co Board, specific to this Trust.

6 Sterile Services

6.1 Both DCH and UHD have in-house sterile services departments (SSD). This is a vital service, decontaminating all the instrumentation, especially for operating theatres, procedure and endoscopy rooms. Without these teams we couldn't operate or scope any patients.

6.2 Many other Trusts have either an outsourced or sub-co providers, often operating at scale. Southampton are just about to open their new offsite facility, run by a commercial company. In Dorset, we are investing in both SSD buildings this year, to make them more resilient and compliant.

6.3 At the time of the April Board discussions on shared Estates, Facilities Management and Procurement (EFMP) services, SSD was considered for a later phase. During the engagement and preparation phase, bringing SSD in for Day One has been raised for the following reasons:

a. Moving to a single shared service would allow greater co-ordination, especially when both services are both undergoing major building works and disruption this year.

b. SSD is an integral part of the Operated Healthcare Facility Agreement (OHFA) required to be HMRC compliant. This would mean capital investment in year for building works and extra instrumentation could go further. Practically this means it is affordable to provide more project management and service leadership capacity to manage the changes. Also, there is greater spending power from the allocated capital money allowing more building works and instruments.

c. The commercial opportunities of refurbed and compliant units are one that the OpCo will be better placed to maximise. This will be a more competitive environment, with Southampton and others having spare capacity. Being in the OpCo will provide a level playing field on operating costs, including tax. Being ready for this earlier will also help protect current non-FT income.

d. A review of recruitment and retention of the staff group working in this service could be led by the OpCo, in year. If there is evidence this would reduce vacancies and turnover, then the move to OpCo could provide a funding source for a banding review or RRP for SSD staff.

6.4 The OHFA includes sterile services as it is integral to support to theatres, endoscopy and procedure room work across the Trusts. It also is a large capital and revenue intensive service linking with procurement & stock supplies, well-maintained estates, and coordinated portering & cleaning. Tax advisor view is that without this the overall viability of the OFHA is at risk.

6.5 Set against this, is the risk of change to these critical services, which are:

1. Change, without clear benefits to staff and service users (e.g. surgeons/theatre teams) can be demoralising, risking impact on productivity and turnover.
2. The two teams have not traditionally had to work together; and whilst two sites will continue, there may need to be some wider team building at leadership and supervisor level to gain the benefits of scale, standardisation and co-ordination.
3. The sites are undergoing major change programmes, to remove backlog capital works. This is absorbing the bandwidth of the leadership teams, as loss of service would have a major impact on productivity and access times for clinical services.

6.6 To mitigate these risks, work with service leaders is needed. The initial view is:

1. Clear rationale, and engagement, tailored to the staff at all levels, including those for whom English is not their first language. Carefully wording of the pay review will be considered.
2. Time and expert support for organisational development and leadership development.
3. To enable backfill of staff and additional project management time to ensure both the business as usual, the refurbishments, and the shared services work are undertaken.

6.7 With further engagement with the service leads, and robust deployment of the mitigations and others to be identified then the Board is asked to consider including SSD within the shared services proposal.

7 Staff consultation

7.1 If the Board agrees to proceed with formal TUPE consultation with staff, then the finalisation of the staff in scope will be completed over June. The in July and August staff would be contacted in writing and offered information and 1:1s meetings.

7.2 Based on headcount, the snapshot estimate of individuals involved is just over 1,600. (not including SSD). As service leaders complete a line by line, named review this may vary slightly.

ALL 3 DORSET TRUSTS

Service Groupings	No of Staff **Headcount**
Catering Services	260.00
Domestic Services	618.00
Estates services	377.00
Facilities Management and Support	21.00
Portering	157.00
Procurement	57.00
Transport services	56.00
Estates services Inventory mgt logistics	58.00
total (headcount)	**1604.00**

7.3 Mindful of summer holidays, and subject to discussions with Trade union representatives, we anticipate a six-week TUPE consultation period, starting before the school holidays, would be used. This is longer than the 30 days set out in some trusts' organisational policies. It is not expected staff would be off the whole of the period for annual leave. If any staff are, then special arrangements would be made to accommodate them.

7.4 Any staff that may have TUPE protection for the OpCo executive roles would be identified early on. This would inform the initial stages of the permanent exec team recruitment, to try and provide leadership in place ahead of the target go live date. Where there are vacancies, initial search and selection would begin. All of these actions could be reversed if the final Board decision were to not proceed.

7.5 The engagement of this many staff, across Dorset, requires a dedicated HR project team, which is now in place, which will need to be supplemented by HR business partner resources from within each Trust (to be identified). This is to supplement the line managers role, and any Shadow Board members or project team staff acting on behalf of the "receiving" organisation.

7.6 It is recognised that any change is disconcerting. The "lift and shift" of services as they are, with pay, pensions, NHS ownership, line management etc not changing for virtually all staff be will important. The actual change being consulted on is the transfer to the 100% NHS owned subsidiary.

7.7 The main exception to this are for procurement staff where a "target operating model" and new structure is proposed. For staff at the top of the services in scope, there maybe some line management change as a result of the OpCo Board being in place. Finally a very small number of staff may be TUPE protected for a role within the PropCo. The work over June will confirm who is any TUPE protection pool.

7.8 Like most NHS trusts the Dorset Trusts have agreed organisational change policies with trade union representatives which address major organisational change including TUPE transfers. Even if trade unions do accept the creation of a Subco model for delivering shared services, they are not likely to object to the Trusts and Subco adopting the agreed organisational change policies and practices when formally consulting about TUPE. Planning should ensure the policies are followed.

7.9 Other factors to reflect in the planning and preparation are to keep separate the TUPE consultation obligations of the Trusts (the transferor employers) and those of the Subco (the transferee employer). This is where having a team of HR Business Partners from the Trusts to engage on behalf of the Trusts will be helpful. The DSS HR&C workstream would act on behalf of the Subco to ensure it complies with TUPE regulations.

7.10 The WOS (Wholly Owned Subsidiary) companies meetings with trade unions and executives should be scheduled at least fortnightly to enable issues to be surfaced and responded to in a timely way. It may be appropriate to formally invite members of the Shadow Board from time to time, if not as standing attendees. The meetings will provide a regular platform for monitoring how feedback and issues are addressed by the Trusts and SubCo and give minuted audit trail of steps taken to inform, consult and comply with TUPE regulations and NHS good practice.

8 Timeline

8.1 The one-month extension to the original timeline provides some contingency for NHSE assurance or TUPE consultation to take longer, or for other preparations if required. The main negative of this extra time is it would be realising the benefits in the case. Any slippage beyond December would be more problematic, as January–March are typically extra busy for Trusts, with winter pressures, and the budget planning setting for the following year.

8.2 The transfer of staff payroll and pension will require sufficient lead times. The strong advice is to avoid the December payroll, as this is run earlier than every other month.

8.3 Having a target date of November go live, is still challenging, and will require continued dedicated leadership and project management. If there is further slippage a contingency date of January 1st would be used. This risks reduced in-year benefits. The shadow Board and FT Boards would be required to approve and adjustment to the timeline.

9 Naming and values

9.1 Staff have fedback the importance of making clear they are still part of the NHS and here for our patients. This is evidenced by being on NHS payscale, pensions, terms, and conditions, and working for an organisation that is 100% NHS and publicly owned, having the NHS logo on uniforms and signs, and working in hospitals and community settings alongside other NHS staff, and above all being focused on the patients and their carers. All of this will continue.

9.2 The Operating Company will need a name, and so a process to draw up a shortlist is attached as an annex. This is one small part of creating the culture and ethos of the new organisation. Board comments on this process are welcome.

9.3 To start building the new culture requires drawing on the rich legacy and experience of the staff and services across the Trusts, and the many sites. This needs to be respectful of the past, and of differences, and positive of the future opportunities available. It needs to be realistic as to the scale of challenges in the NHS, and the EFMP services especially. The goal will be to take the best of the three legacy Trusts, and combine these to create a new, Dorset wide service, better able to serve the Dorset population.

9.4 It will be the role of the Shadow Board to consider how best to set up the process of organisational development, and the cultural baseline and improvement work. The FT Boards will receive an update as part of the September Board report back on overall progress.

10 Pension update

10.1 Some staff during the engagement sessions expressed concern about entitlement to their NHS pension, if they worked in a subsidiary. The FAQs made clear that all known requests by NHS subsidiaries had been approved. However, some staff did not feel sufficiently assured. Therefore, the following written confirmations have been provided by the pension administrator, NHS Business Services Authority. For existing staff:

"Staff who are compulsorily transferred from an NHS organisation to a Wholly Owned Subsidiary (WOS), retain their employment terms and conditions, in accordance with TUPE regulations and access to the NHS Pension Scheme, in accordance with HMT's New Fair Deal guidance."

For new staff (starting after the SubCo has gone live):
"Ministers from the Department of Health and Social Care have reached a decision to accept applications for new starter access to the NHS Pension Scheme from Trust WOSs. The Department of Health and Social Care is satisfied that allowing new starters in trust subsidiary companies into the scheme is consistent with wider scheme access policy, provided that such companies can prove that they are wholly owned by an NHS organisation."

10.2 Therefore, the advice is clear - Dorset Subcos will be successful in their application for NHS pensions provision.

10.3 The only point where definitive advice has not been confirmed is on the speed of managing the transfer, as NHS BSA has no set standard for this. However, from experience this can be several months. The timetable can't be started until the subsidiary requests a pension Direction. This can only happen after the FT Boards approve the subsidiary being set up. Once the Direction application is made, NHS BSA can provide a letter of comfort, whilst the process is being undertaken.

10.4 Therefore, it is proposed to set up the subsidiary as a legal entity, to prepare the Pension Direction application, and then engage NHS BSA to see how soon they can start the process.

11 Setting up the legal entity

11.1 The legal advisors, Hill Dickinson, suggest the formation of a subsidiary company by an NHS Foundation Trust typically would occur after the business case has been approved, which could be in the second half of June.

11.2 In practice Trust subsidiaries need to be in place approximately 3–4 months before the planned operational start date. This balances the need for preparation with a wish to avoid premature costs and revising obligations.

11.3 A number of factors support taking this approach of setting up before the end of June:

i. Allows the subsidiary to enter contracts (e.g. leases, service agreements, employment contracts) in its own name.
ii. Time to open bank accounts, register for VAT, and set up payroll and accounting systems.
iii. Early formation supports the legal transfer of staff under TUPE regulations and allows for recruitment under the new entity as well as the process for seeking NHS pension status.
iv. Enables the Trusts to begin public and internal communications about the new entity with a formal identity.
v. Some services may require registration with regulators, which could only proceed once the company exists.
vi. Allows time to appoint directors, establish governance structures, and hold initial (shadow) subsidiary board meetings prior to go live.
vii. The subsidiary is likely to need to be a legal entity to participate in procurement frameworks or negotiate supplier contracts.

11.4 Therefore, the Board is asked to support the setting up of the legal entity for the reasons listed above. This does not pre-judge the decision making which is due in September. The legal set up is though required to be able to be ready for the go/no go decision to be on track.

12 Other issues for preparation – OpCo Board, Reserve Matters and FBC development.

12.1 The OpCo permanent Board will need recruiting to in a way that can take the baton from the shadow Board. The Shareholder directors are expected to be largely the same as those on the shadow Board, thus providing some continuity.

12.2 For executive roles the TUPE process will be followed. Being a shadow executive is not a claim to being eligible for the permanent roles. If the OpCo permanent exec roles are not filled through the TUPE route, then there will be an open recruitment process. This expected to take several months, and therefore postholders may start after the go live date. This will need to be managed pragmatically. No permanent commitments will be made ahead of the formal go/no go decision of the Boards. The only exception to this is where there is already a vacancy for an equivalent, vacant role e.g. Director of Procurement role.

12.3 Finally, three independent non-executive directors will be recruited to the OpCo Board. As with FT Trust Board recruitment, the selection criteria will be mindful of the existing OpCo Boards' overall experience and skill sets and how to ensure a balanced Board.

12.4 The other issue to enable appropriate pace in set up will be to agree the reserve matters. It will be a Trust Board decision to determine the level of reserved matters it wishes to retain, and the level of authority it will delegate to the company. A draft schedule is attached, and feedback welcome. It considers issues such as strategy, structure and capital, financial reporting and controls, and renumeration. This will be developed and approval will be sought from the Trust Boards prior to the September report seeking go/no go decision.

12.5 Finally the Board is asked to delegate to the CEO non-material updates to the Full Business Case. This is avoid needing to bring back to all three Boards minor changes and updates that may be required, eg to meet NHSE requests. This is in line with recommended practice for NHS business cases being developed and assured with other parties.

4.0 Conclusion

As can be demonstrated from the level of decisions required, there has been a considerable amount of work undertaken since the Board last reviewed the case in April. Significant work still remains, and the project team and workstreams will be very busy up to the target go-live date.

Advice and comments from the Board is welcomed.

5.0 Recommendations

To agree the 11 recommendations, as per the executive summary.

Recommendation
Members are requested to: • **Approve** the 11 recommendations.
Name and Title of Author: Richard Renaut – Chief Strategy & Transformation Officer University Hospitals Dorset **Date** 3rd June 2025 **Appendices** Full Business Case: Dorset Shared Services Annexes to the FBC

OUR DORSET PROVIDER COLLABORATIVE:

SHARED SERVICES: Estates, Facilities Management and Procurement

FULL BUSINESS CASE

JUNE 2025

Version 2.2

Table of Contents

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Version Control

Version	Author	Description	Date
Draft V1.1	Richard Renaut Chief Strategy & Transformation Officer - UHD		01/01/2025
Draft V1.2	Richard Renaut Chief Strategy & Transformation Officer - UHD		01/03/2025
Draft V1.2.1&2	Richard Renaut Chief Strategy & Transformation Officer - UHD	Amendments to finance case and formatting changes.	17 to 30 /04/2025
Draft V2, 2.1 and 2.2	Richard Renaut Chief Strategy & Transformation Officer - UHD	Updates based on feedback from stakeholders and review of the April version of FBC	22/05/2025 to 04/06/25

List of annexes

Annex number	Annex title
1.	Options appraisal pack
2.	NHS Dorset Annual Report
3.	Public Health Dorset Report
4.	Dorset ICS Green Plan
5.	ODPC Summary for Estates and Procurement solutions work programme
6.	OpCo and Trust Hosting Assessment Dorset
7.	Prop Co pros and cons assessment
8.	Financial Model
9.	Equality Impact Assessment
10.	Key Lines of Enquiry
11.	Procurement opportunity assessment – Commercial in confidence
12.	Project Risk Register
13.	Briefing and FAQs for staff
14.	Preparations for TUPE
15.	Shadow Board profiles
16.	Shadow ToR
17.	Staff engagement report
18	September Boards Go/No Go Checklist
19	Company naming process
20.	Pension Direction note
21	Triple lock of T&Cs and NHS ownership note
22.	Reserved Matters
23.	Self-certification assessment (NHSE checklist)

Glossary of Terms

TERM or ABBREVIATION	DESCRIPTION
CSR	Clinical Services Review
CDEL	Capital Departmental Expenditure Limit
CGS	Capital Goods Scheme
CSR	Clinical Services Review
DCH	Dorset County Hospital
DHC	Dorset Healthcare
DHSC	Department of Health and Social Care
EHR	Electronic Health Record
EIP	Efficiency Improvement Programme
FBC	Full Business Case
FM	Facilities Management
HMRC	His Majesty's Revenue and Customs
ICB	Integrated Care Board
ICS	Integrated Community Services
IRR	Internal Rate of Return
JVs	Joint Ventures
KPIs	Key Performance Indicators
KWH	Key Worker Housing
LLP	Limited Liability Partnership
M&E	Mechanical and Electrical
NHP	New Hospitals Programme
NHS	National Health Service

NHSE	National Health Service England
NPV	Net Present Value
NZC	Net Zero Carbon
OBC	Outline Business Case
ODPC	One Dorset Provider Collaborative
OpCo	Operating Company
OFHA	Operated Healthcare Facilities Agreement
PFI	Private Finance Initiative
PSRIF	Patient Safety Incident Response Framework
PV	Photovoltaic (Solar Panels)
PWF	Preferred Way Forward
QIA	Quality Impact Assessment
RBH	Royal Bournemouth Hospital
ROI	Return on Investment
SDAT	Sustainable Development Assessment Tool
SLA	Service Level Agreement
SOC	Strategic Outline Case
SubCo	Subsidiary Company, wholly owned by the NHS
TOM	Target Operating Model
TUPE	Transfer of Undertakings (Protection of Employment)
UHD	University Hospitals Dorset
VAT	Value Added Tax
VFM	Value for Money
WOS	Wholly Owned Subsidiary (also known as SubCo)

1 EXECUTIVE SUMMARY

1.1 The preferred way forward

1.1.1 This Full Business Case (FBC) is being considered by each of the NHS FTs in Dorset, following discussions as a provider collaborative. Estates, Facilities Management and Procurement (EFMP) have been identified as having significant potential benefits, in the preferred option.

There are important principles the Boards have all agreed that must be maintained. These are:

(1) NHS Agenda for Change, Terms & Conditions are maintained for existing and new staff.
(2) Access to NHS Pensions is maintained.
(3) Trade Union recognition remains, as well as full access to staff wellbeing, speak up guardians etc.
(4) Any organisation established remains 100% NHS owned.
(5) Trust assets remain consolidated with the Trust that owns them.

1.1.2 Each Trust is separately asked to consider supporting the preferred way forward (PWF), identified at the Outline Business Case (OBC) stage, and confirmed at the previous Board discussion on the FBC. The PWF has been refined and strengthened based upon discussions at Boards, with regulators and advisors, and through this process. This has now been subject to staff and stakeholder engagement which is summarised in a separate report. This engagement will continue as set out in this case. The five principles were agreed by all three Trust Boards as core to the proposal.

1.1.3 In summary, there are two main stages to achieve the PWF. Step one: Each Dorset Trust establishes a wholly owned subsidiary company, agrees a 25-year lease for buildings and equipment, and a managed service via an OHFA (Operating Healthcare Facility Agreement). This achieves benefits 1 to 7. Step two: One Trust also establishes a second subsidiary, which it has a majority control of and consolidates in its' group structure. Minority shareholding and reserve rights are agreed with the other two Foundation Trusts (FTs). The majority of staff in EFMP transfer in and this becomes the operating company. This then contracts with each Trust subsidiary, so they can deliver the integrated managed service, with the benefits of scale that a shared service can achieve. These enhance benefits 3-5 and unlock further benefits 8-10. These two steps would happen back-to-back to ensure everything happens to maintain continuity of services.

1.1.4 The 10 benefits are set out below in the strategic case. They represent a step change in quality, cost effectiveness and staff engagement, and so align with the strategic objectives set out in the OBC, for improving value for money.

3.1.1 The economic assessment, and benefits ratio are summarized. This the preferred option as "expected" base case, and the up and downside cases. These figures are

for the initial ten years of the economic model. The results are:

	Net Present Cost (savings) £000	Benefits ratio
Downside	58,146	4.08
Expected	**81,530**	**5.35**
Upside	169,530	10.19

1.2 Strategic Case

1.2.1 The strategic reasons are based on ten benefits.

Benefit	**SubCo**	**Shared Service**
1. Dedicated Company Structure, for transparency and accountability	✓	
2. Dedicated Board leadership, for greater client focus	✓	
3. Freedom to operate and innovate	✓	✓
4. Commercial Drive	✓	✓
5. Dedicated workforce	✓	✓
6. Asset Management	✓	
7. Value for money duty	✓	
8. Shared procurement service		✓
9. Shared Services Management		✓
10. Strategic Focus		✓

1.2.2 The benefits identified are in two parts. Benefits 1-7 are from establishing a subsidiary company for each Trust. This is a well-established arrangement, as it has occurred in many NHS Trusts. Thus, there is a strong track record and precedent.

1.2.3 The second set, benefits 8-10, are then accessed by the SubCos sharing services. This is achieved by having the shared service operating company (OpCo) holding most of the staff and supplying the other SubCos. This enables economies of scale that no single Trust can achieve. This scale and synergy, then means benefits 3-5 are further enhanced.

1.2.4 Each benefit listed, is a grouping of specific sub-benefits. These are described in this section to illustrate the impact. This is the impact above carrying on with the current approach (counter factorial). Some could in theory happen without the SubCo. This is explored and where possible quantified.

1.2.5 In the detailed benefits report each benefit is then assessed, using a logic model. This sets out the workings, with assumptions, ranges, inputs, and outputs. The outputs are grouped under:

- cash releasing;
- non-cash releasing (cost avoidance);
- societal benefit;
- enabling (helps improve likelihood of achieving the three other benefits).

1.3 Economic Case

1.3.1 The appraisal of options considers the longlist of ways to best achieve the strategic rationale and benefits. These are then assessed for financial, and value for money comparisons. These include non-cashable and societal value assessments.

1.3.2 The longlist of options are:

A. 'Do nothing different to now' using informal collaboration, on tactical basis. The 'as is' model for DHC and DCH is to continue with development of a federated shared service as part of their joint Trust strategy.

B. Hosted service

C. Outsource services into managed service contract(s).

D. Become a customer of an existing subsidiary company, within the NHS.

E. Set up a single subsidiary company, holding the shared services, with 75% ownership by a lead Trust and transfer of all assets.

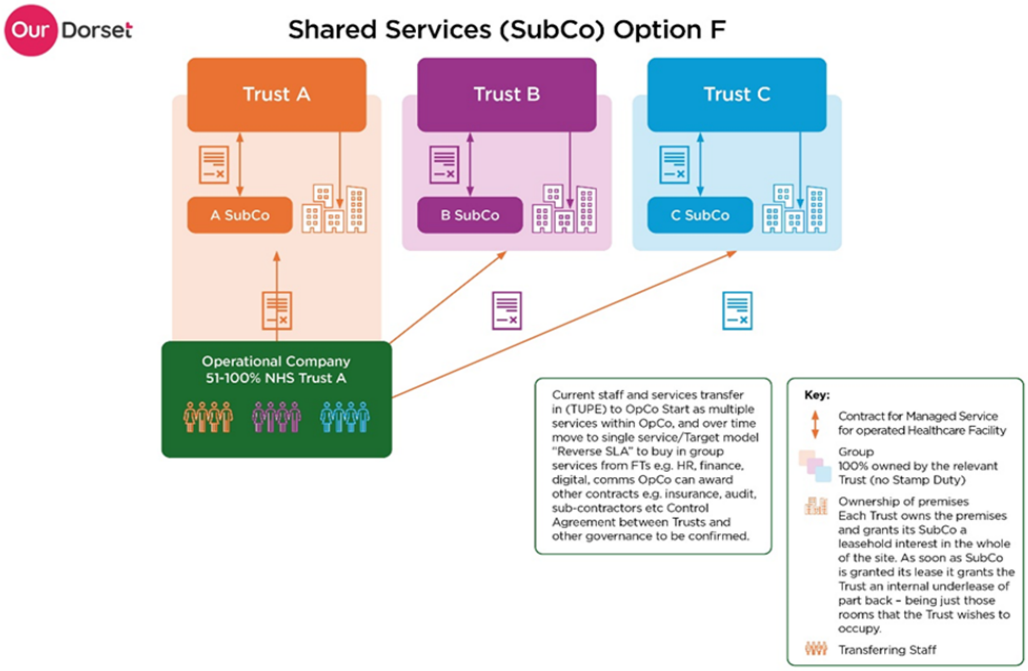
F. Set up a separate subsidiary company for each Trust in Dorset focused on property assets managed service delivery. This is serviced by a single shared service provider in an operating company "OpCo."

Other options that have been ruled out, and reasons for this, are covered in the chapter.

1.3.3 The scoring criteria and process is set out in more detail in annex 01. An expert panel has reviewed the information and made a recommendation for the Board's consideration at OBC stage. Each Board has agreed with the Option F as the PWF. The Full Business Case then uses the preferred way forward as the focus for greater depth of work, especially on benefits, risks, and implementation. More detail is covered by the management chapter.

1.3.4 A hosting arrangement appears possible but has some intrinsic and fundamental weaknesses that make it sub-optimal to other options. These can only be partially mitigated. The proposal for a shared Operating Company (Option F) scored highest. Resolution of issues around implementation are set out in the management chapter. Setting up a single subsidiary company (option E) had the next best score and has greater controls, transparency, and benefits above simple hosting. However, there are problems with this, especially regarding the transfer of assets. Option F is the 'preferred' and option E is the 'reserve' best option and have many similarities.

1.3.5 The visual representation of Option F is set out below.



1.4 Commercial Case

1.4.1 This chapter considers the market assessment, and the models to best enact the preferred option. Critical success factors are also reviewed, including:

- Governance and contractual issues.
- Staffing, retention, engagement.
- Service offering.
- Scope and phasing.

1.4.2 The procurement services part of the case is reviewed. The impact on supply chains, social value procurement, financial and operational benefits are considered.

1.4.3 The rationale for developing an Estates service for major capital schemes is also considered. This is a major strength of the Dorset system with an experienced, collaboration-based team who have successfully delivered over £750m capital works. This could be beneficial to the wider NHS, as well as a trading arm of the shared service. Similar opportunities exist for other centres of excellence that could be developed, e.g. sustainability services, within both estates and procurement, as well as system leadership for Net Zero Carbon (NZC). Facilities Management, key worker housing and others are possible. The market assessment is considered.

1.4.4 A change to be considered is whether to include Sterile Services in the TUPE consultation. This has many of the opportunities to flourish within the OpCo, for example greater resilience, commercial sales, and developing careers and expertise in house. Other services in future scope are considered, and the market assessment, to inform options and benefits.

1.5 Financial Case

1.5.1 This chapter looks at the financial costs and benefits of the shortlist options. These are summarised as per the table.

Table: List of potential benefits

Benefit	Cashable	Non-Cashable	Societal	Enabling
1. Dedicated Company Structure				
a. Board Time on EFM/P moves from minimum at FT to main focus of SubCo. b. Customers can enforce terms, separate accounts not "lost" in wider Trust. c. HSE etc. would hold SubCo responsible for the "managed service" provided.				Y Y Y
2. Dedicated Board leadership, greater client focus				
a. Execs/NEDs have EFM/P professional qualifications. b. Greater assurance, less reactive compliance to regulators. c. KPIs agreed with Trusts, with expected improvements. d. Customer & patient benefits e.g. wayfinding; single system to report issues etc.		 Y Y Y	 Y Y Y	Y
3. Freedom to operate and innovate				
a. Procurements, capital deployments, staffing decisions. b. Able to move resource where needed, shape supply chains etc. c. Take on new services and customers, invest to save, e.g. use of AI and asset tracking tech.		Y Y Y	 Y	Y Y
4. Commercial Drive				
a. Reduce contractor spend, growing team. b. GP practices unable to get quotes, let alone works done; Care homes, vol sec. c. NHP 10+ year opportunity, on client and supplier side d. At scale purchasing, systems etc. for better service. e. Rationalise catering offer in NHS, then offer to care homes, schools etc.	Y Y Y Y Y	Y Y Y	Y Y Y	

5. Dedicated workforce				
a. AFC+ to reflect competitive market, RRPs, profit share etc.		Y		Y
b. Faster vacancy approvals, consistency checking within SubCo only.		Y		Y
c. Strong evidence (Prof West) + improvement methodology (Patient First).	Y	Y		
d. Scale allows more entry level & development roles, reduce turnover.		Y	Y	Y
e. Use of task allocation systems, saving time.		Y		
f. Recruitment in communities, offer volunteer and work experience.			Y	Y
6. Asset Management				
a. "Up" time made contractual, so beds, theatres more available.		Y		
b. Use of community hospitals improved, for rad, endo, clinics etc.		Y	Y	
c. High transactional cost if separated.		Y		
d. £750m investment in estate, if not maintained well, will cost more long term.		Y		
e. Develop expertise, links to utilisation of estates.		Y		
f. Better fill rate of accommodation; regular rent reviews etc.	Y	Y	Y	
g. Expertise developed, legal & fees reduced, rents and rates improved.	Y	Y		
7. Value for money duty				
a. Current costs will benchmark higher, and duty to address this.				Y
b. Outsource (private or subco) instantly lower cost as tax efficient.	Y			
c. NHP descoped schemes, VAT reclaim means the investment can go ahead.	Y	Y		
d. If VAT not charged on med kit, buildings, +20% spend power etc.	Y			
8. Shared procurement service				
a. Paybill reshaped, new career structure.		Y		
b. Single purchasing, strategic supply chain management etc.	Y			
c. Combine spend and standardise - maintenance, contractors etc.	Y		Y	
d. Invest in cutting edge IoMT tracking, reduce stock holdings.	Y	Y	Y	

e. Drive 10% social value impact e.g. Blackpool case study on boost to local economy.			Y	
9. Services Management				
a. Changes to estate (insulation, PV etc.) and servicing BMS controls.	Y	Y	Y	
b. Detailed programme by site for NZC.			Y	
c. Change service model and aims, to BNG and rangers/volunteers.			Y	
d. Multiple services, sites, times & systems for "customer services".		Y		
e. Develop best practice, use of tech, cleaning robots, rotas etc.		Y		Y
10. Strategic Focus				
a. Better governance to drive high impact improvements (&avoid fines).			Y	Y
b. NHS land across Dorset, potential for 2,000 homes.		Y	Y	
c. Enable strategic service changes, e.g. move services, tech enabled change to clinical models, patient edu classes.		Y	Y	

1.5.2 This chapter provides initial assessment of risks and estimates Net Present Cost on a ten-year business plan. The prudent estimate is an £85m betterment to the continue doing the same as now option. The key assumptions and calculations are set out. This includes an expected (base) case, a worse / downside case and a best case / upside scenario. The sensitivities are also assessed with a percentage adjustment based on deliverability. The economic model is an appendix and will be used as the basis of business planning and benefits model for the subsidiary option.

1.5.3 The tax and accounting advice will be developed further, post FBC approval, and prior to go live. The professional tax opinion concludes this is a low-risk approach, compliant with HMRC and previous rulings. This is drawing upon guidance and case law, and the experience of the 60+ wholly owned NHS subsidiaries will inform this. A one-off benefit is included within the base case, but any other financial benefits from accounting and tax regimes are best case scenario only. This means any decision making is on the base case, with the majority of benefits assessed excluding accounting and tax issues. This means that the preferred option is still preferrable, regardless of the tax position.

1.5.4 The option for shared services creates a question about consolidation of accounts. Both the preferred option and second option mean consolidation would remain at Trust level. On this basis the assurance process would remain within NHSE, and the guidance they have issued.

1.6 Management Case

1.6.1 This delivery of the business case is assessed here. The governance in establishing and running the shared service is set out, with an implementation plan for the PWF option. Crucial are staff engagement actions, including a staff FAQs (See annex 14).

1.6.2 The capacity and capability to execute the plan exists within the three Trusts. The experience of the Shadow Board/Trust leadership is set out in the Annex 16, listed the proposed Trust shareholder representatives.

1.6.3 The FT leadership teams have experience of major transactions (mergers), major projects (£750m of capital works and service reconfiguration) as well as operating FT group models. There is also experience of commercial partnerships including Limited Liability Partnership (LLP) Joint Ventures (JVs). One Trust already operates a wholly owned subsidiary.

1.6.4 Board's due diligence, the regulatory approval process and risk management approach are covered. The Board Self Certification is in the Annex 24.

1.6.5 The conclusion is that this is likely to be a significant transaction, requiring high levels of specialist advice and a dedicated project team to ensure successful delivery. This is in place. All this indicates the experience and competence is within the local FTs to make this project deliverable.

1.7 The indicative programme and next steps

1.7.1 Progress is subject to approval to proceed. This is from the respective Board of Directors for each Trust. This is alongside assessment and advice from the NHSE Transactions Team. Advice will also be sought from some of the 60+ established wholly owned subsidiaries already operating within the NHS, and their lessons learnt.

1.7.2 The indicative timeline is:

Engagement with stakeholders, HR and communications starts	March-Oct 2025
Full Business Case approval on preferred way forward.	April 2025
NHSE assurance (Regional + Transactions team, assume 3 months)	April-June 2025 (estimate)
Subject to FBC approval, in parallel with NHSE assurance: due diligence, legal preparations e.g. Service Level Agreements (SLAs), leases or right to occupy, operational policies and governance, recruitment of the Shadow Board, other HR issues, pre and post transaction plans.	April-Sept 2025
Board meetings (in public) to self-certify ready to proceed to next stage of formal staff consultation (TUPE)	June 2025

Staff consultation (indicative dates)	July to August
Board meetings (in public) to make final decision	From September
Target start date for new organisation	From November

1.7.3 For the full programme please see annex 02, this is a live working document. This is based upon learning from similar projects. The staff engagement is critical, and a full programme is planned. This builds on the good staff relationships which exist locally. Ensuring top quality professional advice is key for a successful implementation and has been procured and started. The advisors have experience of NHS collaborative agreements and 30+ subsidiary company set ups and reviews of effectiveness.

1.8 Conclusion

1.8.1 The subsidiary approach unlocks significant advantages in the delivery of Estates, Facilities & Procurement services. The establishment of a shared services vehicle, with majority and minority ownership by the NHS Foundation Trusts in Dorset, offers further opportunities. Together they improve productivity, value for money, and have a wider social-economic benefit & patient outcomes. This in turn can support the NHS mission to improve health outcomes and reduce inequalities.

1.8.2 The scope of services is selected because there are major opportunities, that a shared service can better unlock. Managing the estates, facilities management and procurement in ways involving a group and subsidiary approach, best achieve the objectives. This is backed up by the experience across the NHS in 60+ examples. Other services are identified for possible later stages.

1.8.3 The key principles are very important for staff and the Boards. These are being assured they retain terms, conditions and pension and remain employed by the NHS family, consolidated within the NHS, and assets stay with each Trusts group account. Likewise, the case makes clear the benefits are significant, before considering any best case (upside) from accounting and tax treatment of the activities.

1.8.4 The delivery of a significant transaction requires dedicated leadership and professional advice. This has a strong invest to save approach, with a very strong net benefits ratio. To progress the business case preferred option, upto and beyond the implementation, go-live and first 100 days is a large project. The case sets out the costs, risks, and benefits to inform that decision, with a recommendation of the preferred way forward.

2 STRATEGIC CASE

2.1 Background

2.1.1 The purpose of this Full Business Case (FBC) is to review and recommend the best option to achieve the aims set out by the One Dorset Provider Collaborative (ODPC). These aims are aligned with NHS Dorset Integrated Care System (ICS). These provide strategic alignment, namely in:

- Improving population health outcomes;
- Tackling health inequalities;
- Enhancing productivity and value for money;
- Supporting social-economic development.

2.1.2 The ODPC Board and the three Trust Boards have supported exploring shared services as a keyway to better achieve these aims.

2.1.3 The three Foundation Trusts in Dorset are University Hospitals Dorset (UHD), Dorset Healthcare (DHC) and Dorset County Hospital (DCH). Together they serve a population of over 850,000 people with amongst the oldest populations in the UK, and with significant pockets of coastal deprivation. Population growth is over 1% a year, with fast growth in the over 65s. Despite a long history of strong performance, collaboration and forward thinking the NHS providers in Dorset are facing significant financial and workforce pressures.

2.1.4 Ensuring every “Dorset pound” and the work of NHS staff and partners, is progressing against the ICS aims, means looking afresh at opportunities. The PWF offers away to achieve this strategic alignment. The Estates Facilities Management and Procurement (EFMP) functions have been identified as areas with potential to do even more. Hence this case focus starts with them. This could expand to other services over time, as set out in this case, including digital, other corporate services and others subcontracted already. Others may be developed over time. The reason EFMP have been identified are set out in the options and benefits section.

2.1.5 Some key principles also need establishing at the outset. These are:

a. NHS employment terms and conditions and pensions are respected and will be maintained for all staff.

b. Union recognition.

c. Services should remain wholly owned by the NHS, for the NHS.

d. Assets should remain consolidated with the Trust that has them now.

2.1.6 The core principles are key to the proposal securing Boards & stakeholders support. There are potentially circa 1,300 colleagues involved in the share services in scope, and so having excellent staff engagement and leadership is essential. This is to support staff and unlock the significant potential from working together to deliver the best for patients, public and staff.

2.2 Dorset Integrated Care System overview

2.2.1 The health needs and demographics of the county are set out in key reports, including the NHS Dorset Annual Report (annex 03) and Director of Public Health report (annex 04). Key factors to consider, when assessing this FBC, are:

- An older age profile, leading to greater demand for services, and a smaller workforce pool to supply these.
- A growing population, by 1% a year, leading to pressure on housing and infrastructure. Whilst Dorset remains a great place to live, it is increasingly unaffordable for younger and working aged people.
- Economic growth is amongst the lowest in the UK, over the past 15 years. Health has a role to support a healthy population able to be productive, as well as an anchor institution, supporting employment, supply chain and environmental gains.

2.2.2 The ICS covers two unitary authority councils, with three main NHS Foundation Trusts providing the majority of NHS services. For further information about the Trusts and ICS:

University Hospitals Dorset - https://www.uhd.nhs.uk/
Dorset Healthcare - https://www.dorsethealthcare.nhs.uk/
Dorset County Hospital - https://www.dchft.nhs.uk/
NHS Dorset Integrated Care Board - https://nhsdorset.nhs.uk/

Key statistics about the Trusts include:

Table 1: Overview of the Trusts

	Workforce (WTE) of services in scope	Turnover (£m) of Trust	Capital Assets (£m) of Trust	Non-pay Expenditure (£m) influential of services	CQC rating
Dorset County Hospital	222	306.8	161.0	79.2	Good
Dorset Healthcare (community & mental health)	330	399.2	195.9	69.1	Outstanding
University Hospitals Dorset	703	845.9	549.0	151.9	Good
Total	1256	1551.9	905.9	300.2	

2.2.3 Importantly the ICS includes many other providers including 80 GP practices, South West Ambulance Service Trust (SWAST), a vibrant voluntary and community sector, plus a host of social and community service providers. The potential for a shared service, at scale, to support these other bodies is a future opportunity.

2.3 Strategic Plans

2.3.1 There are numerous strategic plans across Dorset and the wider NHS, into which this proposal fits. This preferred way forward is a major enabler, as at scale and pace it transforms three care services, each crucial for healthcare.

2.3.2 The ICS has the ambition of Dorset becoming the healthiest place in the UK to live. A series of ambitious goals have been set and the partners within the ICS are working towards these. These build upon the ICB's four principles:

- Improving population health outcomes.
- Tackling health inequalities.
- Enhancing productivity and value for money.
- Supporting social-economic development.

2.3.3 This FBC is primarily focused on delivery of the aim for improved productivity and value for money. The preferred option can also support wider aims including socio-economic development through improved supply chains, and local employments and skills development. The faster progress on the sustainability green plan will also benefit the population health aim.

2.3.4 The Dorset Clinical Services Review (CSR) was approved by the Secretary of State for Health in 2019. This is an ambitious programme that sets out prevention at scale, integrated neighborhood working and acute reconfiguration. This aligns with the 10-year NHS plan of three shifts (treatment to prevention, hospital to neighbourhood and analogue to digital). The acute reconfiguration involves the creation of an emergency hospital at Bournemouth, and the UK's largest planned care hospital at Poole. Dorset County Hospital sees major expansion of its Emergency Department and Critical Care Unit. Mental health services are also changing, including new build inpatients, and eating disorders facilities.

2.3.5 After 30 years with no significant capital investments, Dorset is seeing a total of £700m in estates improvements with the bulk through the New Hospitals Programme (NHP) cohort 2, which has permission to proceed. There remain however significant backlog issues in the estate across the county, both in hospitals and GP practices. An infrastructure strategy for future estates capital has been developed, with work on backlog, medical equipment, decarbonisation, digital, are being developed.

2.3.6 The digital strategy for Dorset includes moving to a single Electronic Health Record (EHR) in 2026. This is a collaboration with Somerset. This will address the unsupported systems and low digital maturity across providers and support greater productivity and safety. The overlap with procurement, digital and estate infrastructure and medical equipment is significant.

2.3.7 The Dorset Green Plan (annex 05) sets out the path towards both carbon reduction and other key outcomes, including clean air and reduced plastics. This includes the sustainable development assessment tool (SDAT) which tracks progress. This draws up on the UN's sustainable development goals. Estates, energy, procurement, travel and transport are all key enablers for delivery and also for climate adaptation for changing weather patterns, as well as having a large impact on patients and staff.

2.3.8 Other key strategies include workforce (The NHS Long Term Workforce Plan – find out more – NHS Dorset) clinical strategy and population health.

2.3.9 A consistent approach for continuous improvement, using the NHS Impact and Patient First improvement methodologies will also benefit the services directly, as well as then better serving the “frontline clinical services.” Together these shared Dorset strategic plans provide a robust basis for developing a shared service across the Dorset community.

2.4 Our Dorset Provider Collaborative

2.4.1 The sharing of corporate services including non-clinical frontline services, is one the ODPC is prioritising. Previous work on shared services highlighted opportunities. A major barrier has been the significant change agenda already in place in Dorset. This has included the merger in October 2020 to form UHD, and the move to single chair and executive team for DCH/DHC from 2023. This combined with operational pressures, industrial actions, the major build programmes, a pandemic, and the financial situation has meant focused attention has been required to progress this case. A dedicated Board governance and leadership for the EFMP services would be an enabler to achieve broader and faster benefits realisation.

2.4.2 There is a long history of collaboration in Dorset, and supply of services to best serve the local population. Provider county wide (and beyond) services include for UHD, Oncology, Vascular, Head and Neck surgery, Rheumatology. DCH provides Renal and DHC provides the community, mental health and 111 services. As a result, there are many interfaces and examples of collaborative working. The clinical action networks, form the ‘Can Do’ programme to support collaboration, with prioritised support to an agreed work programme.

2.4.3 The opportunities for procurement, especially in support of clinical services has been identified and discussed at the July 2024 ODPC Board. A potential of £450m “influenceable spend” could benefit from a more developed procurement function. A key will be a move to new target operating model (TOM). This enables better category management and client engagement (from clinicians and others including estates and other high-cost non-pay budget holders). These need combining with specialist procurement knowledge, which is more achievable at scale. These changes will then unlock significant benefits (See 5.3.1). This will require both policies and processes to be aligned, as well as the relationships and accountability to be strengthened and a single controlling mind to drive improvement.

2.4.4 Within Estates, each Trust operates its own service. There are no PFI or outsourced Capital Estates functions. The UHD function has merged and after several years aligned along the ISO9001 Quality Management approach. This is improving the quality and compliance of services and providing a better planned and reliable service. DCH & DHC have a single Director of Estates & Facilities recently appointed and are identifying opportunities for improvement.

2.4.5 Collaboration on the major capital projects has been helpful with each Trust part of the Cohort 2 of the NHP. Despite the pandemic, cost inflation and supply chain shocks of the past few years, the ability to deliver on time and on budget marks out the

exceptional nature of the in-house teams. The opportunity to support the wider NHS as it grapples with major capital change projects is a future opportunity as the Doret schemes complete. This provides both career development and retention of funds and talent within the NHS.

2.5 Financial situation

2.5.1 The Dorset system is currently facing significant financial challenges within its £1.7bn budget. Initial 2025/26 plan submissions place Dorset ICS among the most financially pressured systems nationally. A major contributing factor is the high level of expenditure on Personal Healthcare commissioned by the Integrated Care Board (ICB). Addressing this financial gap will require urgent and transformative change in how services are delivered across the system.

2.5.2 In this context, there is a need to ensure improved productivity, reduce access times and improve finances. Whilst the reconfiguration of services and improved digital will help in the medium term, savings in 2025/26 are needed. 'Low hanging fruit' has already been picked. This business case looks at a step change possible in 2025, which is proven elsewhere in the UK, but does require in-depth preparation & implementation.

2.5.3 The capital situation is equally challenging. After 30 years of low capital investment in Dorset, the significant NHP and other capital investments are hugely beneficial. There remains though many other areas where capital constraints are holding back productivity and slowing the removal of risks to safe service delivery, this includes digital, medical equipment, energy saving & backlog estates. The lack of capital investment nationally has been highlighted in the Darzi Review of 2024. The preferred option enables great capital expenditure, by having an Operated Healthcare Facility Service. This provides a total service, with the benefits set out in this case. This includes a level playing field on VAT recovery with private and other public sector partners. This enables more purchasing power within the same CEDL funding envelope. Apply these capital benefits then unlocks recurrent productivity solutions.

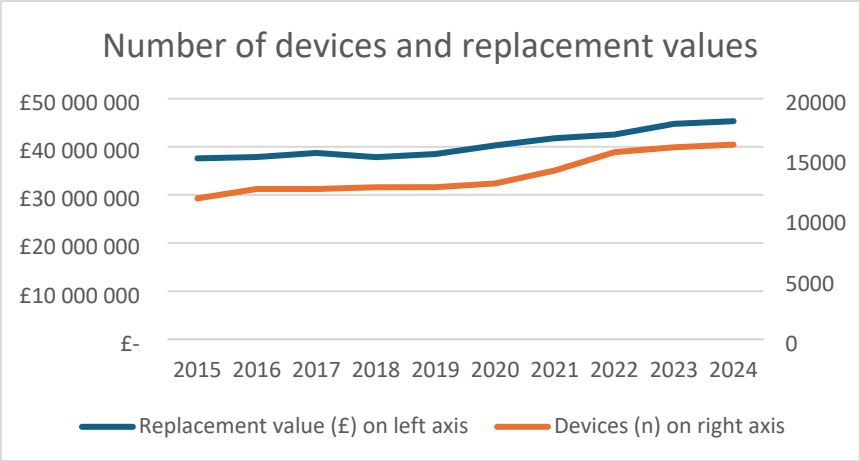
2.5.4 Faster capital investment, or at least to the level of replacing / updating to maintain, is needed. Specific areas include digital, estates backlog, energy efficiency and carbon reduction. It also aids in progressing wider aims such as key worker housing, and additional education facilities to support Dorset's medical school ambition. Significant catch up is also needed for medical equipment including scanners and radiotherapy linear accelerators. Taken together insufficient investment means more downtime on equipment and building failures, leading to cancelled clinical work, safety concerns and lost opportunities. A lack of housing and education facilities slow the recruitment retention and development of the next generation of staff.

2.5.5 Nationally there is an estimated £10bn+ estates backlog. Table 3 indicates the Dorset position. A more detailed review will be undertaken in 2025, through a jointly commissioned 6 facet survey.

Table 3: Estates backlog by Trust (critical infrastructure) Info to follow.

	Total Assets £m	Estimated backlog (Critical & High only) £m	Is typical annual capital spend sufficient to maintain, & reduce backlog?
Dorset County Hospital	161	12 (8)	No
Dorset Healthcare	196	29 (14)	No
University Hospitals Dorset	549	62 (31)	No
Total			

Table 4: Medical equipment. UHD data shows scale of operation, with over £45m of medical devices and 18,000 assets to be supported.



2.5.6 The NHP has been a major investment in Dorset and will run to 2026/2027. However, since the initial allocation there has been very high construction cost inflation, which has reduced the spending power by about 20%. Descoping schemes has been required to live within the allocated sums. Schemes identified at the strategic and outline stages but recurrently descoped include digital investments, refurbishments, and removal of backlog, plus community healthcare modernisation. There are also opportunities for energy savings with net zero schemes also on hold, due to capital limits, despite strong invest to save cases.

2.5.7 This case will not change the Capital Departmental Expenditure Limit (CDEL) as it is consolidated within the Foundation Trust and ICS capital total. A Value Added Tax (VAT) recovery similar to other NHS subsidiary companies and managed services in the NHS should though provide a level playing field with other NHS systems, wider public sector, and all private providers. This will need to be established correctly and be fully compliant with His Majesty's Revenue and Customs (HMRC), rules, and NHSE guidance. To unlock high value, add, high Return on Investment (ROI) schemes like the descoped digital, equipment, energy and backlog reduction supports the benefits identified. The actual VAT benefits are outside the base case for recurrent revenue, so decision making is robustly based upon non-tax reasons.

2.6 National and local drivers, including social value and environmental

sustainability.

2.6.1 The NHS plays a wider role then just delivery of healthcare. As a major employer and 10%+ of the gross domestic product of the county, it is an "anchor institution." This is represented also in education via supporting the colleges and two local universities, research and development and sectors outside of clinical services, such as estates, digital, facilities. There are many other careers in the NHS beyond clinical and having a company focused on EFMP careers would be of great benefit. The local Trusts also play a role as housing provider with 500+ units of accommodation, and potential for 1,000+ units of new keyworker homes (KWH). However, these specialist areas requiring significant services leadership time, and Board attention. Understandably Boards of healthcare organisations focus on clinical services & safety, and fiduciary duties. Therefore, these important wider drivers of social value command less Board time. A company with dedicated and specialist Board leadership can address this.

2.6.2 A well-led organisation is required to also have robust sustainability plans. All the Dorset Trusts have an aligned "green plan", and track progress through the SDAT. However, the dedicated specialist staff is small (less than 5 WTE). The option to grow two or three separate teams, for such a whole system issue is not optimal. To work at scale, provide skill mix and career structure, and allow specialism into the wide-ranging nature of adopting to climate change is a compelling narrative. This will allow Dorset to build on its current progress.

2.7 Strategic Rationale for change in Estates, FM & Procurement

2.7.1 The strategic reasons/benefits for options appraisal, and then recommendation, are:

Benefit	SubCo	Shared
1. Dedicated Company Structure, for transparency and accountability	✓	
2. Dedicated Board leadership, for greater client focus	✓	
3. Freedom to operate and innovate	✓	✓
4. Commercial Drive	✓	✓
5. Dedicated workforce	✓	✓
6. Asset Management	✓	
7. Value for money duty	✓	
8. Shared procurement service		✓
9. Shared Services Management		✓
10. Strategic Focus		✓

A detailed review of each benefit is set out below:

2.7.2 **Dedicated Company Structure**

a. The SubCo exists in law, with its own Board and status. Companies are owned, and are able to own assets, make decisions and operate within company law. The Board has responsibility for the Estates, Facilities management, and Procurement (EFMP) services. This may grow over time, subject to Board decisions. However, this will always remain a much narrower focus, and so allow the Board to focus on improving these services and thinking more strategically about these. This is simply not possible with the current three FT Boards, where running large, complex healthcare services will always, quite rightly take priority.

   This is an enabling benefit for all the others. It is then enhanced by the shared services, as the single OpCo Board will be thinking whole system and have scale.

   The group approach is commonplace amongst both private companies, and the public sector. NHS FTs already have group accounting.

b. The OpCo will hold contracts, with the Subsidiary companies, and potentially with commercial customers. These are legally binding. With this brings a responsibility, professionalism and focus that being an internal department of a large NHS Trust simply does not exist. Customers and regulators, such as the HSE, will be more easily able to see compliance data, and if required can enforce terms on the company and/or the Trust, for issues of non-compliance. This then drives a higher degree of service delivery certainty and contractual compliance. This is helpful in driving transparency, efficiency, and a degree of commercial focus, which is lacking within the three internal service providers who are all operating on different systems. An early area of focus for the OpCo is going to be a shared performance management software system that will underpin a greater standardization and more efficient data collection to support this.

c. The legal accountability of the company board, including personal Director liability, and being able to be prosecuted provides a much sharper edge and accountability for leading a service. This is not currently felt by leads of the services, who may be 2 or 3 steps away from an FT Board, and hence do not personally hold these responsibilities. Whilst this brings an intangible benefit, it feels very real for the individual directors.

2.7.3 **Dedicated Board leadership, for greater client focus**

a. The dedicated Board at both SubCo and OpCo will have a more focused agenda and greater time to oversee and develop the services and assets. This will be an enabler for the other benefits. If the SubCo model didn't have the second step of a shared OpCo, then this benefit would be for the SubCo who would have more external NEDs and specialist execs. With the proposal (Option F) OpCo will be where the additional, subject matter expertise at exec and NED level will be focused. The exec team is expected to include Directors of Procurement, Estates and Facilities, and major capital projects. The FD will also have commercial responsibilities including contract management. Currently these skill sets are not the primary expertise and qualifications of any of the execs in the Dorset NHS system. On the NED side recruitment would be for expertise in these fields, plus HR. Here NED experience of an FT Board would only cover these areas by chance. The result is this expertise is

sitting around the Board table, not 2 or 3 tiers away within a larger NHS Trust. This will enable the latter benefits by quicker, better decisions around the core service.

b. Boards of FTs currently receive assurance to the EFMP services, but this is often relatively briefly discussed and statutory reporting and KPIs, would receive much more detailed, regular, and expert challenge in the proposed OpCo/Prop/Co model. This assurance, plus contract compliance would be the central focus of the company Board – something which can never happen now, as the FT Board responsibilities are so much wider, and do not have contracts for these services, so terms cannot be enforced. This approach of greater Board time and expertise would move from reactive assurance receiving, to one of proactively leading the services at executive level. This allows forward planning and exceeding compliance levels. This can happen now, in theory, but the experience of most FTs Boards is one of reactive response to issues and external stimuli such as CQC, HSE or other regulators. Thus, the OpCo Board focus is a major enabler for quality and safety improvement and reliable consistent compliance.

c. The contract itself would take the management of these services, and their performance to higher levels as evidenced by other SubCos who have been established for years and are providing the total, integrated managed services. The "what gets measured, gets managed" observation is pertinent. This then is an enabler for the other benefits. It cannot be replicated in the other options without a subsidiary company Board.

   The exact KPIs will be agreed with the Trusts as part of the set-up phase when the ten-year contract is agreed. Learning from other Trusts – subco contracting will be used. Total budget, and year on year savings will be a central aspect given the Dorset financial situation. Being safe and legal and providing assurance of this will be the focus for year one (1st full year 2026/27). This will include developing the dashboard of KPIs, with robust underlying data and systems.

   Examples that could be used include: -

   - Reactive response times to requests for works (e.g. cleaning, repairs)
   - Amount of procurement within an up-to-date single contract across Dorset.
   - "Uptime" of facilities such as theatres, which are critical for improved service efficiency.

   With a baseline established for each Trust, the annual business plan can then set improvement targets, which are either no cost or possible with investment, to be agreed.

d. The dedicated Board focus will also give greater customer focus (patients, visitors, staff) as well as to the contract holder. One example of greater customer focus would be a Dorset wide approach to improving PLACE scores (patient led assessment of care environment), sharing expertise. Part of this could be consistent, improved wayfinding, as this is something notoriously poor across NHS hospitals. Taking best practice from Dorset and beyond this could reduce patient stress and improve timely attendance for appointments. This could result in better productivity and outcomes.

A staff-based example could be moving to a single help desk function and online portal for requesting jobs and tracking the progress. Currently the multi-site nature of the NHS in Dorset, means multiple, varied approaches. As staff increasingly work between sites this is frustrating and time consuming. It takes staff away from providing patient care. A dedicated company, with KPIs for patient and staff satisfaction would be both contractually compelled and have the scale and bandwidth to establish better systems.

This is a benefit that in theory could happen now at Trust level but does not and has not. This is the BAU option of carrying on as now, on the hope different Trusts will put the time and energy into a shared service without the governance and contractual discipline of the subsidiary approach. This will not happen, and certainly not across Dorset as without an enabled and dedicated Board it is not likely to see much moving to operating at scale. For a more detailed discussion of this, see Annexes 7&8.

2.7.4 **Freedom to operate and innovate.**

a. The independence of being a separate company (albeit within a group and part of the NHS family), still gives significant room to be agile and focused on the mission of EFMP service delivery. One simple example is the decision-making chain is much shorter, leading to quicker approvals. When contract values are measured in the tens of millions, this can be a substantial benefit. A smaller, more focused, and expert Board would also be better able to fully engage and assess commercial risks, innovations, and trade-offs both in procurement and in how best to deliver the contracted services. As a EFMP provider there is also likely to be higher risk tolerance, that an FT Board, for these reasons. This enables greater service innovation and thus better value for money. It also means the Board can be more involved in high value, complex procurements, where the terms and negotiations could benefit from the Boards time. Quantifying this benefit will be based upon an estimate for better, faster decisions, with more innovative solutions, calculated risk taking and a drive for better terms (this is district from the at-scale procurement benefits listed under 8, below). The benefit calculation is a two-month reduction in procurements, leading to earlier benefits and avoiding inflation as a proxy, on c £40m pa of goods and services.

   Similar faster better decision making can also apply to major construction contracts, and decisions about workforce. As part of the post implementation benefits realisation a compare and contract will be taken to evidence these changes, and ensure the desired outcomes are being achieved.

b. The ability to move resource where needed and manage supply chains will help manage the capital expenditure budget better. Currently the end of financial year ‘rush’ for major capital and procurement exercises, especially with capital budgets can create sub optimal use of resources as small teams are required to often deal with major projects, often with central funds being released late in the year. At a national level 40% of capital is spent in the last 2 months of the year, which cannot be protecting VFM.

   By having a larger, more resilient team in both procurement and major capital projects, and a Dorset wide viewpoint this allows:

- Greater forward planning by using consistent systems and processes.
- Ability to shift Estates and procurement team resources to system priorities.
- Oversight of under, over and slippage on expenditure.
- Management of supply chains, especially in construction, to avoid “Feast and famine” (which generally pushes up costs).

Together this can deliver better value from existing, capital budgets.

c. Taking on new customers is covered in detail in benefit 4, commercial drive, but a key enabler for this will be the freedom to act and innovate, to be an effective supplier to the 3 Trusts and beyond. In theory the current set up allows innovation, in how services are delivered, however, in practice this is difficult to achieve, and difficult to prioritise in a proactive way when the wider organisation is focused on other priority issues as is always the case with healthcare providers.

   The types of innovations and calculated risk taking by the company will be developed in year one, but could include the following: -

   - Move to a single work allocation system and use AI and handheld devices to reduce admin for staff, releasing time to improve value adding work.
   - Developing invest to save cases, such as reduced backlog repairs and new equipment.
   - Developing clinical engagement and data led discussions on the supply of EFMP services, so effort is concentrated on where customers see the greatest benefit.

   Quantifying this benefit requires estimation on both the revenue and capital expenditure in future years, and how the innovation and focus on customer priorities can deliver a more effective service. Benchmarking will be used to identify the best-in-class services. As this does not have a detailed delivery plan at this stage, this is left as an enabler benefit with no financial value in this case but is expected to have significant cashable benefits in the future.

2.7.5 **Commercial Drive**

a. Outsourcing estates works to contractors is a necessity as the restriction on headcount and uncertainty of the volume of work year to year, weigh against developing an in-house team. An operating company can do this as it has the scale and can plan the works over multiple years to ensure a full “order book”. Whilst labour and materials will be similar values to local contractors there is no profit and overheads and thus there could be a 15-20% benefits for the current level of spend.

b. The local market for GP practices estates work is poorly served, with practices often unable to get quotes, let alone work done to reasonable time and costs. This stops primary care developing and meeting patient needs. Currently the Trust Estates team cannot recruit extra staff to do their own minor works (see 4a) let alone have the commercial drive to provide for new customers. An Operating Company would have this, with GPs, other primary care, voluntary and social care providers also possible opportunities.

c. If this the work was cost plus 10-20% overheads and profits, and included minor works to extensions and practice development, this could be a £4-5m market, (£40-50k per practice per year and similar size for other health and social care providers).

This would develop over the first five years of the company's business plan and would definitely not happen with the current approach.

d. A unique opportunity for Dorset is the scale of experience and systems developed to deliver the New Hospitals Programme and other major capital projects. Dorset is the only ICS with the full range of acute and mental health, diagnostics and enabling projects, and the scale. As the local projects complete the teams can be reduced in size from 2027/28 or with a commercially drive operating company, the wider NHS can benefit. This is because whilst Dorset has talented and developed individuals, major capital projects require systems, teams and experience best delivered as a service. This could either be to other Trusts, as advisors and project managers, or to suppliers in the lucrative market to support delivery of the approved new hospitals with a 10 year+ pipeline of work, as well as across over major capital schemes.

   The logic formula approach estimates market size and potential day rates, applies overheads and profits that could be recovered and provides a sensitivity. The Trusts would never undertake this service offer without a subsidiary as it is not core business, has commercial risk and instead would just downsize teams. This would be a loss for the wider NHS as it loses a supplier with NHS values, plus an unrivalled experience to help more projects deliver on time and budget. The OHP contribution to the NHS in Dorset would also be valuable. In addition, it would help retain talent and provide a greater career structure and mean Dorset would also benefit when undertaking capital projects in future.

e. The current NHS FTs in Dorset have a range of "retail" offers from cafes, accommodation, and landlord functions. A commercial drive from an Operating Company could see these services improved resulting in better service to patients, visitors and staff and improved operating income and profit. Examples in greater café footfall and sales, or a higher fill rate for residences (held at UHD and DCH). Other services could be developed including rental incomes from use of sites (e.g. Amazon pick-ups, advertising, add on retail to current offers etc.).

   Quantifying this benefit is an estimate, which will be developed as part of the implementation phase work and is likely to be delivered in year two of the business plan. This is additional, non-NHS income but it can be vary year to year.

f. Catering is a specific large-scale opportunity, as patient meal costs are a large expenditure. UHD has a central production kitchen (CPK), with spare capacity. Some income growth is assumed within the NHP case and excluded here to avoid double counts. This still leaves potential to sell meals to other institutes, such as care homes, schools, and the NHS beyond Dorset. Working the CPK longer hours would be at marginal cost. It also allows staff to work shifts with higher A4C premiums, helping boost the pay of catering staff, making employment more attractive. The logic model assumes market size, CPK capacity, margin on the cost performed, including transport and storage.

2.7.6 **Dedicated workforce**

a. The dedicated workforce is critical to the success of the Operating Company. This set of benefits starts with a different approach to supporting, valuing, and nurturing the people working in Estates, Facilities and Procurement, which is only possible with the dedicated focus and expertise of the Board and executive team made up of professionals in these fields. This combined with the shorter decision-making process, agility and innovation covered above is to enable the company to be a better employer.

   One set of benefits to staff is to protect Agenda for change terms, then develop, with staff a A4C+ in targeted areas. The "plus" could include: -

   - Reviewing recruitment and retention premium (RRP) and levelling up to the best of the three Trusts, funded by reduced vacancies and contractor work. This could go higher if the evidence of market rates and savings potential justifies this.
   - Profit share potential, if the company achieves savings and quality KPIs, to make a profit, allowing a modest reward (e.g. £50 per head, would cost around £64k) but could better align staff with key successes required and support delivery of the wider benefits case.
   - Looking at on call, shifts and at hours worked, to achieve the right balance between boosting value for customers, and staff pay packets, which is made easier to do when services are county wide, at scale, and less work is contracted out.

b. The second set of enabling benefits for workforce are by having the processes focused on EFMP staff groups, without the clinical staff and FT direct NHS employment hurdles. This means the Op Co will not have a headcount limit, consistency process would be within the company and so not have to match with nurses and clinical posts. This all results in quicker more appropriate recruitment and workforce development. One such example is posts being filled quicker, a major annoyance factor EFMP staff often talk about.

c. Benefits 5a and 5b combined with the improving working lives plan to create a more empowered, engaged, and enthused workforce. By addressing some of the most pertinent pay and conditions issues, and offering more development and career structure, then allows work on other issues, such as improved team working, self-guided working, continuous learning, and improvement. This approach has a strong evidence base (Professor Michael West). Key Research Findings - AOD This shows engaged teams create greater safety, are more productive, have less absences and this can be correlated with staff survey results. Currently the staff surveys for EFMP staff are generally below the wider Trust workforce. This is partly reflective of all EFM staff nationally. Learning from established subcos elsewhere, their staff survey results often improve because of the enablers listed above.

Quantifying the benefits of 5a-c and the enablers elsewhere is an estimate. The logic model points to the potential to reduce sickness amongst 800 lower graded staff, if this were 1% reduction, this could be 8 WTE back at work. This is better for staff, patients, and taxpayers.

d. The individual Trusts having a company each will lead to workforce benefits as above. By having a shared service, this gives scale. This allows both more specialist and senior roles but can also support more entry level roles. The latter comes from apprenticeships or other training posts. In theory, these posts could be more common now, but this has not happened, evidencing the difficulty of getting large, clinically focused Trusts to focus on the EFMP workforce. As this is c5% of the total and with very different careers, this is difficult to achieve when there is a competitive private market with lots of non-NHS job opportunities locally. This SubCo benefit grows with a shared service approach, as the larger OpCo has the scale to book whole cohorts of FE college courses and career structures that reward staying within the organisation. This talent pipeline helps reduce turnover, as posts can be filled more easily, and less staff are leaving for private sector alternatives.

   Quantifying the impact of reduced turnover is difficult as it is not just filling roles. There is the saving in time recruiting, onboarding, training, and covering vacancies. This is a significant non cashable benefit, in saving time of existing staff, who can then use the time to better support and manage the higher level of retained staff. It is also a major cost avoidance for when the current workforce retires, leaving a very large number of vacancies. Currently many staff, especially in Estates, are over 55 years old, creating a demographic time bomb. The Operating company approach offers the chance to address this.

e. Many of the EFMP staff are task based, from cleaning, to portering, to topping up stocks. Rotas, allocation of tasks and workflow, can all make a huge difference to overall productivity by using technology and systems, even with old-fashioned visual management (e.g. whiteboards and scorecards) this can have a profound impact. Just a 1% improvement (4-5 minutes per day) for 800 task-based staff could be equivalent to 8 more staff. Having modern systems, IT and AI enabled, is more possible when operating at scale and across the EFMP workforce. This would be a year 2 activity, once basic systems and leadership are established and there has been sufficient time to research best practice and target investment if required.

f. The final workforce benefit is linked to leveraging the Anchor role, to deliver greater societal benefits. The company can look to recruit in areas of deprivation and diversity, with non-traditional entry into roles. This can also include developing work experience and volunteer roles, to help more people into work. EFMP jobs can be conductive to such opportunities, being varied, active and practical. This benefit is then multiplied, when done at scale, especially if this allows dedicated staff to attract and supervise trainees. This in turn boosts the range and quality of job applications later. This benefit is measured under the societal benefits.

2.7.7 **Asset Management**

a. Asset management is putting the buildings and equipment (including medical equipment) under the responsibility of the subsidiaries. This is a game changing benefit. The Boards become the custodians of hundreds of millions of pounds of public sector assets. With this comes a duty to improve the assets, ensure best utilisation and deliver an integrated, managed solution for each Trust.

The first tangible benefit will be to establish a baseline and improvement trajectory for key asset “up” time. This is used for the high value activities such as operating theatres, cath labs, endoscopy rooms and diagnostic scanners. These are critical to high value healthcare activity. In addition, a measure for bed space “up time” will be developed, including speed of cleaning turn around. If this is unplanned downtime this has a direct impact on patients as it can lead to delay or cancellation of care. Sometimes these downtimes are external events, e.g. Poole has suffered both water and electricity disruption across the entire town. Others have been the result of failures of ageing estate. Setting a year-on-year trajectory for improvement will result in productivity, cashable gains, as well as societal benefits, as more patients are treated, without having additional costs.

b. Community hospitals are a generally underused asset in the NHS. Dorset has 12, covering the large rural areas. Many have facilities like diagnostics, operating theatres, and endoscopy, as well as outpatient space. Often the utilisation is lower than in the acute hospitals. Finding out the root causes for this and developing a formula to overcome the costs and “friction” stopping better use of the assets across the whole Dorset system will be a benefit. This has not been overcome within the existing set up of separate Trusts, due to the complexity of asset use, liabilities, and assignment of costs. A SubCo, providing an operated healthcare facility agreement (OHFA), to all three Trusts, is a completely different proposition. Here the subco as provider is best placed to look at asset utilisation as a whole and has the incentive of making best use of the assets. Access for all staff and standardisation of the equipment, estates and facilities will the enable much easier working across the whole of Dorset. Currently staff moving sites may need to use different equipment, follow different policies, and have different support services. Over time these differences should reduce as standardisation happens. The marginal costs of extra activity needs to be covered, but the other costs are “sunk” i.e. already committed. To support greater clinical service productivity would be one way of the SubCo delivering cashable and non-cashable benefits to the system. Thus, the OHFA is a contribution to productivity and activity. Providing better care, at locality level using community hospitals will be a societal benefit.

c. Moving all the assets to a single company to run is not recommended because of the high transaction costs, in legal fees and taxes. It also goes against each Board’s desire to retain control of assets by Trust. This does have a cost, in some additional staff, fees (e.g. insurance and audit) and having a Board for each subsidiary (property company). This ‘negative cashable benefit’ is offset by the other benefits in this section. The benefit of having a dedicated Property company (PropCo) per Trust is the assets remain within the control of the Trust, as the longterm owner.

d. Major investment in estate will be better safeguarded by a PropCo.

e. Co. The NHS track record is maintaining new estate is not good, especially when comparing estate held by a dedicated custodian, such as subsidiary, PFRI or third party. With a once in a generation level of investment, the £750m Dorset is receiving could lead to a few years “coasting”, and then backlog building up. This is much less likely when a Board has a primary function of asset management. The PropCo Boards will make it transparent the lifetime costs and how regular maintenance is better value than coasting, with any short-term saving lost to long term repairs, and

the impact on service productivity. As this is over a 40–60-year life of a building or major refurb, it is counted as a non-cashable benefit, but it is substantial.

f. Having dedicated wholly owned companies managing the estate and equipment assets will allow expertise to develop. Becoming a centre of excellence in asset management could have numerous benefits, beyond just asset management. One is offering this service to other Trusts, another is being able to work with specialists in this field, often data and technology based, to be at the cutting edge (see also innovation benefit). Examples of equipment and stock could include: -

- Asset tracking devices.
- Internet of medical things.
- Remote stock control checking.
- Remote, smart tracking of goods remaining in date.
- Developing smart buildings.

Examples for buildings could be: -

- Using room server data to track utilisation and heating and lighting use.
- Utilisation data leading to being able to rationalise estate and dispose of or rent out under used facilities.
- Ensuring rates are correctly paid for all assets.
- Active, annual updates to asset registers, revaluations.
- Developing shared use policies, to support not just work between the three Trusts, but also with primary care, social care, and voluntary sector.

These can be enabling for other benefits listed, as well as cashable where there are changes e.g. rates, valuations. These are not costed at this stage but may become material in year one once further work is undertaken by the PropCo teams.

g. Better fill rate of accommodation and other properties where the SubCo takes on the landlord role should lead to improved income. This is a cashable benefit. By having dedicated leadership and expertise, regular rent reviews and good asset management, so rental income can be improved. Primarily this is for staff accommodation at UHD and DCH, other rented property could include letting clinics and other space to tenants.

h Developing the centre of excellence approach in asset management will also reduce the legal fees and advisory costs. Currently Dorset benchmarks as high expenditure in these areas. Following more detailed work, the option to develop in-house expertise/reduce reliance on and unit costs of advice will be assessed. This would be a cashable saving. Having the Pro Co approach gives this external drive and focus and Board oversight, which increases the change of a faster, more sustainable way to reduce costs in this area.

2.7.8 Value for Money Duty

a. Value for money (VFM) duty is a requirement on Trust Boards to ensure the Trust is delivering the most it can for the budget allocated. Benchmarking on productivity provides transparency on this. The model Hospital is the predominant tool to do this and looks at weighted activity unit (WAU). This takes total costs and patient care activity (weighted for complexity). Many Trusts already have the benefits of subsidiary

companies or outsourcing and managed services. This reduces their cost base and thus allowing a better WAU. The Trust Boards duty to ensure VFM is also aligned with the Treasury guidance on using public money. This makes it clear that any tax benefits are secondary, and the Boards decision needs to be based on benefits other than tax. Nine out of the ten benefits listed in this case are non-tax based.

b. In considering the value for money duty, to outsource to a managed service provider would achieve an immediate VAT efficiency gain. This option goes against the Board's shared principle of NHS ownership, keeping Agenda for Change, etc. It would likely achieve the same service level but at a lower cost. Given the imperative to find savings, this option needs considering along with the subsidiary model. The subsidiary achieves the VFM, whilst also providing assurance on T&Cs and NHS ownership. This option F achieves this whilst meeting the principles.

   The financial analysis for the capital goods scheme (CGS) VAT reclaim is in the base case, because this is recovery on actual expenditure that has been incurred. It is thus highly likely to be achieved.

   A benefit in the upside case is focused on future revenue, where VAT is currently applied. Taking the 2024/25 expected expenditure and following the correct tax with an HMRC-compliant approach, this results in a reduction in recurrent revenue costs. This is future expenditure and tax rules can change in the future. This is therefore considered an "upside" benefit. It is thus excluded from the benefits assessment.

c. On future capital expenditure, there is a similar "upside" benefit. This is because the levels of CAPEX can vary considerably, plus tax rules can change. Future estimates are the potential to have c16% more capital "spending power." This is because about 4% of the 20% is currently recoverable.

   The extra spending power will help address issues like the cash-limited New Hospital funding, where the spending power has been reduced by inflation and programme delays. This has led to the Dorset system having to descope schemes. For example, the Dorset County Hospital new Emergency Department and critical care unit has had to restrict the full scheme to stay in budget. The benefits of having a level-playing on tax for capital projects has considerable impact, e.g., being able to offset inflation and investment at a greater level.

   The actual benefits will be felt following the business case approval and implementation. As these are not known, the upside case is used to put a theoretical value, but it is not used for the decision. The decision uses the base case financials.

d. Having a SubCo, providing a managed service, will reduce the revaluation values. This reduces capital charges and Public Dividend Capital requirement.

   An initial estimate of the impact per Trust will be developed. This will require engagement with valuers and affects the annual revaluation amount and has other implications. This will be explored more at the post-FBC stage, as it is complex and requires external expert input. For these reasons, no value is put in the base case. There may be some cash benefit and cost avoidance. Calculations for future builds are not yet complete. Again, these are excluded as future tax rules may change.

2.7.9 **Shared services has procurement as a major area of benefit.**

a. A key part is creating a single, specialist and skilled team, able to act strategically & manage categories. This provides a career structure, from entry-level to very senior roles. Overall, the new Target Operating Model (TOM) is broadly cost-neutral, with slightly fewer posts (through vacancies & turnover), but greater seniority and pay. This is thus an enabling benefit.

b. The main benefits of shared procurement have been calculated already. These savings are predicated on having a single controlling mind from a single procurement service. The detailed workings have been developed by the teams, and the ranges of savings are set out in the case. These have upper/lower ranges and estimates over five years. The savings would not be affected by changes to tax rules. Therefore, these benefits are important but will be left in the "upside case" only.

c. Combine spend and standardisation, and use of innovations in procurement will potentially increase the chance of delivering significant savings. These can be non-recurrent, e.g., reduction in stock, or recurrent, e.g., asset tracking. The assumption is these are enabling benefits, which will help achieve the higher end of the benefits range, and quicker. Prudently a value is not included in the base case.

d. Procurement to achieve greater social value is a societal benefit. This can be better achieved when the NHS in Dorset acts as one and looks at total procurement for the catchment area. Combined with the team expertise (see 8a), this allows the ability to shape the market and drive social value, as well as economic value. Other public purchasing can also potentially be harnessed. Examples of this approach include Blackpool, who have driven economic development. Other examples include reduced carbon from setting clear requirements in tenders. These benefits are best achieved by a locally based subsidiary company and would be at risk with the other options e.g. if a national outsourced provider were used.

2.7.10 **Shared Services Management**

a. Operating at scale allows the development of greater expertise to manage some of the high-value aspects of the EFMP services. The largest single item is energy. Here, prices are negotiated nationally, but the reduction in volume, through energy conservation actions and active use of building management systems (BMS), can have significant impacts beyond what Trusts are currently doing. This can include deploying capital better, such as fabric-first insulation & energy generation from solar and other sources. Dorset's geology also offers the opportunity for geothermal energy. This is a major opportunity for environmental, renewable energy. This could create an energy heat distribution network across the three major hospitals. The total energy bill for the NHS in Dorset is significant, and dedicated management of demand, conservation, and generation could release significant cashable savings.

b. Net Zero carbon is a challenging objective for healthcare, and few Trusts have a fully costed, realistic plan to achieve this. Developing a NZC team is only possible in Dorset

by combining current expertise, which is fragmented across providers. As the bulk of carbon reduction can be enabled by EFMP, the OpCo is the ideal location to base the expertise. This can also be offered to others, such as GPs, care homes, and other care providers. Failure to make sufficient progress can lead to fines, as NZC is a legislative requirement. This benefit has high social value and also cost avoidance. There are potential cashable savings, but to avoid double counts, these are left under other benefits, e.g., energy, procurement, waste.

c. The OpCo has the potential to be an anchor institution in its own right. With the enabler of a dedicated Board & leadership team, plus innovation, this could be further developed if an "at scale" approach was taken for changing service models, and prioritising social value gains. Examples include looking to employ benefits to work and volunteers to do tasks that might be a win-win for the individual, the company, and the customer. Specifically, this could be (i) grounds work to improve biodiversity net gain (BNG), which will increasingly be a cost and income stream potential; (ii) job roles in cafes & catering that might provide entry-level roles, from which careers can start.

d. Moving to a single process for customer services could improve service quality, save money, save clinical staff time. This will take time, including aligning systems, and so it is not a year one benefit. However, the potential to do this increases as scale increases. Getting good systems will help save staff time and allow focus on the key issues. Good customer services can save staff time (non-cash releasing), improve measurable levels of staff and public survey responses, and improve measures such as PLACE.

e. Another advantage of scale is the ability to spread good practice across the county and between sectors. Examples include how to manage backlog & daily estates reporting, how to deploy new technology, and adopting a "fail first" approach (where assessed as correct risk). Specifically, this can include major new methods of working, such as move away from planned preventative maintenance (PPM) towards risk assessment maintenance. This is a new concept and needs testing but offers very significant productivity opportunities. It requires methodical long-term thinking, dedicated monitoring, and adjustment, and a risk appetite for change. Thus, these at scale improvements will be enabled by the subsidiary approach.

2.7.11 **Strategic Benefits**

a. Better governance at scale will drive improvements beyond those set out in Benefits 1 & 2. The scale of the OpCo being 2x to 6x larger than each SubCo (if they didn't combine) opens new opportunities. Developing the dashboard of KPIs would be expanded to allow drill-down to all services/sites, creating more depth and comparators that can share and drive friendly competition between local teams. It can also foster cross-sector working, e.g., the mental health expertise of Dorset healthcare can benefit the acute inpatients at the acute hospitals.

Another important dimension is the adaptation of a single change and improvement methodology and management practice & behaviours. This organisational development (OD) design of the operating company will have profound, evidence-based impact. Outcomes are in faster patient improvements, from engaged, high-

functioning teams. The method is NHS Impact/Patient First and Learning from EFM services that have done this e.g. in Sussex and elsewhere, will be used.

Better governance includes better compliance and reduced risk of regulatory actions and potentially fines and litigations. The avoidance of these is both cost avoidance and societal benefits, as it means less risk of harms. This can be better achieved at the scale of the OpCo, and transparency of the company structure allows better systems and greater expertise than any one Trust can achieve alone.

b. Property and use of NHS land is complex, specialist, and very long-term. The development of NHS key worker housing is a strategic benefit of huge proportions. There is potential for up to 2,000 homes across Dorset on NHS land, if the numerous hurdles can be navigated.

These hurdles include:

- Estates masterplans
- Service redesigns
- Capital rules
- Viable business cases
- Planning permissions
- Construction management
- Lots of time
- A risk appetite.

This is why there has been virtually zero NHS key worker homes built for decades. This proposal seeks to unlock this, by operating at scale across Dorset. The benefit will be greater staff recruitment & retention, especially at the early stages of professional careers and families. In many cases, staff will also be able to walk to work, saving time, money, and improving the health environment. It will also be able to add value for senior living.

A second complementary property usage could be for senior living. This has five benefits:

i. For the resident – it provides quality, purpose-built homes, which lead to a better quality of life.
ii. This reduces demand on health & social care services.
iii. By marketing to local seniors, this will often free up family-sized homes, which are often under-occupied with multiple spare bedrooms and a weight to maintain for an older person. These are exactly the homes young NHS professionals are seeking.
iv. The higher premiums that quality senior living accommodation provides, plus density, can provide a cross-subsidy to the key workers, helping keep rents down.
v. Creating multi-generation communities across Dorset, which is evidenced to lead to a better quality of life for all.

These are thus cashable, non-cashable & societal benefits that are enabled by at-scale, big thinking for key issues facing society.

c. Enabling the NHS strategy delivery is also much better delivered via the proposal. The three shifts—to prevention, to neighbourhoods, and to digital services—are

designed to make the NHS sustainable for the long term. Prevention can be aided by societal benefits in this case, including:

- ✓ Environment
- ✓ Housing
- ✓ Transport.

Neighbourhood working can be facilitated by use of estates, allowing frictionless movement of services & staff, and boosting GPs & others' ability to provide quality care locally.

Digital can be supported for better procurement, at scale, as well as greater integration of digital into equipment & estates decisions. As equipment becomes smarter with time, the internet of medical things approach will expand. By remaining part of the NHS family in Dorset, it allows the subsidiary to stay closely aligned with the parent services and their strategies, which is unlikely in other options for lacking Dorset-wide NHS focus on operations.

2.8 Conclusion.

There are considerable benefits, grouped under the ten headings. These will be developed and tracked, both through the Economic Model, and the processes summarized in the Management Chapter.

3 ECONOMIC CASE

3.2 Introduction

3.2.1 This chapter covers:

- Appraisal of options to best achieve the strategic objectives benefits.
- Process to identify, weigh, and select the best option, the preferred way forward (PWF).
- Economic analysis of the PWF, including cashable, non-cashable and societal benefits.

3.2.2 Initial expert external advice, plus the advice of the NHSE Transactions team and regional team has been received and helped shaped the approach. It should be noted formal engagement of the services and stakeholders is starting and will step up following FBC approval and the implementation planning stage. This will allow greater staff service engagement and so the benefits, costs and risks will be further developed.

3.3 Option appraisal process summary

3.3.1 The process involves the following stages:

- Identifying the long list of options that could achieve the listed strategic rationale and benefits.
- Assess these against the criteria using a robust and transparent process, that then produces a shortlist.
- Assess the short list via financial appraisal.
- Recommend a PWF based on benefits, delivery, and financial appraisal.

3.4 Identify long list of options

3.4.1 The research into options to best deliver the nine strategic reasons are:

A. 'Do nothing different to now' using informal collaboration, on tactical basis. The 'as is' model for DHC and DCH is to continue with development of a federated shared service as part of their joint Trust strategy.
B. Hosted service
C. Outsource services into managed service contract(s).
D. Become a customer of an existing subsidiary company, within the NHS.
E. Set up a single subsidiary company, holding the shared services, with 75% ownership by a lead Trust and transfer of all assets.
F. Set up a separate subsidiary company for each Trust in Dorset focused on property assets managed service delivery. This is serviced by a single shared service provider in an operating company "OpCo."

3.4.2 To note there is already a subsidiary company operating in Dorset, providing

pharmacy services to DCH. This is not included as an option as any change would still require the same assurance and approvals as options D and E above. This is because the transaction guidance of February 2024 makes clear such significant change would still require regulatory assessment, to the same extent as a new subsidiary company. Therefore, it is no different to establishing a new SubCo. It does though demonstrate the experience and success of the subsidiary company model in Dorset.

3.4.3 A 'lead provider' model is considered. This is where one Trust provides the services on behalf of the other Trusts This has initial appeal as relatively simple and has been used in Dorset and elsewhere. It also has significant limitations, many of which cannot be mitigated. Given the importance of properly assessing this option, an option B briefing paper exploring lead provider option is attached (Annex 07) and summarised at 3.5.2. This has been developed to help inform the assessment & scoring of the options, based on objective information and evidence.

3.5 Options appraisal

3.5.1 The criteria and process used has been applied numerous times in Dorset to help with complex and contentious decision making. This process was designed by legal advisors and has been tested through judicial review. The process is to score against the criteria using the available evidence and the expert opinion and wider knowledge of those scoring. Scores are ranked 0-3, from not meeting criteria, partially meets, fully meets, and exceeds (3 points). Scores are then added up. It is made clear at the outset the scores are advisory, to guide a decision leading to a recommendation. The fuller description of the process is in the briefing pack to the scoring panel (Annex 01).

3.5.2 The process involved scorers, mixed between senior leaders drawn from Executive Directors, subject matter experts and service leads. The scoring is undertaken in a workshop format, to advise if there is broad consensus, or significant outlier opinions.

3.5.3 The first-round scores are collated. If any scores have extreme differences, this allows a second round to discuss why these may have arisen. This surfaces if this is a case of differing interpretation of the same data, that through discussion and sense making can be moderated, or there are fundamental and difficult to reconcile differences. The scores are advisory, but after the second-round, scorers are free to adjust their scores based upon the discussion. This can help build a consensus recommendation.

3.5.4 The final scores are then collated, and the highest scoring becomes the Preferred Way Forward. If the scores are so close, a second or third option could also go forward for more detailed assessment.

3.6 Scoring the options

3.6.1 The longlist options have potential to deliver the nine strategic reasons for considering the change. Option A is retained as the 'do nothing different' which can be used as the

counterfactual to compare whether the costs of change are worthwhile. The long description of options is attached at Annex 01.

3.6.2 The outsource services to managed provider(s) would achieve the strategic reasons but would break the principle of staff remaining in the NHS (although terms and conditions and pension could be Transfer of Undertakings (Protection of Employment) (TUPE) protected. However, this is not as good, or robust, as staying employed within the NHS. The option is still included as a comparator for the workshop scorers to assess.

The relative merits of the "hosted service" option versus the variety of options for a shared service/operating company (OpCo) needs careful consideration. These are set out in the annex 07. The summary of these are listed below:

Dedicated Board focusing on services.	The Shared service or OpCo would have its own Board and leadership team to focus 100% on the services that it provides.
Specialist Board Members	A dedicated Board would allow for specialist Board members to be appointed. This could include executive and non-executives with experience in running a shared service, or with service expertise in areas like estates, procurement, capital developments.
Conflicts of interest – reducing the risk	By having a OpCo results in less chance of conflicts of interest occurring around the prioritisation of services and developments due to having an independent Board.
Multiple roles lead to less accountability and non-value added "distraction".	With the creation of a OpCo where each Trust has a stake but is not directly the provider of the services. This gives far greater clarity on roles and responsibilities, without reliance on personal relationships.
Risk and Reward	OpCo has a pre-agreed formula for the benefits to flow via their contracts and shareholding. It is in everyone's interest to maximise benefits overall and focus attention on delivery. The formula and governance will be agreed as part of the setting up process. This reduces non-value adding work for the leadership teams of each Trust.
Due diligence for baseline and differential service levels	It is easier to create a single culture within an OpCo, as it is less of a "takeover". It is easier for an OpCo to hold multiple service contracts, with differing levels of investment, KPIs and outcomes, when there is transparency on inputs (e.g. investments, assets etc) and clarity for outcomes. The service is not "buried" within a larger Trust. Future investment, and benefits realisation, is also easier for a managed service.
Incentives for Delivery	The leadership team of the OpCo has its' purpose clear: delivering the best services to its customers (the Trusts). As they remain wholly NHS, their purpose is not profit maximisation, and risk minimisation, but best serving all their shareholders – the Trusts, and in turn the patients.
Strategic Direction	OpCo provides the opportunity of having an "at scale approach" for procurement and estates, and over time other services, and potentially other customers. An OpCo can take a single strategic direction, better bid for work, both of which are more difficult with hosting.

An important consideration is the extent that limitations on the hosted option can be mitigated. Some can be partially mitigated, but some have very limited mitigations, as there are some fundamental weaknesses to hosting (see below table).

	Full mitigation	Partial mitigation	limited mitigation	no effective mitigation
Dedicated Board focus on services				X
Specialist Board Members				X
Potential conflicts of interest and perceptions of favouritism towards the host				X
Multiple roles lead to less accountability and non-value added “distraction”.			X	
Ownership of risk and reward needs to be transparent			X	
Due diligence for baseline and differential service levels			X	
Incentives for Delivery				X
Strategic Direction			X	

There are some limitations, or trade-offs, for a subsidiary option. Key amongst these are the overheads of the governance, including separate Boards. However, governance is one of the key benefits, and differentiators between the options. Therefore, the scoring panel were mindful of the additional costs, and benefits need to be weighed to arrive at the best option.

The results of this scoring by the expert panel are set out in the annex 01, along with the supporting information.

3.7 Financial appraisal

3.7.1 This section has been updated for FBC, following engagement with stakeholders, and outputs from the specialist advisors. An initial financial opportunity plan has been developed, covering cashable, non-cashable (including cost avoidance), and societal benefits. The preferred way forward has been assessed as to confidence of delivery of the savings using a risk adjustment formula. For the FBC, this has been peer reviewed both amongst the Trusts, with expert advisors, including from a subsidiary company from out of the region, with a similar service mix. Regional and NHSE transaction teams’ advice has also be sought.

3.7.2 The ‘do nothing different’ option includes a 2% assumed Efficiency Improvement Programme (EIP) per year. The source of this has not been identified and so delivery needs risk rating. It is through a comparator to the other options. The non-cashable, & societal are set at zero, to assume a baseline.

3.7.3 An assessment of addressable spend across all categories identified numerous opportunities to deliver 'Expected Savings' will be expected to be between aggregate saving of £21.1m over 5 years (Do Minimum) and £58.3m (Do Maximum) in aggregate (cumulative). These savings are over and above the Trust Procurement teams' historical run-rate which on average is £2.4m per annum (0.88%) over the last 5 years (see tables below for historic levels of savings by Trust).

UHD

Year	Non pay Budget	Cash Releasing FYE	Cash Releasing % of adj Non pay
19/20			
20/21	£ 124,015,000	£ 523,107	0.42%
21/22	£ 138,393,000	£ 1,213,517	0.88%
22/23	£ 127,038,000	£ 1,657,612	1.30%
23/24	£ 151,927,000	£ 1,871,953	1.23%
Total	£ 135,343,250	£ 1,316,547	0.97%

DCH

Year	Non pay Budget	Cash Releasing	Cash Releasing % of adj Non pay
19/20	£ 63,140,662	£ 1,146,443	1.80%
20/21	£ 69,344,636	£ 415,789	0.60%
21/22	£ 75,736,753	£ 299,658	0.40%
22/23	£ 76,558,785	£ 431,355	0.60%
23/24	£ 79,175,134	£ 307,710	0.40%
Total	£ 72,791,194	£ 520,191	0.71%

DHC

Year	Non pay Budget	Cash Releasing	Cash Releasing % of adj Non pay
19/20	£ 61,901,000	£ 407,000	0.66%
20/21	£ 61,275,000	£ 666,000	1.09%
21/22	£ 62,821,000	£ 847,000	1.35%
22/23	£ 63,543,000	£ 520,000	0.82%
23/24	£ 69,114,000	£ 303,000	0.44%
Total	£ 63,730,800	£ 548,600	0.86%

	Total
Average Spend	£ 271,865,244
Average Savings	£ 2,385,338
	0.88%

3.7.4 The scored options will then have a 'base case' and 'best case / upside and worst case / downside' to provide a range and sensitivity. The modelling will be over a ten year forward plan. Where savings are recurrent, or one off's, this is made clear.

3.7.5 The currently identified opportunities for benefits realisation are listed below. This list is expected to change and grow as the engagement and expert advice is used to better understand benefits, risks, and best practice from across the NHS. Model Hospital and other benchmarking information will form the basis of quantifying many of these.

Table: List of potential benefits

Benefit	SubCo	Shared
1. Dedicated Company Structure, for transparency and accountability	✓	
2. Dedicated Board leadership, for greater client focus	✓	
3. Freedom to operate and innovate	✓	✓
4. Commercial Drive	✓	✓
5. Dedicated workforce	✓	✓
6. Asset Management	✓	
7. Value for money duty	✓	
8. Shared procurement service		•
9. Services Management		•
10. Strategic Focus		•

3.7.6 The financial model summary is attached at Annex 09. This provides the details and "logical model" about each identified benefit.

3.8 Better staff engagement and wellbeing

3.8.1 A new Operating Company (OpCo) presents a unique opportunity to foster an environment where staff engagement and wellbeing are prioritised. By combining the strengths, resources, and cultures of two (or more) organisations, an OpCo can create a dynamic workplace that emphasises both professional growth and personal wellbeing.

1. **Enhanced Collaboration and Learning Opportunities** - In an Operating Company, employees often find themselves working alongside colleagues from different organisations, bringing fresh perspectives and diverse skills to the table. This exposure can spark creativity, boost job satisfaction, and provide valuable learning opportunities that contribute to both individual and team development. Employees feel more engaged when they have the chance to expand their skill sets and collaborate in meaningful ways, increasing their sense of purpose and commitment to the business's goals. Patients always come first when it comes to the NHS and not only does this benefit staff this also benefits patients and their experience within the hospital by providing a better service and hospital estate.

2. **Access to Broader Support Networks -** A new OpCo can offer a broader support network for staff, as resources and benefits from all parent companies can be pooled. This might include enhanced mental health services, wellbeing programs, and access to a wider array of employee benefits that promote work-life balance. Offering these services helps ensure employees feel valued and supported, reducing stress and promoting overall wellbeing. It has been said that by having happy and motivated staff leads to better working and higher team morale.

3. **Increased Employee Autonomy and Ownership** - With the launch of a new OpCo, employees may have the opportunity to shape the direction of the company from the ground up. The sense of ownership and empowerment that comes from contributing to the creation of a new organisation can drive higher levels of engagement. Staff are more likely to feel a deep connection to the company's success, which in turn increases their motivation, job satisfaction, and emotional investment in the company's mission which in turn can help reduce staff turnover.

4. **Improved Workplace Culture** - By blending the best aspects of the corporate cultures of all parent organisations, an OpCo can create a work environment that values respect and dignity, working together for patients, diversity, innovation, and collaboration. When employees feel that they are part of a culture that aligns with their own values and encourages personal growth, it fosters a sense of belonging. This sense of belonging is crucial for both engagement and mental wellbeing, as employees feel more connected and supported in their daily work.

By focusing on staff engagement and wellbeing from the outset, a new OpCo can attract top talent, and retain a highly motivated and productive workforce that are all committed to enhancing quality of care for patients.
As an example, please see below a 2024 staff survey summary from SSL, a SubCo

provider of EFM. Their recent staff survey provided significant positive feedback. Achieving over 75% participation from nearly 400 staff, which is significantly higher than similar surveys in the NHS. There were a variety of questions and free text fields, split into four key areas:

- Values and Respect 92% Positive/Neutral
- Leadership and Company Direction 89% Positive/Neutral
- Training and Development 87% Positive/Neutral
- Job Satisfaction 89% Positive/Neutral

In addition to the staff survey, SSL have implemented a comprehensive induction programme, staff buddy scheme, introductions of staff groups including EDI Forum, regular newsletters, and team briefings. All of these have contributed to staff feeling informed, engaged, and listened to.

3.9 Value for Money

3.9.1 Once the benefits have been identified and assessed, a 'logic model' will be applied that sets out the steps required to realise the benefit. This helps make explicit the assumptions, activities and costs, level of uncertainty and risk. This allows a credible range to be identified, and any costs to achieving this, to show a net figure. This will also identify one off and recurrent savings.

3.9.2 This approach is also used for non-cashable, which might involve cost avoidance, such as a lower maintenance cost in the future, or release of staff time to undertake clinical work. This could improve staff morale, quality of care and reduce overspends. However, if this does not result in a reduction in budget, it is a non-cashable benefit. Where there are long running overspends, such as a run rate of over 12 months above budgets, the Chief Finance Officers (CFOs) will need to determine if this is cashable.

3.9.3 Expert advice for procurement opportunities is from Capita who have already undertaken an assessment of spend by category for the Dorset ICS (including the ICB, NHS Dorset). Estates opportunities and the baseline position for the estates functions across Dorset will be undertaken in house. This will use well established, beneficiary information, such as model hospital. The detail of these is set out in the finance chapter.

3.9.4 Societal benefits will be assessed using a recognised Treasury formula looking at quality adjusted life years. Such an approach allows a total cost to benefit ratio calculation.

3.9.5 The advice from other shared service / subsidiaries is to phase growth plans for services and benefits. This allows the core to be established, the governance to work in practise, and a stable organisation to form. For avoidance of doubt, the opportunity of shared services in Dorset is significant but a transition period is needed. For example, there is a three-year plan for procurement. The "overhead" of a shared service organisation gets proportionally smaller the more these services and benefits are taken on. For this reason, there could be future expansion of the services beyond EFMP.

3.9.6 The following list of services, will require separate business cases and potentially NHSE transaction team assessment if at sufficient scale: -

- Digital
- Private patients' management
- Transactional corporate services (HR, Finance, etc.)
- Services currently outsourced (subject to successful, competitive bids).

For these to progress it would require all Boards to approve this, based upon a business case, and service lead agreement (SLA), and where appropriate market testing.

The Board of the shared service provider would also need to approve, based upon a business plan that is viable, and sustainable. Liaison with the NHSE transactions team would inform whether further regulatory approval would be required.

3.10 Key principles for economic assessment

3.10.1 The principles and assumptions used for the FBC, to provide a consistent approach to economic cost and benefits:

- Any company or LLP will aim to make small profits (c2.5%) or break even. All profits stay within the NHS.
- Corporation tax and other taxes will be payable in line with the appropriate tax regimes and guidance (e.g. Managing public money).
- Any retained profit is required for cash flow and then can be used for investments and developments including to achieve the wider social purpose goals, staff developments and innovations in line with the strategic goals of both the ICS and Foundation Trusts. This can include charitable grants.
- The 'wholly NHS owned' is a fixed point of principle and the Boards commit to not selling any stake to non-NHS bodies. This will be strengthened by the "triple lock" proposal.
- NHS pensions will be available to existing and new staff The shared service will apply to the NHS Business Authority to ensure NHS pension provision is retained for all staff and new starters. Therefore, this is cost neutral.
- The subsidiary company will use the NHS logo, in line with branding guidance.
- Unions will be recognised within the organisations, as well as Freedom to Speak Up Guardians, and staff networks.
- Any VAT recovery be returned to the Trust for whom the expenditure was incurred. Application of VAT reclaims will follow the Trust governance to ensure VFM, ROI and other due processes.
- Historic expenditure, having a VAT reclaim, is assumed in the base case, following Trust and auditor advice. This is expected to indicate historic expenditure being counted as income and expenditure.
- Where the funding source is NHP and other central funded schemes, there will be a planning assumption expenditure is prioritised for schemes that were in scope of the original NHP Strategic Outline Case (SOC) / OBC. This is subject to there being a sufficient benefits ratio and still remaining valid. There would also be local schemes, not part of the NHP governance or control that could come into scope. Application of these capital benefits could include backlog reduction, or schemes to improve productivity. These are not however counted

in the revenue benefits case, so as to retain the prudent approach on capital and tax related benefits.

- As a OHFA service, the assumption is that assets transfers into the Trust subsidiary organisation, either as a lease or a right to occupy agreement. The Trust will only need to maintain a minimal “intelligent client” function and avoid duplicate costs.

The economic model groups benefits under headings of cashable, non-cashable (cost avoiding), societal and enabling. The actual deployment of any capital would be subject to the usual Trust level business case process.

The benefits, net of costs, and risks and mitigation are used by the evaluators to score the options. Further information is set out in the finance chapter, and the Annex covering the process and evidence.

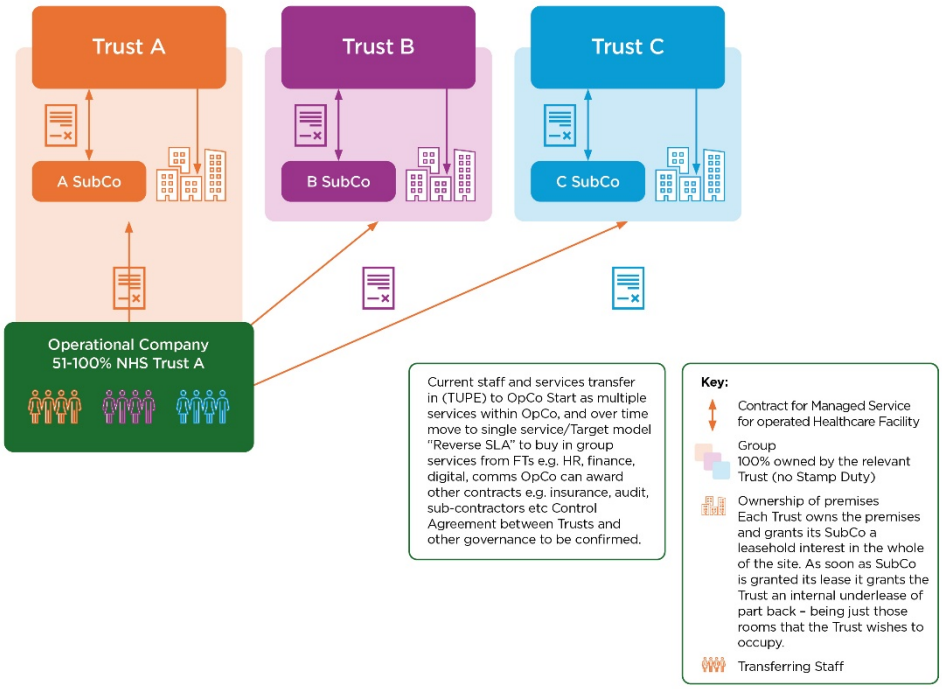
3.11 Preferred option

3.11.1 The detailed scoring of the options is attached in the annex 01 The consensus of the panel is to recommend Option F.

3.11.2 Each Trust establishes a subsidiary, 3 in total. One Trust also establishes a subsidiary, known as the Op Co. This enables a shared service model. The use of subsidiary companies’ model is well established across the NHS. There is a is heavier level of governance to run, but this is more than offset by the greater focus, transparency, and benefits.

3.11.3 The issue of consolidation of accounts has been carefully considered and advice has been taken. The Option F approach ensures consolidation at a local level is retained, whilst assets remain within each Trust. It thus achieves the benefits of a SubCo, plus the benefits of shared services. Therefore, the preferred option is F (see diagram below):

Shared Services (SubCo) Option F



4 COMMERCIAL CASE

4.1 Commercial Case Introduction

4.1.1 This chapter covers the market assessment, the scope of services being assessed. Consideration is given to possible future phases and what is out of scope.

4.1.2 Also covered are the delivery vehicle options, informed by legal and accounting advice.

4.1.3 Transfer of assets, liabilities and risk register are also covered. The legal advice and workforce protections are also reviewed. An initial plan for stakeholder and staff engagement is also included.

4.2 Services in scope

4.2.1 The services that are in scope are proposed as below, but subject to further discussion and refinement in the implementation stage.

- Procurement (including category management, sourcing, contract management, supplier relationship management).
- Materials Management /supply chain & managing outsourced contracts.
- Housekeeping
- Portering & Security
- Catering
- Operational Estates.
- Fire Safety, Estates Health and Safety.
- Sustainability staff, including energy and waste management.
- Grounds staff.
- Property Management, including residences.
- Capital / Estates development, including project management of major constructions.
- Medical Engineering.
- Travel Team, including Car Park Management.
- Potential to include Sterile Services.

4.2.2 The established staff (and vacancies) pay and non-pay budgets, and income will be collated by Trust and department / service. Any contracts held by these services will continue to be managed e.g. outsource housekeeping at Poole Hospital.

4.2.3 Future phases of services could be:

Digital	Potential for economies of scale, resilience, standardisation, and single application of systems. Also, for single approach to digitisation, and Electronic Health Record deployment.
Commercial	Mixed model for commercial development across and

(inc Private Patients)	within Trusts. Significant opportunity for growth, in ways that support NHS. Especially for Private Patients, as Dorset has much lower private patient work than expected, and facilities which lend themselves to being differentiated. Other opportunities include expanding services to other sectors, e.g. GP practices.
Corporate Support Transactional Services	HR, Finance, and others to work via SLAs into the shared service.

4.2.4 Catering and Sterile Services are both receiving capital investment and these services could operate on a county (or wider) basis. The changes in service models and investments are already underway to create central production kitchen at the Royal Bournemouth Hospital (RBH) and to refurbish the Sterile Services Unit at Alderney Hospital. Both will have considerable spare capacity. A company leadership team with freedom to act and be commercial could deliver significant value add in providing these services more widely.

4.2.5 It is recognised other subsidiary companies often operate these and other services. In Dorset some of these are outsourced (see list below). Further research and advice will be gathered to see if plans can be developed, especially for when contracts come up for renewal. Examples include:

- Laundry
- Managed equipment
- Waste disposal and incineration (currently leased facility to commercial provider at RBH).
- Transactional finance and payroll
- Pharmacy dispensing.
- Others to be identified.

4.2.6 Primary care as a customer is a significant opportunity. As 68 separate organisations with over 100 locations, there remains significant potential for a shared service provider to offer a health-centric, competitive service as none exists locally.

4.2.7 Sterile Services was previously considered an opportunity for a later phase. However, on reviewing the opportunities that the OpCo brings, and applying it to this service, there is a strong case to consider including it within the scope of services that the TUPE consultation should cover. The benefits include greater Board focus, on issues of safety and quality of service, productivity, and investment; closer alignment with standardization that the procurement workstream requires e.g. theatre instruments; closer alignment with Estates where the partnership is critical to ensure maximum “up time” for services, and the commercial opportunity for selling of spare sterilization capacity. For workforce, the dedicated HR recruitment and retention and understanding of the jobs market would help address vacancy and retention issues in what is a demanding job, but low paid (typically Band 2) workforce.

4.2.8 If operating across Dorset as a shared sterile service on two sites but with a single leadership, this results in greater resilience, the ability to have greater depth and

seniority of leaders and subject matter experts, and more easily co-ordinate issues like cross cover, quality control, supply of services to community and commercial sites. For these reasons it is proposed to undertake staff engagement, with a final decision alongside the wider preferred way forward decision towards the end of this process. As this is a service that has many private sector operators across the NHS, this is an opportunity to provide a way of staff gaining the triple lock protection on pay, pensions, and public ownership.

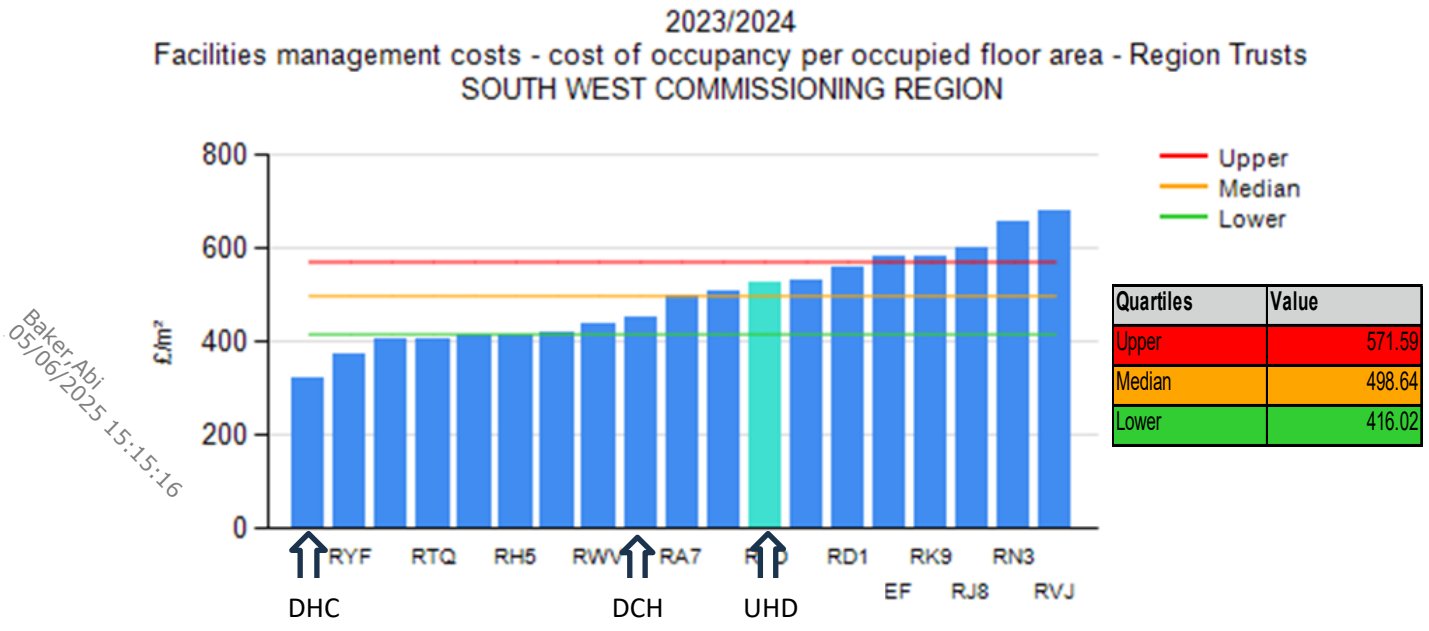
4.3 Market assessment for a shared service provider

4.3.1 All the services in scope do have NHS and private sector comparators. There are Trusts in the UK with managed services provided by subsidiary companies, outsourced service or PFIs already. Therefore, there is nothing novel or contentious in the proposed options being considered.

4.3.2 The Model Hospital provides benchmarking information to compare the cost of these services, neutral to the type of provider. These can be grouped under large, medium, and small acute, community provider and mixed providers. Care is needed in reviewing the data as cost allocations and local context, plus interpretation of the data rules can lead to anomalies. All that said, the benchmarking provides a useful starting point for discussions as to opportunities.

4.3.3 The initial review of Model Hospital data for the Estates and FM services in scope, against peer benchmarking in the SW. There are numerous caveats to the data. This is comparing SW trusts with very different services (community, mental health, large and small acute hospitals); UHD has much higher energy and estates costs due to the extensive construction works; the £/m2 metric rewards low site occupancy, and not the total productivity of the service; this is just cost and has no link to quality or value add of the services.

4.3.4 Noting all the caveats this identifies opportunity to move the cost base towards the lowest quartile, especially for UHD. Likewise, it shows the very low cost of DHC £/m2 may have opportunities for higher site utilization. The benchmarking has many data issues to explore but will be used to inform year one to three benefits opportunities.



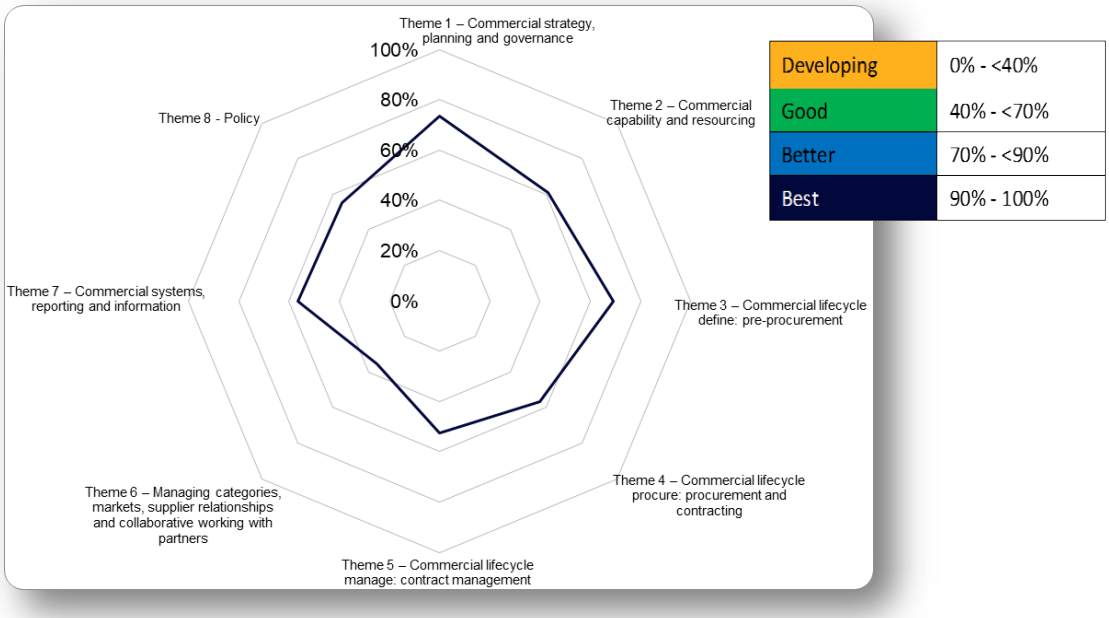
4.3.5 For Procurement, a maturity assessment has been undertaken to understand the current state of procurement across NHS Dorset. The assessment was based upon 16.5 hours of Discovery workshops held with the Trusts Procurement Senior Leadership Teams throughout September 2024. Workshops and interviews covered the eight themes of the NHS CCIAF framework. See annex 12 for the Dorset ICS Procurement opportunities assessment. Based on the 70 questions a current maturity score was calculated against each theme, providing an assessed performance level from 1 “Developing” up to 4 “Best”.

4.3.6 The graphics below summarise the average scores for the three Trust Procurement services:

Graphic 3: Maturity Assessment Summary

No	Theme Areas	Average Rating	Maturity
1	Commercial strategy, planning and governance	73%	Better
2	Commercial capability and resourcing	61%	Good
3	Commercial lifecycle (Define): pre-procurement	69%	Good
4	Commercial lifecycle (Procure): procurement and contracting	56%	Good
5	Commercial lifecycle (Manage): contract management	53%	Good
6	Managing categories, markets, supplier relationships, and working collaboratively with partners	35%	Developing
7	Commercial systems, reporting and information	57%	Good
8	Policy	55%	Good

Graphic 4: Maturity Assessment Spider Diagram



The development of a shared procurement service and move towards the Target Operating Model builds upon this self-assessment work.

4.4 Delivery vehicle options

4.4.1 Legal and accounting expertise has been procured to advise on the best 'delivery vehicle' for shared services. This has informed the preferred option. Further work in the implementation phase will develop this further. This will include developing the full suite of legal documentation.

4.4.2 The OpCo will be formed as a separate legal entity (which may be an LLP, or a company limited by shares but with the majority ownership of one of the Trusts), which will have three separate contracts in place for the relevant services between itself and each of the Sub-Co's wholly owned subsidiaries. The OpCo company will be the legal connection between the newly established Sub-Co subsidiaries.

4.4.3 There are several options available for forming the delivery (OpCo) element of the structure. It has not yet been decided whether the OpCo company will take the form of a limited liability partnership or a private limited company, though it will have one Trust as the majority owner (51%) and two as minority. Thus, it will be 100% NHS owned overall. An agreement will be put into place to govern the arrangements between the Trusts in OpCo, depending on the organisational structure of the company this will take the form of either a member's agreement or a shareholder's agreement.

4.4.4 Exploration has been undertaken on whether a more employee owned / led model, such as a co-operative ('John Lewis Partnership' model) could be developed, to give staff greater say, and some form of bonus for meeting or exceeding targets and budgeted savings. The conclusion of this is it would require some of the ownership to be with individuals, which would be in opposition to the principle of 100% public ownership. Therefore, other forms of staff engagement and responsibilities for providing ever improving services would be part of the organisational development plan.

4.5 Transfer of assets, liabilities, and risk management

4.5.1 Based on the legal and accounting advice a recommendation will be made on what assets should transfer, where license to occupy is required, novation of contacts and other issues. A key decision for Trust Boards, based upon professional advice, will be whether to include targeted estate, or the entire estate in the transaction. This case is based upon the full estate transferring via a lease to the SubCo (as per option F). This is because if only targeted estate, it will mean in effect two estate teams per site. Subsidiary companies operate both models in the NHS, but learning from established SubCos is the this creates cost and uncertainty which is unhelpful.

4.5.2 The table below sets out key checklist of non-staff areas where work is required at the implementation phase.

Item	Details
A Business Transfer Agreement	Which will be used to transfer assets, staff, equipment etc. from the Trust to a subsidiary / shared service
Managed Services Agreement	Detailing the estates services and any facilities the subsidiary will provide to the Trust
License to occupy	From a financial perspective, it is imperative for VAT, corporation tax and Stamp Duty Land Tax purposes that the Trust grant their subsidiary a non- exclusive right/license to enter any site/premises site and provide services, rather than an exclusive right of occupation via a lease
Any Building Contract documents	(If required)
Support/Service Level Agreement	Which will document the support services to be provided by an individual Trust to its subsidiary
Finance documents	These will cover any loans made by the Trust to the subsidiary and any third-party funding from charities etc.
Novation Agreements	To enable current contracts to be transferred directly to the subsidiary. All contracts will need to be reviewed as part of this work
Risk Transfer	Review of risk transfer options
Lifecycle Payments	Agreement on Capital Investments required by the Trust to the SubCo / shared service
Governance & Monitoring	Agreement on formal and informal Governance and Monitoring arrangements
Director Appointments	Appointment of Key Roles, including any conflicts of interest.

4.5.3 The contractual relationship between the shared services and Trust(s) will also need establishing as to how this will operate. Key documents will include:

Loan agreements	For capital investments.
Project agreement	Service specifications, payment methods, methodology for the unitary charge, Key Performance Indicators (KPI) and incentives / penalties.
Sub-contracts	Transfer of existing contracts to providers, which move from Trust to subsidiary company.
Corporate service SLAs	The service level agreements between the companies and corporate support e.g. Finance, HR, Risk, Digital.

4.5.4 A risk register will use the format common to the NHS in Dorset, to identify, score, mitigate and manage risk. This will also include incident reporting, and full involvement with Patient Safety Incident Reporting Framework (PSIRF). A summary of Facilities

Management and Procurement related risks in the three Trusts will be developed as part of the due diligence process within the implementation phase.

4.5.5 An initial assessment of project risks, to successful implementation of this business case is set out in the management chapter.

4.6 Staffing

4.6.1 The success of any organisation has staff at its core. This section covers both the 'soft' engagement and culture, as well as the 'hard' legal and financial aspects that are required. Overall, the vision is to create a great place to work, that provides excellent services to patients, staff and partners, built upon the NHS values.

4.6.2 The staff base is significant. Below is an estimate of the staff numbers in scope across the three main service areas. Over May and June service leads are working up the detail of what services are in and out of scope. In addition, there may be some supporting corporate services, and sterile services. This will be scrutinized further over June, ahead of the TUPE consultation starting, when a final list will be agreed. Each Trust Board is being asked to support the decision to progress to formal consultation. The exact staff list, by name, and overall, TUPE process, will be the responsibility of the HR programme team to run. Further details on the TUPE process are set out in a separate briefing document on this, in the annex 15.

Service Groupings Estimated numbers	Total Nos of Staff (Headcount)	DHC sum of staff (headcount)	DCH Sum of staff (headcount)	UHD Sum of staff (headcount)
Catering Services	260	70	67	123
Domestic Services	618	219	121	278
Estates services	377	86	146	145
Facilities Management & Support	21	12	3	6
Portering	157	0	38	119
Procurement	57	12	24	21
Transport services	56	27	24	5
Inventory mgt logistics	58			58
total (headcount)	**1604**	**426**	**423**	**755**

4.6.3 Following approval of the full business case preferred option, a full staff engagement process has started. This is ahead of any formal TUPE consultation. Hundreds of staff have attended face to face and virtual briefings, led by Trust executive team members, and service leads. A report on the common themes and questions, and responses and changes is part of the June pack for Boards. This co-created approach with staff and leaders of the services has resulted in improvements and protections, for example the triple lock on pay, terms and conditions and NHS ownership.

4.6.4 Union representation has attended many meetings and there has been regular dialogue. This open, collaborative process has had disagreements on issues of both substance and process and is summarised in the report. The Trusts accept Unison is opposed in principle to the concept of subsidiary companies. All parties are aligned on

the importance of protecting pay, terms and conditions, pensions, and the need for public sector services to remain successful.

4.6.5 The first stage will be 'appreciative enquiry' to gather data with an open mind, using open questioning. This can be via focus groups and interviews, staff survey results and other quantitative methods including email, social media, and other methods.

4.6.6 In parallel it will be important to explain what is and is not in scope, the change management process, and the decision-making points. This will use the HR advice from the transaction guidance. It will also draw upon learning from other Trusts. The key principles set out at the start of this business case will guide this, including continuation of NHS Terms and Conditions, NHS Pension membership, Union recognition and NHS ownership of the new company. It will also need to be clear on the strategic reasons for change, and why the 'Do nothing different' option is not sustainable.

4.6.7 The level of staff interest in a partnership model (4.4.4), what is practical and legal, and unintended consequences (e.g. to wider NHS staff & services) will also be considered.

4.6.8 A key part of the due diligence is reviewing the policies and procedures of each employing Trust. This will include identifying any significant differences in policy and practice and any potential banding discrepancies. The staffing due diligence will also need to transparently share staff vacancies, sickness and leave, and ongoing HR investigations or processes, and similar information.

4.6.9 TUPE will apply for all staff transferring in. The process needs designing to be reassuring for staff and clear on their rights and responsibilities. New employees would be recruited directly to the subsidiary company, as well as existing staff being promoted. Transferring staff will mean having to retain three sets of policies and procedures. Either one can then be adopted by the company, or a 4th one can be produced taking parts from all 3. This would be decided during the implementation stage.

4.6.10 It is expected that across Dorset ICS, the NHS will continue to move towards standardising HR policies and practice, for example an 'NHS passport' that recognises training from one organisation to another, avoiding repeat mandatory and essential training. As all Trusts and the company follow the Agenda for Change handbook the differences are small. As time progresses the alignment will reduce variation further.

4.6.11 It is important to establish the OpCo as part of the 'NHS family' in Dorset, and that day-to-day contact and presence on all sites will continue. Whilst there will be a greater professionalism and client focus, with transparent KPIs and service levels, the ethos of being here for the patient, and ensuring taxpayer value, will continue. Linked to this senior clinicians and clinical service leads will also be asked for their views on the proposed changes, and benefits. This will be especially important to ensure the clinicians voice in procurement decisions, such as alignment of suppliers.

4.6.12 Based on the appreciative enquiry, and engagement work, the OpCo implementation

phase co-created both up to go live and then in the first year of operation, to establish the new cultures and values, aligned with the NHS.

4.7 Commercial development opportunities

4.7.1 The final part of this chapter is to assess the opportunity to provide services outside the areas currently served by the constituent organisations. These are considered for years 2+ of the business case, as safe transfer and operation of current services will be the priority in year one. However, one of the strategic reasons for the change is to be able to better exploit the skills and capacity of the services in scope. Some of the services expected come into scope later (see table below).

4.7.2 By having a set up as an operating company, this allows a level playing field with other commercial companies, managed services, and other NHS subsidiary companies. This level playing field is in both governance (see next chapter) and in the tax treatment.

4.7.3 One trading opportunity is in the capital development of Estates. Dorset has a strong track record of large, complex estate development across multiple sites. The total programme is £700m+. This is during a period of relatively limited NHS major capital works or where works have been less than successful (e.g. Brighton, Birmingham, Liverpool). Having built up an almost unique in-house expertise there will be a decision point from 2027+. The choice is to downsize the capital development team or consider whether the expected growth in major capital projects would offer an opportunity to help the NHS. This could be in support for the NHS as the client, or in helping the construction industry to be a better supplier. This would help retain the team and processes that have been successful, as well as providing a new income stream to the shared service. There are a small number of SubCos operating in this sector, so this is not unique. Dorset does though have an unrivalled experience.

4.7.4 Similar arrangements could grow over time for other areas of expertise, such as environmental sustainability. As the NHS transitions to a net zero future, this skillset will also be relevant for the wider public sector and large private sector organisations.

4.7.5 Table of summary of a commercial strategy:

Phase 1		Phase 2 Subject to Trust business case		Phase 3 Subject to business plan
Establish core: Procurement, Estates & Facilities Management	→	Growth in Customer base.	→	Growth in service range.
Establish SLA's, governance & benefits delivery.		Major capital projects, primary care, other commercial opportunities.		e.g., digital, private patients, other contracted services.

4.8 Conclusion

4.8.1 There are well established models and markets for what is proposed, both in the vehicle for delivery, and in the services in scope. The phasing represents a pragmatic approach to the opportunity. Significant attention is required for staff engagement, as one critical success factor.

5 FINANCIAL CASE

5.1 Financial analysis

5.1.1 This section provides the financial analysis with greatest detail focused on the preferred option. This is an estimation over the next ten years, to provide a financial base case. This includes likely additional costs to be incurred, and savings programme (based on benefits in the economic case). Non-financial and societal benefits are excluded.

5.1.2 An upside (best) and downside (worst) scenarios are included. Upside is largely based around the speed and scale of benefits realisation. Revenue benefits, VAT treatment in line with other providers, will be set out. VAT revenue is included as "upside only," and therefore is not included in the decision-making weighting. Downside scenario includes cost pressures on the revenue budget, which outstrip any funding growth plus slower/smaller benefits realisation.

5.1.3 A cashflow forecast has been developed for the full business case financial model and is part of the finance workstream preparations ahead of a go live decision.

5.1.4 The level of cashable savings delivered from the non-pay budgets of each Trust have been low, over the past 5 years, averaging just 0.88%. This is the context for looking at the increased savings via option F.

UHD

Year	Non pay Budget	Cash Releasing FYE	Cash Releasing % of adj Non pay
19/20			
20/21	£ 124,015,000	£ 523,107	0.42%
21/22	£ 138,393,000	£ 1,213,517	0.88%
22/23	£ 127,038,000	£ 1,657,612	1.30%
23/24	£ 151,927,000	£ 1,871,953	1.23%
Total	£ 135,343,250	£ 1,316,547	0.97%

DCH

Year	Non pay Budget	Cash Releasing	Cash Releasing % of adj Non pay
19/20	£ 63,140,662	£ 1,146,443	1.80%
20/21	£ 69,344,636	£ 415,789	0.60%
21/22	£ 75,736,753	£ 299,658	0.40%
22/23	£ 76,558,785	£ 431,355	0.60%
23/24	£ 79,175,134	£ 307,710	0.40%
Total	£ 72,791,194	£ 520,191	0.71%

DHC

Year	Non pay Budget	Cash Releasing	Cash Releasing % of adj Non pay
19/20	£ 61,901,000	£ 407,000	0.66%
20/21	£ 61,275,000	£ 666,000	1.09%
21/22	£ 62,821,000	£ 847,000	1.35%
22/23	£ 63,543,000	£ 520,000	0.82%
23/24	£ 69,114,000	£ 303,000	0.44%
Total	£ 63,730,800	£ 548,600	0.86%

	Total
Average Spend	£ 271,865,244
Average Savings	£ 2,385,338
	0.88%

5.1.5 There will be an SLA with support services, such as Finance, HR, Digital, Risk and Governance, Communications and other services currently used by EFM and Procurement. These are based upon a cost neutral level of service provided. How this works across the three Trusts would need to be explored as part of the implementation and due diligence phase. Whilst there could be savings these are not included. However, the additional overheads of a shared service (Board, running costs e.g. insurance, audit, reporting etc) are included to provide a prudent assessment against status quo.

5.2 Estates and Procurement capital

5.2.1 The subsidiary companies will also require a capital plan, nested within the overall

consolidated group structure and the ICS capital plan. Therefore, any capital expenditure would be included within the CDEL for Dorset ICS. This is part of the overall limit on the NHS. To avoid over or underspends there would need to be very close alignment of plans, monitoring, and actions.

5.2.2 Specialist VAT advisors will develop the detail, based upon legal, accountancy and a compliant approach with HMRC guidance. The benefits would flow back to the Trust that expended the capital, based upon an agreement within the contract between the subsidiary company and Trust.

5.2.3 Within the base case an assumption is made about potential VAT recovery. This in line with managed services and other subsidiary companies experience, so it's not novel. The range of VAT recovery on revenue spend is from no more than current levels (base case), to full recovery, (upside). This prudent approach is based upon future levels of revenue on VAT able goods and services not being certain, and because VAT rules may change.

5.2.4 In a similar way future capital expenditure is also not certain, as capital availability can change, as well as VAT rules. The base case assumes no benefit. The upside case assumes a 16% recovery (i.e. full VAT recovery above the typical 4% currently recovered on fees). Whilst capital, this is an annualized amount. The benefits of +16% more capital expenditure in improving services, productivity and reduced backlog is not quantified. This would need to be part of the business case for this expenditure. Therefore, a prudent approach is used.

5.2.5 The historic capital expenditure to which full VAT recovery can be applied (new builds, refurbishments, medical equipment) estimated further, more detailed work is planned for the implementation phase with specialist VAT advisors. However, an initial estimate is made. This looks at capital expenditure in the past nine years, for which VAT has not already been recovered.

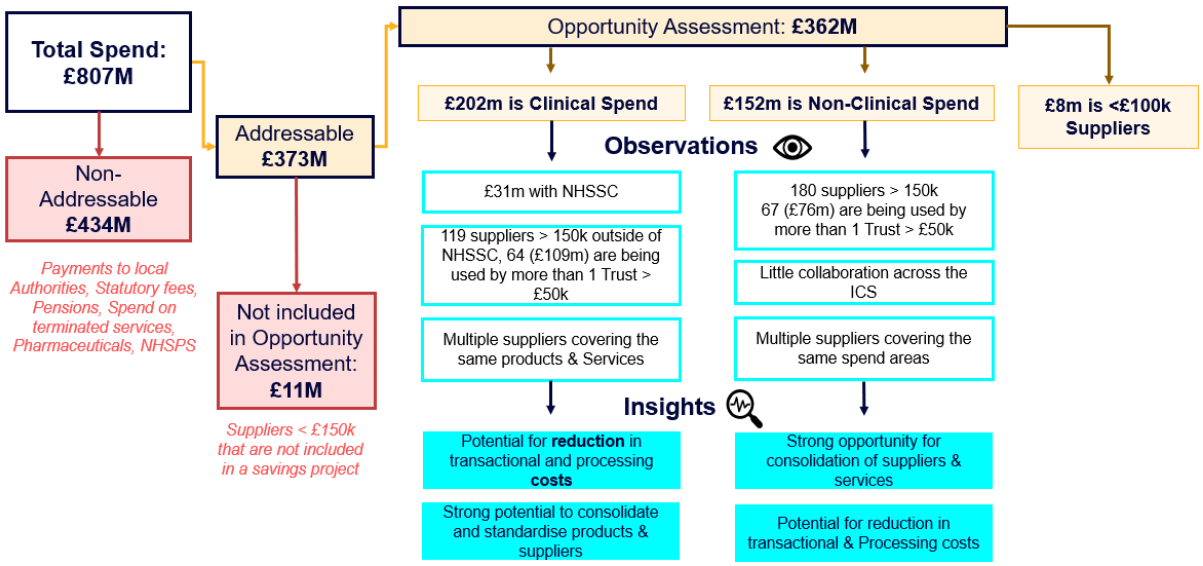
5.2.6 The benefits case for Estates services, including cashable savings have been identified and are being worked up as part of the financial model and benefits tracking process. Currently the benefits are deemed non-cashable (i.e. cost avoidance) but will over time be assessed, and some will lead to budget reduction adjustments, turning them into cashable benefits. The initial benefits for moving to a shared service are summarised as:

- UHD EFM costs move down towards sector average, releasing £1m cost improvement.
- Dorset wider energy savings of 5%, subject to more detailed assessment of the logic model and actions required to deliver this.
- Other benefits currently in scoping stage.

5.2.7 The reapplication of capital (within CDEL) would be agreed between the subsidiary company and Trust, in line with the Medium-Term Capital Programme of each Trust and the Dorset ICS.

5.3 Benefits assessment

5.3.1 The procurement benefits have been developed with expert help from the Capita team, plus the service leads. The following information provides the overview.



Do Minimum 2% reduction on addressable spend, and do maximum 5%

Do Minimum	01/02/2025 - 31/03/2025	25/26	26/27	27/28	28/29	01/04/2029 - 31/01/2030	Total
Clinical (In-Year)	£5,713	£588,094	£1,570,056	£2,248,739	£2,807,502	£2,740,566	**£9,960,671**
Non-Clinical (In-Year)	£0	£454,644	£1,720,256	£2,507,430	£3,168,461	£3,315,883	**£11,166,674**
Total Savings	**£5,713**	**£1,042,738**	**£3,290,312**	**£4,756,170**	**£5,975,963**	**£6,056,450**	**£21,127,345**

Do Maximum	01/02/2025 - 31/03/2025	25/26	26/27	27/28	28/29	01/04/2029 - 31/01/2030	Total
Clinical (In-Year)	£14,283	£1,714,964	£4,940,166	£6,529,941	£7,622,796	£7,007,916	**£27,830,067**
Non-Clinical (In-Year)	£0	£1,364,222	£5,449,094	£7,029,789	£8,410,569	£8,195,833	**£30,449,506**
Total Savings	**£14,283**	**£3,079,186**	**£10,389,260**	**£13,559,730**	**£16,033,364**	**£15,203,749**	**£58,279,573**

Non-Financial Benefits

A full list of non-financial benefits is outlined in section 5.10, and in summary includes:

- Improved stakeholder experience in working with Procurement.
- Improved motivation, career development and progression for Procurement staff.
- Better transparency of spend performance and compliance.
- Enhanced supplier performance and innovation.
- Reduced supply chain risk.
- Reduced administration for Procurement and non-Procurement staff.
- Increased staff capability.

Financial Benefits – Savings

Financial benefits are driven by enhanced procurement practices, including the embedding of category management and more effective collaboration across Dorset PS partners leading to a greater spend being managed at an ICS level. This will

result in significantly greater procurement savings year-on-year and the potential for future income generation.

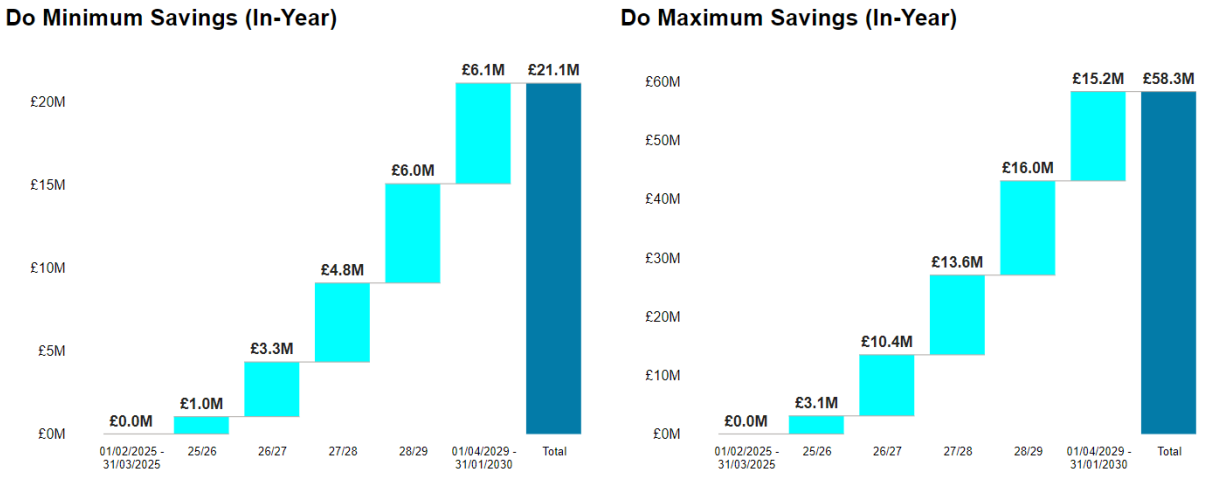
Following the implementation of the TOM, underpinned by a transformation and saving opportunities programme, significant financial benefits can be realised. The financial benefits are outlined within Section 12, and a high-level financial summary is provided below:

- From **£807m** of annual spend, **£373m** has been identified as addressable.
- An assessment of addressable spend across all categories identified numerous opportunities to deliver between **£21.1m (Do Minimum)** and **£58.3m (Do Maximum)** in aggregate (cumulative) savings over 5 years.

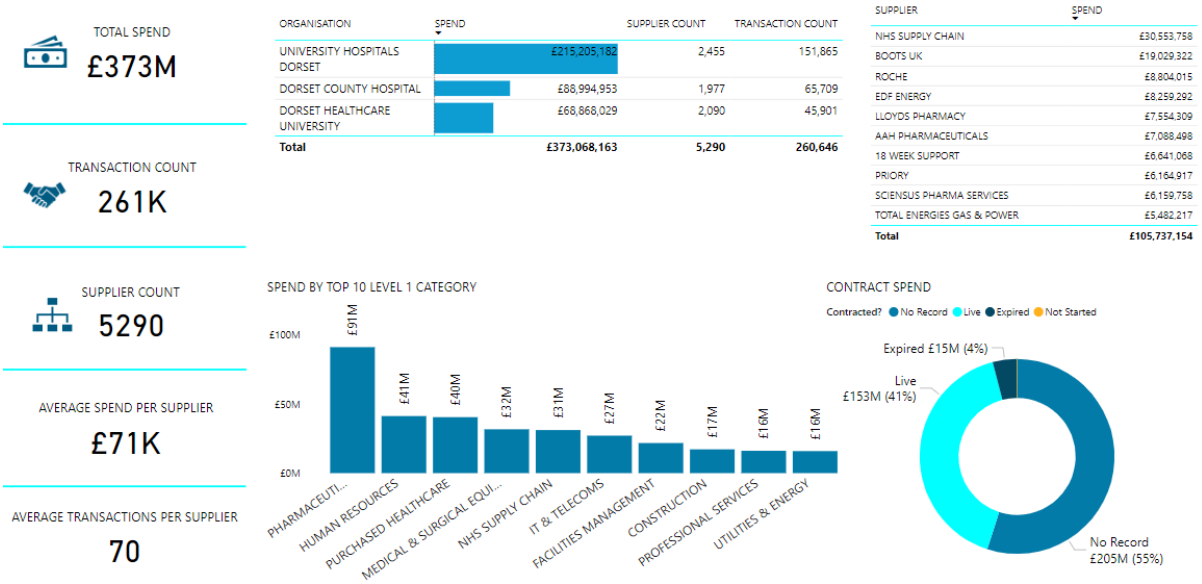
Total In-Year Savings **£21.1m** to **£58.3m** in aggregate over 5 years

The savings forecasts were developed through analysis of the spend data, contracts, and interviews or workshops with the HoPs and their teams. The opportunities underpinning the full year effect savings are detailed within annex 09 – these were reviewed in meetings with HoPs, and anything deemed unfeasible was removed, however the HoPs would not have been able to accurately or viably validate actual savings numbers during the timeframes.

A waterfall of the 5-year profile of the "Do Minimum" & "Do Maximum" cumulative in-year savings is shown below:



Graphic 1: In-Year Savings (Do Minimum & Do Maximum)



5.3.2 The full business case for the procurement is available. It has been supported by each Trust and the provider collaborative Board. It is based upon a shared service model. The importance of this for sustainable success is set out in the annex 7 (OpCo and hosting assessment Dorset). This concludes the OpCo approach is far more effective route.

	UHD	DCH	DHC	Total
Current Budget	£2,159,396	£588,382	£565,434	£3,313,212
% Total	65%	18%	17%	100%

Total addressable spend by Trust		
	£m	
UHD	215	58.0%
DCH	89	23.5%
DHC	69	18.5%
	373	100%

5.4 Upside and downside modelling

5.4.1 The upside scenario has been developed for the FBC financial model. It models a higher level of achievement of benefits (cashable and non-cashable). It also estimates some additional VAT recovery that managed services and subsidiary companies within the NHS are already achieving elsewhere. Once again, the range varies depending upon the % recovery, and the scope of expenditure this applies to. As with the capital, the benefits on revenue would be an agreed redistribution between the originating Trust and the shared service.

5.4.2 The downside modelling is based upon slower and smaller achievement of cashable

and non-cashable benefits, no VAT recovery, plus rising costs. The likelihood of the downside case being worse than the 'do nothing different' option is very low, even when including the overhead, and set up costs of the subsidiary companies. On this basis the recommendation is to proceed with the preferred way forward.

5.4.3 The Net Present Cost of each option is set out in detail in the economic model annex and summarized in the table below. This is the level of savings compared to the "do nothing different" scenario. The model if based upon ten years. The greatest detail is in years 1-5, and many of the cashable benefits phased prudentially over that time period. Many non-cashable benefits are expected to be directly or indirectly turned into economic benefits over time once the subsidiaries are up and running. These however are excluded, to give the most prudent assessment.

5.4.4 In summary the preferred option "expected" base case, and the up and downside cases, for the initial ten years of the economic model are:

	Net Present Cost (savings) £000	Benefits ratio
Downside	58,146	4.08
Expected	**81,530**	**5.35**
Upside	169,530	10.19

5.5 Conclusion

5.5.1 There are significant benefits from the services in scope becoming shared. These are cashable, non-cashable and societal. These will take time to fully realise, and so a transition approach is required. There are risks and mitigations, and the downside / worse case is det out, along with an upside / best case. The Dorset ICS requirement for significant cashable savings indicates a need to progress to a decision, the implementation, at pace and scale.

6 MANAGEMENT CASE

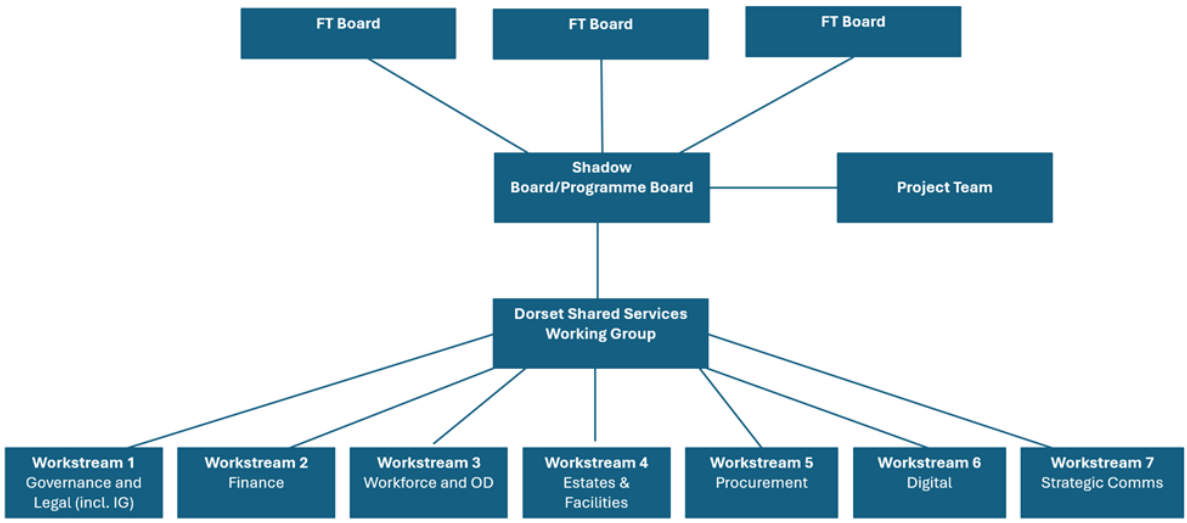
6.1 Programme and Project Management

6.1.1 This section covers the management of change, governance, risk management, and benefits realisation. It also sets out the capacity and capability being assembled to ensure a successful transaction. The chapter is based upon the guidance provided by the NHSE Transactions Team, for transactions and specifically the guidance on subsidiaries. The focus is on the delivery of the preferred option.

6.1.2 The NHSE Transactions Team will assess whether this proposal is a 'material' or 'substantial' transaction and the level of scrutiny they will require. In line with the guidance no costs have been incurred in developing the initial proposal, and minimal costs to develop this FBC. Early and very helpful discussions with the NHSE Transactions Team, ODPC and Trust's Boards have taken place on developing the proposal, providing advice, and how best to protect the key principles.

6.1.3 Project governance describes the Project Board, project team, workstream leads for Finance, Estates and Facilities Management, Procurement, Governance, Digital, HR and Communications (see diagram below). This continues to strengthen as the project develops. The use of a project structure, tracking the critical path, and work towards the go/no go checklist are all progressing. Use of input from the professional advisors provides support and challenge. The production of the self-certification assessment is a key product, from the current phase of the project.

High Level programme governance structure



6.1.4 Reporting and accountability lines in the structure chart, make clear the Trusts are the ultimate responsible bodies. A Programme Board has overseen much of this work on behalf of the Trust Boards. This has been meeting on a fortnightly basis. It will evolve into the Shadow Board, following approval of this case, the Shadow Board Terms of Reference, and agreement of the subsidiary Directors.

6.1.5 The Shadow Board will take on the role of the existing programme Board which has oversight of the delivery. The weekly working group will continue to co-ordinate all the workstreams, ensuring progress against the action plan, timelines, and cross cutting issues.

6.1.6 The project team is locally resourced with dedicated HR, Communications, and project management professionals. The programme advisors are Hill Dickinson LLP (legal and governance) and Colbeck Brighton (finance and tax). There is also support from the Dorset Provider Collaborative. Resources are also set aside for a governance/shadow Board secretariat

6.1.7 The Shadow Board will have 2 FT Shareholder Directors (total of 6) acting as non-executives. The Shadow Chair will be drawn from an existing FT Trust Board as well. The profiles of these Directors are set out in the annex 15.

6.1.8 Shadow exec director roles will be filled via secondments or interims. These do not affect the TUPE process or the permanent recruitment to roles.

6.2 Project Plan and milestones

Draft outline business case reviewed by each Trust & NHSE contacted.	Oct –Dec 2024
Engage professional advice (legal and financial)	Jan 2025
Develop initial project plan, benefits, risks and mitigations. Test Boards' alignment, and direction of travel	Feb-March 2025
Outline Business Case approval	Feb/March 2025
Engagement with stakeholders, HR and communications	March-Oct 2025
Full Business Case approval – proceed to engagement	April 2025
NHSE assurance (Regional + Transactions team, assume 3 months)	April-June 2025 (estimate)
Board meetings (in public) to approve updated FBC, and self-certify ready to proceed to next stage of formal staff consultation (TUPE)	June 2025
Subject to FBC approval, in parallel with NHSE assurance: due diligence, legal preparations e.g. Service Level Agreements (SLAs), leases or right to occupy, operational policies and governance, recruitment of Shadow Board, other HR issues, pre and post transaction plans. Start operating programme via Shadow Board.	June - Sept 2025
Preparations for TUPE consultation	June 2025
TUPE Consultation (target date)	July-August 2025
Trust Boards (in public) receive TUPE consultation results and preparedness to go live. Final decision point to proceed.	From September 2025
Target start date for new organization	From November
Phased growth as services transfer in, transition to transform work starts, and benefits start to be delivered	From November 2025

6.3 Transaction assessment

6.3.1 The NHSE transaction guidance for subsidiaries is a very helpful guide. Annex 11 includes the responses to the key lines of enquiry listed in the guidance.

6.3.2 The SW region has also been kept closely involved. A letter of support has been received from NHS Dorset.

6.3.3 The assurance process has Red / Amber / Green ratings by Transactions Team. This will provide independent, expert feedback on the robustness of the FBC and ability to implement. This feedback is expected to include suggested actions to inform the project plan, timeline, and resourcing of the programme sufficient to achieve the objectives. This is helpful and sought after advice. The process is clear that the Boards have the legal and governance responsibility to enact.

6.4 Boards due diligence

6.4.1 The Boards are accountable for the process for assurance regarding due diligence and the go/no go decision. This is due in the project plan by September. To be ready includes:

- Baseline assessment of budget, assets and liabilities, material risks.
- Service scope and SLAs required, and variations by Trust to reflect differential starting positions.
- Any sub-contracting and novation of contracts.
- The business plan, including risks, cashflow, assumptions, mitigations.
- The appointment of professional advisors.
- Business continuity plans.
- Reserve matters and legal transfers.
- Management team and Board governance for the shared services.
- 100-day post transaction plan.
- “Safe and legal” go/no go checklist.

6.5 Benefits realisation plan

6.5.1 The Benefits Realisation Plan outcomes are set out in the economic model. The benefits are grouped under the ten headings with a specific line for each sub benefit. Some are cashable savings, others enabling, societal or non-cashable (including cost avoiding).

6.5.2 The learning from Trust mergers, service reconfigurations and other major change projects is to be clear in identifying benefits and use a logic model to track the key elements leading to a measurable outcome. However overly detail assessment prior

to having the leadership team in place, is not productive. Once the team with the means to deliver, is in place, then this is the best way to gain ownership and increase the chances of delivery.

6.5.3 This means to embed ownership the implementation planning and business plan needs to be written the subsidiary leaders. The use of logic models to identify the opportunity, inputs, outputs and quantified impact, will allow clarity of the key drivers for success. It will also segment the larger benefits, and the risks and mitigations.

6.5.4 The financial model identifies numerous opportunities under each of the ten benefits headings. These are grouped as cashable, non-cashable, enabling, or societal benefits. The two largest cashable benefits are shared procurement, and the level playing field for tax. The numerous other benefits are under the other groupings. The non-cashable may well become cashable with further work. This will use the methodology embedded within UHD, which has a tracking tool to moves from ideas stage through to completion. Stages in between include initial quantification of opportunity, decide if a Quality Impact Assessment (QIA) is needed, and then if there is a cashable savings (leading to a budget adjustment), or if it is cost avoiding, (such as reducing overspends) or quality improving (which would be a non-cashable benefit). Taking this approach the long list of benefits will be worked through as part of the first 100 days and year one business plan.

6.5.5 Learning from benefits realisation from other transactions in Dorset and other subsidiary companies is being applied. For each benefit the “logic model” approach is summarized in the economic model, with a named lead, estimated scale of benefit, risk rating affecting percentage of delivery.

6.5.6 The overall approach of “transition to transform” is used, based on the learning from elsewhere e.g. Lancs and South Cumbria, and the UHD merger. This is to recognize whilst benefits and plans are identified, the safe transition of staff and leadership is the crucial first step. Once staff and leadership are successfully transferred then they are far better placed to deliver. This will include moving to the Target Operating Model for procurement, identifying new benefits, and being held to account for the performance. This requires assembling and empowering the new leadership team and allowing them to work and use the benefits of being an operating company.

6.5.7 The three Trusts, as customers and shareholders, will then be able to hold to account the managed service provided, via the contractual arrangements to ensure delivery of the KPIs, service levels and value for money.

6.6 Main risks and mitigations

6.6.1 The main risks and mitigations identified for the programme can be found at annex 13, noting that this is a live document and is updated regularly. There is a monthly risk register review meeting in place and the risk register is a standing agenda item for the Programme Board/Shadow Board meetings. The initial highest risks, and their mitigations are set out below.

6.6.2 Review of each Board's risk appetite statements will be undertaken, to assure the measured and calculated change is supported, and tolerance of risk, in return for delivery of benefits, is supported. Boards will be asked to reflect on risks and rewards of the proposed change as part of the Board approval process. This will include level of risk pre and post mitigation.

6.6.3 Scoring of project risks uses the Trusts' standard 5x5 scoring on impact and likelihood of the risk occurring :

IMPACT	Very High	5	5	10	15	20	25
	High	4	4	8	12	16	20
	Medium	3	3	6	9	12	15
	Low	2	2	4	6	8	10
	Very low	1	1	2	3	4	5
RISK SCORE MATRIX			1	2	3	4	5
			Very Low	Low	Medium	High	Very High
			LIKELIHOOD				

6.6.4 The highest risks, and mitigations, for this stage of the project are:

Risk or Issue	Risk Code	Name	Risk Description, Causes & Consequences	Initial Score	Current Score	Target Score	Risk Owner	Mitigation/Last Updated	State	Next Review Date
Risk	Implementation	Union opposed to decision on Shared services	Unions opposed to the principle of NHS subsidiaries. Fears for longterm risk to pay, pensions and remaining NHS owned, despite clear commitment by Boards. Impact: negative view on Subco which may result in disengagement from others. Worst case scenario, protests begin which will derail the project.	15	15	10	HR workstream	Mitigations: communication of overall benefits, and protection to pay, pensions, 100% NHS ownership etc. Pre-meets with unions before engagement, and then in April/May. Update: triple lock for extra protection; pension advice nationally os reassuring; 25 years contract; Walk through of full business case and key benefits e.g. ability to bring more work in house to public sector. More meetings with unions planned. Correspondence with Head of Health at Unison, with specific reference to key concerns.	Active	29-Jun-25
Risk	implementation	Wider stakeholder interest	Wider stakeholders (i.e. MPs, Councillors, staff not in scope), raising concerns, similar to those raised by unions. Impact: negative view of proposal, may result in disengagement and/or increased resources needed to address negative publicity and/or incorrect information re: pay, jobs, pensions, ownership).	15	15	6	Comms team	Mitigations: communications including the key benefits of Subco, protection for staff and public ownership, etc Increase communications and briefings to wider audience. Hold June Boards in public to review full business case. Update: disucssions with MPs, planned or happening; Meeting with BCP councillors; dedicated comms professional time allocated.	Active	29-Jun-25
Risk	Implementation	Resource availability	Resource availability. Project team/key staff with particular expertise may have other commitments and can only provide a limited amount of time on the project. Finance for set up flagged, and then preparations for TUPE transfer. Impact: lack of resources may result in slippage on timelines, or quality of work affecting progress through each stage, and ultimatley the timeline.	12	9	6	Finance workstream	mitigation: external legal and finance resource procured. Secondment/bank staff used to strengthem workstreams; agreement by exec teams of the level of importance of the project; resource plan and timelines agreed. Update: work underway to identify governace team support; June Board recommendations to include add 1 month to target start date at, set up legal entity to allow preparatory work and stagger this over several months ; finance work underway to specify ledger and other day one finance actions;	Active	29-Jun-25
Risk	Implementation	Anticipated benefits not achieved or take longer than expected to be delivered.	Anticipated benefits not achieved or take longer than expected to be delivered. Risk bsuiness as usual delivery may crowd out cash out savings. Impact: lower financial and quality of service provided, than anticiated.	12	12	6	Finance workstream	Mitigation: ensure there is a robust benefits realisation plan. Use of Capita to focus help on largest cashable savings, around procurement at Dorset level. Update: Capita approved and mobilising; robust methodology for cost improvement, to take long list of details benefits, and track through to budget adjustements; tax opinion recieved and confirms low risk approach being taken.	Active	29-Jun-25
Risk	Implementation	Incomplete or inaccurate data on "as is" services being migrated, and overall preparedness for transfer of services.	Incomplete or inaccurate data on "as is" services being migrated causes difficulties with the transition or inaccurate representation of the benefits achieved. Lack of preparation for transfer on "safe and legal" basis, where lift and shift the case for the majority of services, and then planning benefits delivery and set up in Nov-March 2026 period. Impact: Errors or omissions in any of the data provided could delay delivery of the benefits associated with transformation. Lack of preparedness may result in hihger cost, lower quality and/or staff morale being affected.	12	12	6	EFM, HR and Finance workstreams	Mitigation: Review / confirmation of critical data to be completed during mobilisation of the transformation programme, to reduce the likelihood of errors or omissions, and enable early interventions to be put in place if required. Workstream leads repsonsible for their areas. Ensure good 'baseline' as part of the due diligence process. Any KPIs to be based on robust data sources. Ensuring the correct people with subject matter expertise are part of the project team and data collection. Update: review of specs/KPIs are progressing with the EFM workstream. Budgets mitigation - lift and shift services is the basis wiht budget transfers and run rates to be agreed before Sept. Reasonable endeavours approach with "safe and legal" transfer being the priority.	Active	29-Jun-25

6.7 Post project evaluation (PPE) strategy.

6.7.1 This strategy will review formally at each stage of the project, for what went well and what could be done better.

6.7.2 Also to include a pre-mortem stage, i.e. planning ahead for the next stage, considering scenarios, headwinds, and mitigations.

6.7.3 Objective measures for the PPE include:

- Benefits realisation against the strategic reasons
- Project timeline
- Staff satisfaction scores
- Performance against KPIs.
- Contractual delivery for the three managed services.

6.8 Subsidiary Company Governance.

6.8.1 Hill Dickinson LLP are the legal advisors and have helped establish many other subsidiary companies. They have a detailed checklist and process for setting up the subsidiaries. Also, learning from other subsidiary companies has been gleaned from multiple conversations with established providers. These will feed into the work programme of the shadow Board who will help shape the proposal ahead of the go/no go decision by each FT Board. This work will happen over June-September.

6.8.2 Key to this will be establishing Shadow Boards, for the subsidiary companies (PropCo) and for shared services in the OpCo. This requires a mix of directors and non-executive directors. For the OpCo the majority are independent, but six will be shareholder representatives. Five will be OpCo execs, including an MD and FD. There will then be 3 independents, including the chair. Advice has been provided on how this will work, and ensure Board duties are fulfilled, including on any potential conflicts of interests. As the subsidiaries are part of a group structure and aligned around NHS values, this should be minimal. Learning from established Trust-SubCos then maintaining strong relationships, built on transparent data and performance is very important.

6.8.3 The mix of skills and experience of the OpCo Board membership will be assessed to see if there are specific gaps against an “ideal” Board. This will the shape the recruitment for the independent non-executives role, to provide overall balance.

6.8.4 The shadow Board’s main role will be to ensure and assure readiness for the set up and passing the go/no go checklist, prior to the decision of the FT Boards. It will take the role of Programme Board, whilst the working group will undertake the work and co-ordination of the workstreams. Part of this set up will be to oversee the legal and governance preparations on issues such as Board and committees, SFIs and policies.

6.8.5 The reserve matters list will also be reviewed and needs agreeing between the Trusts

and the Shadow Board. The proposed reserve matters are set out in the Annex 22 and 23. This includes the “triple lock” protections on pay, terms and conditions, pension and NHS ownership.

6.8.6 Each Trust retains its’ own capital programme, within the overall ICS capital plan. The PropCos role will be to inform and guide the Trusts in developing both the longterm and annual capital programmes, to best ensure the assets and investments fit with the wider Trust and ICS strategy. This will include at least monthly capital plan updates, which will be common to all parties, as part of the transparency and alignment necessary to make the most of the opportunities for full system working.

7 Conclusion

7.1.1 Whilst there is significant work to manage the programme to successful delivery, there is the skill and experience within Dorset ICS to deliver.This is being supplemented by professional advice. Following FBC approval there remains a large body of work, pre and post a go live date. Sufficient resource and leadership focus has been committed to ensure the project can be completed following a go/no go decision, targeted for September 2025.

7.1.2 This is a strong platform to then ensure the benefits are deliverable. These will the support considerable progress towards the ICS four aims, thus achieve the strategic goals identified at the start of this business case.

Our Dorset Provider Collaborative Shared Services OPTIONS APPRAISAL

February 2025

Contents

1. Options Appraisal Process

1.1 Introduction

The Boards of the three Foundation Trusts in Dorset have supported the Our Dorset Provider Collaborative (ODPC) to work more closely to provide better services to patients, and better use the resources available. As part of the 2024/5 ODPC work programme shared services has been identified as an area of opportunity.

Following discussion between executive teams the priority focus has been on Procurement and Estates functions, with other services possible at later stages. This is based upon the initial list of benefits identified. These have been included in the draft outline business case (OBC). The draft OBC has been developed to provide a framework to review the options and turn initial discussions into a more formalised approach. Each part of the draft needs careful reviewing and further work. A key part is the options appraisal, which this paper seeks to ensure is done in a robust and systematic way.

The options appraisal is to review the options and assess their relative strengths in best meeting the strategic objectives set out in the draft OBC.

This paper details the process that will be followed in conducting the options appraisal and provides guidance to evaluators on how scoring will be undertaken. It also outlines the governance that will surround the process, methodology and criteria that will be used to benchmark each of the options.

Supporting material to the options appraisal includes the key papers and slides provided to ODPC stakeholder groups to inform the panel of the detail of each option. A spreadsheet table has been provided which includes a commentary for panellists to consider regarding key features, issues, strengths and/or weaknesses per criteria. It is entirely for the Panel's discretion to assess that commentary and any other issues they foresee before assigning their own scoring.

1.2 The Appraisal Panel

The role of the Appraisal Panel is to review the evidence provided for a range of viable options available for the delivery of a subsidiary company.

The Appraisal Panel has been selected to represent a wide range of characteristics and to provide expertise and experience. The panel consists of the following members:

Members
Richard Renaut – Chief Strategy and Transformation Officer – UHD
Andrew Monahan – Finance Business Partner – UHD
Tim Goodson – Governance Advisor
Chris Hearn – CFO – DHC/DCH
Nicholas Johnson – Deputy CEO, Chief Strategy & Transformation Officer – DHC/DCH
Claire Abraham – Deputy CFO – DCH/DHC
David McLaughlin – Director of Estates and Facilities - DCH/DHC
Pete Papworth – CFO – UHD
Louise Betteridge – Strategic Finance Team – DCH

Sarah Macklin – Head of Programmes – OPDC
Ben Print – Senior Programme Manager - OPDC

The panel's purpose is to understand and evaluate the options and recommend a preferred way forward (PWF) for detailed work up, designs and costings. The panel's evaluation will be managed under a robust facilitated process to generate an audit trail that can be scrutinised and referred back to. This will need to demonstrate how the recommendation was made on best use of funding available to maximise benefits for patients, staff and taxpayers.

The scoring panel's deliberations will be presented as a preferred way forward (PWF) to the ODPC Board and the boards of the Trusts (as part of the outline business case). The recommendation of PWF is advisory, the ultimate decision maker is the board of each organisation.

1.3 The Criteria and Scoring Process

3.3.1 The Criteria

The criteria are based upon the Treasury "5 case" business case format. They are then amended to reflect the subject matter.

The scoring criteria are as shown in the table below. There are five categories, 15 scoring criteria. The five MVP options are to be scored across each of the 15 criteria:

Criteria Heading	Factors to consider in scoring - thresholds to be adapted for each review (factors may be chosen that are bespoke to the assessment being undertaken, but it is expected that most of the below will apply)	Ref to Treasury Criteria
Strategic alignment	• Option fits ODPC strategic aims • Option fits individual Trust's strategic aims • Option fits ICS strategic aims	Strategic Case – alignment with strategic aims
Economic benefits	• Option is Value for Money (VFM) after any costs • Option has clear, measurable benefits (cashable and cost avoiding) • Option can enable wider societal benefits	Economic Case – option appraisal to maximise net benefits
Commercial feasibility	• Option has a commercially viable route for delivery • Option is compliment with procurement requirements • Option meets Trust governance requirements	Commercial Case – market response expected, robustness of procurement

Financial	• Any estimated revenue costs/benefits where known at outline stage • Any estimated capital costs/benefits where known at outline stage • Affordability to enact the option	Financial – affordability and return on investment by making savings, higher productivity net of costs
Deliverability / Timing	• Scheme is deliverable within the time and resources available • Risk profile and mitigations within the risk appetite of the Boards • Likelihood of benefits realisation being achieved	Management – how will risks and timing be successfully managed to deliver benefits

It is a considered decision not to weight any criteria. This based upon experience of using this approach for large, complex decision making, including with the New Hospital Programme in Dorset. This approach has been used to decide options, and scope reductions, and decision around programme prioritisation. Weighing the criteria equally reflects the importance of each "case," reduces complexity and also stays true to this being advisory to inform the expert panel judgement.

Each of the 15 criteria needs to be assessed individually and then scored. The Panel will be asked to score each option against each criterion giving a score between 0 and 3:

Score	Definition
0	Does not meet criteria
1	Partially meets criteria
2	Meets criteria
3	Exceeds criteria

In addition, the experience from the Dorset Clinical Service (CSR) and the legal and best practice advice is to keep the scoring simple and evidence based and not to weight the criteria. This is because it is difficult to defend a weighting for such a complex subject matter evaluation.

There are 15 criteria against which to score. A scheme that "meets" the criteria (scores 2 for all criteria) would score a total of 30. If all criteria are "exceeded" (15x3) this would be a theoretical maximum score of 45.

All options prepared are expected to meet the minimum requirement but the degree to which they meet the criteria will vary. Recording why, and the evidence used in reaching a score is important. Likewise, reflecting and moderating scores to ensure a consistency and common understanding is important. This takes the form of looking at areas of consensus and "outliers" to determine if there

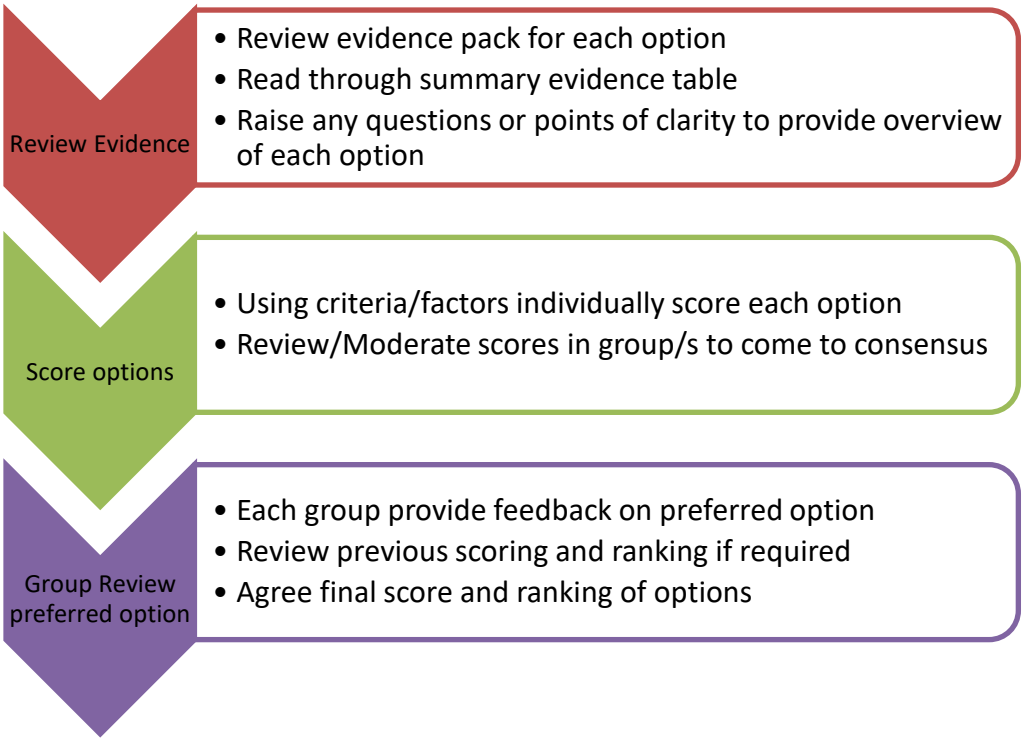
are genuine different views, or if it is differences in interpretation, or misunderstanding of the evidence.

Score forms will be provided and used to capture and feedback analysis and results on the day, along with discussion in groups and plenary.

3.3.2 The Scoring Process

The scoring process serves to inform the Panel's deliberations and recommendation; it is not designed to bind it. It provides an audit trail to support and evidence the subsequent decision that results. However, the quality of the recommendation is reliant on the quality of information, including where assumptions are made, and being transparent where estimates and judgement calls are made. The expertise and insight of the Panel is critical to arriving at the best preferred way forward, with open discussion important. It should be noted that more than one PWF is possible, if it is not judged equal. The key point is that the PWFs will be worked up for the Full Business Case. As such the time and resources could be abortive if too many, lower scoring options are continued beyond this stage. This is why the options appraisal is so important, and the options are fully scrutinised at this stage.

A visual and worked example of the process is set out below:



General Arrangements

The Workshop will be facilitated by members of the Strategy & Transformation team. All scoring and formal commentary is to be captured on the day on the forms provided and via electronic means.

Preparation and Review

Papers will be issued to allow participants to familiarise themselves with the background to each option. To ensure a 'level playing field' all options are prequalified as satisfying the minimum catering criteria, so they can be compared as 'like-for-like' solutions based on how well they deliver and the extra benefits they may enable. It is recommended the Panel review this information to maximise the evaluation's effectiveness.

Introduction

The session will open with who's who, roles and protocols, agenda followed by briefing session. In order to level the playing field between familiar options and newer ideas, the initial session will focus on outlining the options and answering questions where panellists are unclear what is proposed. This will be important to give everyone a good basic understanding of each option before any scoring is started.

Individual Marking

Each panellist will use the forms provided to give initial individual scoring for each option against the 15 criteria – they can also provide general commentary if they wish to supplement or critique the commentary provided in advance in the information packs. Some discussion is expected but the aim is capture raw first impressions from the Panel on an individual basis.

Initial Analysis

The scores will be collated electronically and analysed to be presented back to the Panel. The presentation that follows will run through the scoring highlighting areas of high and low consensus of scoring on each criterion. The latter will be the focus for additional discussion in groups.

Moderation

The panel will split into two groups so that where there is divergent scoring there is an opportunity for additional discussion and information sharing. In open forum Panellist can share reasons for high or low scores and all are invited to review their previous scores in the light of what is learnt.

If there are several zero scores it will also be important to discuss this to establish if there is a case for discounting an option from further debate. A commentary is desired for any changes to marking or if there is wide agreement to eliminate an option.

Once a group has finished moderation scores can be updated and the preferred option noted for discussion as a single group to come to an agreed preferred option.

Sense Check

The final preferred option can be questioned and walked through a final time to ensure it represents the overall view of the panel, based on the moderated scores. This is the option that will be presented for further work up into the full business case.

Recommendations

The output of the Evaluation should be to propose a preference to ODPC & Boards to deliberate and decide upon. If following the Panel discussions and deliberations, two or more options remain close then the Panel can make this clear.

Further clarifications and explanation can be provided; however, it is unlikely there will be significant new information available that has not already been shared. Therefore, the Panel, and then ODPC will be asked to make a recommendation based upon the best information available currently.

Additional commentary can be captured and included in the recommendation to Trust Board, indicating the overall preferred way forward that will be worked up.

1.4 Scoring Guidance

Below are *suggestions* to guide panel members in scoring the options. They are not binding. Scoring requires judgement of many complex issues and thus the overall scoring is only to provide a structure for deliberations and differentiate between the options.

FIVE CATEGORIES, 15 SCORING CRITERIA	
Criteria	***Rationale for score 0-3***
1.Strategic alignment	
Option fits ODPC strategic aims	
Options fit individual Trust's strategic aims	
Option fits ICS strategic aims	
2. Economic Benefits	
Option is value for money (VFM) after any costs	
Option has clear, measurable benefits (cashable and cost avoiding)	
Option can enable wider societal benefits	
3. Commercial feasibility	
Option has a commercially viable route for delivery	
Option is compliant with procurement requirement	
Option meets Trust governance requirements	
4. Financial	

Any estimated revenue costs/benefits where known at outline stage	
Any estimated capital costs/benefits where known at outline stage	
Affordability to enact the option	
5. Deliverability/Timing	
Scheme is deliverable within the time and resources available	
Risk profile and mitigations within the risk appetite of the Boards	
Likelihood of benefits realisation being achieved	

2 Next Steps

Following the options appraisal the scoring group will make a recommendation to ODPC Board with a Preferred Way Forward (PWF). This will inform the Outline Business Case and then Full Business Case. The following steps are likely to occur:

1) PWF is written up so it is a full "end to end" description of how to achieve the objectives.

2) A detailed timetable is developed, based upon achieving a viable OBC and FBC submission.

3) Specialist legal/governance and accounting expertise is procured, to work on the PWF.

Options appraisal method

Briefing pack Jan 2025

Introduction/Background

These slides are intended to explain the standard options appraisal method used by Our Dorset Provider Collaborative. They are based upon the tried and tested options appraisals methodology used in Dorset to help decide upon the best option for New Hospitals Programme, and other strategic decisions.

We need to be consistent in our approach, as such every options appraisal MUST:

- use all five criteria per this method
- score 0-3 per this method with average scores determining the outcome
- Have a balanced expert evaluation panel with a majority of independent scorers (minimum panel size = 7) and subject matter experts on hand to help advise.

Each options appraisal SHOULD/COULD:

- be accompanied by a word document containing the scoring method, evidence for each option and explanation of the criteria and factors that relate to the options under analysis

- Pre-score factors based on factual evidence where this is available and objective ie measurably one option is better than another without the need for judgement e.g. option A is quicker to implement than option B. Such scoring should be allocated by the expert team in advance and so is 'fixed' for the panel and not subject to their scoring.

- Remind panel members to score independently– when results aggregated scoring team can draw attention to outlying scores for moderation

- Remind Panel members the appraisal is not the decision, the end result of scoring is a recommendation, ranking options. These are then presented for the final decision by Trust Boards.

Ground rules

Suggested ground rules for scoring workshops:

- Follow the process, so we can explain (defend) the outcome
- Accept we're using best available evidence – mostly estimates
- Usually scoring is relative to the other options and subject to individual judgement by the panel members
- Where something isn't clear or understood, members should ask experts present
- Give plenty of time for panel members to discuss options and be clear on what they are scoring
- Score individually in the room, then provide scores back to the panel as averages per group, then moderate as a group/s.
- Remind the panel the options appraisal is a recommendation
- Remind the panel that scores need to avoid bias and be based on justifiable evidence/experience

Strategic reasons for shared service

1. **Enables shared** services which better facilitate collaboration and integration of Trusts to drive transformation of clinical services which improves patient experience and outcomes, achieve economies of scale for cashable savings and resilience.
2. A greater **client focus** and improved performance, from transparency and strengthened governance.
3. **Maintenance of the estate**, through robust contracts, especially important to maintain the major capital investments in Dorset.
4. **Leveraging the expertise** around major capital projects for wider NHS benefit.
5. **Addressing descoped capital projects**, without a call of central capital funds (one-off VAT benefit).
6. Improving social value by being an **anchor institution**, especially focused on employment and training in specialist areas like Estates.
7. **Procurement for social value**, as well as Value for Money (VFM) by better local supply chains and market development, done once.
8. Delivery of the **NHS Green Plan**, including 80% carbon reduction by 2030. This requires specialist expertise, procurement, and capital, which is best done at scale. Estates and procurement are core delivery areas.

The List of Options

The research into options to best deliver the nine strategic reasons are:

A. **'Do nothing different to now' using informal collaboration, on tactical basis. The 'as is' model for DHC and DCH is to continue with development of a federated shared service as part of their joint Trust strategy.**

B. **Hosted service**

C. **Outsource services into managed service contract(s).**

D. **Become a customer of an existing subsidiary company, within the NHS.**

E. **Set up a single subsidiary company, holding the shared services, with 75% ownership by a lead Trust and transfer of all assets.**

F. **Set up a separate subsidiary company for each Trust in Dorset focused on property assets managed service delivery. This is serviced by a single shared service provider in an operating company "OpCo".**

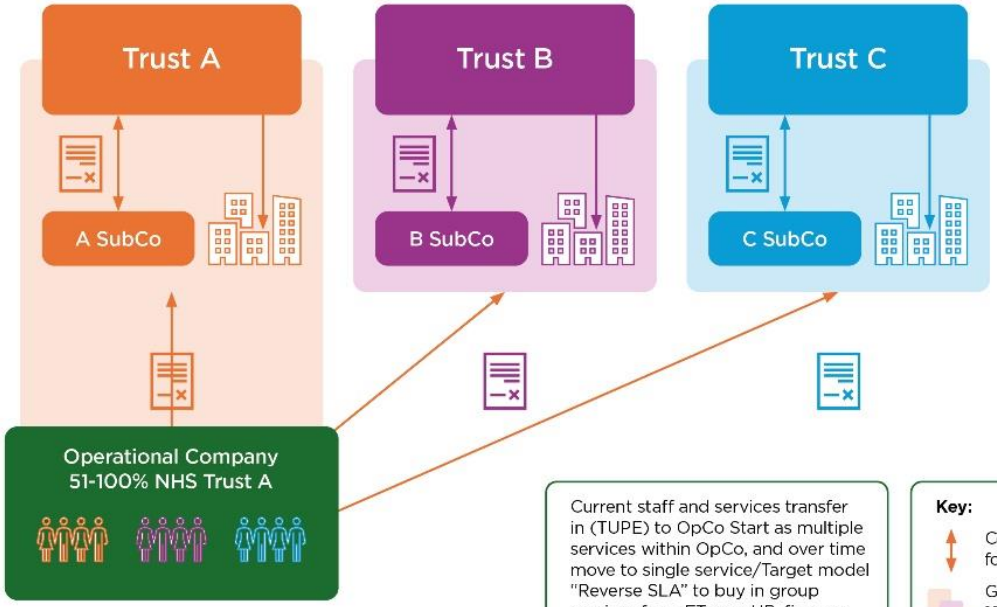
To note there is already a subsidiary company operating in Dorset, providing pharmacy services to DCH. This is not included as an option to expand and provide as D and E above. This is because the transaction guidance of February 2024 makes clear such significant change would still require regulatory assessment, to the same extent as a new subsidiary company. Therefore, it is no different to the D and E options. It does though demonstrate the experience and success of the subsidiary company model in Dorset.

A 'Hosted Service' model could be considered. This is where one Trust provides the services on behalf of the other Trusts. Whilst it has some advantages, such as limited change for the host Trust, and economies of scale, it does not have the strategic reason (ii): greater client focus and transparent governance of options B-E. This can mean difficulty in delivery of differential services and benefits from the different baseline, backlog, and investment levels. Without the governance this can lead to friction amongst partners. Strategic reason (v) is also not deliverable. The option of a lead provider model is thus excluded.

Please see next slides for structure diagrams.

Our Dorset

Shared Services (SubCo) Option F



Current staff and services transfer in (TUPE) to OpCo Start as multiple services within OpCo, and over time move to single service/Target model "Reverse SLA" to buy in group services from FTs e.g. HR, finance, digital, comms OpCo can award other contracts e.g. insurance, audit, sub-contractors etc Control Agreement between Trusts and other governance to be confirmed.

Key:

- Contract for Managed Service for operated Healthcare Facility
- Group 100% owned by the relevant Trust (no Stamp Duty)
- Ownership of premises Each Trust owns the premises and grants its SubCo a leasehold interest in the whole of the site. As soon as SubCo is granted its lease it grants the Trust an internal underlease of part back – being just those rooms that the Trust wishes to occupy.
- Transferring Staff

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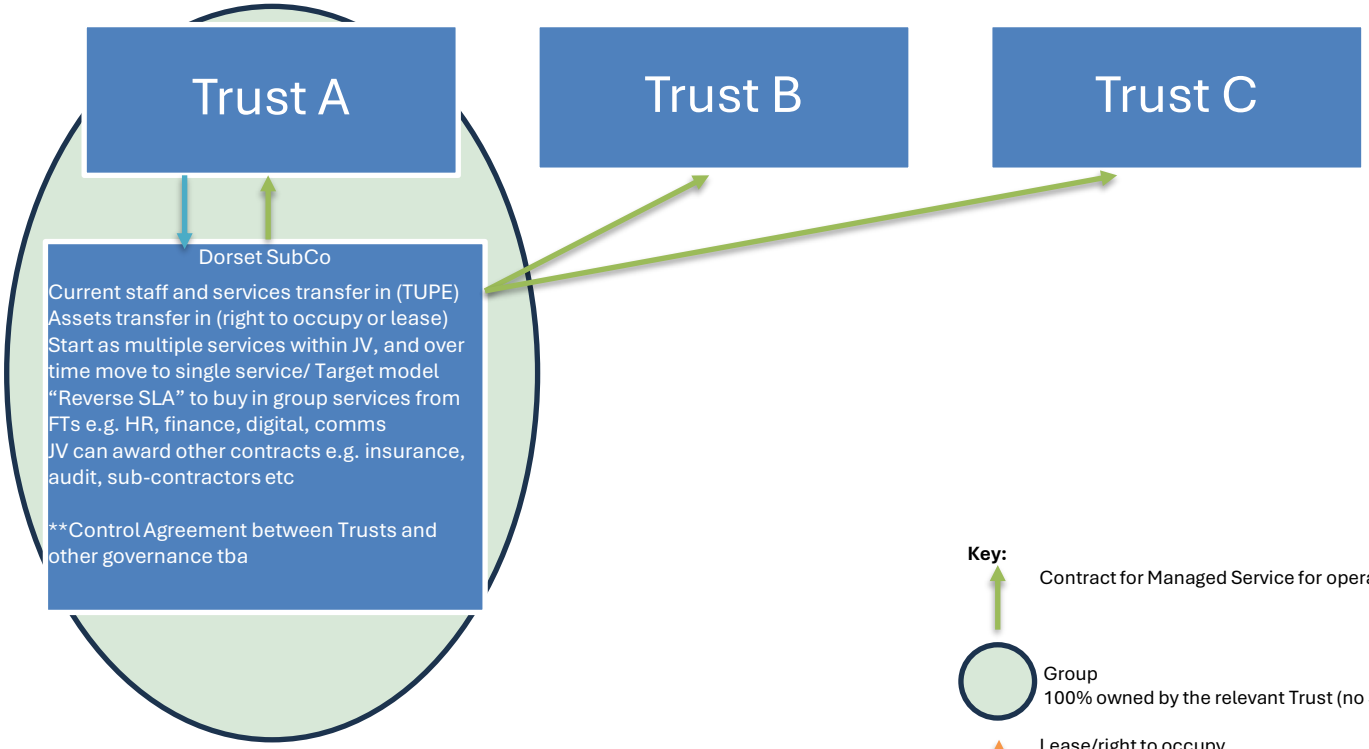
Our Dorset

Single SubCo (option E)



Key:

- Contract for Managed Service for operated Healthcare Facility
- Group
  100% owned by the relevant Trust (no Stamp Duty)
- Lease/right to occupy
  Soft and hard FM, Procurement services contract
- Ownership at 75% (for SDLT and consolidation)

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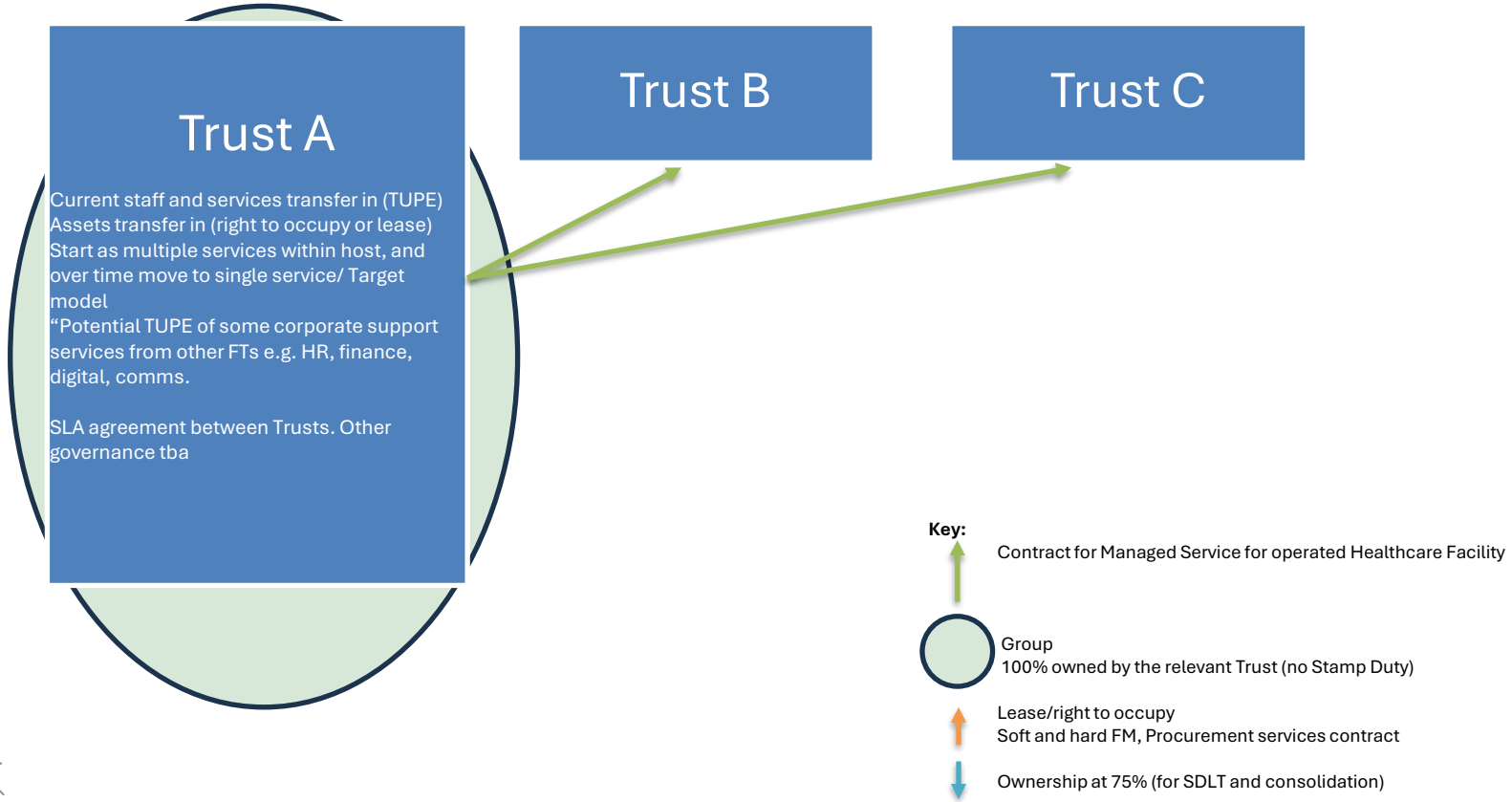
Hosted service (option B)



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Initial view: pros and cons

Option	Pros	Cons
A - 'Do nothing different to now'	Easy, little change	Very unlikely to deliver benefits, based on experience to date
B - Hosting	Simple Quick - if all agree	Cannot separate service from host trust, so holding to account difficult. Lacks dedicated leadership and focus. Issues of differences and due diligence. Lack of control by two of the Trusts See 8 reasons (and limited mitigations) paper
C. Outsource services into a 'managed service' with commercial partner(s).	Delivers focus and transparency VAT fully reclaimed	Not NHS owned – fundamental principle breached TUPE required to non-NHS organisation
D- D. Become a customer of an existing subsidiary company, within the NHS	Already established providers Keeps publicly owned.	Loss of control of service out of area May needs regulatory approval for another SubCo Existing providers not yet well established as regional/national suppliers
E – Single Subco, 75% ownership	Creates ability to hold to account Greater transparency Can hold separate contracts	Needs one Trust with 75% ownership, may be difficult to agree Needs approval from NHSE
F – Single Operating Company, 3 Subco	Creates ability to hold to account Greater transparency Can hold separate contracts Shared ownership within NHS FTs Flexibility to add in other services Provides accounts consolidation at a local level	Extra governance layer Needs approval from NHSE

Board membership

NHS University Hospitals Dorset NHS Foundation Trust

UHD SubCo

Some FT execs & NEDs
Some OpCo execs
An independent Chair

NHS Dorset County Hospital NHS Foundation Trust

DCH SubCo

Some FT execs & NEDs
Some OpCo execs
An independent Chair

NHS Dorset HealthCare University NHS Foundation Trust

DHC SubCo

Some FT execs & NEDs
Some OpCo execs
An independent Chair

Could Subco indept chairs be same person?

Extra costs:
5 JV execs (at least 2 existing)
Indept chair
2 OpCo NEDs
Subco chair(s)
Company Secretary

Operating Company, 100% NHS owned.

Independent Chair
Director team (MD, FD, E&F, Capital, Sustainability)
2 OpCo NEDs
3 Shareholder NEDs (FT execs e.g. CFOs)

Our Dorset

NHS Dorset County Hospital NHS Foundation Trust

NHS Dorset HealthCare University NHS Foundation Trust

NHS University Hospitals Dorset NHS Foundation Trust

List of potential benefits

Description	Cashable	Non Cashable	Societal
Rentals/carparking/accom/retail/telecommms/other income	Y		
Ability to work with vol sector/wider public sector needing estates/FM	Y		Y
Major capital projects consultancy	Y		
GP commercial opportunities (estates/FM/supply goods and services etc)	Y		
Geothermal local heat network	Y		Y
Energy efficiencies	Y		Y
Consolidated / scaled expertise environmental opportunities		Y	Y
Revaluations	Y		
Estates rationalisation / improved utilisation from global view on use of estate		Y	Y
Consolidation and market testing maintenance contracts	Y		
Links with 3rd sector for grounds maintenance/BNG		Y	Y
Reduction in single use items / clinical waste			Y
Reporting / shared data / Alignment of systems / data fields		Y	
Digital & AI integration / IOT / RCM	Y	Y	
Improved patient experience through standardisation / environment		Y	Y
Centralised view of systems - compliance		Y	Y
Emergency response planning / service resilence		Y	Y
Fleet management / central management		Y	
Operational economies of scale	Y	Y	
Improved stock control through standardisation / centralised stores	Y		
Centralised / standardised licensing	Y		
Faster progress of sustainable development assessment tool			Y
Single procurement of influenceable spend	Y		Y
User friendly digital procurement system		Y	Y

Overview of Process

Review Evidence

- Review evidence pack for each option in workshop
- Experts on hand to provide overview of each option
- Read through summary evidence table

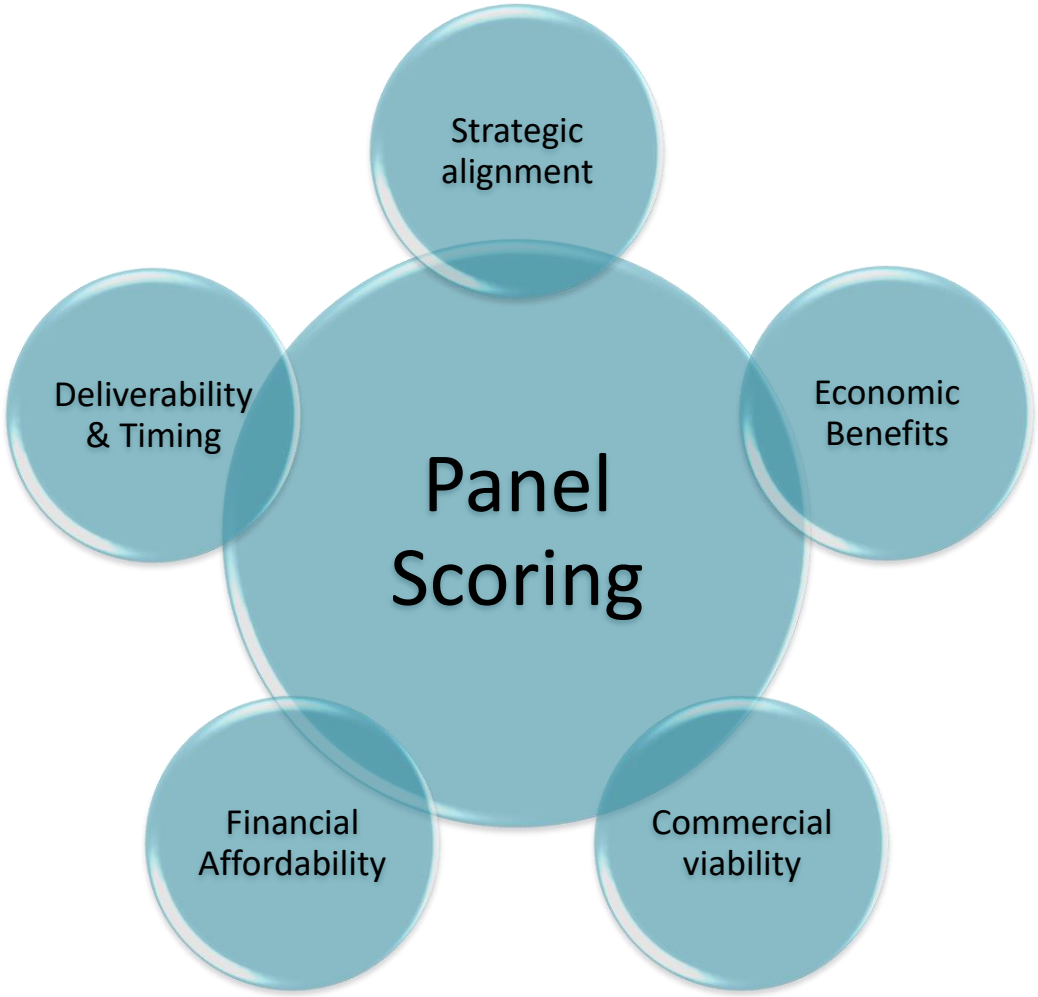
Score options

- Using criteria/factors individually score each option
- Experts on hand to provide advice/assistance
- Review/Moderate scores in group/s to come to consensus

Group Review preferred option

- Each group provide feedback on preferred option
- Review previous scoring and ranking if required
- Agree final score and ranking of options

Five criteria



Scoring

Score Awarded	Description
0	Criteria not met
1	Criteria partially met
2	Criteria met
3	Criteria exceeded

Scoring Criteria (for outline case)

Criteria Heading	Factors to consider in scoring - thresholds to be adapted for each review (factors may be chosen that are bespoke to the assessment being undertaken, but it is expected that most of the below will apply)	Ref to Treasury Criteria
Strategic alignment	1. Option fits ODPC strategic aims 2. Option fits individual Trust's strategic aims 3. Option fits ICS strategic aims	Strategic Case – alignment with strategic aims
Economic benefits	1. Option is Value for Money (VFM) after any costs 2. Option has clear, measurable benefits (cashable and cost avoiding) 3. Option can enable wider societal benefits	Economic case – option appraisal to maximise net benefits
Commercial feasibility	1. Option has a commercially viable route for delivery 2. Option is compliant with procurement requirements 3. Option meets Trust governance requirements	Commercial case – market response expected, robustness of procurement
Financial	1. Any estimated revenue costs/benefits where known at outline stage 2. Any estimated capital costs/benefits where known at outline stage 3. Affordability to enact the option	Financial – affordability and return on investment by making savings, higher productivity net of costs.
Deliverability / Timing	1. Scheme is deliverable within the time and resources available 2. Risk profile and mitigations within the risk appetite of the Boards 3. Likelihood of benefits realisation being achieved	Management – how will risks and timing be successfully managed to deliver benefits

Scoring Guidance

Initial Scoring

- Score each option for all factors individually using a supplied form
- Some scores are factual/quantitative, some judgement/qualitative
- Use expertise in room and from support team for scoring
- Scoring will be relative to other options in most cases
- Not unusual for many options to be similar in scoring, if there are limited differentiating factors
- Scores will be entered onto spreadsheet and averages provided

Moderation in group/s

- Revisit scores as a group, look at variation, ensure evidence-based
- Examine all options against each criteria in turn
- Discuss & moderate scores and outliers
- Group agreement on final option essential

Present back preferred option for agreement

Our Dorset

NHS Dorset County Hospital NHS Foundation Trust

NHS Dorset HealthCare University NHS Foundation Trust

NHS University Hospitals Dorset NHS Foundation Trust

Scoring Example

Criteria	Factors	Option A	Option B	Option C	Option D	Option E	Option F
Strategic alignment	Option fits ODPC strategic aims Option fits individual Trust's strategic aims Option fits ICS strategic aims	2 2 2	0 1 2	etc			
Economic benefits	Option is Value for Money (VFM) after any costs Option has clear, measurable benefits (cashable and cost avoiding) Option can enable wider societal benefits	3 3 2	3 0 1				
Commercial feasibility	Option has a commercially viable route for delivery Option is compliment with procurement requirements Option meets Trust governance requirements	2 2 2	2 3 0				
Financial	Any estimated revenue costs/benefits where known at outline stage Any estimated capital costs/benefits where known at outline stage Affordability to enact the option	1 2 3	1 2 3				
Deliverability / Timing	Scheme is deliverable within the time and resources available Risk profile and mitigations within the risk appetite of the Boards Likelihood of benefits realisation being achieved	1 1 2	0 1 2				

Our Dorset

NHS Dorset County Hospital NHS Foundation Trust

NHS Dorset HealthCare University NHS Foundation Trust

NHS University Hospitals Dorset NHS Foundation Trust

	A. 'Do nothing different to now' using informal collaboration, on tactical basis. The 'as is' model for DHC and DCH is to continue with development of a federated shared service as part of their joint Trust strategy.	Scores	B. Hosted Service	Scores	C. Outsource services into managed service contracts.	Scores	D. Become a customer of an existing subsidiary company, within the NHS	Scores	E. E.5Set up a single subsidiary company, holding the shared services, with 75% ownership by a lead Trust and transfer of all assets.	Scores	F. F.5Set up a separate subsidiary company for each Trust in Dorset focused on property assets managed service delivery. This is serviced by a single shared service provider in an operating company "OpCo".	Scores
1.Strategic alignment												
Option fits ODPC strategic aims	Collaboration has a limited track record of success; unlikely to deliver optimal result	1	Use of a commercial partner may limit ability to transition existing staff on NHS T&Cs, as well as potentially causing benefits leakage out of NHS	0	May be hard to manage and drive effectively to meet target	1	Viable option but does not address how 3 FTs will work effectively together to maximise benefit and minimise cost	2	Should deliver best collaboration and both maximise savings and protect recently upgraded facilities	3	Collaboration achieved, with vehicle able to take on future services	3
Option fits individual Trust's strategic aims	Unlikely, unless other projects with higher benefits case are dominating management bandwidth	0	Trusts are keen to retain all staff within NHS, and to retain benefits within NHS also	0	Lack of control and influence ov er the existing subsidiary limits the appeal of this	1	Keeps control fully within each FT, but at cost of a sub-optimal benefit delivery.	1	Trusts are aligned on need to deliver savings to allow increased spending on patient care	3	Each Trust retains strategic control of estate and capex, and can more easily set individual contract priorities	2
Option fits ICS strategic aims	ICS looking for FTs to work more effectively together. With historical loose collaboration showing limited effectiveness, fit is poor	0	As for Trusts	0	as for Trusts	1	Strong reliance on collaboration will slow progress. Fallback option if shared ownership company not viable	2	Best option for delivering savings (reducing deficit) and protecting recent NHP and similar investments	3	Fully aligned with ICS aims	3
2. Economic Benefits												
Option is Value for Money (VFM) after any costs	Low cost to do, but benefits also likely to be lower	1	Commercial partner may bring new tools and better data to help increase benefits, but will likely charge higher fees for this which will reduce VFM. They will be less motivated to enable societal benefits which don't impact their profit	1	Lower cost to set up Would need to validate that existing subsidiaries have capability in the areas we've targeted for savings	2	Duplication of companies, management and systems etc likely to impact benefits case	1	Need to work through cost/benefit in greater detail through the project btu expected to deliver strong benefits at an affordable cost	2	Small extra cost of SubCo Boards, but most costs within the JVCO, so maximises savings	3
Option has clear, measurable benefits (cashable and cost avoiding)	The stronger the collaboration the greater the opportunity for benefits. This approach may provide a sub-set of the available benefits	1	Likely to be able to deliver solid gross benefits (before their charges) and to be able to leverage wider economies of scale	2	May bring existing best practice and greater leverage to increase benefits. Could bring existing processes and systems (avoid reinventing the wheel) Could be partially offset by benefi[illegible] from Dorset to the parent [illegible] existing sub	1	If 3 companies are able to collaborate more effectively than FTs currently do then benefits can be achieved through focused alignment	1	Capita study has demonstrated strong potential procurement benefits and past experience on estates also supports ability to achieve benefits	2	Capita study has demonstrated strong potential procurement benefits and past experience on estates also supports ability to achieve benefits	2
Option can enable wider societal benefits	Societal benefits from greater staff development, social value employment etc are likely to be low	1	Societal benefits are likely to be a lower priority for the commercial partner who will be focused on their ability to generate profit	0	As an existing NHS compa[illegible] they will understand the importance of soci[illegible] benefits, but it is unclear they would be motivated to deliver these in Dorset	1	Limited ability to achieve societal benefits beyond the status quo scenario	1	Ability to deliver is maximised – for example through apprenticeships, local supply chain etc	3	Ability to deliver. Easier than one Trust dominating.	3
3. Commercial Feasability												
Option has a commercially viable route for delivery	With a modified status quo position it is likely to be viable. Achieving collaboration across Trusts will be more difficult without harmonised functional leadership and a single entity to drive this forward	1	Existing examples of managed service providers assumed to exist, but [illegible] out of line with government policy	1	Using an exisiting company should ensure commercial viability	2	With each company as a Sub of a separate FT, this should be commercially viable	2	Precise details of the structure to be determined with help from external advisers but Subcos have been successfully set up before so no reason to believe this can't be done	2	OpCo well established model.	2
Option is compliment with procurement requirements	Yes – current processes assumed to be compliant	2	May be possible to construct so it is compliant but external provider likely to be a challenge to get approved	1	Yes - their current processes are assumed to be compliant	2	FTs likely to start by transferring existing processes so should be compliant	2	No external parties involved so should comply. Will develop future state processes and governance to ensure compliance	2	Fully compliant with procurement. Develops ability to compete for future work	3
Option meets Trust governance requirements	Provided no issues with current approach this will meet the minimum hurdle	2	External commercial partner may limit ability of Trust management to provide effective oversight	1	An exisiting company from outside the Dorset area may limit ability of FT management to influence and oversee governance	1	Each FT will retain governance and control	2	Trust governance requirements will be given careful consideration. Oversight from 3 FT Boards will need careful structuring	2		1
4. Financial												
Capital cost/impact of scheme	Limited cost to implement. No staff or entity changes. Potential costs to support improved data sharing (eg systems/interfaces) between participating FTs	2	Commercial partner may be willing to absorb some of the implementation costs and re-use existing systems investments. Up-front cost could therefore be low (perhaps replaced by recurring licence fees for access to software etc?)	2	If they have existing capability and systems this may reduce up-front cost (beyond interfaces etc), but company may leverage this through licence fees or a one-time set-up charge	2	Costs associated with set-up of separate companies, IT systems etc will be duplicated 3x	1	Some cost to implement, including potential one-time up-front costs. Future costs will be calibrated against potential savings which can be delivered	2	Some cost to implement, including potential one-time up-front costs. Future costs will be calibrated against potential savings which can be delivered. Capital plans tailored to each	2
Revenue cost/impact of scheme	Benefits case expected to be lower, but one-time implementation costs also likely to be lower	1	Net revenue benefit likely to be lower due to commercial partner profit element	1	Opportunity to leverage cost base more effectively and drive higher productivity could increase gross benefits, before provider charges	2	Dependence on collaboration (as for status quo) likely to limit benefits, although Subco teams may feel more empowered to work together than they do today. Duplication	1	Will push hard for benefits maximisation across all 3 FTs which should comfortably offset operating costs of separate Subco	2	Revenue savings achieved at OpCo , as most effective way to deliver.	2
Value for money/Savings identified as a result of the scheme	Likely to be lowest level of potential savings	0	Expect potential benefits to be lower due to commercial partner profit element	1	May contribute to higher gross savings for Dorset, but these likely to be offset by higher charges/share of gains going to shareholders of existing subsidiary	1	Potential benefits overall likely to be lower than an integrated Subco	1	Expect net benefits to be highest overall due to focused management combined with efficiency of a single Subco	3	Many savings are made much more likely by this approach.	3
5. Deliverability/Timing												
Scheme is deliverable within the time and resource available	Lack of change to structures and most processes, with scope to move gradually should ensure deliverability	2	Commercial partner likely to bring their own delivery methodology which should de-risk implementation (but could be resistance to change from some existing personnel)	2	Need to confirm that existing subsidiary management have bandwidth available to support integration of 3 additional FTs	1	Each FT will be able to move at their own pace so can determine appetite and available resource separately	2	Needs alignment and cooperation from FTs as part of approval process. Each FT will need to sign-up to the timeline/resource plan, with PMO overseeing deliver	2	Deliverable, and resolves delay issues like consolidation.	3
Risk profile and mitigations within the risk appetite of the Boards	Low risk, low return	1	staff acceptance/resistance which could be high (and result in engagement from elected representatives)	1	how the 3 FTs can coordinate together to maximise targeted savings, as well as high risks around governance	1	Low risk, low return scenario	1	Strong expected financial and societal benefits whilst retaining staff within NHS should minimise project risk	2	Boards have indicated support	2
Likelihood of benefits realisation being achieved	Low benefits and will be harder to achieve due to dependence on collaboration	1	Once commercial partner has committed to benefits they are likely to deliver (or forfeit their fees)	2	High risk that benefits not achieved due to complex structure and involvement of another NHS with potentially conflicting interests	0	Each FT should be able to realise benefits which don't depend on collaboration, but wider benefits will be hard to achieve	1	A management team focused on specific targets should maximise benefits and drive early realisation rather than being lost among other Trust priorities	2	OpCo increases chance of delivery above counterfactual	2
Total		12		15		20		19		35		36

"Does not meet" Score 0
"Partially meets" Score 1
"Fully meets" Score 2
"Exceeds" Score 3

	A. 'Do nothing different to now' using informal collaboration, on tactical basis. The 'as is' model for DHC and DCH is to continue with development of a federated shared service as part of their joint Trust strategy.	Scores	B. Hosted Service	Scores	C. Outsource services into managed service contracts.	Scores	D. Become a customer of an existing subsidiary company, within the NHS	Scores	E. E.Set up a single subsidiary company, holding the shared services, with 75% ownership by a lead Trust and transfer of all assets.	Scores	F. F.Set up a separate subsidiary company for each Trust in Dorset focused on property assets managed service delivery. This is serviced by a single shared service provider in an operating company "OpCo".	Scores
1. Strategic alignment												
Option fits ODPC strategic aims	Collaboration has a limited track record of success; unlikely to deliver optimal result	1	Use of a commercial partner may limit ability to transition existing staff on NHS T&Cs, as well as potentially causing benefits leakage out of NHS	0	May be hard to manage and drive effectively to meet target	1	Viable option but does not address how 3 FTs will work effectively together to maximise benefit and minimise cost	2	Should deliver best collaboration and both maximise savings and protect recently upgraded facilities	3	Collaboration achieved, with vehicle able to take on future services	3
Option fits individual Trust's strategic aims	Unlikely, unless other projects with higher benefits case are dominating management bandwidth	0	Trusts are keen to retain all staff within NHS, and to retain benefits within NHS also	0	Lack of control and influence ov er the existing subsidiary limits the appeal of this	1	Keeps control fully within each FT, but at cost of a sub-optimal benefit delivery.	1	Trusts are aligned on need to deliver savings to allow increased spending on patient care	3	Each Trust retains strategic control of estate and capex, and can more easily set individual contract priorities	2
Option fits ICS strategic aims	ICS looking for FTs to work more effectively together. With historical loose collaboration showing limited effectiveness, fit is poor	0	As for Trusts	0	as for Trusts	1	Strong reliance on collaboration will slow progress. Fallback option if shared ownership company not viable	2	Best option for delivering savings (reducing deficit) and protecting recent NHP and similar investments	3	Fully aligned with ICS aims	3
2. Economic Benefits												
Option is Value for Money (VFM) after any costs	Low cost to do, but benefits also likely to be lower	1	Commercial partner may bring new tools and better data to help increase benefits, but will likely charge higher fees for this which will reduce VFM. They will be less motivated to enable societal benefits which don't impact their profit	1	Lower cost to set up Would need to validate that existing subsidiaries have capability in the areas we've targeted for savings	2	Duplication of companies, management and systems etc likely to impact benefits case	1	Need to work through cost/benefit in greater detail through the project btu expected to deliver strong benefits at an affordable cost	2	Small extra cost of SubCo Boards, but most costs within the JVCO, so maximises savings	3
Option has clear, measurable benefits (cashable and cost avoiding)	The stronger the collaboration the greater the opportunity for benefits. This approach may provide a sub-set of the available benefits	1	Likely to be able to deliver solid gross benefits (before their charges) and to be able to leverage wider economies of scale	2	May bring existing best practice and greater leverage to increase benefits. Could bring existing processes and systems (avoid reinventing the wheel) Could be partially offset by benefits leakage from Dorset to the parent of existing subco	2	If 3 companies are able to collaborate more effectively than FTs currently do then benefits can be achieved through focused alignment	1	Capita study has demonstrated strong potential procurement benefits and past experience on estates also supports ability to achieve benefits	2	Capita study has demonstrated strong potential procurement benefits and past experience on estates also supports ability to achieve benefits	2
Option can enable wider societal benefits	Societal benefits from greater staff development, social value employment etc are likely to be low	1	Societal benefits are likely to be a lower priority for the commercial partner who will be focused on their ability to generate profit	0	As an existing NHS company they will understand the importance of societal benefits, but not clear they would be motivated to deliver these in Dorset	1	Limited ability to achieve societal benefits beyond the status quo scenario	1	Ability to deliver is maximised – for example through apprenticeships, local supply chain etc	3	Ability to deliver. Easier than one Trust dominating.	3
3. Commercial Feasability												
Option has a commercially viable route for delivery	With a modified status quo position it is likely to be viable. Achieving collaboration across Trusts will be more difficult without harmonised functional leadership and a single entity to drive this forward	1	Existing examples of managed service providers assumed to exist, but feels out of line with government policy	1	Using an exisiting company should ensure commercial viability	2	With each company as a Sub of a separate FT, this should be commercially viable	2	Precise details of the structure to be determined with help from external advisers but Subcos have been successfully set up before so no reason to believe this can't be done	2	OpCo well established model.	2
Option is compliment with procurement requirements	Yes – current processes assumed to be compliant	2	May be possible to construct so it is compliant but external provider likely to be a challenge to get approved	1	Yes - their current processes are assumed to be compliant	2	FTs likely to start by transferring existing processes so should be compliant	2	No external parties involved so should comply. Will develop future state processes and governance to ensure compliance	2	Fully compliant with procurement. Develops ability to compete for future work	3
Option meets Trust governance requirements	Provided no issues with current approach this will meet the minimum hurdle	2	External commercial partner may limit ability of Trust management to provide effective oversight	1	An exisiting company from outside the Dorset area may limit ability of FT management to influence and oversee governance	1	Each FT will retain governance and control	2	Trust governance requirements will be given careful consideration. Oversight from 3 FT Boards will need careful structuring	2		1
4. Financial												
Capital cost/impact of scheme	Limited cost to implement. No staff or entity changes. Potential costs to support improved data sharing (eg systems/interfaces) between participating FTs	2	[illegible] absorb some of the implementation costs and re-use existing systems investments. Up-front cost could therefore be low (perhaps replaced by recurring licence fees for access to software etc?)	2	If they have existing capability and systems this may reduce up-front cost (beyond interfaces etc), but company may leverage this through licence fees or a one-time set-up charge	2	Costs associated with set-up of separate companies, IT systems etc will be duplicated 3x	1	Some cost to implement, including potential one-time up-front costs. Future costs will be calibrated against potential savings which can be delivered	2	[illegible] including potential one-time up-front costs. Future costs will be calibrated against potential savings which can be delivered. Capital plans tailored to each	2
Revenue cost/impact of scheme	Benefits case expected to be lower, but one-time implementation costs also likely to be lower	1	Net revenue benefit likely to be lower due to commercial partner profit element	1	Opportunity to leverage cost base more effectively and drive higher productivity could increase gross benefits, before provider charges	2	Dependence on collaboration (as for status quo) likely to limit benefits, although Subco teams may feel more empowered to work together than they do today. Duplication of	1	Will push hard for benefits maximisation across all 3 FTs which should comfortably offset operating costs of separate Subco	2	Revenue savings achieved at OpCo , as most effective way to deliver.	2
Value for money/Savings identified as a result of the scheme	Likely to be lowest level of potential savings	0	Expect potential benefits to be lower due to commercial partner profit element	1	May contribute to higher gross savings for Dorset, but these likely to be offset by higher charges/share of gains going to shareholders of existing subsidiary	1	Potential benefits overall likely to be lower than an integrated Subco	1	Expect net benefits to be highest overall due to focused management combined with efficiency of a single Subco	3	Many savings are made much more likely by this approach.	3
5. Deliverability/Timing												
Scheme is deliverable within the time and resource available	Lack of change to structures and most processes, with scope to move gradually should ensure deliverability	2	Commercial partner likely to bring their own delivery methodology which should de-risk implementation (but could be resistance to change from some existing personnel)	2	Need to confirm that existing subsidiary management have bandwidth available to support integration of 3 additional FTs	1	Each FT will be able to move at their own pace so can determine appetite and available resource separately	2	Needs alignment and cooperation from FTs as part of approval process. Each FT will need to sign-up to the timeline/resource plan, with PMO overseeing deliver	2	Deliverable, and resolves delay issues like consolidation.	3
Risk profile and mitigations within the risk appetite of the Boards	Low risk, low return	1	Implementation risk likely to centre around staff acceptance/resistance which could be high (and result in engagement from	1	Risk of benefits leakage and challenge of how the 3 FTs can coordinate together to maximise targeted savings, as well as high	1	Low risk, low return scenario	1	Strong expected financial and societal benefits whilst retaining staff within NHS should minimise project risk	2	Boards have indicated support	2
Likelihood of benefits realisation being achieved	Low benefits and will be harder to achieve due to dependence on collaboration	1	Once commercial partner has committed to benefits they are likely to deliver (or forfeit their fees)	2	High risk that benefits not achieved due to complex structure and involvement of another NHS with potentially conflicting interests	0	Each FT should be able to realise benefits which don't depend on collaboration, but wider benefits will be hard to achieve	1	A management team focused on specific targets should maximise benefits and drive early realisation rather than being lost among other Trust priorities	2	OpCo increases chance of delivery above counter factoral.	2
Total		12		15		20		19		35		36

Catering options appraisal scoring:
"Does not meet" Score 0
"Partially meets" Score 1
"Fully meets" Score 2
"Exceeds" Score 3

	A. 'Do nothing different to now' using informal collaboration, on tactical basis. The 'as is' model for DHC and DCH is to continue with development of a federated shared service as part of their joint Trust strategy.	Scores	B. Hosted Service	Scores	C. Outsource services into managed service contracts.	Scores	D. Become a customer of an existing subsidiary company, within the NHS	Scores	E. E.Set up a single subsidiary company, holding the shared services, with 75% ownership by a lead Trust and transfer of all assets.	Scores	F. F.Set up a separate subsidiary company for each Trust in Dorset focused on property assets managed service delivery. This is serviced by a single shared service provider in an operating company "OpCo".	Scores
1. Strategic alignment												
Option fits ODPC strategic aims												
Option fits individual Trust's strategic aims												
Option fits ICS strategic aims												
2. Economic Benefits												
Option is Value for Money (VFM) after any costs												
Option has clear, measurable benefits (cashable and cost avoiding)												
Option can enable wider societal benefits												
3. Commercial Feasability												
Option has a commercially viable route for delivery												
Option is compliment with procurement requirements												
Option meets Trust governance requirements												
4. Financial												
Capital cost/impact of scheme												
Revenue cost/impact of scheme												
Value for money/Savings identified as a result of the scheme												
5. Deliverability/Timing												
Scheme is deliverable within the time and resource available												
Risk profile and mitigations within the risk appetite of the Boards												
Likelihood of benefits realisation being achieved												
Total		0		0		0		0		0		0

DRAFT Briefing Note
January 2025:

Assessing relative merits of a Operatimg Company and a Trust Hosting Arrangement

Our Dorset Provider Collaborative (ODPC) is developing a shared support services business case. Part of this is evaluating options for delivery. Following the first options appraisal workshop further work was requested to assess the hosting arrangement as an option. Eight issues were identified, where the hosting was seen as sub optimal to a OpCo. These are expanded upon here, including the effectiveness of mitigations. There were no specific benefits identified of hosting above an OpCo.

This paper should be read in conjunction with the scoring process briefing paper and the other options in the draft business case.

Key issues identified, are:

1. Dedicated Board focus on services
2. Specialist Board Members
3. Potential conflicts of interest and perceptions of favouritism towards the host
4. Multiple roles lead to less accountability and non-value added "distraction".
5. Ownership of risk and reward needs to be transparent.
6. Due diligence for baseline and differential service levels
7. Incentives for Delivery
8. Strategic Direction

Potential mitigations are assessed. These are how a hosted service could mitigate the disadvantage it faces to an OpCo. These are grouped as "full mitigation," "partial mitigation," "limited mitigation" and "no effective mitigation."

A conclusion to help inform the scoring process is suggested at the end.

1. Dedicated Board focus on services

The OpCo would have its own Board and leadership team to focus 100% on the services that it provides. This will never be the case for a hosted service where time at the main Trust Board, including of executives, would be limited, and priority will always be the frontline clinical services. This is evidenced by the actual board agendas.

In private sector organisations a group structure is common, allowing focus and leadership at the right size, on the right subject matter, to drive greatest value. This allows the group to provide overall direction and gain the benefits, whilst holding to account the organisations within the group. An OpCo would fulfil that purpose and is thus preferrable to hosting.

This issue cannot be mitigated effectively, as there can only be one Board. Other remedies are considered at the end of this section.

Summary: no effective mitigation.

2. **Specialist Board Members**

A dedicated Board would allow for specialist Board members to be appointed. This could include executives and non-executives with experience in running a shared service, or with service expertise in areas like estates & FM, procurement, capital developments. A Trust Board is much less likely to be able to secure such places for specialist like these, as the number of Board members is limited, whilst retaining an effective Board.

In a Trust the services are placed under a Board level executive as part of their portfolio. It is highly unlikely the executive will be a master of all these disciplines. Chief Finance Officers can often be accountable for Estates, Capital Development, Procurement, Digital, for example, yet most will have no formal qualifications in these areas and often limited operational experience. Whilst executive directors can provide leadership, the service level expertise is one or two steps away from the Board table. A dedicated OpCo would change that, as it's much more likely professionals in those disciplines are Board members.

A further benefit is that an OpCo is more likely to attract talent from beyond the NHS, by offering roles that are more professionally focused, comparability to other sectors, and freedom to act. This should lead to a wider number of applicants, at senior levels.

If hosting the only mitigations would be to increase the size of the Board of the host organisation for more executives. As FT Boards need a NED majority, then this means multiple of twos. TO have Estates&FM, Capital and procurement at the Board table, would means 6 more Board members, making Boards c40% bigger. This would be unacceptable as it is unworkable.

Summary: no effective mitigation.

3. **Potential conflicts of interest and perceptions of favouritism towards the host**

Where a Trust provides a service to other Trusts there is a much higher chance of conflicts of interests occurring around the prioritisation of services and developments. There is a real risk of conflicts of interest as the lead Executive can never be totally independent of their host Trust's priorities and accountabilities, as they are answerable and accountable to their FT Board first.

Service Level Agreements (SLAs) can set out the host and customer Trust roles and responsibilities, level of investment and KPIs. However, these are not truly enforceable within the NHS, and the customer Trust has very little leverage in such relationships. Firstly, this is because the host Trust has control of the majority of information and expertise and is likely to see most of the benefits. Secondly there is less transparency on costs, savings and allocation of overheads, when the service is embedded in a much larger organisation. Thirdly the employees of the host service are more likely to be culturally and practically aligned to their host employer and have an unconscious bias towards where they work. This can lead to prioritising the "home" Trust's requirements.

This can often lead to the perceptions of favouritism to the host Trust. Examples include benefits are usually seen as accruing to the host Trust receiving a higher level of service, greater attentiveness to host needs, and greater alignment of future plans with the host Trust values and priorities.

A third reason why conflicts can occur is when a host provider struggles to meet the expectations of the customer Trust(s). This may be real or perceived. It can be partly mitigated through highly professional and well-resourced contract management. Where services are so critical to overall performance of a Trust, (as estates, FM, procurement, digital and capital development are) then this

can become a high stakes risk for a Trust to "surrender" these core support services to a third party over whom there is a "complex" relationship. This complexity comes from many clinical pathways and other relationships existing outside the direct host-customer contract. These can come into play when Trusts are in dispute over the level of service provided.

Hosting arrangements do exist across the NHS, but many once established have struggled or are unwound. Within Dorset very few support service *hosting* arrangements existing, and ones that have previously been set up (Digital, Audit etc) have been unwound or moved to third party, i.e. no longer hosted by a local Trust. This evidences why a more independent provider such as a OpCo, is more likely to proceed than a hosting arrangement.

Summary: no effective mitigation.

4. **Multiple roles lead to less accountability and non-value added "distraction".**

Any Executive that is accountable for running a shared service will inevitably have to deal with any concerns from other Trust executives buying in that service. That makes for a more complex set of relationships where the host Executive has multiple 'hats' with their counterparts and peers. They would move from being in a peer-to-peer relationship, to one where they are either a customer or a host provider. This could all occur in the same meeting e.g. when looking at causes for any financial under performance as a Trust and system. With the support services in scope, being core to delivery of quality, performance, and financial balance, (as procurement and estates/FM are), this can result in significant stress on relationships.

Where there are split hosted services (e.g. one trust hosts procurement, one hosts Estates, and third capital developments etc) the relationships become ever more complex, and less effective. This is because of lower level of clarity, and therefore accountability. Experience shows a lot of time can then be spent on "transactional" work resolving relatively minor issues (such as allocations of costs, risks and benefits). This is time not spent on improving the services. This non-value add activity is part of why several support services where unwound.

Where there is less transparency and diffused hosting, overlaid with perceptions of favouritism this can lead to lower levels of trust. If services are then not performing in line with expectations, Trusts can start 'blaming' other Trusts, which affects not just the hosted services, but the entire functionality of the Trusts relationships with each other.

The mitigation is to have excellent, high trust relationships and high performing services. However as this cannot be guaranteed to be maintained forever, it is at best a partial mitigation. As this is based upon person relationships at exec level, and execs can change, and the wider context of the NHS delivery becomes more challenging, this is an ineffective mitigation, and also time consuming. This non-value add time means the core exec role is diminished, overall leading to a negative impact. This is why several Dorset organisations have decided to "unwind hosting" as referenced above.

This can be avoided with the creation of a OpCo where each Trust is ultimately a shareholder, but not directly the provider of the services. This gives far greater clarity on roles and responsibilities, without reliance on personal relationships.

Summary: limited mitigation (but difficult to maintain).

5. **Ownership of risk and reward needs to be transparent.**

A hosted service will be a small percentage of the overall Trust turnover, and it can be very difficult to assess the allocation of benefits, and risks, separate from the whole Trust. Also difficult is agreeing where any savings and cost pressures should be distributed. Should the host keep them all, as the one running the service, and holding the risk? Likewise, the customer Trusts will expect those benefits to flow to their way, otherwise why surrender the service to the host in the first place?

A simplistic mitigation could be 50-50 agreements on risk and reward shared between host and customer. However, this is flawed as most issues are more complex. The simplest example is savings from a shared procurement for supplies. Should the largest savings go to the Trust with the lowest volume, and most to gain from pooling, or should it go to the largest volume Trust, as it's their volume that is has already got the best prices and is critical to getting the best overall price. This could play out over thousands of product lines. In reality most situations are more complex, and benefits often only achieved over several financial years.

The result is each benefit, risk, investment needs to be considered individually, to assess allocations between Trusts. This will require a lot of time for analysis and negotiation. The negotiations are largely win-lose, as whether the benefit sits with the host or the customer. This gets ever more complex with multiple Trusts hosting different services. Any time spent negotiating is ultimately not value adding.

In comparison the OpCo would have a pre-agreed formula for the overall risks benefits to flow via their shareholding. It is in everyone's interest to maximise benefits overall and focus attention on delivery. The formula and governance will be agreed as part of the setting up process and then reviewed annually via contract setting. This reduces non-value adding work for the leadership teams of each Trust.

Summary: limited mitigation (at significant cost of time).

6. **Due diligence for baseline and differential service levels**

A significant difficulty with a hosted service, learnt from experience, is that the services being pooled will inevitably have a different baseline for almost every aspect of what they do. For estates this could be investment in both revenue and capital, the capital backlog, the maturity of their systems of governance and assurance, the expertise of the staff (and any vacancies), as well as less tangible, but very important aspects like culture and morale.

A hosted service and a OpCo will both need to deal with this. Both options will require due diligence and skilful programmes of integration. The differences are:

- It is easier to create a single culture within OpCo, as it is less of a "takeover".
- It is easier for a OpCo to hold multiple service contracts, with differing levels of investment, KPIs and outcomes. A single host Trust's regulators are unlikely to support one service holding such different approaches.
- The transparency on inputs (e.g. investments, assets etc) and clarity for outcomes is harder to show in a host (as the service is "buried" within a larger Trust's overheads)
- Future investment, and benefits realisation is also easier for a OpCo to demonstrate.

The hosted Trust's Board could in theory accept it has different levels of investment, risk, outcomes within the services. Where there are statutory responsibilities e.g. Health and Safety for estates, or IPC this is difficult to defend legally. This would require a rapid investment and alignment process

that is likely to be beyond the affordability of the health system. Or it could lead to one Trust service being degraded to level it to the another. Both these scenarios are unlikely to be acceptable to all the Boards. This is likely to be a major source of tension.

In contrast a OPCO can hold three or more contracts (one per Trust). These would allow for transparent service levels, on Day One based upon the current service levels. Over time these may converge, or not, depending upon the customer appetite and conscious decision making around service levels and investment priorities.

In conclusion this is an issue for both a OPCO and a hosted service, but it is easier for the OPCO to address.

Summary: limited mitigation.

7. Incentives and alignment for Delivery

The main purpose of a Trust and its Board/Executives is the delivery of high-quality patient care. The use of the Board members time should be dedicated as much as possible to delivering this objective. The running of a shared service function built around support services is by its very nature not the direct delivery of patient care. Time spent by CEOs and other executives running such a service is ultimately taking time away from focussing on direct patient care. A Board must ask itself where it wants its top team focussing its attention on.

In comparison the leadership team of the OpCo has its' purpose as delivering the best services to its customers (the Trusts). As they remain wholly NHS, their purpose is not profit maximisation (and commercial risk minimisation), but rather best serving their shareholders – the Trusts.

A hosted service will need to contribute to the host Trust's bottom line, to justify being hosted. This is a fundamental, intrinsic tension. The exec team of the host, as well as needing to lead the services to support the wider Trust also needs to keep the hosted service's customers happy. This is a second intrinsic tension. Neither of these intrinsic issues with hosting have mitigations.

Summary: no effective mitigation.

8. Strategic Direction

The outsourcing of support services and more transactional functions to specialist providers of such services is not new. This has been part of the cost savings programme of Trusts for some time. (Examples listed below, some are managed commercial service, others are via SubCos/other NHS providers).

This ad hoc, service by service arrangement can continue. It does though miss the opportunity of having an "at scale approach" for procurement, estates and FM, then over time other services, such as digital, transactional HR, Finance, and other areas like Sterile Services. It also loses the benefits out of the Dorset ICS area as some of the cashable benefits would be retained by the external provider. This also undermines some of the local societal benefits, such as local employment and skills development.

A local Host and a OpCo are therefore better options than the ad hoc approach. Taking a single strategic direction, alongside developing deep expertise in managing the market, contracts and staff are all preferrable.

This less so with the “multiple hosted services” (i.e. each trust hosts a different service). This has many of the disadvantages of 1-7, with multiple decision making and a much slower progress. It is also likely having higher overheads and lack critical mass. It will be difficult to create centres of excellence from combining the contract management expertise in a single organisation. Some of the synergies e.g. in sustainability across estates and procurement, would be lost.

The ad-hoc approach in Dorset has resulted in services that were once in-house are now provided by dedicated providers include (this list is not exhaustive):
:

- East Lancashire Financial Services ‘ELFs’ for financial service functions,
- Salisbury FT for Payroll,
- KPMG for Internal Audit,
- TIAA Counter Fraud,
- Boots for Outpatient Pharmacy at UHD
- A wholly owned SubCo for Pharmacy at DCH,
- Saba for Car Parking at UHD,
- Mitie for Housekeeping at Poole Hospital,
- One Dorset Pathology with a managed service for IT and equipment,
- Equipment maintenance with a mix of in-house and managed contracts,
- Homecare drug delivery for complex, chronic disease drugs.
- Laundry with Sunlight and other providers

What the above shows is that there is appetite for alternative providers where these are demonstrably better than in-house. However, some external providers, especially where they can operate at national level, and recover VAT, will almost always be lower cost than in-house, or even locally hosted single Dorset provider.

A further issue has been in-house teams are often not able to bid effectively for work, when it is market tested. This is because of the lack of capacity and skills to develop bids, demonstrate at scale efficiency, and to be separated from the client-side decision making process. This has made it harder to progress market testing and thus to test value for money. It also means when a test is undertaken there is very little chance of a compliant bid by the in-house team. This has been demonstrated with areas like carparking and housekeeping. A OPCO would overcome this, by having the skills and capacity to both set up and maintain a professional, commercial contractual relationship. When services are then tendered, this would allow the OPCO to consider responding to tenders. Therefore, some of the above example areas could become part of a business plan for growth in later phases, subject to winning in competitive tenders. Likewise, the OPCO could also compete for other commercial opportunities e.g. supply of services to GP practices, voluntary and public sector organisations.

What the list also shows is that these are mainly non-core services. There is limited track record in Dorset in having entire “core” services provided outside the Trust, in a way that could risk core delivery of performance. With a OpCo, with dedicated management, at scale expertise, and the clarity and transparency, this would allow core support services to improve towards the top quartile productivity and quality, with all the benefits staying within the local NHS, and crucially the control of those services still being aligned with the Dorset strategic direction. Therefore, a OPCO is considerably better placed than a hosted service to deliver the strategic direction.

Summary: limited mitigation.

Can the disbenefits of hosting arrangements be overcome?

	Full mitigation	Partial mitigation	limited mitigation	no effective mitigation
Dedicated Board focus on services				X
Specialist Board Members				X
Potential conflicts of interest and perceptions of favouritism towards the host				X
Multiple roles lead to less accountability and non-value added "distraction".			X	
Ownership of risk and reward needs to be transparent			X	
Due diligence for baseline and differential service levels			X	
Incentives for Delivery				X
Strategic Direction			X	

Further considerations

The panel undertaking the scoring also considered other ways of mitigating hosted arrangements.

a) Why not a sub-Board within a Trust to achieve the same dedication?

A sub-Board within a Trust could also be established to gain specialist members, this would deliver some benefits it terms of expert knowledge and experience of its membership. However, this would still mean a customer and provider relationship between Trusts, with ultimately the accountability still resting with the main Trust Board and members, making it hard to ever separate the services truly from the host. This increases potential conflicts of interest and will inevitably draw the main Board members into challenging decisions at some point where they will have multiple roles as the receiver and provider of services. The OpCo is a much cleaner solution as no one Trust is the host. Therefore, this mitigation was abandoned.

b) Why not have different Trusts hosting different services?

This would mean every Trust Board having to dedicate time to running a shared service function. This is unlikely to result in the services being prioritised by the Board as individually they would still be a minor part of the Trusts business. It would also mean a more complex set of arrangements where every Trust was a provider and receiver of services, and they would end up bidding for capital and revenue investment between themselves. It is also likely that each Host would wish to prioritise the service that they were running. This is unlikely to lead to optimum decision making. This would also result in each Trust having to have a contract manager for each service it was buying in, where this could potentially be shared between the Trust with a OpCo/single provider arrangement. This was considered complex, and distracting. This mitigation option was abandoned.

c) Why not have one Trust host everything?

This is better than b) but is not supported by the Trust Boards, for reasons largely covered in issue 3, and inherent with the other reasons.

Conclusion: Benefits of a OpCo over a Trust Hosting Arrangement (even after mitigations)

1.	Dedicated Board focusing on services.	The OpCo would have its own Board and leadership team to focus 100% on the services that it provides.
2.	Specialist Board Members	A dedicated Board would allow for specialist Board members to be appointed. This could include executive and non-executives with experience in running a shared service, or with service expertise in areas like estates, procurement, capital developments.
3.	Conflicts of interest – reducing the risk	By having a OpCo results in less chance of conflicts of interest occurring around the prioritisation of services and developments due to having an independent Board.
4.	Multiple roles lead to less accountability and non-value added "distraction".	With the creation of a OpCo where each Trust is ultimately a shareholder, but not directly the provider of the services. This gives far greater clarity on roles and responsibilities, without reliance on personal relationships.
5.	Risk and Reward	OpCo has a pre-agreed formula for the benefits to flow via their shareholding. It is in everyone's interest to maximise benefits overall and focus attention on delivery. The formula and governance will be agreed as part of the setting up process. This reduces non-value adding work for the leadership teams of each Trust.
6.	Due diligence for baseline and differential service levels	It is easier to create a single culture within OpCo, as it is less of a "takeover". It is easier for a OpCo to hold multiple service contracts, with differing levels of investment, KPIs and outcomes, when there is transparency on inputs (e.g. investments, assets etc) and clarity for outcomes. The service is not "buried" within a larger Trust. Future investment, and benefits realisation, is also easier for a OpCo.
7.	Incentives for Delivery	The leadership team of the OpCo has its' purpose clear: delivering the best services to its customers (the Trusts). As they remain wholly NHS, their purpose is not profit maximisation, and risk minimisation, but best serving all their shareholders – the Trusts, and in turn the patients.
8.	Strategic Direction	OpCo provides the opportunity of having an "at scale approach" for procurement and estates, and over time other services, and potentially other customers. A OpCo can take a single strategic direction, better bid for work, both of which are more difficult with hosting.

Ends.

DORSET SHARED SERVICES – CHAIR & CEO BRIEFING:
PROCUREMENT, ESTATES & FACILITIES - JOINT WORKING OPPORTUNITIES STRUCTURE UPDATE (1-7) – 12 FEB 2025

1 Background

1.1 Section 46 of the NHS Act 2006 gives NHS Foundation Trusts the ability to form subsidiary companies for the purposes of exercising their functions (for core NHS healthcare provision purposes) and for income generation purposes.

1.2 Several options have been considered to establish a structure for the three partner Trust (Dorset County Hospital NHS Foundation Trust (DCH), Dorset HealthCare University NHS Foundation Trust (DHC), and University Hospitals Dorset NHS Foundation Trust (UHD)) (the Trusts) operations to create an effective shared service:

A – Do nothing (informal collaboration on tactical basis)

B – Hosted service

C – Outsource services into managed services

D – Become a customer of an existing subsidiary company within the NHS

E– Set up a subsidiary company with shared ownership, wholly within the NHS in Dorset

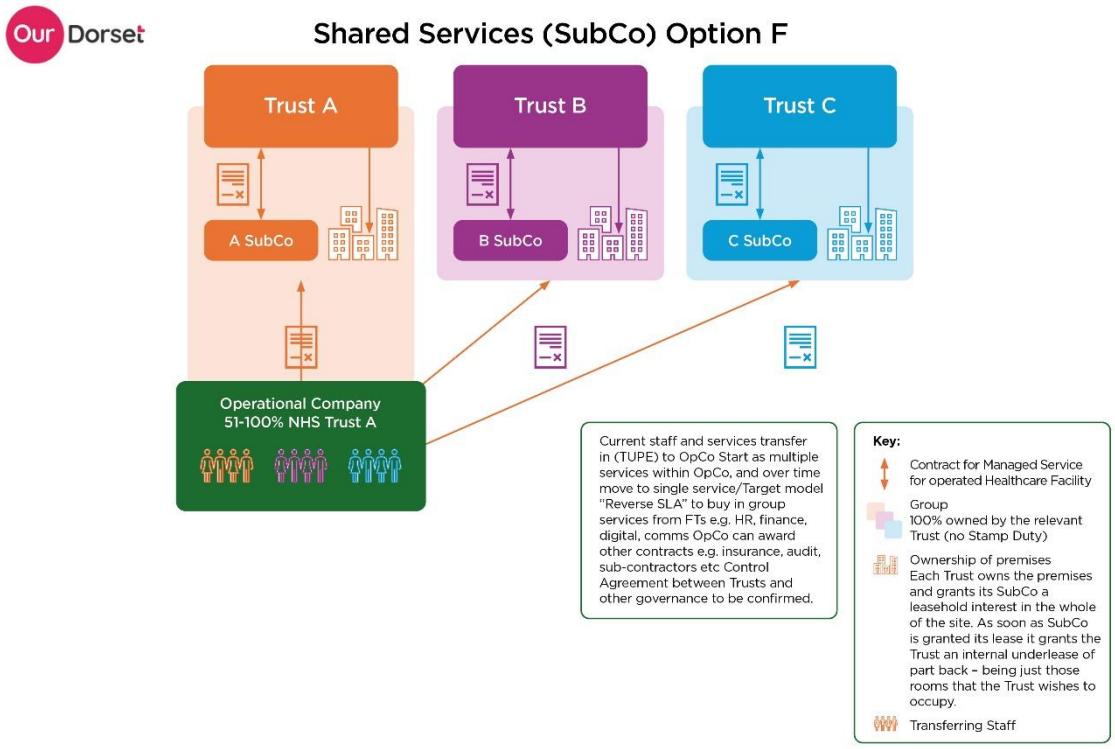
F – Set up a separate subsidiary company for each Trust in Dorset

1.3 Option E has been explored in some detail and this has revealed concerns around ownership. We understand that the Trusts envision the subsidiary being equally and jointly owned between them. However the subsidiary would not be capable of being consolidated into the accounts of any NHS body unless there was a majority shareholder.

1.4 Consolidation of accounts at DoH level for the subsidiary would require approval of the Secretary of State and would entail the DoH being comfortable that all aspects of the structure were sound and there were absolutely no going concern issues.

1.5 Based on information received from NHSE the expectation is that this option would extend the current timeline by at least 6 months. It is expected that if the accounts were to be consolidated at DoH level then DoH would want to be involved in some way in the future, which could jeopardise the future plans of the company.

2 Option F structure (separate Sub-Co's)



3 How it works

3.1 Each Trust will establish its own wholly owned subsidiary company (Sub-Co) and set up the board/governance for this to suit the requirements for its operation.

3.2 Contracts will be put in place between each Trust and its respective Sub-Co for an operated healthcare facility services and estate management services contracts.

3.3 The Sub-Co will then contract with OpCo (see the solid green box in the diagram above), a separate subsidiary set up for the purpose by one of the Trusts who holds a majority ownership stake in OpCo, for the services relevant to the activity of the respective Sub-Co's parent Trust. These contracts will contain detailed service level agreements and agreed performance metrics.

3.4 Each Sub-Co will be granted either leases, or licences, by its parent Trust which will give it the legal right to operate from the facility:

3.4.1 If a lease is granted by the parent Trust to Sub-Co then the lease to Sub-Co will be of all of the facility for a term which is co-terminus with the OpCo. In the lease to Sub-Co each parent Trust will retain the right to enter the Sub-Co facilities. Following the grant of the lease to the Sub-Co, Sub-Co will also then grant its parent Trust an underlease of the rooms which the parent Trust occupies within the facilities.

3.4.2 If a licence is granted then Sub-Co will only be granted a contractual right to enter onto the facility to carry out the services and ownership of the facilities will remain with the parent Trust.

3.5 Each Sub-Co will appoint its own board.

3.6 It is expected that each Sub-Co and OpCo will need to procure support services, such as information technology, occupational health, Human Resources etc. from the Trusts.

3.7 The OpCo will be formed as a separate legal entity (which may be an LLP or a company limited by shares but with the majority ownership of one of the Trusts), which will have three separate contracts in place for the relevant services between itself and each of the Sub-Co's wholly owned subsidiaries. *The OpCo company will be the legal connection between the newly established Sub-Co subsidiaries.*

3.8 Staff who perform the relevant services will be transferred to the OpCo. It is expected that some staff will also remain in the Trust, or move to the Sub-Co to perform the role of the intelligent client.

3.9 Some members of the Trust Board will serve on the Sub-Co Board (numbers and roles to be determined) and there will need to be consideration of each Trust's role on the OpCo board. We would expect all three Trusts to have representation on the OpCo Board not just the majority owner. We would expect to include governance controls such that all designated major decisions (reserved decisions), once they have passed through the Sub-Co Boards or the OpCo Board, will have to be approved by the relevant Trust Board(s), or their designated representatives in the case of OpCo.

3.10 In this scenario each Sub-Co is wholly owned by its respective NHS Trust, the parent Trust would consolidate the financial statements of its Sub-Co in its own accounts using full consolidation under IFRS 10 or UK GAAP.

3.10.1 The Sub-Co's assets, liabilities, income, and expenses are fully included in the parent Trust's consolidated financial statements.

3.10.2 Intercompany transactions (e.g., leases, services) between the Sub-Co and the parent Trust would be eliminated in consolidation.

3.10.3 The OpCo is structured to be majority owned by one Trust and could be either 100% owned or down to 51% owned by the host Trust. Its consolidation treatment would depend on the **control or significant influence** exerted by the host Trust:

3.11 The OpCo (majority-owned by one of the Trusts) will be consolidated into the majority shareholder Trust's accounts:

3.11.1 If **100% owned**, full consolidation applies.

3.11.2 If **between 51%-99% owned**, the **majority owner** consolidates OpCo and recognizes a **non-controlling interest** for the minority Trusts.

3.11.3 If below 50% ownership but with **joint control**, it may be treated as a **joint venture (JVCo)** under **IFRS 11** (Joint Arrangements), accounted for using the **equity method**.

3.12 The OpCo agreement will determine how profits/losses are shared among the participating Trusts, and this allocation will drive how each Trust accounts for its share of the JVCo.

3.13 Transactions between Trusts, Sub-Co's, and OpCo must be carefully accounted for:

3.13.1 Service agreements: Revenue recognition policies must be clear for services rendered between entities.

3.13.2 Lease agreements: Whether a lease is classified as an operating lease or finance lease under IFRS 16 will impact balance sheet and income statement treatments.

3.13.3 Profit-sharing mechanisms within the OpCo must be documented to ensure proper financial reporting.

3.14 There will be decisions to be made around the non-controlling interest and also judgement as to whether the other (non-hosting) Trusts would be associates (generally above 20% of the voting interest per IAS 28). If so, they will need to account via the equity method to represent their significant influence in the entity, but this approach avoids an issue for DHSC of a body in the NHS area without a parent (owner/host) to consolidate it.

4 Advantages and disadvantages of the Sub-Co – OpCo approach

4.1 Generally, the advantages of using the corporate entities in this way include:

4.1.1 companies and limited liability partnerships can usually be set up easily;

4.1.2 the Trusts would have the benefit of limited liability;

4.1.3 cost savings can be achieved as the Sub-Co and OpCo will operated under a different VAT regime which will be able to deliver a supply to the Trusts which is tax efficient;

4.1.4 there are many options for participating Trusts to be involved in a legal entity i.e. membership/share structure etc.;

4.1.5 the OpCo structure enables the parties to achieve shared services goal for the relevant services delivered;

4.1.6 companies and limited liability partnerships are widely accepted and have a strong identity for dealings with third parties and for creating internal management and employee structures;

4.1.7 the Companies Act 2006 provides a detailed legal framework for the constitution and management of a company. A company provides a clear structure for internal accounting and reporting;

4.1.8 a company or limited liability partnership is a constant entity in which the assets and liabilities of the Trusts can be vested, because it can hold and own assets in its own name;

4.1.9 a company or limited liability partnership can separate its ownership from the Trust;

4.1.10 a company or limited liability partnership is a separate legal entity and therefore has the capacity to act in its own right, e.g. it can bid for funding, enter into contracts etc.; and

4.1.11 a company or limited liability partnership can offer more financing possibilities than an unincorporated entity (e.g. a contractual joint venture).

4.2 Possible drawbacks to using the OpCo and Sub-Co approach include:

4.2.1 liquidation of a company may be difficult to achieve in contentious circumstances. Even a members' voluntary liquidation tends to carry some stigma;

4.2.2 there are costs and time associated with setting up a company which do not arise in relation to unincorporated structures. Audit fees are payable on an on-going basis;

4.2.3 information about a company is publicly available through inspection of records at Companies House;

4.2.4 a company will be regulated by relevant corporate laws in the jurisdiction of its incorporation. This can lead to additional administration and costs; and

4.2.5 there are rules controlling how a director can act which could be contrary to the appointing Trust's interest.

5 Summary of the features of the model

5.1 We set out below a summary of key issues and considerations in relation to the Sub-Co OpCo joint venture model (Option F). Unless otherwise stated, these key issues and considerations will apply equally regardless of the form of the corporate vehicle chosen for the joint venture.

CORPORATE OPERATING COMPANY (OpCo)	
Key Features	• Under Option F with the Sub-Co and OpCo, new legal entities would be created and this would give formality and structure to the relationship. • Crucially, OpCo would be a separate entity. This would mean that the OpCo entity would contract in its own name and have its own liability. • The OpCo entity's governance structure could simply be set out in the constitutional documents (i.e. the company's articles of association). This would therefore normally state, for example, that each Trust will appoint an equal number of directors to the board and the decisions on the running of OpCo would be made by the board involving all participating Trusts. • However, if certain matters are to be kept confidential and/or reserved for the decision of the Trusts, these matters can be set out in a separate shareholders agreement (or the equivalent "members agreement" for a limited liability partnership). These documents therefore help to regulate the relationship of the Trusts in the operating company.
Directors' responsibilities and other responsibilities and duties under the Companies Act 2006 and other laws and regulations	• The corporate entities (Sub-Co and OpCo) will have on-going administrative functions. • The Companies Act 2006 prescribes certain duties that directors of a company will need to comply with. The directors appointed to the company board by each Trust will need to be aware of these duties. An important note for the directors to bear in mind is that their duties are owed to the company and **not** the member Trust that appointed them. Directors of companies also have many other duties under a wide variety of other laws and regulations such as insolvency and health and safety legislation. • We can provide you with further information / a briefing note on the on-going administrative matters for a company and on directors' duties under the Companies Act 2006, if this would be helpful.
Vires	• NHS Foundation Trusts have the power to form or participate in corporate vehicles. • A proposal to set up Sub-Co (and OpCo) from an NHS Foundation Trust needs to be reported to NHS England, a business case submitted and approved in line with guidance.
Liability	• Liability would be ring fenced in Sub-Co and OpCo. • A shareholders' agreement (or the equivalent for a limited liability partnership) could be entered into to regulate how the Trusts contribute funding to OpCo (otherwise the default position would be that no Trust would have an obligation to contribute further funds once the entity is set up).
Procurement	• The Trusts will be exempt from the public procurement rules if they are able to rely on the vertical exemption in the Act.

Employment / pensions	• There may be TUPE transfers or secondments from the Trusts, or even existing suppliers, to OpCo. OpCo could inherit a workforce on a mix of terms and conditions and pensions, with potential cost and management implications (as well as cultural issues). • However, the exact nature of the change and services transferred to the OpCo will determine the scale of the transfers. • OpCo would need to apply for a "Pension Direction" which will provide the ongoing membership of the NHS Pension Scheme for transferring employees.
Insurance / NHS Resolution	• It will be for Sub-Co and OpCo to ensure that they are either a member of the appropriate NHSR schemes, as required, or otherwise commercially insured or indemnified for any claims brought against the entity.
Governance	• A corporate vehicle offers flexibility and can be adapted and varied in its ownership and governance structure to evolve with the Trusts requirements and the projects operated through it. The governance model can evolve over time as the relationship between the Trusts is tested and evolves. For example, at the outset the Trusts can retain significant control whilst trialling the working relationship and look to increase delegation as the relationship matures. • Consideration would need to be given as to any linkage with the evolving provider collaborative structure and its governance here, given that OpCo would operate as a separate legal entity.
Ability to add new partners	• It is possible to add new partner organisations as participants in the OpCo company over time, though in order to benefit from the procurement exemption, they would need to be public sector entities – no private sector participation is permitted. Those looking to participate in OpCo would need to confirm they have the requisite powers to do so.
Ability to add new services	• This would be relatively straightforward and provision could be made in the legal documentation to enable this. It may trigger staff transfer depending on the scope and nature of the services being added.

6 THE OPERATING COMPANY ELEMENT (OPCO)

6.1 There are several options available for forming the delivery (OpCo) element of the structure. It has not yet been decided whether the OpCo company will take the form of a limited liability partnership or a private limited company, though it will have one Trust as the majority owner (51-100%) and be 100% NHS owned. An agreement will be put into place to govern the arrangements between the Trusts in OpCo, depending on the organisational structure of the company this will take the form of either a member's agreement or a shareholder's agreement.

6.2 The set up of OpCo requires clear articulation of its powers, an agreed overarching constitution (**articles of association**), a shareholder or members agreement setting out matters reserved to the participating organisations and decisions need to be made about funding, staffing etc.

6.3 Governance of OpCo is through its board of directors, who are accountable to its shareholders or members (i.e. the participating Trusts in proportions to be determined). The board of directors do not need to be directors of the host Trust or even just the participating organisations (though we would suggest that each Trust has representation on the board) and the directors can make decisions about OpCo and the services it provides. The shareholder or member organisations

will need to pay careful attention to retaining oversight of the quality of OpCo's outputs and establish suitable reporting and accountability mechanisms to do so.

6.4 OpCo can take on responsibility for the provision of a specific set of services by entering contracts with the Trust members (to provide or subcontract elements of services).

6.5 OpCo will be a separate legal entity to that of the host Trust and other member Trusts. It allows OpCo to employ staff, hold assets and enter contracts.

6.6 The **shareholders agreement**, will set out the Trusts shared visions, how they will work together and take decisions, how they will hold each other to account, and any risk or gain sharing arrangements (to the extent that these are not covered in the articles of association). The role of the host/owner of OpCo and their responsibilities should be clearly established, and the Trusts will need to agree how the decision-making powers for OpCo will be exercised collaboratively between the Trust partners.

6.7 As there are two layers to this arrangement (wholly owned subsidiary (Sub-Co) and the Operating Company (OpCo)) the Trusts should consider which assets, estates and responsibilities will sit at which level. This will allow us to establish the leases and/or licences that need to be put into place. The above will be clearly documented in the relevant company agreement, along with any other required documentation.

6.8 There can be a mechanism for the OpCo to purchase in-group services from the Trusts, whilst also having the ability to award other contracts.

7 MANAGING ANY TERMINATION OF THE ARRANGEMENTS

7.1 If the Trusts (or a Trust) wish to exit the arrangements then there will be a clear contractual process set out as to how this can be managed to mitigate costs and manage the transition of assets, staff and contracts. The mechanics of the termination procedure will allow sufficient time for, for example, staff transfers to be managed.

7.2 Depending on the scenario there may be complex splits required where services have become integrated which are then split back into the three Trusts but it would be possible for the Trusts to agree a replacement hosted approach for specific services to be retained where this was a practical and pragmatic solution.

7.3 The way the company has been funded will also be of critical importance. For example, if the Trusts have provided loan funding in addition to equity, the mechanism should provide either for a successor Trust to assume that obligation or for this to be dealt with in any division on dissolution of the company if the venture is ending.

7.4 The fate of assets contributed by an exiting Trust from the OpCo will also be relevant, for example:

7.4.1 Is there any intellectual property which should either remain with the OpCo or be ceded by it?

7.4.2 Does the trading name of the OpCo refer to the Trust who is terminating and, if so, should the name be changed?

7.4.3 Are there shared assets such as property or computer facilities?

Tax consequences

7.5 The tax consequences of exiting a subsidiary structure for the Trusts will be dependent on the timeframe from entry to exit, the structure employed in relation to the movement of assets and the assets procured during the life of the structure.

7.6 It has been assumed for the purpose of this paper that any exit from the structure would result in the movement of all assets from the subsidiary back into an NHS body.

7.7 Whilst the below capture the main tax implications (subject to change dependant on the circumstances and legislation in place at the time). A more detailed analysis would need to be undertaken at the time of exit:

7.7.1 Any capital allowances claimed will be subject to repayment, either in total or part, dependent on the type of capital allowance claimed.

7.7.2 Any building assets that were transferred to the subsidiary at Go Live, and subject to a capital goods scheme adjustment, would need to be reviewed and VAT claimed may be liable for repayment where the exit takes place within 10 years of the transfer (generally speaking).

7.7.3 All stock would need to be sold to the NHS body, the VAT incurred by it would be mostly blocked from recovery.

7.7.4 Assets that have been procured during the life of the structure would have to be sold to the NHS body, the VAT incurred by it would be mostly blocked from recovery.

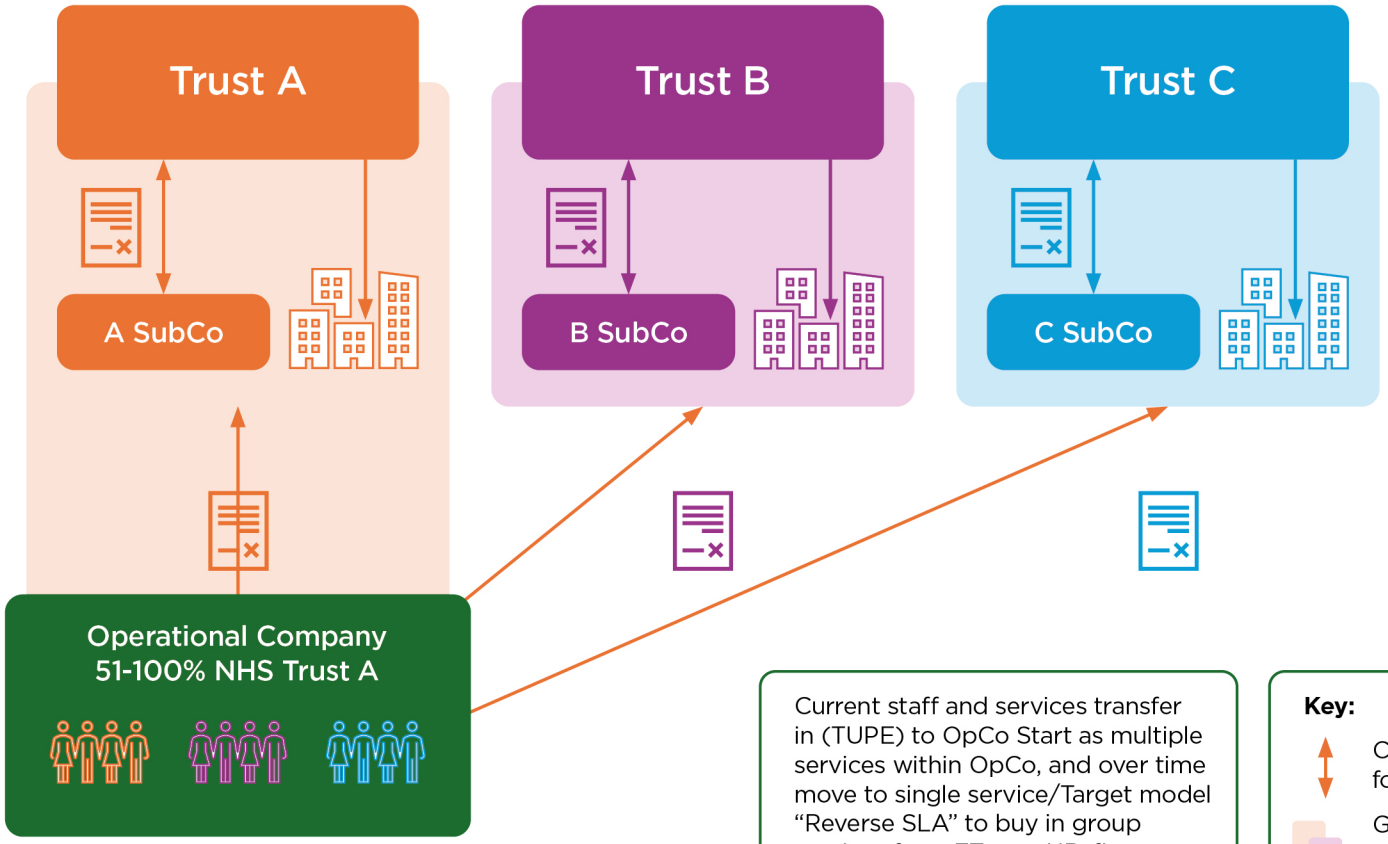
7.7.5 Furniture and other similar goods that have been procured during the life of the structure would have to be sold to the NHS body, the VAT incurred by it would be mostly blocked from recovery.

7.8 Each of these points needs to be addressed and an appropriate regime devised, which does not leave the OpCo or SubCo company stranded in circumstances where a Trust party has decided to leave.

-o0o-

8 If you have any queries regarding this advice note please do not hesitate to contact Steve Rourke, Robert McGough, Andrea Proudlock or Anthony Robson.

Shared Services (SubCo) Option F



Current staff and services transfer in (TUPE) to OpCo Start as multiple services within OpCo, and over time move to single service/Target model "Reverse SLA" to buy in group services from FTs e.g. HR, finance, digital, comms OpCo can award other contracts e.g. insurance, audit, sub-contractors etc Control Agreement between Trusts and other governance to be confirmed.

Key:

- Contract for Managed Service for operated Healthcare Facility
- Group
  100% owned by the relevant Trust (no Stamp Duty)
- Ownership of premises
  Each Trust owns the premises and grants its SubCo a leasehold interest in the whole of the site. As soon as SubCo is granted its lease it grants the Trust an internal underlease of part back – being just those rooms that the Trust wishes to occupy.
- Transferring Staff

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Appraisal Panel Members		
David McLaughin	Director of Estates and Facilities	DCH/DHC
Nicholas Johnson	Deputy Chief Executive	DCH/DHC
Andrew Monahan	Finance Business Partner	UHD
Louise Betteridge	Senior Finance and Strategic Development Specialist	DHC
Richard Renaut	Chief Strategy and Transformation Officer	UHD
Sarah Macklin	Delivery Director	ODPC
Tim Goodson	Governance Advisor	External
Pete Papworth	Chief Finance Officer	UHD
Chris Hearn	Chief Finance Officer	DCH/DHC

Options Scoring Summary

Name of scorer	Option A	Option B	Option C	Option D	Option E	Option F
David McLaughlin	24	16	7	17	27	30
Nick Johnson	19	28	35	30	39	44
Andrew Monahan	16	15	10	21	36	37
Louise Betteridge	21	19	17	17	31	32
Sarah Macklin	9	16	16	15	31	38
Tim Goodson	19	23	22	24	31	34
Pete Papworth	19	26	24	25	30	25
Chris Hearn	16	17	15	18	24	31
Richard Renaut	17	23	17	21	26	36
Total	**160**	**183**	**163**	**188**	**275**	**307**

Catering options appraisal scoring:
"Does not meet" Score 0
"Partially meets" Score 1
"Fully meets" Score 2
"Exceeds" Score 3

	A. 'Do nothing different to now' using informal collaboration, on tactical basis. The 'as is' model for DHC and DCH is to continue with development of a federated shared service as part of their joint Trust strategy.	Scores	B. Hosted Service	Scores	C. Outsource services into managed service contracts.	Scores	D. Become a customer of an existing subsidiary company, within the NHS	Scores	E. E.Set up a single subsidiary company, holding the shared services, with 75% ownership by a lead Trust and transfer of all assets.	Scores	F. F.Set up a separate subsidiary company for each Trust in Dorset focused on property assets managed service delivery. This is serviced by a single shared service provider in an operating company "OpCo".	Scores
1.Strategic alignment												
Option fits ODPC strategic aims		1		1		1		1		2		2
Option fits individual Trust's strategic aims		1		1		1		1		2		2
Option fits ICS strategic aims		2		2		1		2		2		2
2. Economic Benefits												
Option is Value for Money (VFM) after any costs		2		2		0		1		2		3
Option has clear, measurable benefits (cashable and cost avoiding)		2		1		0		1		2		2
Option can enable wider societal benefits		2		1		1		1		2		2
3. Commercial Feasability												
Option has a commercially viable route for delivery		2		2		2		2		2		2
Option is compliment with procurement requirements												
Option meets Trust governance requirements		3		1		1		2		1		2
4. Financial												
Capital cost/impact of scheme		2		1		0		1		3		3

Revenue cost/impact of scheme		2		1		0		1		3		3
Value for money/Savings identified as a result of the scheme		1		0		0		1		2		2
5. Deliverability/Timing												
Scheme is deliverable within the time and resource available		2		1		0		1		1		1
Risk profile and mitigations within the risk appetite of the Boards		2		1		0		1		1		2
Likelihood of benefits realisation being achieved		0		1		0		1		2		2
Toital		24		16		7		17		27		30

Catering options appraisal scoring:
"Does not meet" Score 0
"Partially meets" Score 1
"Fully meets" Score 2
"Exceeds" Score 3

	A. 'Do nothing different to now' using informal collaboration, on tactical basis. The 'as is' model for DHC and DCH is to continue with development of a federated shared service as part of their joint Trust strategy.	Scores	B. Hosted Service	Scores	C. Outsource services into managed service contracts.	Scores	D. Become a customer of an existing subsidiary company, within the NHS	Scores	E. E.Set up a single subsidiary company, holding the shared services, with 75% ownership by a lead Trust and transfer of all assets.	Scores	F. F.Set up a separate subsidiary company for each Trust in Dorset focused on property assets managed service delivery. This is serviced by a single shared service provider in an operating company "OpCo".	Scores
1.Strategic alignment												
Option fits ODPC strategic aims		1		2		2		2		3		3
Option fits individual Trust's strategic aims		1		1		2		2		3		3
Option fits ICS strategic aims		1		2		2		2		3		3
2. Economic Benefits												
Option is Value for Money (VFM) after any costs		1		2		1		1		2		3
Option has clear, measurable benefits (cashable and cost avoiding)		1		3		3		3		3		3
Option can enable wider societal benefits		1		2		1		1		3		3
3. Commercial Feasability												
Option has a commercially viable route for delivery		1		1		3		2		3		3
Option is compliment with procurement requirements		3		3		3		2		3		3
Option meets Trust governance requirements		1		2		3		2		1		3
4. Financial												
Capital cost/impact of scheme		1		2		2		2		3		3

Revenue cost/impact of scheme		1		2		2		2		3		3
Value for money/Savings identified as a result of the scheme		1		1		3		2		3		3
5. Deliverability/Timing												
Scheme is deliverable within the time and resource available		3		3		3		3		3		3
Risk profile and mitigations within the risk appetite of the Boards		1		1		2		2		1		3
Likelihood of benefits realisation being achieved		1		1		3		2		2		2
Toital		19		28		35		30		39		44

Catering options appraisal scoring:
"Does not meet" Score 0
"Partially meets" Score 1
"Fully meets" Score 2
"Exceeds" Score 3

	A. 'Do nothing different to now' using informal collaboration, on tactical basis. The 'as is' model for DHC and DCH is to continue with development of a federated shared service as part of their joint Trust strategy.	Scores	B. Hosted Service	Scores	C. Outsource services into managed service contracts.	Scores	D. Become a customer of an existing subsidiary company, within the NHS	Scores	E. E.Set up a single subsidiary company, holding the shared services, with 75% ownership by a lead Trust and transfer of all assets.	Scores	F. F.Set up a separate subsidiary company for each Trust in Dorset focused on property assets managed service delivery. This is serviced by a single shared service provider in an operating company "OpCo".	Scores
1.Strategic alignment												
Option fits ODPC strategic aims		1		0		1		2		3		3
Option fits individual Trust's strategic aims		0		0		1		1		3		3
Option fits ICS strategic aims		0		0		1		2		3		3
2. Economic Benefits												
Option is Value for Money (VFM) after any costs		1		1		2		1		2		2
Option has clear, measurable benefits (cashable and cost avoiding)		1		2		2		1		2		2
Option can enable wider societal benefits		1		0		1		1		3		3
3. Commercial Feasability												
Option has a commercially viable route for delivery		1		1		2		2		2	As per option E, but with the additional benefits of not having a single lead Trust	3
Option is compliment with procurement requirements		2		1				2		2		2
Option meets Trust governance requirements		2		1				2		3		3
4. Financial												
Capital cost/impact of scheme		2		2				1		2		2
Revenue cost/impact of scheme		1		1				1		2		2
Value for money/Savings identified as a result of the scheme		0		1				1		3		3
5. Deliverability/Timing												

Scheme is deliverable within the time and resource available		2		2				2		2		2
Risk profile and mitigations within the risk appetite of the Boards		1		1				1		2		2
Likelihood of benefits realisation being achieved		1		2				1		2		2
Toital		16		15		10		21		36		37

Catering options appraisal scoring:
"Does not meet" Score 0
"Partially meets" Score 1
"Fully meets" Score 2
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	A. 'Do nothing different to now' using informal collaboration, on tactical basis. The 'as is' model for DHC and DCH is to continue with development of a federated shared service as part of their joint Trust strategy.	Scores	B. Hosted Service	Scores	C. Outsource services into managed service contracts.	Scores	D. Become a customer of an existing subsidiary company, within the NHS	Scores	E. E.Set up a single subsidiary company, holding the shared services, with 75% ownership by a lead Trust and transfer of all assets.	Scores	F. F.Set up a separate subsidiary company for each Trust in Dorset focused on property assets managed service delivery. This is serviced by a single shared service provider in an operating company "OpCo".	Scores
1.Strategic alignment												
Option fits ODPC strategic aims	Aim is to collaborate within ICS	0		0		0		0		2		2
Option fits individual Trust's strategic aims	DCH and DHC workinng together continues	1		1		0		0		2		2
Option fits ICS strategic aims	DCH and DHC workinng together continues but excludes UHD	1		1		0		0		2		2
2. Economic Benefits												
Option is Value for Money (VFM) after any costs	Savings will be made by two trust working together	1		1		2		2		3		3
Option has clear, measurable benefits (cashable and cost avoiding)	Already being realised	2		2		0		0		2		2
Option can enable wider societal benefits	Less cost working together can be spent wlsewhere	1		1		0		0		2		2
3. Commercial Feasability												
Option has a commercially viable route for delivery		1		0		1		1		2		2
Option is compliant with procurement requirements		2		2		2		2		2		2
Option meets Trust governance requirements		2		2		2		2		2		2
4. Financial												
Capital cost/impact of scheme		2		2		2		2		2		2

Revenue cost/impact of scheme		2		2		2		2		2		2
Value for money/Savings identified as a result of the scheme		2		1		1		1		3		3
5. Deliverability/Timing												
Scheme is deliverable within the time and resource available		1		2		2		2		0		1
Risk profile and mitigations within the risk appetite of the Boards		2		1		2		2		2		2
Likelihood of benefits realisation being achieved		1		1		1		1		3		3
Toital		21		19		17		17		31		32

Catering options appraisal scoring:
"Does not meet" Score 0
"Partially meets" Score 1
"Fully meets" Score 2
"Exceeds" Score 3

	A. 'Do nothing different to now' using informal collaboration, on tactical basis. The 'as is' model for DHC and DCH is to continue with development of a federated shared service as part of their joint Trust strategy.	Scores	B. Hosted Service	Scores	C. Outsource services into managed service contracts.	Scores	D. Become a customer of an existing subsidiary company, within the NHS	Scores	E. E.Set up a single subsidiary company, holding the shared services, with 75% ownership by a lead Trust and transfer of all assets.	Scores	F. F.Set up a separate subsidiary company for each Trust in Dorset focused on property assets managed service delivery. This is serviced by a single shared service provider in an operating company "OpCo".	Scores
1.Strategic alignment												
Option fits ODPC strategic aims	Only delivers what is currently being delivered, it doesn't deliver a shared service or achieve better facilities collaboration and integration of Trust	0	Brings collaboration across all areas within Dorset	2	Doesn't deliver collaboration or integration of Trusts, it removes services entirely from, Trusts wouldn't be the anchor institution	1	The expertise and knowledge will sit outside of Dorset (ODPC) and will be difficult to ever bring back. Could lead to a different take on what the local market and anchor institutions are. Some benefits will be gained though.	1	Should deliver best collaboration and both maximise savings and protect recently upgraded facilities	3	Brings collaboration across all areas within Dorset	3
Option fits individual Trust's strategic aims	Only delivers the current position as opposed to future strategic aims, would keep services ticking over.	1	Brings collaboration as well as retaining and growing Dorset skill set, but non host Trusts may have reservations on fit	1	Removes most strategic aims from the Trusts / NHS control	1	Removes most strategic aims from the Trusts	0	Trusts are aligned on need to deliver savings to allow increased spending on patient care	1	Brings collaboration as well as retaining and growing Dorset skill set	3
Option fits ICS strategic aims	Wouldn't progress anything beyond the current position	0	Brings collaboration as well as retaining and growing Dorset skill set, would be one step removed from the ICS though	2	Removes most strategic aims from the Trusts / NHS control	1	Removes most strategic aims from the Trusts. ICS may see wider Wessex benefit if with UHS	1	Best option for delivering savings (reducing deficit) and protecting recent NHP and similar investments	2	Brings collaboration as well as retaining and growing Dorset skill set, would be one step removed from the ICS though	2
2. Economic Benefits												
Option is Value for Money (VFM) after any costs	Enhanced purchasing power would not be achieved in the services	1	Single set up would bring EoS.	2	Economies could be achieved via larger commercial organisation, however a profit element would be charged to the NHS	2	Costs would be low as WOS already exists, and could bring even more value to bigger purchasing power.	3	Need to work through cost/benefit in greater detail through the project btu expected to deliver strong benefits at an affordable cost	2	Better value with a single WOS but would require good staff to run it	2
Option has clear, measurable benefits (cashable and cost avoiding)	Potential benefits are being missed, and Trusts not working together will favour the suppliers of services,	1	Should be able to establish clear benefits.	2	A provider should be able to demonstrate where savings can be made.	2	Benefits of existing WOS should be set out and transferable	2	Capita study has demonstrated strong potential procurement benefits and past experience on estates also supports ability to achieve benefits	2	Should be able to establish clear benefits.	2
Option can enable wider societal benefits	Societal benefits can still be gained at a individual Trust level, but hard to exceed what is already being done.	2	Could become an anchor institution in its own right, all within Dorset, could be contrained within NHS	1	Unlikely to be as high a priority for a profit focused organisation, but some will likely still be delivered.	1	Benefits of existing WOS should be set out and transferable	2	Ability to deliver is maximised – for example through apprenticeships, local supply chain etc	2	Could become an anchor institution in its own right, all within Dorset, more scope to work outside of NHS	3
3. Commercial Feasability												
Option has a commercially viable route for delivery	it is already in place and delivering to a large extent, but it misses future potential to achieve more than the current position.	2	Option would be to grow existing set up so should be good route.	2	Commercial partners do exist for most areas.	2	Already established and operating.	2	Precise details of the structure to be determined with help from external advisers but Subcos have been successfully set up before so no reason to believe this can't be done	2	Many examples in the NHS of this so should be viable	2
Option is compliment with procurement requirements	Current services are compliant.	2	Many examples in the NHS of this so should be viable	2	Option could be compliant if properly put together.	2	Already established and operating.	2	No external parties involved so should comply. Will develop future state processes and governance to ensure compliance	2	Many examples in the NHS of this so should be viable	2
Option meets Trust governance requirements	Current services meet governance rules.	2	Governance would initially be set by Trust so should meet requirements	2	Controls could be put in place, however any provider may wish to keep some governance issues to themselves.	1	Already established and operating. Control is removed from the Trust/Dorset own governance so harder to influence	1	Trust governance requirements will be given careful consideration. Oversight from 3 FT Boards will need careful structuring	2	Governance would initially be set by Trust so should meet requirements	2
4. Financial												
Capital cost/impact of scheme	Low if any capital costs required as already up a and running, no impact should be felt.	3	Existing Trusts have systems so would depend if they could expand them for the other Trusts	1	Future capital supplied by external organisation would come at a higher cost than the NHS can currently secure its capital.	1	Already established, but hard to know how scalable it currently is.	2	Some cost to implement, including potential one-time up-front costs. Future costs will be calibrated against potential savings which can be delivered	2	Existing Trusts have systems so would depend if they could expand them for the other Trusts	2

Revenue cost/impact of scheme	Low cost option as the status quo, but potentially misses future opportunities.	1	As partly already established in host Trusts, it should have lower cost	2	Unclear if any savings would be offset by profit element for the provider.	1	Greater opportunity should be available with larger purchasing power	3	Will push hard for benefits maximisation across all 3 FTs which should comfortably offset operating costs of separate Subco	2	A single WOS should have lower cost than multiples, but could be higher cost to establish	2
Value for money/Savings identified as a result of the scheme	Opportunity still exists to deliver savings, but scope would be more limited. No VAT opoortunity	1	Potentially large benefits, but loss of VAT advantage of a WOS is material	1	Value for money could be challenged due to external profit element.	2	Has great potential but this may not come back to Dorset as a customer of the WOS rather than the owner.	2	Expect net benefits to be highest overall due to focused management combined with efficiency of a single Subco	3	potentially has largest benefits with all retained in Dorset	3
5. Deliverability/Timing												
Scheme is deliverable within the time and resource available	Already in place, but doesn't add anything new.	2	Could be complex to agree and set up	1	Likely to be more complex for the Trust to navigate with different commercial providers and the politics both internally and externally that would sit alongside this.	2	Already established but would be a large expansion, may need to do one Trust as a time.	1	Needs alignment and cooperation from FTs as part of approval process. Each FT will need to sign-up to the timeline/resource plan, with PMO overseeing deliver	2	Could be complex to agree on set up. Not many multiple Trust WOS exist.	2
Risk profile and mitigations within the risk appetite of the Boards	A low risk option and nothing much changes.	2	This is a large organisation to set up which brings risks, and relies on a good board to oversee it, could put some of	1	Would be a high risk strategy to devolve the Trusts of their internal teams to be totally outsourced.	1	Potentially a lower risk option as already established, but the move outside of Dorset could be less attractive, and loss of control may be of greater concern.	1	Strong expected financial and societal benefits whilst retaining staff within NHS should minimise project risk	2	This is a large organisation to set up which brings risks, and relies on a good board to oversee it, could put some of	2
Likelihood of benefits realisation being achieved	Would miss out on future benefits of going at scales.	1	Benefits should be deliverable but loss of VAT benefit has to be a factor	1	Commercial providers likely to be driven by delivering benefits.	2	Already established and working, but benefits might now all flow to Dorset as a client rather than as a owner of the WOS.	1	A management team focused on specific targets should maximise benefits and drive early realisation rather than being lost among other Trust priorities	2	Benefits should be deliverable by the WOS	2
Toital		19		23		22		24		31		34

Catering options appraisal scoring:
"Does not meet" Score 0
"Partially meets" Score 1
"Fully meets" Score 2
"Exceeds" Score 3

	A. 'Do nothing different to now' using informal collaboration, on tactical basis. The 'as is' model for DHC and DCH is to continue with development of a federated shared service as part of their joint Trust strategy.	Scores	B. Hosted Service	Scores	C. Outsource services into managed service contracts.	Scores	D. Become a customer of an existing subsidiary company, within the NHS	Scores	E. E.Set up a single subsidiary company, holding the shared services, with 75% ownership by a lead Trust and transfer of all assets.	Scores	F. F.Set up a separate subsidiary company for each Trust in Dorset focused on property assets managed service delivery. This is serviced by a single shared service provider in an operating company "OpCo".	Scores
1.Strategic alignment												
Option fits ODPC strategic aims	Relies on 3 separate teams working together in addition to operational delivery responsibilities with no structure or economy of scale to enable this to work effectively.	0	Does not enable shared leadership and governance	0	Does not mature and develop partnership or shared governance models for maturity	0	No development of shared leadership models or ownership of shared financial planning	0	Partially meets objectives but does not foster joint working collaboration in the same way as would be managed by one Trust	2	Meets objectives to move towards shared decision making and governance realising the benefits across the system. Enables blueprint for future shared services so that the model can be developed and include governance of the collaborative board.	3
Option fits individual Trust's strategic aims	Does not fit aim to spend NHS pound well and tot realise benefits at scale.	0	Unlikely any Trust would want to have loss of oversight and control	1	Lack of influence or control over outcomes and potential for staff not to remain on NHS contracts	0	Potentially will deliver savings, but with less influence and control over prirorities	1	Potentially meets strategic aims to make savings but likely to result in competitive desire to be the lead Trust.	1	Delivers savings opportunities and retains Trust control of assets so is the best of both models.	2
Option fits ICS strategic aims	Does not support delivering more together as a single system approach	0	Potentially if the Hosted service is able to deliver economies of scale	1	Does not allow as easily for spread of practice to further shared services	0	Longer-term and wider scale benefits could be lost / company may not have scalability or option to address Dorset specific needs	1	Meets need for economy of scale and savings	2	Increased likelihood of working strategically on estates and capital services across Dorset with one single governing body including all Trusts.	3
2. Economic Benefits												
Option is Value for Money (VFM) after any costs	Low cost to do, but unlikely to deliver any new savings	0	Could be built into the framework agreement but unlikely to be as high as if managed within NHS provision	1	Lower cost to set up potential that savings would not be realised as more arms length arrangement and reliant on expertise across multiple fields - not as useful for future-proofing further shared service models in Dorset	2	Risk that Dorest specific needs are not delivered as woul dbe part of a wider system of priorities and deliverables	1	Need to work through cost/benefit in greater detail through the project btu expected to deliver strong benefits at an affordable cost	2	Small extra cost of SubCo Boards, but most costs within the JVCO, so maximises savings and paves way for future shared services with increased savings opportunities	3
Option has clear, measurable benefits (cashable and cost avoiding)	With no change this would be limited to exisiting planning processes and likely to reduce potential savings benefits	1	Likely to be able to deliver benefits and would be accountable for this as part of the hosting arrangement	2	May bring existing best practice and greater leverage to increase benefits. Could bring existing processes and systems (avoid reinventing the wheel) Could be partially offset by benefits leakage from Dorset to the parent of existing subco	2	If 3 companies are able to collaborate more effectively than FTs currently do then benefits can be achieved through focused alignment	1	Capita study has demonstrated strong potential procurement benefits and past experience on estates also supports ability to achieve benefits	2	Capita study has demonstrated strong potential procurement benefits and past experience on estates also supports ability to achieve benefits	2
Option can enable wider societal benefits	No benefits outside of existing Trust arrangements	0	Societal benefits are likely to be a lower priority, unless specificallyadded to metrics of the host arrangement	1	As an existing NHS company they will understand the importance of societal benefits, but not clear they would be motivated to deliver these in Dorset	1	Limited ability to achieve societal benefits beyond the status quo scenario	1	Ability to deliver is maximised – for example through apprenticeships, local supply chain etc	3	Ability to deliver. Easier than one Trust dominating. Option to also work with local voluntary services.	3
3. Commercial Feasability												
Option has a commercially viable route for delivery	With a modified status quo position it is likely to be viable. Achieving collaboration across Trusts will be more difficult without harmonised functional leadership and a single entity to drive this forward	1	Assumes ability to identify a host and complete in timely way in order to deliver	0	Using an exisiting company should ensure commercial viability	2	With each company as a Sub of a separate FT, this should be commercially viable	2	Precise details of the structure to be determined with help from external advisers but Subcos have been successfully set up before so no reason to believe this can't be done	2	OpCo well established model.	2
Option is compliment with procurement requirements	Yes – current processes assumed to be compliant as single Trusts	2	Would require enhanced work compared to other options, likely to increase burden of internal links for overseeing this	1	Yes - their current processes are assumed to be compliant	2	FTs likely to start by transferring existing processes so should be compliant	2	No external parties involved so should comply. Will develop future state processes and governance to ensure compliance	2	Fully compliant with procurement. Develops ability to compete for future work	3

Option meets Trust governance requirements	Does not enhance existing arrangements, althought existing arrangements fit for purpose as separate Trusts	2	External commercial partner may limit ability of Trust management to provide effective oversight	1	An exisiting company from outside the Dorset area may limit ability of FT management to influence and oversee governance	1	Each FT will retain governance and control	2	Trust governance requirements will be given careful consideration. Oversight from 3 FT Boards will need careful structuring	2	Requires work to ensure shared givernance and leadership model allows each Trust to have oversight and shared decision making, but offers greatest scale of effeciency with continued	3
4. Financial												
Capital cost/impact of scheme	Limited cost to implement. No staff or entity changes. Potential costs to support improved data sharing (eg systems/interfaces) between participating FTs	2	Commercial partner may be willing to absorb some of the implementation costs and re-use existing systems investments. Up-front cost could therefore be low (perhaps replaced by recurring licence fees for access to software etc?)	2	If they have existing capability and systems this may reduce up-front cost (beyond interfaces etc), but company may leverage this through licence fees or a one-time set-up charge - unknown at present and time would be required to assess	2	Costs associated with set-up of separate companies, IT systems etc will be duplicated 3x	1	Some cost to implement, including potential one-time up-front costs. Future costs will be calibrated against potential savings which can be delivered	2	Some cost to implement, including potential one-time up-front costs. Future costs will be calibrated against potential savings which can be delivered. Capital plans tailored to each Trust investment	2
Revenue cost/impact of scheme	Benefits case expected to be lower, but one-time implementation costs also likely to be lower	1	Net revenue benefit likely to be lower due to commercial partner profit element	1	Opportunity to leverage cost base more effectively and drive higher productivity could increase gross benefits, before provider charges	2	quo) likely to limit benefits, although Subco teams may feel more empowered to work together than they do today. Duplication of costs high and scope for cost avoidance is limited	1	Will push hard for benefits maximisation across all 3 FTs which should comfortably offset operating costs of separate Subco	2	Revenue savings achieved at OpCo , as most effective way to deliver.	2
Value for money/Savings identified as a result of the scheme	Likely to be lowest level of potential savings	0	Expect potential benefits to be lower due to commercial partner profit element	1	May contribute to higher gross savings for Dorset, but these likely to be offset by higher charges/share of gains going to shareholders of existing subsidiary	1	Potential benefits overall likely to be lower than an integrated Subco	1	Expect net benefits to be highest overall due to focused management combined with efficiency of a single Subco	3	Many savings are made much more likely by this approach.	3
5. Deliverability/Timing												
Scheme is deliverable within the time and resource available	Lack of change to structures and most processes, with scope to move gradually should ensure deliverability	2	Commercial partner likely to bring their own delivery methodology which should de-risk implementation (but could be resistance to change from some existing personnel)	1	Need to confirm that existing subsidiary management have bandwidth available to support integration of 3 additional FTs	0	Each FT will be able to move at their own pace so can determine appetite and available resource separately	1	Needs alignment and cooperation from FTs as part of approval process. Each FT will need to sign-up to the timeline/resource plan, with PMO overseeing deliver	2	Deliverable, and resolves delay issues like consolidation.	3
Risk profile and mitigations within the risk appetite of the Boards	Low risk, low return	1	staff acceptance/resistance which could be high (and result in engagement from elected representatives)	1	the 3 FTs can coordinate together to maximise targeted savings, as well as high risks around governance	1	Low risk, low return scenario	1	Strong expected financial and societal benefits whilst retaining staff within NHS should minimise project risk	2	Boards have indicated support	2
Likelihood of benefits realisation being achieved	Low benefits and will be harder to achieve due to dependence on collaboration	1	Once commercial partner has committed to benefits they are likely to deliver (or forfeit their fees)	2	High risk that benefits not achieved due to complex structure and involvement of another NHS with potentially conflicting interests	0	Each FT should be able to realise benefits which don't depend on collaboration, but wider benefits will be hard to achieve	1	A management team focused on specific targets should maximise benefits and drive early realisation rather than being lost among other Trust priorities	2	OpCo increases chance of delivery above counter factoral.	2
Toital		9		16		16		15		31		38

Catering options appraisal scoring:
"Does not meet" Score 0
"Partially meets" Score 1
"Fully meets" Score 2
"Exceeds" Score 3

	A. 'Do nothing different to now' using informal collaboration, on tactical basis. The 'as is' model for DHC and DCH is to continue with development of a federated shared service as part of their joint Trust strategy.	Scores	B. Hosted Service	Scores	C. Outsource services into managed service contracts.	Scores	D. Become a customer of an existing subsidiary company, within the NHS	Scores	E. E.Set up a single subsidiary company, holding the shared services, with 75% ownership by a lead Trust and transfer of all assets.	Scores	F. F.Set up a separate subsidiary company for each Trust in Dorset focused on property assets managed service delivery. This is serviced by a single shared service provider in an operating company "OpCo".	Scores
1.Strategic alignment												
Option fits ODPC strategic aims	Does not achieve collaboration across providers including associated improvements and cost savings	0	Achieves collaboration across all providers with associated service improvments and cost savings.	2	Potential to do collectively, but will not protect staff T&Cs and will not deliver full savings potential due to supplier margin/ profit.	1	Could be done jointly, with staff protected and achieving the benefits from staff coming together into a single service. Would deliver some savings but not all available due to existing subco profit requirements. Loss of control of assets.	1	Achieves collaboration across all providers with associated cost savings. Dedicated focus will deliver considerable service improvments. 75% ownership risks bias/ perception of bias and therefore potential for unwinding.	2	Achieves collaboration driving cost savings. Dedicated focus will deliver considerable service improvments. Staff and assets protected. Most likely to be sustained.	3
Option fits individual Trust's strategic aims	Partially meets DCH/DHC priorities associated with ferreration, but does not achieve anything wider.	1	Achieves collaboration across all providers with associated service improvments and cost savings.	2	Would deliver savings and service efficiencies, and reduce headcount/ WTE. Would not protect NHS staff and would require loss of control of assets. Would not retain all savings due to supplier margins.	1	Staff protected and would achieve service improvments through a single service at scale with dedicated leadership/ oversight. Would deliver some savings but not all available due to existing subco profit requirements. Loss of control of assets.	1	Achieves cost savings and with dedicated focus will deliver considerable service improvments. 75% ownership risks bias/ perception of bias and therefore potential for unwinding. Loss of control of assets from those with a lower shareholding.	1	Achieves collaboration driving cost savings. Dedicated focus will deliver considerable service improvments. Staff and assets protected. Most likely to be sustained.	3
Option fits ICS strategic aims	Noes not achieve collaboration across providers including associated improvements and cost savings	0	Achieves collaboration across all providers with associated service improvments and cost savings.	2	Would deliver savings and service efficiencies, and reduce headcount/ WTE. Could be done across ICS partners. Would not protect NHS staff and would require loss of control of assets. Would not retain all savings due to supplier margins.	1	Staff protected and would achieve service improvments through a single service at scale with dedicated leadership/ oversight. Would deliver some savings but not all available due to existing subco profit requirements. Loss of control of assets.	1	Achieves cost savings and with dedicated focus will deliver considerable service improvments. 75% ownership risks bias/ perception of bias and therefore potential for unwinding.	2	Achieves collaboration driving cost savings. Dedicated focus will deliver considerable service improvments. Staff and assets protected. Most likely to be sustained.	3
2. Economic Benefits												
Option is Value for Money (VFM) after any costs	Existing budgeted costs continue. Benchmarking highlights further savings opportunities - more likely to be achieved through greater collaboration.	1	Cost savings achieved through colleaboration/ economies of scale. No additional overheads.	2	Significant savings achieved through MSC structure, however partially off-set by supplier margins/ profits.	2	Significant savings achieved through MSC structure, however partially off-set by existing subco margins/ profits requirements.	2	Significant savings achieved through MSC structure, with limited additional costs.	2	Significant savings achieved through MSC structure, with limited additional costs.	2
Option has clear, measurable benefits (cashable and cost avoiding)	Some benefits through fedaration of 2 providers.	0	Clear and measurable benefits both in terms of cost reduction, recruitment and retention, and service outcome metrics/ KPIs.	2	Clear and measurable benefits in financial savings, service resilience and outcomes (managed through clear, contractual KPIs). Specific expertise and scale driving further economies of scale above a hosted service.	2	Clear and measurable benefits in financial savings, service resilience and outcomes (managed through clear, contractual KPIs). Specific expertise and scale driving further economies of scale above a hosted service but probably not as great as a private sector MSC.	2	Clear and measurable financial savings through economies of scale including benefits in recruitment and retention. Service resilience and outcomes benefits driven by dedicated boards focus and managed through clear, contractual KPIs. Limited set up costs and lower margins than private sector MSC.	3	Clear and measurable financial savings through economies of scale including benefits in recruitment and retention. Service resilience and outcomes benefits driven by dedicated boards focus and managed through clear, contractual KPIs. Limited set up costs and lower margins than private sector MSC.	3
Option can enable wider societal benefits	Existing benefits only in relation to local workforce.	1	Workforce related societal benefits associated with a single service supporting staff development and better deployment.	1	Contract will require demonstrable societal benefits, however likely to be off-set by reduced benefits for local workforce.	1	Workforce related societal benefits associated with a single service supporting staff development and better deployment. Contractual requirement to deliver additional societal benefits.	2	Workforce related societal benefits associated with a single service supporting staff development and better deployment. Full alignment with Dorset would drive a focus on the delivery of wider societal benefits and local ownership would support investment to support this.	2	Workforce related societal benefits associated with a single service supporting staff development and better deployment. Full alignment with Dorset would drive a focus on the delivery of wider societal benefits and local ownership would support investment to support this.	2
3. Commercial Feasability												
Option has a commercially viable route for delivery	No change to existing in-house provision.	2	No commercial issues envisaged with consolidation of existing services within a single host NHS Trust.	2	Likely to require numerous contracts/ commercial partners for different specialist elements.	1	Existing subcos in place and demonstrating commercial viability. Expansion therefore expected to benefit this and improve viability through economies of scale.	2	Existing subcos in place and demonstrating commercial viability. No anticipated viability issues in replicating this within Dorset. Potential risk to future unwinding linked to ownership split.	2	Existing subcos in place and demonstrating commercial viability. No anticipated viability issues in replicating this within Dorset. Most likely option not to be unwound in the future.	3
Option is compliment with procurement requirements	No change to existing provision.	2	No commercial issues envisaged with consolidation of existing services within a single host NHS Trust.	2	Compliant procurment options avalaible to secure an external partner.	2	Compliant procurment options avalaible to secure an external partner.	2	No procurement issues anticipated as existing services already in place.	2	No procurement issues anticipated as existing services already in place.	2
Option meets Trust governance requirements	No additional/ amended governance required.	3	Additional governance will be required and delivered through Contracts/ Service Level Agreements.	2	Outsourcing arrangements are commonplace and existing governance arrangements in place to support.	2	Outsourcing arrangements are commonplace and existing governance arrangements in place to support.	2	Significant additional governance required - to be designed and implemented.	1	Significant additional governance required - to be designed and implemented. Additional layer to Option E.	1
4. Financial												

Capital cost/impact of scheme	No anticipated additional capital costs.	2	Minimal additional capital costs - limited to system integration/ alignment and data sharing/ BI.	2	Potential for additional capital costs linked to existing/ aged equipment which an external supplier may mandate replacement to support operation performance/ KPI achievement.	1	Potential for additional capital costs linked to existing/ aged equipment which an external supplier may mandate replacement to support operation performance/ KPI achievement.	1	Minimal additional capital costs - limited to system integration/ alignment and data sharing/ BI. Capital replacement costs can be tailored to live within existing budgets/ savings opportunities.	2	Minimal additional capital costs - limited to system integration/ alignment and data sharing/ BI. Capital replacement costs can be tailored to live within existing budgets/ savings opportunities.	2
Revenue cost/impact of scheme	No significant revenue benefit anticipated above the status quo.	1	Financial benefits through collaboration and single functions. Likely to be lower than through outsourcing, but 100% retained.	2	Financial benefits through collaboration and private sector expertise and investment in technology etc and tax advantages. Off-set in part by supplier profit requirements.	2	Financial benefits through collaboration greater economies of scale and tax advantages. Off-set in part by existing subco profit requirements.	2	Financial benefits through collaboration with dedicated leadership focus, enhanced by tax advantages. Small additional cost of structure/ governance.	3	Financial benefits through collaboration with dedicated leadership focus, enhanced by tax advantages. Small additional cost of structure/ governance.	3
Value for money/Savings identified as a result of the scheme	As above - no significant additional benefits anticipated.	1	As above - additional benefits providing greater VFM.	2	As above - additional benefits providing greater VFM. Greater by with private profit off-set.	2	As above - additional benefits providing greater VFM. Greater by with existing subco profit off-set.	2	As above - additional benefits providing greater VFM. 100% retained locally, but with small additional cost of structure/ governance.	3	As above - additional benefits providing greater VFM. 100% retained locally, but with small additional cost of structure/ governance.	3
5. Deliverability/Timing												
Scheme is deliverable within the time and resource available	Minimal change required.	3	Significant change - requiring resource allocation and leadership capacity.	1	Significant change, but with implementation resource/ capacity provided by suppliers.	2	Significant change, likely with some capacity provided by existing subco, but expect resource requirements in addition.	1	Significant additional resource required, time delays likely due to national assurance/ approval process.	1	Significant additional resource required, time delays likely due to national assurance/ approval process.	1
Risk profile and mitigations within the risk appetite of the Boards	No risk, but no return (financial risk mitigation).	2	Risk of disruption to current service through transition, and risk to non-host organisations in relation to ongoing service provision.	1	Outsourcing arrangements are commonplace and existing governance arrangements in place to support. Deemed to be low risk overall due to contractual protections and transition/ implementation resource and expertise from supplier.	2	Outsourcing arrangements are commonplace and existing governance arrangements in place to support. Deemed to be low risk overall due to contractual protections and transition/ implementation experience from own set-up.	2	Risk of disruption during transition, mitigated through expert leadership and oversight, including enhanced governance and additional resource for implementation.	2	Risk of disruption during transition, mitigated through expert leadership and oversight, including enhanced governance and additional resource for implementation.	2
Likelihood of benefits realisation being achieved	No additional benefits.	0	Benefits likely to be slow linked to significant change within limited additional resources and no external/ focused expertise/ leadership.	1	Benefits likely to be delivered at pace.	2	Benefits likely to be delivered - slower than outsourced MSC - faster than hosted.	2	Benefits likely to be delivered at pace due to structure and specific, dedicated leadership resource/ oversight.	2	Benefits likely to be delivered at pace due to structure and specific, dedicated leadership resource/ oversight.	2
Toital		19		26		24		25		30		35

Catering options appraisal scoring:
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	A. 'Do nothing different to now' using informal collaboration, on tactical basis. The 'as is' model for DHC and DCH is to continue with development of a federated shared service as part of their joint Trust strategy.	Scores	B. Hosted Service	Scores	C. Outsource services into managed service contracts.	Scores	D. Become a customer of an existing subsidiary company, within the NHS	Scores	E. E.Set up a single subsidiary company, holding the shared services, with 75% ownership by a lead Trust and transfer of all assets.	Scores	F. F.Set up a separate subsidiary company for each Trust in Dorset focused on property assets managed service delivery. This is serviced by a single shared service provider in an operating company "OpCo".	Scores
1.Strategic alignment												
Option fits ODPC strategic aims	Collaboration has a limited track record of success; unlikely to deliver optimal result	0	Use of a commercial partner may limit ability to transition existing staff on NHS T&Cs, as well as potentially causing benefits leakage out of NHS	1	May be hard to manage and drive effectively to meet target	0	Viable option but does not address how 3 FTs will work effectively together to maximise benefit and minimise cost	1	Should deliver best collaboration and both maximise savings and protect recently upgraded facilities	3	Collaboration achieved, with vehicle able to take on future services	3
Option fits individual Trust's strategic aims	Unlikely, unless other projects with higher benefits case are dominating management bandwidth	1	Trusts are keen to retain all staff within NHS, and to retain benefits within NHS also	1	Lack of control and influence ov er the existing subsidiary limits the appeal of this	1	Keeps control fully within each FT, but at cost of a sub-optimal benefit delivery.	1	Trusts are aligned on need to deliver savings to allow increased spending on patient care	2	Each Trust retains strategic control of estate and capex, and can more easily set individual contract priorities	3
Option fits ICS strategic aims	ICS looking for FTs to work more effectively together. With historical loose collaboration showing limited effectiveness, fit is poor	0	As for Trusts	1	as for Trusts	1	Strong reliance on collaboration will slow progress. Fallback option if shared ownership company not viable	0	Best option for delivering savings (reducing deficit) and protecting recent NHP and similar investments	2	Fully aligned with ICS aims	3
2. Economic Benefits												
Option is Value for Money (VFM) after any costs	Low cost to do, but benefits also likely to be lower	1	Commercial partner may bring new tools and better data to help increase benefits, but will likely charge higher fees for this which will reduce VFM. They will be less motivated to enable societal benefits which don't impact their profit	1	Lower cost to set up Would need to validate that existing subsidiaries have capability in the areas we've targeted for savings	1	Duplication of companies, management and systems etc likely to impact benefits case	2	Need to work through cost/benefit in greater detail through the project btu expected to deliver strong benefits at an affordable cost	1	Small extra cost of SubCo Boards, but most costs within the JVCO, so maximises savings	2
Option has clear, measurable benefits (cashable and cost avoiding)	The stronger the collaboration the greater the opportunity for benefits. This approach may provide a sub-set of the available benefits	0	Likely to be able to deliver solid gross benefits (before their charges) and to be able to leverage wider economies of scale	1	May bring existing best practice and greater leverage to increase benefits. Could bring existing processes and systems (avoid reinventing the wheel) Could be partially offset by benefits leakage from Dorset to the parent of existing subco	1	If 3 companies are able to collaborate more effectively than FTs currently do then benefits can be achieved through focused alignment	1	Capita study has demonstrated strong potential procurement benefits and past experience on estates also supports ability to achieve benefits	1	Capita study has demonstrated strong potential procurement benefits and past experience on estates also supports ability to achieve benefits	2
Option can enable wider societal benefits	Societal benefits from greater staff development, social value employment etc are likely to be low		Societal benefits are likely to be a lower priority for the commercial partner who will be focused on their ability to generate profit		As an existing NHS company they will understand the importance of societal benefits, but not clear they would be motivated to deliver these in Dorset		Limited ability to achieve societal benefits beyond the status quo scenario		Ability to deliver is maximised – for example through apprenticeships, local supply chain etc		Ability to deliver. Easier than one Trust dominating.	
3. Commercial Feasability												
Option has a commercially viable route for delivery	With a modified status quo position it is likely to be viable. Achieving collaboration across Trusts will be more difficult without harmonised functional leadership and a single entity to drive this forward	1	Existing examples of managed service providers assumed to exist, but feels out of line with government policy	1	Using an exisiting company should ensure commercial viability	1	With each company as a Sub of a separate FT, this should be commercially viable	2	Precise details of the structure to be determined with help from external advisers but Subcos have been successfully set up before so no reason to believe this can't be done	2	OpCo well established model.	2
Option is compliment with procurement requirements	Yes – current processes assumed to be compliant		May be possible to construct so it is compliant but external provider likely to be a challenge to get approved		Yes - their current processes are assumed to be compliant		FTs likely to start by transferring existing processes so should be compliant		No external parties involved so should comply. Will develop future state processes and governance to ensure compliance		Fully compliant with procurement. Develops ability to compete for future work	
Option meets Trust governance requirements	Provided no issues with current approach this will meet the minimum hurdle	3	External commercial partner may limit ability of Trust management to provide effective oversight	2	An exisiting company from outside the Dorset area may limit ability of FT management to influence and oversee governance	1	Each FT will retain governance and control	1	Trust governance requirements will be given careful consideration. Oversight from 3 FT Boards will need careful structuring	1		2
4. Financial												

Capital cost/impact of scheme	Limited cost to implement. No staff or entity changes. Potential costs to support improved data sharing (eg systems/interfaces) between participating FTs	2	Commercial partner may be willing to absorb some of the implementation costs and re-use existing systems investments. Up-front cost could therefore be low (perhaps replaced by recurring licence fees for access to software etc?)	1	If they have existing capability and systems this may reduce up-front cost (beyond interfaces etc), but company may leverage this through licence fees or a one-time set-up charge	1	Costs associated with set-up of separate companies, IT systems etc will be duplicated 3x	2	Some cost to implement, including potential one-time up-front costs. Future costs will be calibrated against potential savings which can be delivered	2	Some cost to implement, including potential one-time up-front costs. Future costs will be calibrated against potential savings which can be delivered. Capital plans tailored to each	2
Revenue cost/impact of scheme	Benefits case expected to be lower, but one-time implementation costs also likely to be lower	1	Net revenue benefit likely to be lower due to commercial partner profit element	1	Opportunity to leverage cost base more effectively and drive higher productivity could increase gross benefits, before provider charges	2	Dependence on collaboration (as for status quo) likely to limit benefits, although Subco teams may feel more empowered to work together than they do today. Duplication of	2	Will push hard for benefits maximisation across all 3 FTs which should comfortably offset operating costs of separate Subco	2	Revenue savings achieved at OpCo , as most effective way to deliver.	3
Value for money/Savings identified as a result of the scheme	Likely to be lowest level of potential savings	0	Expect potential benefits to be lower due to commercial partner profit element	1	May contribute to higher gross savings for Dorset, but these likely to be offset by higher charges/share of gains going to shareholders of existing subsidiary	1	Potential benefits overall likely to be lower than an integrated Subco	1	Expect net benefits to be highest overall due to focused management combined with efficiency of a single Subco	2	Many savings are made much more likely by this approach.	3
5. Deliverability/Timing												
Scheme is deliverable within the time and resource available	Lack of change to structures and most processes, with scope to move gradually should ensure deliverability	3	Commercial partner likely to bring their own delivery methodology which should de-risk implementation (but could be resistance to change from some existing personnel)	2	Need to confirm that existing subsidiary management have bandwidth available to support integration of 3 additional FTs	1	Each FT will be able to move at their own pace so can determine appetite and available resource separately	1	Needs alignment and cooperation from FTs as part of approval process. Each FT will need to sign-up to the timeline/resource plan, with PMO overseeing deliver	2	Deliverable, and resolves delay issues like consolidation.	2
Risk profile and mitigations within the risk appetite of the Boards	Low risk, low return	2	staff acceptance/resistance which could be high (and result in engagement from elected representatives)	2	the 3 FTs can coordinate together to maximise targeted savings, as well as high risks around governance	2	Low risk, low return scenario	2	Strong expected financial and societal benefits whilst retaining staff within NHS should minimise project risk	2	Boards have indicated support	2
Likelihood of benefits realisation being achieved	Low benefits and will be harder to achieve due to dependence on collaboration	2	Once commercial partner has committed to benefits they are likely to deliver (or forfeit their fees)	2	High risk that benefits not achieved due to complex structure and involvement of another NHS with potentially conflicting interests	2	Each FT should be able to realise benefits which don't depend on collaboration, but wider benefits will be hard to achieve	2	A management team focused on specific targets should maximise benefits and drive early realisation rather than being lost among other Trust priorities	2	OpCo increases chance of delivery above counter factoral.	2
Toital		16		17		15		18		24		31

Catering options appraisal scoring:
"Does not meet" Score 0
"Partially meets" Score 1
"Fully meets" Score 2
"Exceeds" Score 3

	A. 'Do nothing different to now' using informal collaboration, on tactical basis. The 'as is' model for DHC and DCH is to continue with development of a federated shared service as part of their joint Trust strategy.	Scores	B. Hosted Service	Scores	C. Outsource services into managed service contracts.	Scores	D. Become a customer of an existing subsidiary company, within the NHS	Scores	E. E.Set up a single subsidiary company, holding the shared services, with 75% ownership by a lead Trust and transfer of all assets.	Scores	F. F.Set up a separate subsidiary company for each Trust in Dorset focused on property assets managed service delivery. This is serviced by a single shared service provider in an operating company "OpCo".	Scores
1.Strategic alignment												
Option fits ODPC strategic aims	Fails to progress strategy of joint working for residents benefit	0		2		0		1		1		3
Option fits individual Trust's strategic aims	Ad hoc could continue, but slow and sub optimal	1		1		0		2		1		3
Option fits ICS strategic aims	Ad hoc could continue, but slow and sub optimal	1		2		0		1		2		3
2. Economic Benefits												
Option is Value for Money (VFM) after any costs	No cost of change, but leaves Dorset finances as unsustainable, and will always benchmark worse than they could be, as not on level playing field with other Trusts/Systems.	1		2		2		2		2		2
Option has clear, measurable benefits (cashable and cost avoiding)	Continue as BAU with different sets of benefits, measured in different ways	1		2		2		2		2		2
Option can enable wider societal benefits		1		1		1		2		3		3
3. Commercial Feasability												
Option has a commercially viable route for delivery		2		2		2		1		3		2
Option is compliment with procurement requirements		2		2		2		2		2		2
Option meets Trust governance requirements		2		1		1		1		2		2
4. Financial												
Capital cost/impact of scheme		1		2		1		1		0		2

Revenue cost/impact of scheme		1		2		1		1		2		2
Value for money/Savings identified as a result of the scheme		0		1		1		2		2		2
5. Deliverability/Timing												
Scheme is deliverable within the time and resource available		2		1		2		1		2		2
Risk profile and mitigations within the risk appetite of the Boards		1		1		0		1		0		3
Likelihood of benefits realisation being achieved		1		1		2		1		2		3
Total		17		23		17		21		26		36

Annual Report and Accounts

1 April 2023 to 31 March 2024

Contents

Introduction

Introduction

Statement from the Chair and Chief Executive

As we look back over the period April 2023 to March 2024, it is clear the last year has been challenging for the NHS nationally and here in Dorset. Yet despite financial and operational pressures, we are proud of the progress that our workforce, working with our wider partners, has achieved. Our people are our most important asset, and we value their dedication and commitment to delivering the objectives of the Dorset Integrated Care System.

We know that many in our communities are still waiting too long for operations or to be discharged from hospital once they have no clinical need to remain. We continue to work hard with teams across health and care services in Dorset to reduce waiting times and improve people's experience of care. We are pleased to report improvements in performance in many of the key operational standards, and this puts Dorset in a strong position for further improvement in the coming year.

We remain personally committed to improving access to services and reducing inequalities. By working with our communities, we aim to better understand the contributing factors to health inequalities in Dorset, to find ways to tackle these inequalities and provide more equitable access to health and care services. Within NHS Dorset we recognise that there is much work still to be done on addressing matters of equality, diversity and inclusion. There is great work underway through our organisational development team, and our LGBTQ+, Pro-Ability and Ethnic Community staff networks. We will continue to champion this work as part of our commitment to creating a safe and equitable working environment.

We have been pleased to see the Integrated Care Partnership continue to develop over the last year. By working with our partners though the Integrated Care Partnership we continue to focus on the broader social and economic challenges which our communities face. We believe that by prioritising work in areas such as social mobility, employment and housing, the wider Dorset system can come together to improve these factors which have a significant impact on our residents' health and wellbeing.

Our work this year with our communities, especially with our residents on Portland, has demonstrated the strength that comes from community-led design and collaborative working between partners. We are excited about the potential of our Integrated Neighbourhood Teams work to foster a culture of co-design and to develop services in ways and locations that matter to our communities. We are keenly aware that only by listening to our communities are we able to work together to achieve the best possible improvements in their health and wellbeing.

We are continuing to focus on our commitment to deliver services in a manner that respects the needs of this generation and future generations, by promoting working in a way which creates a positive social impact for our communities and reduces the negative impact on our environment. We recognise that our impact in the community is so much broader than the health services we commission, and we take seriously our responsibilities as an anchor institution.

We would like to thank all our staff, and all our colleagues working in the wider health and care sector, for their continued hard work and enthusiasm. Special thanks are due to the ICB's Deputy Chief Executive Officer who acted as Interim Chief Executive Officer during Patricia's leave of absence between November and April. Our thanks also go to our communities, for their ongoing support and engagement with us – your voices are key in enabling us to build a sustainable health and care system in Dorset.

As we head into a new year, we are excited about the future of health and care in Dorset. We will continue to support work which connects services with the needs of local communities and maximises the opportunities for out of hospital care. We also remain committed to increasing the focus on preventative health, helping our communities to stay well and have ownership of their wellbeing. For our residents who require hospital care the coming year will see development works funded by the New Hospitals Programme, and in addition the opening of the BEACH Building will enable University Hospitals Dorset to become the major emergency hospital for the region.

Finally, we know that the financial situation for NHS Dorset, and the NHS as a whole, will continue to be incredibly challenging. However, we remain dedicated to providing high quality, safe care to our communities and supporting collaborative work across the system as we jointly work towards our ambition of making Dorset the healthiest place to live.

Jenni Douglas-Todd
Chair

Patricia Miller OBE
Chief Executive Officer

Performance Report

Performance Report

Statement from the Accountable Officer on performance

The following section provides the view of our Accountable Officer, and a summary of our performance. Full details of our performance, with details of key achievements and risks are provided in the Performance Overview and Performance Analysis below.

Key Positives

The last financial year has continued to be one of challenge for the NHS as a whole and our communities in Dorset, yet despite these pressures we are proud of the work of all our partners to continue to deliver and develop services, and there has been much positive operational performance including:

- a continued focus on the recovery of services with a strong focus on health inequalities, with patient-centred care remained at the forefront and the maintenance of high standards of care remaining a priority
- positive progress in mental health services, delivery of the Primary Care Access Recovery plan, and recovery and delivery of pharmacy, optometry and dental services
- refurbishment of key parts of the estate in Dorset to maximise productivity and efficiency, and progress in the New Hospitals Programme schemes to support performance delivery in the future
- a strong focus on collaboration and integration between partners to foster integrated care pathways to support seamless service provision for patients.

In addition, the report below details many examples of innovative work and positive outcomes in a range of work programmes across Dorset including the system's performance against the national standards, elective care, cancer treatment, primary and community care services, urgent and emergency care, maternity services, vaccinations, medicines optimisation, children and young people, learning disability and autism, and mental health.

Our vision for research is for every person in Dorset to have the opportunity to take part in research, and the report below outlines the progress in research and innovation that has been made over the last year. We remain committed to delivering services in a manner that respects the needs of this generation and future generations, and our progress against the NHS Dorset Green Plan is detailed in the report. NHS Dorset and our NHS partners are committed to providing high quality and safe care. We have continued to work hard over the reporting period to improve quality and safety, and the report details how we are achieving this.

Since our last report covering 2022/23, we have continued with our commitment to support broader social and economic development, engage with our people and communities, and tackling health inequalities. This work is central to our delivery of the Integrated Care System purposes and is detailed in the report.

Principle Risks

Many of the risks we faced this year were common across the country, and the Key Issues and Risks section of the report below details the key risks for NHS Dorset during the reporting period. Industrial action from several staff groups has impacted on performance delivery. We will continue to keep the possibility of further industrial action under review for the coming year, alongside risks around high and complex demand for services, and limited workforce supply, which impact retention as well as staff health and wellbeing.

The financial position has been challenging for the NHS, and this year we were unable to achieve a breakeven position. The report provides further details on the financial performance for the reporting period, with further information available in the Annual Accounts. Increased demand for personal health commissioning has significantly influenced the financial position. This has created a significant challenge for the system in managing resources and balancing patient choice to promote cost-effective, patient-centred care. Over the coming year we will continue to work hard to deliver the Integrated Care System purpose of enhancing value for money.

Future Plans

The sections below on our performance during the reporting period provide details of future plans for many of the services that we commission in Dorset and some of the challenges, or risks, to the delivery of this work. These workstreams are all underpinned by our ambition to deliver on the Integrated Care System purposes.

Over the coming year we will be continuing the work we have commenced in 2022/23 in developing our relationships with our partners and working together to deliver the best possible outcomes for our communities. This incudes working with NHS partners on delivery of the Five Pillars in our Joint Forward Plan, with our Integrated Care Partnership colleagues to deliver the Integrated Care Strategy and with our local authority partners and their Health and Wellbeing Boards to deliver the objectives of the Joint Health and Wellbeing Strategy.

Performance Overview

Overview

About Us

The introduction of the Health and Care Act 2022 led to the establishment of the Integrated Care Board (ICB) on 1 July 2022, a statutory organisation responsible for meeting the healthcare needs of people and communities in Dorset. The organisation moved from being a GP-led membership organisation to a unitary Board.

The Integrated Care Board for Dorset is called 'NHS Dorset' and is responsible for leading the Dorset Integrated Care System (ICS) on behalf of the system partners.

The organisation took on the functions of the Dorset Clinical Commissioning Group (CCG) and additional responsibilities were also introduced, delegated from NHS England.

We are responsible for planning, buying and monitoring (also known as commissioning) health services from healthcare providers, such as hospitals and GP practices for our local Dorset population to ensure the highest quality healthcare. We also have a performance monitoring role of these services, which includes responding to any concerns from our patients on services offered.

NHS Dorset will work with others to deliver the four national Integrated Care System strategic objectives. These objectives are to:

- Improve outcomes in population health and healthcare.
- Tackle inequalities in outcome and access.
- Enhance productivity and value for money.
- Help the NHS deliver broader social and economic development.

Prior to the establishment of NHS Dorset, leaders of organisations working in partnership in Dorset had agreed three values as guiding principles for how we work. These values are:

- Ambition - working together to achieve the best possible outcomes for local communities.
- Community-driven - moving to a more person centric focus, improving wellbeing, and better use of resources.
- Partnership - ensuring all organisations and individuals are population and community driven, moving away from organisationally driven behaviours.

These are underpinned by the principles of trust, honesty, respect, candour and kindness.

The Integrated Care System encompasses the following Dorset NHS organisations and local authorities:

- Bournemouth, Christchurch and Poole Council
- Dorset Council
- Dorset County Hospital NHS Foundation Trust
- Dorset HealthCare University NHS Foundation Trust
- NHS Dorset Integrated Care Board
- Public Health Dorset
- South Western Ambulance Service NHS Foundation Trust (SWASFT)
- University Hospitals Dorset NHS Foundation Trust.

However, the Integrated Care System is broader than this, working in partnership with the primary care, people and communities and the voluntary, community and social enterprise sector (VCSE).

Our Constitution

Our NHS Dorset Constitution is a formal document which sets out the governing principles, rules and procedures for our organisation which will ensure integrity, honesty and accountability. It also commits the organisation to taking decisions in an open and transparent way and places the interests of patients and public at its heart. The current version of our Constitution can be found on our website. Sitting alongside our Constitution is our Governance Handbook which sets out key supporting documents.

The population we serve

We have a registered Dorset GP population of approximately 825,000 people. The area we serve also has a high transient population with university students during term time and an increase in visitors during holiday periods. Overall, the local population shows a steady increase with much of the growth happening among older people.

People in Dorset generally live healthier and longer lives compared to the average for England, but this is not evenly spread across our population – the data reveals unacceptable inequalities between different groups. One of the four strategic objectives of the Integrated Care System is to tackle inequalities in outcome and access. We want everyone in Dorset to receive the same high quality of care, regardless of where they live, what health condition they have, or any other personal characteristic.

Increased longevity brings new challenges to health and care systems, because as we grow older more of us develop long-term conditions such as diabetes and dementia. In line with the Integrated Care System's strategic objectives, we are working to improve outcomes in population health and healthcare.

We also know that people who act as carers are at high risk of experiencing worse health outcomes, having their employment or education disrupted and becoming socially isolated, which in turn impacts on their role as a carer.

Our providers

We commission (buy) services from a range of providers including:

- Dorset County Hospital NHS Foundation Trust
- Dorset HealthCare University NHS Foundation Trust
- University Hospitals Dorset NHS Foundation Trust
- Salisbury NHS Foundation Trust
- University Hospital Southampton NHS Foundation Trust
- Somerset NHS Foundation Trust
- South Western Ambulance Service NHS Foundation Trust
- general practices
- third sector – which are non-governmental and non-profit-making organisations or associations, including charities and voluntary agencies
- independent sector care homes and hospitals.

How we work

NHS Dorset has developed an Operating Model setting out how we will work to deliver our priorities and objectives. It helps our teams and partners understand how we work and make decisions and provides assurance to the ICB Board on how we discharge our functions.

To reflect the functions of NHS Dorset, the internal structure comprises eight directorates led by a Chief Officer:

- Patricia Miller, Chief Executive Officer
- Rob Morgan, Chief Finance Officer
- Debbie Simmons, Chief Nursing Officer
- Paul Johnson, Chief Medical Officer
- Neil Bacon, Chief Strategy and Transformation Officer
- David Freeman, Chief Commissioning Officer
- Dean Spencer, Chief Operating Officer
- Dawn Harvey, Chief People Officer
- Stephen Slough, Chief Digital Information Officer.

Integrated Care Partnership

In 2022, NHS Dorset and the local authorities in our area, Dorset Council and Bournemouth, Christchurch and Poole Council, established the Integrated Care Partnership in accordance with section 116ZA of the Local Government and Public Involvement in Health Act 2007.

In addition to local councils and local NHS organisations, membership of the Integrated Care Partnership includes representatives from the police and fire services, the voluntary and community sector, primary care, public health, the education sector, the Local Enterprise Partnership, Healthwatch Dorset, the Wessex Academic Health Science Network, and public engagement groups.

The Integrated Care Partnership works with a shared purpose towards the four national Integrated Care System strategic objectives detailed above. To support this, the Integrated Care Partnership has written a strategy outlining how it will achieve its vision to work together to deliver the best possible improvements in health and wellbeing. The Integrated Care Partnership aims to achieve its vision by focusing on three key priorities: prevention and early help, thriving communities and working better together. The strategy is based on conversations with a wide range of people including leaders in our health and care organisations, people working on the frontline, and people living and working in Dorset.

Last year the Integrated Care Partnership focused on creating its strategy and considering the next steps in implementing its vision and priorities. This year the focus has been on identifying key priorities and turning the strategy into action. As part of its commitment to transparency and accountability, the Integrated Care Partnership holds quarterly meetings which are open to the public to attend in person or to view via a livestream. Meeting papers and minutes are also published online. The Integrated Care Partnership has also introduced reporting to the ICB Board meetings which is also held in public.

In April 2023, Cecilia Bufton was appointed as the Integrated Care Partnership Convenor and Independent Chair. To take on the role, Cecilia stepped down from her position as a Non-Executive Member of the NHS Dorset ICB Board. Prior to joining NHS Dorset in July 2022, Cecilia was Group Product Marketing Director at Tunstall Healthcare Group. Before that she was the Vice President, Global Hospital Business for Linde Healthcare and since 2016 she has been a freelance Business Advisor, specialising in strategic marketing, product innovation and business development. Cecilia is also Chair of two charity Boards, The Macular Society and Plant Heritage, and a Trustee of the Talbot Village Trust.

Key highlights from the work of the Integrated Care Partnership and its work towards delivering the Integrated Care Partnership strategy objectives during the reporting period include:

- Considering the Joint Forward Plan produced by NHS partner organisations and how this links to the delivery of the Integrated Care Partnership strategy.
- Exploring local authority partners' strategic priorities and how these align with the priorities set out in the Integrated Care Partnership strategy.

- Establishing a commitment to focus on housing, as one of the key ways to contribute to social and economic development of our communities and to tackle health inequalities.
- Reviewing the Integrated Care Partnership's Terms of Reference to ensure the governance of the joint committee is appropriate.
- Receiving updates on the Place Based Partnership work which is underway in the Dorset system and understanding the benefits of this approach for our communities.
- Discussing data on social mobility and the labour market, to better understand the challenges and opportunities for Dorset communities.
- Undertaking a workshop to consider the role of the Integrated Care Partnership, engagement with organisations and organisational culture, and how the Integrated Care Partnership would move forward.

The full strategy and more information about the work of the Integrated Care Partnership is available to read on the Our Dorset website.

Joint Forward Plan

The Joint Forward Plan for Dorset was written in conjunction with system partners and was published in July 2023. The focus of the plan is to explain how the work we will do will help people to become healthier and happier. The plan is enabled by working together, to make Dorset the best place to live when it comes to health and wellbeing. For the people of Dorset this plan provides opportunity to make our ambition to make Dorset the healthiest place to live become a reality, working with people and communities to improve wellbeing, not just for those currently living in Dorset, but for future generations. This will be achieved through working together as unified teams with health and social care organisations, community and voluntary organisations, local businesses, and local authorities to transform what we do.

The Joint Forward Plan is the key document that takes us from where we are now to the future and is reviewed every 12 months. The refreshed version for 2024 does not fundamentally change the 2023 version of the Joint Forward Plan, which covered the period 2023–2028. The refresh is an opportunity to take a look back on progress and impact since first publication in July 2023, and a look forward at the priorities for the coming year.

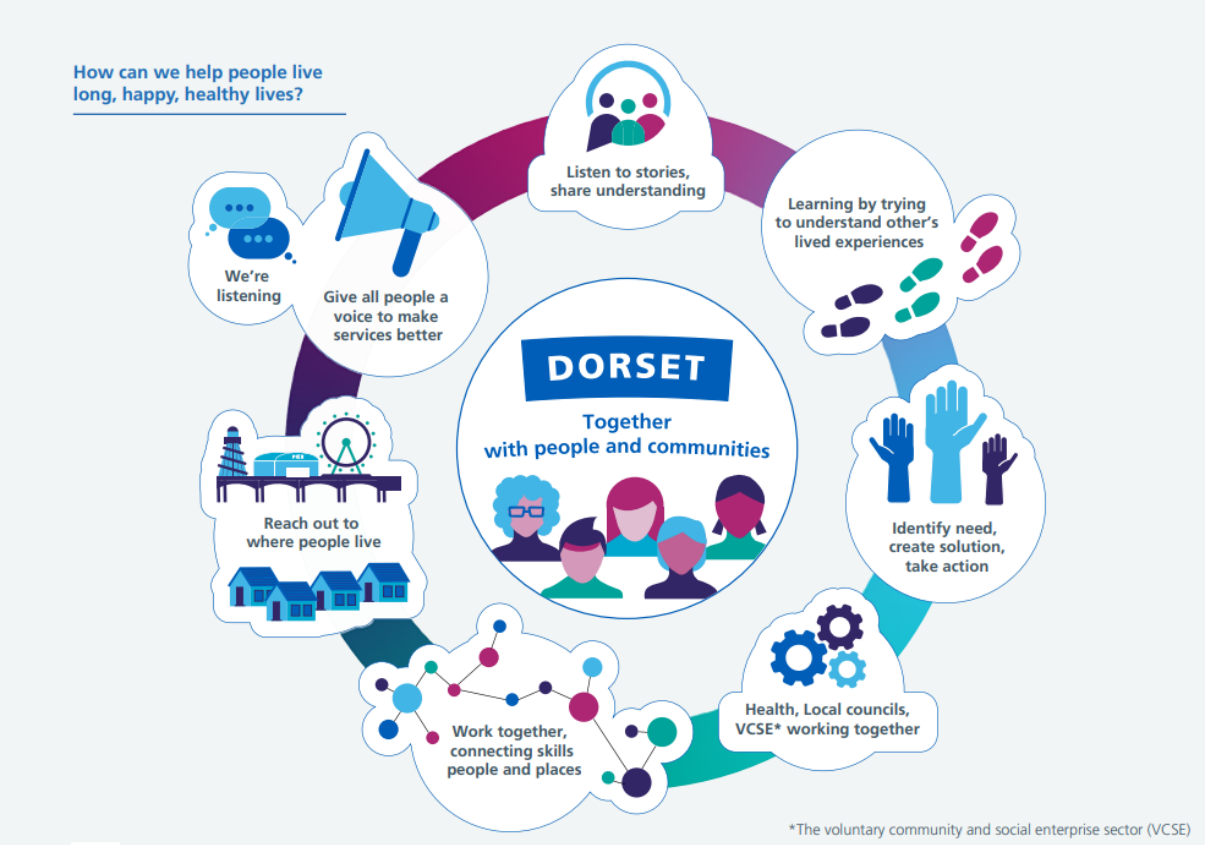
The latest version has been updated to include new sections regarding:

- Vaccination Plans
- Urgent and Emergency care
- Neighbourhood and Place
- Research and Innovation
- Updated Clinical Plan
- Updated Finance Plan
- Population Health
- Healthwatch Dorset
- Women's Health Hubs
- Estates Strategy.

We have also updated a number of areas to provide further details on progress and to ensure we are aligned with expectations of NHS England 2024/25 Operational Planning Guidance, including:

- Success stories and case studies to showcase Dorset system working
- Evidence of progress and the impact of the work against each pillar of the plan
- An updated Governance Structure
- Mental Health

- Children and Young People
- Obesity
- Workforce
- Sustainability
- Oral Health.



Our key successes have been driven by building the team working partnership as outlined in the diagram above. Our approach to the Women's Health Hubs has been a great example of a partnership programme led by the voluntary, community and social enterprise sector. Dorset Women CIC are driving this programme supported by NHS Dorset, Wessex Health Partners and Health Innovation Wessex to understand and then deliver the primary objectives to increase access and reduce variation. Our research plan has allowed us to work with the voluntary, community and social enterprise sector who have supported members of our homeless community to become the research leads, to increase our knowledge and shape future models of care and support. Teams from all our partners have shaped the Joint Forward Plan and the refresh has provided an opportunity to show what we can have achieved in the last year. Further details of our progress in relation to the Joint Forward Plan can be found by following the link below.

The 2024 refresh of the Joint Forward Plan will be published at the end of June 2024 and can be accessed on our website: [Joint Forward Plan – NHS Dorset]

Performance Synopsis

The key performance highlights for NHS Dorset from 01 April 2023 to 31 March 2024 are:

- A continued focus on the recovery of services with a strong focus on health inequalities, making every contact count, and ensuring adherence to Evidence Based Interventions (EBIs).
- In April 2023, NHS Dorset took responsibility for pharmacy, optometry and dental services and we continue to work with our providers to recover and transform these services.
- Dorset continues to be committed to the delivery of the Primary Care Access Recovery plan, focusing on improving digital infrastructure, developing and supporting our workforce, moving to a model of modern general practice and supporting the sustainability of primary care.
- Positive progress has been seen in mental health services with improvements in annual health checks, partnering with the voluntary sector to build and strengthen local neighbourhood and community assets aimed at improving mental wellbeing, and reduced waiting times for children, young people, and families to access mental health services.
- Patient-centred care remained at the forefront and maintaining high standards of care remained a priority, with efforts directed towards patient safety, infection control, and continuous improvement in clinical outcomes across various specialties.
- The refurbishment of key estate in the county to maximise productivity and improve efficiencies including South Walks House in Dorchester, and the day case unit in Weymouth.
- Progress in the New Hospitals Programme schemes to support performance delivery in the future, including the BEACH (births, emergency care, critical care and child health) building in Bournemouth, and the St Anne's site in Poole.
- Preparation for the significant transfer of services as part of the Clinical Services Review to minimise and mitigate impact on performance as much as possible.
- A strong focus on collaboration and integration between partners to foster integrated care pathways to support seamless transition for patients across different settings including the introduction of a place-based no criteria to reside approach.

However, there have been several significant challenges including:

- Industrial action from several staff groups impacting performance delivery. Teams worked tirelessly to mitigate the impact of industrial action as much as possible with patient safety at the forefront.
- The balance between system resilience, and recovery. We continue to operate within a backdrop of high and complex demand, and limited workforce supply, which impact retention as well as staff health and wellbeing.
- A financially demanding period, the system did not achieve a breakeven financial position. Consequently, robust system approaches were put in place including the introduction of a triple-lock sign off process for significant investments with sign off required by the organisation, system, and NHS England South West and the System Recovery Group meeting overseeing the delivery of schemes to reduce cost.
- Increased demand for personal health commissioning significantly influencing the financial position. This creates a significant challenge for the system in managing resources and balancing patient choice to promote cost-effective, patient centred care.

The NHS System Oversight Framework 2022/23 describes NHS England's approach to NHS oversight for 2023/24. The framework was not updated for 2023/24 however a national consultation is taking place during 2024/25 to introduce a new National Oversight Framework. The current oversight metrics align to the five national themes of the System Oversight Framework of quality of care, access and outcomes, preventing ill health and reducing inequalities, people, finance and use of resources, and leadership and capability. The annual performance review between NHS Dorset and NHS England for 2023/24 is currently being undertaken.

The Key Issues and Risks section in the Performance Analysis below, further expands on the challenges we have faced, the mitigations we have taken to address these and those issues which have ceased to be key risks during the year.

Performance Analysis

The following section provides information on our achievements from 01 April 2023 to 31 March 2024 and how we have worked to meet our statutory duties.

NHS Constitution standards and operational targets

Our performance against the NHS Constitution standards and key operational targets are set out in the following section. The red/amber/green rating assessment is used to indicate the performance for the period ending 31 March 2024. As noted in previous years, performance against the constitutional standards should be read with caution as the focus has been on recovery following the suspension of routine activity in 2020/21.

We are proud of the continued response of the Dorset system and the way we have worked together to maintain essential services during the continued pressures on the system including industrial action. Teams worked tirelessly to mitigate the impact of industrial action as much as possible with patient safety at the forefront. We have prioritised the most clinically urgent patients and those with unacceptably long waits, continued to recover services, and supported our staff.

Throughout 2023/24 we have continued to see an increase in demand for urgent and emergency care services, higher acuity of patients, and increased number of patients not meeting the clinical criteria to reside, which has impacted on the performance across the system. Collaboration and integration between partners are prioritised to establish integrated care pathways and ensure a seamless transition for patients, including the adoption of a place-based approach to those patients with no criteria to reside.

During the period, we have continued to focus on the recovery of elective services, tackling long waiting lists, access to cancer diagnosis and treatment and improvements in diagnostics, theatre usage and outpatients. This has seen us deliver our planned reduction in the number of people waiting more than 78 weeks from referral to starting treatment. However, our position at the end of March 2024 for all long waiting times was worse than planned due to the impact of industrial action. In addition, we have an emphasis on addressing health inequalities, and prioritising patient centered care whilst upholding high standards of care and prioritising patient safety. Key estate refurbishments, such as South Walks House in Dorchester and the day case unit in Weymouth, aim to boost productivity and efficiency.

During 2024/25 we will continue to prioritise the most clinically urgent patients and reduce long waiting times with a specific focus on those patients waiting beyond 65-weeks for planned care. There will be a strong focus on enhancing productivity and efficiencies through Model Health System and learning from Getting It Right First Time (GIRFT) feedback. We will continue to progress New Hospitals Programme schemes such as the BEACH building in Bournemouth and the St Anne's site in Poole to support future performance delivery. There will be a focus on preparation for the significant transfer of services as part of the Clinical Services Review to minimise and mitigate impact on performance as much as possible.

Further details on the programmes of work undertaken within Elective Care can be seen in the next section.

Table 01: NHS Constitution standards performance

ICB Based Indicators	Operational Standard	2023/24	2022/23	2021/22	2020/21		Reporting Month
Patients on incomplete non-emergency pathways (yet to start treatment) waiting no more than 18 weeks from referral	92%	60.1%	54.9%	60.5%	N/A		Mar-24
Patients on incomplete non-emergency pathways (yet to start treatment) waiting no more than 104 weeks from referral - 0 by June 2022	0	0	0	484	14		Mar-24
Patients on incomplete non-emergency pathways (yet to start treatment) waiting no more than 78 weeks from referral - 0 by March 2023	0	55	116	1241	N/A		Mar-24
Patients on incomplete non-emergency pathways (yet to start treatment) waiting no more than 52 weeks from referral - 0 by March 2025	N/A	4343	5231	4309	8897		Mar-24
Clock stops at 89% or better of 19/20 equivalent	89%	91.1%	99.7%	88.6%	84.0%		Mar-24
Advice & Guidance rate as per 100 first Outpatient Attendances	16	14.3	14.6	7.7	9.9		Feb-24
Patient Initiated Follow Ups as percentage of Total Outpatient Attendances	5%	5.2%	7.3%	1.4%	1.1%		Mar-24
Outpatient virtual activity	25%	20.8%	20.8%	22.9%	28.9%		Mar-24
Percentage of patients waiting 6 weeks or more for a diagnostic test (15 key tests)	99%	87.9%	85.2%	83.8%	N/A		Mar-24
Maximum two-week wait for first outpatient appointment for patients referred urgently for suspected cancer by a GP	93%	61.8%	55.2%	64.3%	81.0%		Mar-24
Maximum 31-day wait from diagnosis to first definitive treatment for cancer	96%	96.1%	96.1%	97.7%	93.0%		Mar-24
Maximum 62-day wait from diagnosis to first definitive treatment for cancer	85%	73.7%	66.7%	72.9%	60.0%		Mar-24
60% of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral	60%	100.0%	84.0%	91.3%	100.0%		Mar-24
75% of people with common mental health conditions referred to the improved access to psychological therapies (IAPT) programme will be treated within six weeks of referral	75%	95.8%	96.0%	97.0%	98.0%		Mar-24

66.7% of dementia diagnosis of the estimated number of people with dementia	66.70%	56.1%	56.0%	55.70%	56.0%	Mar-24
A&E Waits - percentage of A&E attendances where the patient spent 4 hours or less in A&E from arrival to transfer, admission of discharge ICB Total	95%	72.9%	73.90%	65.70%	81.0%	Mar-24
No Criteria to Reside: Percentage of beds occupied	N/A	18.0%	22.70%	N/A	N/A	Mar-24
NHS 111 service: SWAST: calls answered in 60 seconds	95%	86.70%	86.60%	48.20%	88.0%	Mar-24
NHS 999 service: SWAST: Category 1 mean response duration	7 mins	8 mins	8.5 mins	12.3 mins	7.3 mins	Mar-24

Key Issues and Risks

A new Board Assurance Framework for the ICB has been in development over 2023/24 and, following review by the Risk and Audit Committee, was approved by the ICB Board in March 2024. The new Board Assurance Framework will enable the ICB Board and its committees to focus on the strategic risks of the organisation and the residual risk which remains once all possible mitigations are in place. The Board Assurance Framework reflects the strategic objectives set out in the Joint Five Year Forward Plan and the related strategic risks to delivery of these objectives. Further information on strategic risk is provided in the Corporate Governance Statement as part of the Accountability Report below.

The Board Assurance Framework is supported by our Corporate Risk Register which documents the operational risks reported within the organisation. New and emerging risks are identified by operational teams, through programme and project management and by the operational delivery groups. These are recorded on the local risk registers held within directorates. If the rating of the risks on the local risk registers reaches the threshold, the risk would be reviewed for entry to the Corporate Risk Register. The Corporate Risk Register is regularly reported to the ICB Board and Risk and Audit Committee. In addition, the Quality, Experience and Safety Committee reviews the full Corporate Risk Register, with the other committees reviewing the risks relevant to their areas of work. Further information on operational risk is provided in the Governance Statement below.

We are committed to minimising risks to which we are exposed, strategically, corporately and operationally. The overall aim is to reduce the likelihood of loss of services due to adverse events, financial challenges or performance, or quality and safety of commissioned services that could ultimately impact the people of Dorset.

During the period 1 April 2023 to 31 March 2024, key operational risks identified were as follows:

Risks	Our Actions
Financial Challenge - financial duties	**How we have addressed this**
If we do not meet our financial duties and/or the Dorset Integrated Care System does not manage expenditure within its financial envelope, then the impact on the future financial position will affect the delivery of services including elective recovery and will hinder transformation.	Dorset ICS delivered a deficit position of £14.6m for the financial year 2023/24. The final deficit position will be held in the ICB, with a small surplus offset in Dorset Healthcare. This risk should be considered as realised and in the 2023/24 financial year the ICB did not deliver its finance plan. Following submission of the final operational plans in May, we are now reviewing what the financial risk will look like for 2024/25 but medium-term financial planning suggests a five-year window until the ICS is back in underlying financial balance.
Financial Challenge – deficit position	**How we have addressed this**
If NHS Dorset ICB maintains a deficit position beyond 2024/25, it may compromise its ability to manage expenses within its budget, jeopardise its financial stability, and impede service delivery and transformation in Dorset.	NHS Dorset has not achieved a breakeven financial position in 2023/24. The deficit will need to be repaid starting in the 2025/26 financial year. This risk should be considered materialised and following submission of the final operational plans in May, we are now reviewing what this financial risk will look like for 2024/25. Medium term financial planning suggests a five-year period for the system to return to an underlying financial balanced position and submitted plans for the 2024/25 year show a deficit position of £21.3 million.
Overspend on Personal Health Commissioning	**How we have addressed this**
Increasing cost of care continues to significantly impact on the Personal Health Commissioning budget. There are limited savings plans against this budget and significant savings are more likely to be realised through different commissioning approaches.	This risk is not going to improve in the short term as a cost savings plan is to be issued by the ICB finance team. The service is working with exemplar partners to explore all opportunities to realise greater efficiencies in its operating model and in the commissioning of services to support people's care need. This risk will be reviewed and reframed in quarter one of 2024/25 in line with the new financial year.
Non-Emergency Patient Transport Service (NEPTS) arrangements	**How we have addressed this**
The contract holder served notice to terminate their contract with NHS Dorset on the 24 October 2023, the proposed options to continue a service until the contract end would have fundamentally changed the signed contract held, which through procurement regulation has the potential to put NHS Dorset at risk of legal challenge.	Under the procurement process the ICB Board has approved Provider Selection Regime (PSR) urgent direct award to our planned transport provider. This provider went live delivering the service on the 15 April 2024. This risk is being reviewed in quarter one of 2024 and the recommendation will be to close the risk as the risk score will be minimal.
High Demand for Acute Mental Health Inpatient Beds	**How we have addressed this**

The current flow and high demand for acute mental health in-patient beds, has significant implications on the wider health economy with the likelihood of patients becoming stranded in acute general hospitals or being left in community settings despite having acute mental health needs. This in turn increases the risk to patient safety. Such demand creates challenges across the general acute sector where individuals may end up waiting for a suitable bed to become available. This pressure is compounded by challenges within community mental health services where workforce pressures are limiting overall capacity.	For much of 2023/24 demand remained high and this was reflected in the number of out of area placements. Collaborative work was progressed across the system to work towards improving the situation. Our aim was to reduce the number of out of area placements to near zero by the end of June 2024. By the end of March there was one adult mental health patient inappropriately placed out of area. This is a marked improvement and demonstrative of the significant efforts undertaken throughout 2023/24.
National target of zero 65 week waits to be achieved by March 2024	**How we have addressed this**
There is an elective backlog of long waiting patients and a national recovery target to ensure there are zero patients waiting longer than 65 weeks by the end of March 2024. Elective capacity is at risk due to continued increase in demand on urgent and emergency care, hospital flow. The continued impact of industrial action, particularly consultants, will impact on the system's capacity and ability to achieve 65 week trajectories. Robust plans are needed for identifying future risk, trajectories, and capacity planning.	2023/24 saw industrial action significantly impact the capacity available to achieve the originally agreed operating plan standards. In response to this, NHS England asked all systems to undertake an additional planning round for the second part of the year, known as H2. Through this process, original trajectories were reviewed and submitted. The system expected to have 1,053 65+week waiters at the end of March 2024, signalling a significant move from the original trajectory of zero. In addition, in February 2024, a significant change to national reporting took place. Community Paediatrics was moved from referral to treatment (RTT) reporting to community health services reporting. This reduced the submitted trajectory to 782. Despite the challenges faced during 2023/24 the system concluded the year with 658 65+ week waiters. 124 patients better than expected. Both insourcing and the use of independent sector providers supported the reduction in 65-week waiters. In comparison to March 2023, the system reduced the number of patients waiting beyond 65-weeks by 634. As we move into 2024/25, trajectories to achieve the ambition of zero 65+week waiters by the end of September 2024 have been agreed with additional capacity through insourcing and independent sector providers being utilised along with additional estate being opened to create additional capacity. Providers are aiming to ensure all patients within the 65-week cohort receive a first appointment by the end of July 2024. It is important to note the submitted trajectories do not include any impact of further industrial action, as per national guidance, and junior doctor industrial action is expected in Q1 of 2024/25.

National target for starting the Autism Spectrum Disorder (ASD) assessment process within three months of referral in Dorset	How we have addressed this
Increasing demand for neurodiverse assessment and diagnosis across the children and young people population of Dorset has increased waiting times for assessment and diagnosis. This has resulted in poorer outcomes for children, young people and their families, a negative impact on the ICB's ability to support statutory Special Educational Needs and Disabilities (SEND) requirements and increased costs associated with private providers being approached under the 'Right to Choice' legislation.	Wait list funding and regular reporting continues to be in place to NHS Dorset from providers. Based on monthly statistics, planned intended outcomes are likely to be achieved. There are different approaches being used to achieve these, including private assessment providers, secondments and increased workforce. Work is commencing in relation to scoping opportunities for waiting well - Health Innovation Wessex have been asked to do some work to explore and consider any learning nationally/internationally we may want to consider. The timescale for a resolution is anticipated to be a long term need as is the case nationally.
Failure to achieve the SEND Written Statement of Action plan with BCP Council	**How we have addressed this**
NHS Dorset is at risk of not meeting the statutory SEND responsibilities in BCP. The local area partnership is currently under a ministerial directive after failure to achieve the SEND Written Statement of Action, developed in 2021. This is a partnership directive, and we are responding accordingly and working with partners to implement our SEND Improvement Plan at pace.	NHS Dorset and health provider partners are collectively working to improve collaboration within the Bournemouth Christchurch and Poole (BCP) SEND partnership following the ministerial direction received following the last SEND inspection in 2021. A revised Partnership SEND Improvement Plan was submitted in January 2024 and has subsequently been approved by the DfE and NHSE. The BCP SEND improvement plan identifies eight areas for improvement. We recognise that whilst some progress has been made through the joint SEND improvement work, there is a need for pace as families in BCP are continuing to tell us that their lived experience is not reflective of the progress we think our partnership working has made. Key themes include the importance of being able to access the right support at the right time, improved communication between multi agency services as well as between partners and families in the BCP area. The improvement plan covers the period 2023/2026, with most of the improvement work aimed to be completed in the year 2024/2025. NHS Dorset reports on progress of the BCP SEND improvement plan into ICB and local authority governance structures.
Recruitment to the Learning Disability/Autism Programme Officer Role	**How we have addressed this**
The NHS Long Term Plan made a commitment to improve the quality of care within an inpatient setting for children and adults with a Learning Disability and/or Autism. There is a mandatory requirement for all NHS Commissioners who are	Arrangements are in place to cover key aspects of the programme officer role. Actions are focused on out of area placements with those admitted to local acute mental health units in Dorset subject to the normal contractual quality

responsible for arranging and funding the care of people with Learning Disabilities and/or Autism in inpatient mental health services, to have robust and effective systems in place to identify and promptly address any concerns relating to quality of care and individual safety at the earliest possible opportunity.	oversight. The dedicated post for commissioner oversight visits is included in the ICB potential new structure. This risk remains open with a moderate risk score.

During the period 1 April 2023 to 31 March 2024, key operational risks identified that have been closed are as follows:

Risks closed during the reporting period	Our Actions
University Hospitals Dorset's Patient Administration System	**How we have addressed this**
There have been issues with inaccuracies in University Hospitals Dorset's Patient Administration System caused by the lack of connection from the system to the NHS Spine system.	There will be continuous monitoring of University Hospitals Dorset regarding their current and future actions regarding the Patient Administration System connectivity to the NHS Spine/amending Patient Administration System records. The Shared Learning Panel meet monthly and will escalate if there is a theme in harm to patients.
Capacity in the Continuous Positive Airways Pressure treatment pathway	**How we have addressed this**
During Covid-19, there were significant pressures on the treatment service due to workforce issues and an international shortage of Continuous Positive Airways Pressure (CPAP) devices. This resulted in patients waiting significantly longer for treatment. In addition to this backlog of patients waiting for treatment, the current treatment provider closed the routine CPAP treatment pathway.	The Dorset Sleep Service (DSS) commenced on the 1 August 2023. The backlog has now been resolved and all patients treated.
Risk: Ambulance Response Times	**How we have addressed this**
Since escalating to Resource Escalation Action Plan (REAP) level 4 on 17 June 2021, responding to Category 2 incidents within the national Ambulance Response Programme (ARP) Standards has been a significant challenge. Dorset has seen increased levels of hours lost due to ambulance handover delays, with a growing number of ambulances queueing outside Emergency Departments. Consequently, this has meant there are fewer vehicles available on the roads to respond to Category 2 incidents within the national Ambulance Response Programme Standards. Patients could experience harm as a result of the extended operational response times.	There has been a national change to the way handover wait times are being calculated and these have been updated within the national Ambulance Quality Indicators (AQIs) - the impact of these changes is currently unknown. In addition, the emergency ambulance resource in Dorset has been re-aligned to increase the number of vehicles available during the evening and overnight as this is a time that has been identified when ambulance queueing can occur. Work is progressing in relation to streamlining emergency direct referral pathways and flow through Emergency Departments. This risk has been closed and a new risk added with a risk score of moderate.

New and Emerging Risks

The Dorset Integrated Care System faces several risks that could impact its ability to maintain and/or improve performance.

Workforce remains a significant challenge, with recruitment and retention remaining a high priority within the system's People Plan. 2023/24 saw an unprecedented level of industrial action. Our junior doctor workforce has not seen resolution to their disputes with a high risk of further industrial action from this group. This could lead to disruptions in services, delays in treatment, and increased pressure on remaining staff. Should this occur, mitigations and contingency plans will be enacted, to maintain essential services and minimise disruption.

In line with the Clinical Services Review, there are significant plans to reconfigure estate in the east of the county. While these changes aim to improve service delivery, several risks and challenges accompany such a major undertaking. Careful planning and phasing are in place to minimise disruption and maintain continuity of care.

Financial constraints also present a major risk with limited budgets and rising costs which can impact the availability of services. The expectations of our communities are evolving, with an increasing demand for personalised care, greater transparency, and more involvement in healthcare decisions. Meeting these expectations requires the system to remain patient-centred, focusing on communication, empathy, and tailored care approaches.

The increasing prevalence of chronic diseases and an aging population, both place additional demands on healthcare services. Integration and coordination of care along with prevention efforts are vital as the system matures. The need for seamless communication and collaboration across different parts of the system is essential. Fragmentation can lead to inefficiencies, duplicated efforts, and gaps in patient care. Efforts to improve integration, such as through our Integrated Neighbourhood Teams, will be crucial. Prevention will play in important role through promoting healthy lifestyles with the aim of preventing the onset of chronic diseases. Encouraging regular physical activity, healthy eating, smoking cessation, and regular health screenings can reduce the prevalence of conditions such as diabetes, cardiovascular diseases, and obesity.

As we increase our efforts to diagnose more cancers earlier, which is crucial for improving patient outcomes, this can create additional demand and potentially impact the delivery of the cancer standards. Cancer pathway reviews and productivity improvements will be vital to mitigating the impact upon patient care and performance.

The ongoing impact of the COVID-19 continues to pose challenges. The system is still addressing the long-term effects, including increased demand for healthcare services, and addressing backlogs. In addition, there has been an increase in mental health issues impacting adults, children and young people since the pandemic. Several factors contribute to this including prolonged social isolation, economic uncertainty, grief from loss of loved ones, and the ongoing fear of illness. For healthcare workers, the relentless pressure, long hours, and emotional strain have exacerbated these issues.

The political and regulatory environment also plays a critical role, especially changes in healthcare policy, funding arrangements, and regulatory requirements. The system needs to remain adaptable and responsive to such changes, ensuring it can maintain continuity of high quality, safe care and meet its operational goals.

Future years will see further introduction and integration of new technologies such as digital health tools and artificial intelligence. These innovations create opportunities to improve efficiencies and outcomes, however successful implementation will require training, infrastructure, and support. It is important to ensure access to such technologies is equitable to avoid exacerbating health inequalities.

Elective Care Programme

The elective care function within NHS Dorset is responsible for the commissioning of elective (planned, non-cancer) services in Dorset, ensuring we provide services that meet the needs of our local population and provide value for money. We work in close partnership with provider organisations to set local strategy, deliver improvements and enhance productivity and standards of care. The elective programme oversees the delivery of national performance and recovery targets for elective services. The elective care team responds to patient feedback and manages resolution for issues raised to us by our communities, ensuring that themes are identified and reflected in the commissioning strategy.

The elective care programme reports to the system Planned Care Delivery Group which consists of senior operational, performance and clinical representatives from NHS Dorset, Dorset County Hospital, Dorset Healthcare and University Hospitals Dorset.

Throughout 2023/24 the continued focus of the programme has been on elective recovery - protecting, maximising and creating elective capacity, whilst reducing health inequalities and inequity. The Planned Care Delivery Group has led the formation of a Planned Care Strategy, which is in the final stages of engagement and development. This is due to be completed during the first part of 2024/25.

We have made good progress over the last year in reaching the goals we set in our operational plan, despite some of the challenges we have seen. This includes:

- 106% elective recovery (as at 31.01.2024)
- Eliminated 104 week waits
- Reduced 78 week waits from 116 (31.3.23) to 55 (as at 31.3.24)
- Reduced 65 week waits from 1,070 (31.3.23) to 658 (as at 31.3.24)
- Reduced the total size of the waiting list in Dorset from 94,904 (31.3.23) to 91,533 (as at 31.3.24)
- Progressed towards reducing 52 week waits from 5,231 (31.3.23) to 4,343 (as at 31.3.24)
- 79.9% day case (latest 31.12.23)
- 74.9% theatre utilisation (as at 31.3.24)
- Improved Diagnostic Waiting Times and Activity (DM01) performance from 66.9% (31.3.23) to 87.9% (as at 31.3.24).

Work in many areas has contributed towards progress made, whilst ensuring resource is directed in an equitable manner.

<u>Health Inequalities</u>

Over the last 12 months, the Elective Health Inequalities Steering Group has led a programme of work to develop knowledge of health inequalities in elective services so that approaches can be adjusted to reduce disparities in access and outcomes for patients.

Achievements include the following:

- Trial of a 100-day approach to projects to test a fast-paced method.
- Continued development of the Dorset Intelligence and Insight Service (DiiS) dashboard, aligned to the national Health Inequalities Statement, to inform elective care priorities.
- Digital Inclusion:
    - Seeking assurance that alternatives to digital appointments are available across specialities.
    - Analysis of preferred appointment type by protected characteristics and health inclusion groups.

- Literature review of evidence around health inequalities and approaches used within Elective Care to inform future priority areas.

Evidence Based Interventions

Evidence Based Interventions (EBI) policies outline the access criteria that must be met before certain procedures and treatments can be carried out. They aim to:

- Free up valuable resources such as time, so that more effective interventions can be carried out.
- Reduce harm or the risk of harm to patients.
- Help clinicians maintain professional practice.
- Create headroom for innovation.
- Maximise value and avoid waste.

Throughout 2023/24 NHS Dorset completed a review of the policies in place to ensure they were up to date with the latest guidance.

- NHS Dorset has aligned policies with 57 national policies developed by NHS England and the Academy of Royal Medical Colleges. These policies cover interventions which should not be undertaken under any usual circumstance (category 1 interventions), and interventions to only be undertaken when certain clinical criteria have been met (category 2 interventions).
- Trusts have reviewed any patient currently awaiting a category 1 procedure to confirm clinical exceptionality.
- A review of a further 26 policies held locally has commenced.

Offering alternative choice for long-waiting patients

Dorset delivered a national alternative choice ask to offer all patients waiting over 40 weeks, on both admitted and non-admitted pathways, the opportunity to explore the option of an alternative provider. NHS Dorset and local providers worked hard to set up a process successfully and at pace.

The NHS in Dorset processed 205 requests for alternative choice, finding potential alternatives for 47 patients.

Advice and Guidance

Advice and guidance is the ability for GPs to seek advice on treatments or pathways without making a referral. Effective use of specialist advice and guidance reduces inappropriate referrals and appointments, releasing resource for those in most need. It also can ensure patients are referred to the right place first time. NHS acute hospital trusts in Dorset now have advice and guidance available in almost all specialties for consultant-led care. Additionally, University Hospitals Dorset, Dorset County Hospital and Dorset HealthCare offer advice and guidance to good effect in multiple non-consultant-led specialties.

More than 55% of requests for specialist advice this year were successful in diverting a referral. This meant that patients were treated by their GP using the specialist advice given or were referred to a more appropriate pathway such as for diagnostic testing.

Getting it Right First Time (GIRFT)

Getting It Right First Time is a clinically led national programme which aims to enhance productivity and drive improvements in patient experience and outcomes.

NHS Dorset and local provider trusts have engaged with the programme to drive improvements in specific medical specialties, including Cancer, Ear, Nose and Throat (ENT), Gynaecology, Urology, General Surgery, Trauma and Orthopaedics and Ophthalmology. Improvements to the theatre and outpatient departments will support this.

Through this work some key achievements have been made, such as increases in the number of high-volume cataract lists to meet the GIRFT benchmarks set, which enable more people to be seen faster whilst maintaining a safe care environment.

Commissioning for choice and improvements

The elective care team at NHS Dorset is responsible for the commissioning of elective services. This includes needs assessments, review of current provisions and development of service specifications to guide delivery and ensure the aims of the service are achieved. One example is the development and set up of a new Dorset-based sleep service at Dorset County Hospital. This service will work across the county, improving access for Dorset patients to sleep therapies including Continuous Positive Airway Pressure (CPAP) devices.

Outpatient assessment centre/ diagnostic testing

The Dorset Community Diagnostic Centre (CDC) Programme is responsible for rolling out additional diagnostic capacity across Dorset in line with the Richards Review and Dorset's strategy for delivery.

The CDC Steering Group sets the overall direction of the work programme, and the working groups monitor progress on a regular basis to ensure both successful planning and execution of the implementation plans as well as performance against the submitted profiling for activity.

Despite key challenges in recruitment, procurement and availability of equipment and contractors' ability to deliver within set timelines, progress has been made in many areas including:

- Ultrasound, Dexa scanning and phlebotomy services started in the Dorset Health Village situated in Beales, Poole.
- Colposcopy services, additional endoscopy capacity (including cytosponge and trans-nasal endoscopy) and extended CT scanner capacity with two machines now in place at Poole Hospital and being operated weekends and evenings.
- Endoscopy contractors secured for modular build at Poole hospital, progressing Royal Institute of British Architects stages of design. Preparation of the site has started.
- The refurbishment of the @healthvillage at South Walks House, Dorchester includes additional diagnostics and outpatients. The diagnostics has been completed and the facility opened.
- Additional Ultrasound, X-ray and audiology capacity has been established at Weymouth Hospital.
- Additional MRI services have been delivered through AECC University College in Bournemouth and with a mobile unit placed in Portland for six months, there has been a reduction in waiting times.

Dorset Cancer Partnership

The Dorset Cancer Partnership has worked closely with the Wessex Cancer Alliance to deliver the cancer requirements of the Operational Planning guidance. NHS Dorset achieved the Faster Diagnosis Standard in March 2024 with 75.9%, 0.9% above the standard. The proportion of cancers diagnosed at early stage has remained fairly consistent at 56-58%. Alongside the specific actions below, work has progressed to maintain partnership working across the Integrated Care System and with Wessex Cancer Alliance, with a focus on supporting Primary Care with implementation of the GP contract for early diagnosis of cancer, a focus on earlier diagnosis, community engagement and reducing health

inequalities, work with acute trust partners to improve referral pathways and productivity, and increasing usage of risk stratified follow up and personalised care and support planning for patients with a cancer diagnosis.

Progress against each of the requirements specified in the Operational Planning guidance is as follows:

Lower Gastrointestinal Plan
Implement and maintain priority pathway changes for lower gastrointestinal (GI), so at least 80% of Faster Diagnosis Standard (FDS) lower GI referrals are accompanied by a Faecal Immunochemical Test (FIT result). Implement a 'safety netting' pathway for individuals with a FIT result of less than 10. Reduce variation in FIT completion rates in coastal communities.

Outcome
Dorset implemented a 'FIT<10 safety netting pathway' in January 2023; this led to an appropriate reduction in Lower GI suspected cancer referrals of 26% compared with the previous year. This was decommissioned in January 2024 to reflect the change in the NICE guidance and implementation of 'C the Signs' to enable primary care safety netting. The proportion of patients with a FIT result accompanying their referral rose from 28% in quarter 1 to 64.4% in January 2024. This is below target however is a significant improvement. Colonoscopies performed without a FIT result reduced to 17% against a target for the year of less than 20%. Lower GI FDS had improved from a low of 27% in 2022 to 59% in February 2024. In May 2024 the Lower GI suspected cancer referral form was updated to make provision of a FIT result mandatory for patients referred due to having either a positive or negative FIT result and to tighten the criteria for patients being referred due to not being able to complete a FIT. The impact on referrals is being monitored.

Dorset has been supporting Primary Care to implement use of FIT in the following ways:

- Regularly shared Primary Care Network (PCN) level benchmarking data regarding the proportion of FIT results with referrals, met with PCNs to discuss this dataset and resolve queries arising.
- Delivered a Primary Care Cancer Conference with 90 attendees including a talk on Lower GI and FIT from a Consultant Gastroenterologist.
- Resolved FIT coding issues in secondary care that were impacting on the primary care recording and safety netting processes and developed a Dorset FIT dashboard.
- Commissioned 'C the Signs' as an 18-month pilot from August 2023 to support earlier detection of cancer and to enable primary care to safety net patients given a FIT test; practices were incentivised to use C the Signs and all signed up. Supported uptake with regular training and drop-in sessions. Uptake is high and evaluation has begun.
- Delivered a CORE20plus5 project funded by NHS England Inequalities in Health Innovation Programme, Wessex Cancer Alliance and NHS Dorset focused on improving FIT completion rates in coastal communities. This has included a population survey generating 900 responses, four focus groups with people that have barriers to access including people with learning disabilities, homeless people and builders; and meetings with fishermen and farmers, to understand confidence, knowledge and barriers to completing GP-issued FIT tests. A bowel symptoms and FIT awareness campaign ran during bowel cancer awareness month in April. Wessex Cancer Alliance ran this on our behalf and is currently evaluating the impact.

Prostate Plan
Implement and maintain priority pathway changes for prostate cancer (best practice timed pathway - BPTP).

Outcome
Wessex Cancer Alliance completed a deep dive into prostate pathways at Dorset County Hospital, University Hospitals Dorset and Hampshire provider trusts. A subsequent action plan for the implementation of BPTP has been developed and will be implemented in 2024/25. During 2023/24, the prostate referral criteria were revised to align with the updated NICE guidance which led to an appropriate reduction in urgent suspected cancer referrals. Both trusts have transitioned from general-

to local-anaesthetic template biopsies, releasing theatre and workforce capacity and supporting Faster Diagnosis Standard performance. Urology Faster Diagnosis Standard performance has improved from a low of 44% in April 2023 to 78% in February 2024.

Skin Plan
To implement and maintain priority pathway changes for skin (teledermatology).

Outcome
Skin Faster Diagnosis Standard was at 89% in February 2024, recovered from a low of 52% in July 2023. However, this recovery is due to outsourcing. Dorset has been accepted onto a Skin Analytics pilot part funded by NHS England via SBRI Healthcare. This is post-referral machine learning triage for suspected skin cancer patients. The service will go live at the end of March 2024 and is expected to enable the dermatology services at both local trusts to significantly reduce demand on consultant capacity for suspected skin cancer patients and phase out the requirement for outsourcing. The teledermatology will be carried out in the Community Diagnostic Centres.

A pre-referral teledermatology pathway has also been developed during 2023/24 with two GP practices and this is due to start in April 2024 for 12 months. This is to test whether patients can be appropriately directed prior to GP appointment to a Community Teledermatology Clinic with the aim to enable the patient to be referred to the right service first time.

Cancer diagnostic capacity plan
Increase and prioritise diagnostic and treatment capacity, including ensuring that new diagnostic capacity is prioritised for urgent suspected cancer, particularly via community diagnostic centres (CDCs).

Outcome
The cancer plan was incorporated into the Dorset diagnostic plan including via the community diagnostic centres (CDCs). Additional CDC diagnostic activity was carried out including ultrasound scanning for urgent suspected cancers and GP Direct Access gynaecology patients, CT scanning for Targeted Lung Health Check patients, dermoscopy activity, and mammography for patients undergoing surveillance due to breast family history elevated risk. GP Direct Access implementation is underway, and this will use CT and MRI capacity in the CDCs during 2024/25.

Early Diagnosis – Targeted Lung Health Checks Plan
Expand the Targeted Lung Health Checks (TLHC) programme and ensure sufficient diagnostic and treatment service capacity to meet this new demand.

Outcome
The Dorset TLHC programme trajectory invites all 55-74 year old current and ex-smokers in Dorset for a lung health check over the next four years. The programme expanded in 2023/24 from Weymouth to North Bournemouth however did not achieve planned activity trajectory due to delays with IT configuration followed by IT issues after going live that required resolution. Implementation of the new TLHC-funded CT scanner at Weymouth Community Hospital was also delayed. IT issues were resolved and the service is now getting back on track and carrying out recruitment to expand the service for 2024/25.

In 2023/24, 1,372 Lung Health Checks were carried out in Portland and Kinson (North Bournemouth) areas – these are the most deprived areas in Dorset for people aged 55-74 and have a relatively high proportion of current and ex-smokers smokers. Nine early-stage lung cancers were subsequently diagnosed, plus 8 other cancers.

Wessex Cancer Alliance is leading on discussions with NHS England South East Specialised Commissioning to ensure that University Hospital Southampton has enough surgical capacity for these patients as around 80% are expected to be early stage requiring surgery at University Hospital Southampton as the tertiary centre.

Non-specific symptoms plan
To provide 100% population coverage by March 2024 for non-specific symptoms (NSS) pathways.

Outcome
The Wessex NSS/Rapid Investigation Service (RIS) has been live throughout the year with 100% coverage for Dorset. This pathway is configured within the 'C the Signs' decision support tool to ensure primary care referrers consider this pathway. The RIS service has noticed the improvement in referral quality for those using 'C the Signs'. Around 400 referrals from Dorset were made to the service in 2023/24 and around 20 cancers were diagnosed.

Surveillance services for liver – plan
1. Establish whether local providers are consistently inviting patients with cirrhosis/advanced fibrosis to 6-monthly ultrasounds surveillance.
2. Support providers to establish systems and processes to invite those eligible for liver surveillance where these do not exist.
3. Work with the relevant ICB(s) and the local community diagnostic centres programme(s) to ensure sufficient ultrasound capacity is commissioned to provide 6-monthly liver surveillance to people with cirrhosis/advanced fibrosis.
4. Support local systems to offer peer support and/or pathway navigators to improve attendance at 6-monthly ultrasound surveillance for patients with cirrhosis/advanced fibrosis.

Outcome
An action plan is in place. The plan is delayed and has been on NHS Dorset's risk register this year. Both local acute trusts have been inviting patients for surveillance, but this has been difficult to quantify due to challenges related to IT system as this is a relatively small group of patients with specific requirements. Somerset Cancer Register is developing an Active Surveillance module to enable these patients to be managed which could be available in quarter 4 of 2024/25. Ultrasound scan liver surveillance capacity was not included in the community diagnostic centres plan for 2024/25 and there are trust capacity concerns for provision of Ultrasound scan liver surveillance. Wessex Cancer Alliance has funded support for trusts to identify eligible patients and ensure they are being invited.

Bowel Cancer Screening plan
Work with regional public health commissioners to increase colonoscopy capacity to accommodate both the extension of the NHS bowel cancer screening programme to 54 year olds and the inclusion of Lynch syndrome patients.

Outcome
The Bowel Cancer Screening Programme has been extended to 54 year olds in Dorset and has included Lynch syndrome patients. The endoscopy build programme will further support capacity as the screening programme is extended to 50 year olds in quarter 1 of 2024/25.

People at high risk of breast cancer plan
Increase capacity within the NHS breast screening programme for patients with BRCA.

Outcome
The NHS Breast Screening Programme has included capacity for patients with BRCA.

Other areas of the Dorset Cancer plan, not specified in the national guidance were as follows:

C the Signs Plan
Pilot the 'C the Signs' decision support tool in primary care to improve the Faster Diagnosis Standard, including right referral first time, and improved quality of referrals, and to improve early diagnosis of cancer.

Outcome
'C the Signs' went live in August 2023 for all Dorset GP practices. All 68 practices have signed the data sharing agreement, and 67 practices are actively using 'C the Signs'. Around 70% of all urgent

suspected cancer referrals were made through ‘C the Signs’ for the month of February 2024, and 3,702 risk assessments have been carried out since launch. The first six months of ‘C the Signs’ has shown a non-significant increase in the proportion of cancers diagnosed following urgent suspected cancer referral and this is expected to continue to increase as the system is embedded into everyday practice. Positive feedback has been received on the higher quality of ‘C the Signs’ referrals to the non-specific symptoms service.

Gynaecology Plan
Implement General Practice Direct Access to ultrasound scanning for women with unscheduled postmenopausal bleeding on systemic Hormone Replacement Therapy.

Outcome
The postmenopausal bleeding GP Direct Access pathway went live at University Hospitals Dorset in November 2023 and led to an appropriate reduction in urgent suspected cancer gynaecology referrals. University Hospitals Dorset gynaecology faster diagnosis standard performance increased from 33% in November 2023 to 76% in February 2024 due to the combined reduction in urgent suspected cancer referrals and the use of outsourcing.

Capsule Sponge Plan
Capsule Sponge was piloted in three GP practices as a case finding tool for Barret’s oesophagus and oesophageal cancer. This is part of a nationally funded SBRI Healthcare pilot. The evaluation is due in May/June 2024/25.

Primary and Community Care Services

General Practice and wider primary care providers play a key role within the health and care system, especially in relation to improving health outcomes and reducing inequalities.

During 2023/2024, NHS Dorset received delegated authority from NHS England for commissioning Community Pharmacy, Optometry and Dental Services. These are familiar NHS providers in our high streets and will now enable us to work closer with our colleagues in these settings and bring together all primary care services to help reduce known inequalities and improve access within our neighbourhoods across Dorset.

Together with General Practice providers, we now have approximately 450 settings across Dorset delivering NHS Primary Medical Services to residents and visitors to our county.

NHS Dorset worked with Primary Care Networks (PCNs) across Dorset to support the healthcare system during periods of industrial action. In January 2024, PCNs created over 2,000 additional appointments across the period of industrial action utilising its skill mix of staff. The additional appointments were offered as 'same day' to help support the population of Dorset in accessing same day care, acknowledging the significant challenges in the acute sector during this period.

We have supported 28 GP Practices across Dorset in accessing the General Practice Improvement Programme (GPIP) led by NHS England. The predecessor to the GPIP, the Accelerate Programme, was not taken up by any GP Practices within Dorset. The Dorset General Practice Alliance has supported NHS Dorset in its promotion of the programme. This is indicative of a more collaborative approach between all parties to achieving the aims of General Practice.

General Practice access continues to be a challenge across the UK. However, we have seen significant strides in General Practices access within Dorset over the last year. In October 2022, routine wait times were significantly impacted by Covid and flu vaccination programmes, increasing the wait times by 4%. Throughout 2023/2024 NHS Dorset has put significant focus and energy to support General Practice access via the Capacity and Access Improvement Plan, and the Primary Care Access Recovery Plan. In the lead up to October 2023 there was a concern that the Covid and flu vaccination programmes would cause another spike in routine wait times, however, due to the hard work and focus in this area, October 2023 did not lead to any increase in routine wait times. This demonstrates a more stable and

resilient General Practice whilst representing a stronger foundation to continue further access improvement work moving forwards.

NHS Premises Improvement Grant Funding was invested in nine GP Practices to increase or reconfigure their practice space. This has enabled additional access to healthcare professionals across eight PCNs in Dorset.

NHS Dorset arranged and funded professional Reinforced Autoclaved Aerated Concrete (RAAC) surveys to be undertaken at GP Practice sites based on the construction dates of the premises. No concerns regarding RAAC in GP Practices within Dorset were identified.

The RCGP (Royal College of General Practitioners) Veteran Friendly GP Practice Accreditation programme aims to support primary care providers in understanding and addressing the health needs of veterans. This includes addressing hidden health inequalities and promoting veterans' engagement with primary care services. The programme involves appointing a clinical focal point for veteran health matters and providing information and eLearning to use NHS referral pathways efficiently. Dorset has a high number of veteran patients, which is why 70% of GP Practices in the area are now accredited. All PCNs have at least one accredited GP Practice. The goal is to accredit all Practices in the next year.

Through the Additional Roles Reimbursement Scheme introduced in England in 2019, PCNs can recruit to, and claim reimbursement for the salaries of, roles introduced into general practice to expand the multidisciplinary team. By February 2024 the whole time equivalent (WTE) figure for these roles was 430 across Dorset.

Implementation of the Primary Care Access Recovery Plan saw significant investment into moving towards a modern model of general practice, aiming to improve patient choice (type of appointments and range of health and care professionals) and the patient journey (experience) through general practice. The General Practice Improvement Program supported practices and Primary Care Networks in utilising their digital systems to better understand their demand and capacity. The triangulation of this learning with patient survey results, Patient Participation Group (PPG) engagement, Friends and Family Test has allowed for the delivery of services that meet the needs of the local population. Dorset General Practices offer patient choice for accessing general practice via walk-ins, telephone and online consultation. Patients are also empowered to consider the type of appointment they would prefer, considering face to face appointments, telephone appointments and virtual appointments. Primary Care Networks, via the Network contract Capacity and Access plans and the Enhanced Access plans, are bringing practice resources together, to offer at scale services to their patient populations. The types of services have been selected in line with the wants and needs of the patient population. The patient participation groups, along with our third sector colleagues have been instrumental in understanding how Primary Care Networks can meet the needs of the local population.

Primary Care Services to Asylum and Refugee Community

During 2023/2024, NHS Dorset has ensured enhanced primary care provision to those who are seeking asylum in the UK or have been placed in Dorset as part of the national resettlement programmes. General Practice services have been provided within the temporary accommodation facilities and to those who have moved into their own homes in Dorset. Enhanced health checks are provided as well as ensuring vaccination and screening programmes are offered appropriately. Access to General Practice is a fundamental part of NHS services to individuals and families in these communities.

Better Care Fund

The Better Care Fund supports joining up health and social care and provides us with opportunities to improve health and wellbeing, improve quality of care, as well as enhancing efficiency and productivity. During this reporting period we have continued with current plans across both the Dorset and Bournemouth, Christchurch and Poole Councils. We have continued to further develop the model of intermediate care services to strengthen and expand services to support people to return to independence, ideally in their own homes.

Our new model of integrated community services is developing with recognition of how children and young people may also be included.

The re-procurement of the integrated community equipment service is now in place with an expanded offer to the local population.

Diabetes

NHS Dorset has continued to support the Integrated Care System with improving outcomes for people diagnosed with diabetes and supporting the drive to preventing people developing type 2 diabetes.

Some of the highlights from this year include:

- Development of a Dorset Diabetes dashboard as part of the Dorset Intelligence and Insights Service (DiiS) dataset, that can be used by system partners and clinicians to monitor progress and outcomes. In February 2024 we launched further insight that shows the prevalence of pre-diabetes in Dorset. This data will enable services to tackle health inequalities and improve outcomes for people at risk of developing Type 2 diabetes.
- A series of educational webinars have been offered to all Health Care Professionals support the delivery of care for people with diabetes. This has supported more integrated working across primary, community and secondary care, and will ensure more consistent outcomes for people living with diabetes.
- Collaboration between Paediatric and Young Persons Diabetes Services (YPDS) in Dorset has led to positive outcomes. Dorset has seen increased patient engagement, with multi-disciplinary team appointment attendance rising from 71% in 2022 to 77% in 2023, by offering a choice of in-person and virtual clinics. Technological uptake has increased, with 93% of Type 1 patients using sensors in 2023 compared to 85% in 2022.
- The Diabetes Inpatient Care Group has developed a system-wide Hypoglycaemia Pathway, working together with the South Western Ambulance Service to identify high-risk patients and ensuring access to specialist care. This will improve outcomes for people who experience hypoglycaemia and should prevent repeat ambulance callouts in the future.
- We have worked with our providers under the remit of the National Institute for Health and Care Excellence (NICE) guidance to implement Continuous Glucose Monitoring (CGM) devices for designated high-risk cohorts of the diabetes population in Dorset. We plan to continue to explore and consider medical technologies over the coming year.
- We have supported the implementation of the NHS Type 2 Diabetes Path to Remission Programme in Dorset. The programme is based on research showing that a three month specially formulated ‘soup and shake’ diet followed by healthy lifestyle support helped people living with type 2 diabetes and obesity to lose weight, improve their blood sugar levels, reduce diabetes-related medication and can put some participants with type 2 diabetes into remission. Eligible residents in Dorset will be able to access this offer from 1 April 2024.
- A new Diabetes website has been developed for people living in Dorset. This will provide a ‘one stop shop’ to better inform people living with, or at risk of developing, diabetes of local services and support available to them in Dorset. This is due to be launched by Summer 2024.

Portland Project

Following a public meeting between residents and representatives of the Dorset Integrated Care System, work has been underway on understanding the challenges and needs of the residents of Portland, by way of data analysis, community conversations and stakeholder input. A further community event is planned in early 2024/25 to feedback the priorities identified and work towards improving services for local people. See more at [Portland Together – Our Dorset]

Immediacare

Over the last year we have tested a new approach to supporting care homes and their residents more effectively. We have introduced a system called Immedicare whereby care homes who are concerned about a resident can make a videocall to experienced nurses 24 hours per day, 7 days per week. The videocall allows the nurses to see and speak to the resident and diagnose and treat any issues.

This service has been provided to 77 care homes in Dorset and manages 450 urgent requests for help each month. The nurses guide and support care homes to give whatever treatment is required, such as dressing a wound or lifting someone who has fallen. The nurses can prescribe medicines or arrange for an ambulance or GP visit if needed. They also have direct access to hospital consultants for specialist advice. This approach minimises delays in treatment and avoidable trips to hospital. It ensures some of our most vulnerable residents can get expert care around-the-clock in the familiar surroundings of their home.

Virtual Wards

Virtual wards support people, who would otherwise be in a hospital, to receive the care, monitoring and treatment they need in their own home. Over the past year Dorset has been developing virtual ward capacity. We are able to care and treat people who are unwell with cardiology and respiratory issues, as well as older people, people needing intravenous antibiotics and children. Our children's virtual ward is nationally recognised and is very popular with parents with other young children at home. In Dorset we can look after 205 people on a virtual ward supported with remote monitoring. We aim to increase this to 360 people in the next 6 months. People on a virtual ward have positive things to say about the care they have received at home. At University Hospital Dorset, virtual wards have supported the early discharge of 487 people saving 3,037 hospital bed days (data to December 2023).

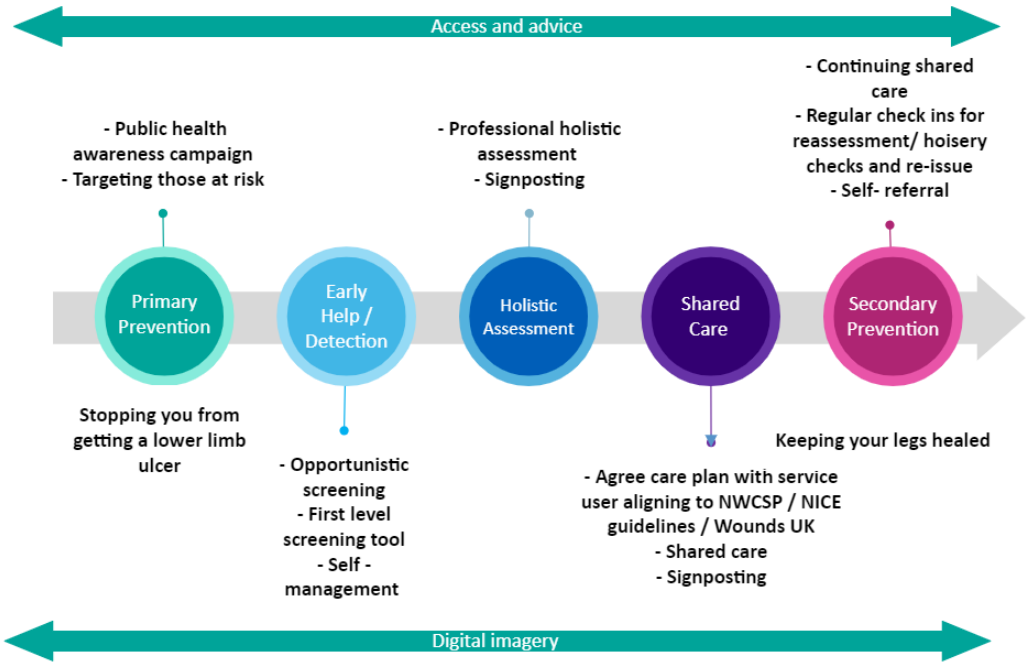
Lower Limb Wound Care

Lower limb ulceration can be physically debilitating and have a profound impact on someone's life, feeling forced to give up work, lose contact with friends and family often due to isolation and perceived stigma. Treatment can be time consuming and uncomfortable with people often needing to be seen 2-3 times a week for up to an hour each time, impacting both on nursing time as well as the individual. Most people can be healed within 3 months with the right care and lifestyle changes.

There has been an increase in the number of people needing treatment, often with more than one wound and both legs or feet affected. Further impacted by a reduced workforce due to staff sickness, retirements and recruitment issues, people are taking longer to heal and are therefore more at risk of further complications.

This led us to review services and talk to people with leg and foot ulcers and their carers by visiting GP practices, community clinics, care homes, hospital outpatient clinics and people in their homes. They told us what matters to them, and clinicians gave their views on what needed to change to improve outcomes for people. We also met with related groups such as the Lymphoedema Support Group and the Dorset Race Equality Council.

As a result of these conversations we worked with clinicians to design improved services in line with best practice.



The new model provides more focus on:

- primary prevention – stopping ulcers in the first place.
- early detection and self-care.
- secondary prevention - keeping legs and feet healthy.

The lower limb health team includes services such as podiatry, lymphoedema, diabetes and is reshaping care delivery across the county. Led by The Adam Practice in Poole and Royal Manor Healthcare on Portland, these teams are working closely together to offer timely and comprehensive care, removing the need for referrals and enabling people receive the help they require seamlessly.

To ensure everyone achieves the best outcomes regardless of their age, ability or where they live, we are developing Dorset-wide tools to assist individuals, carers and families as well as all healthcare staff to have the consistent knowledge and capability to provide each level of care. These include:

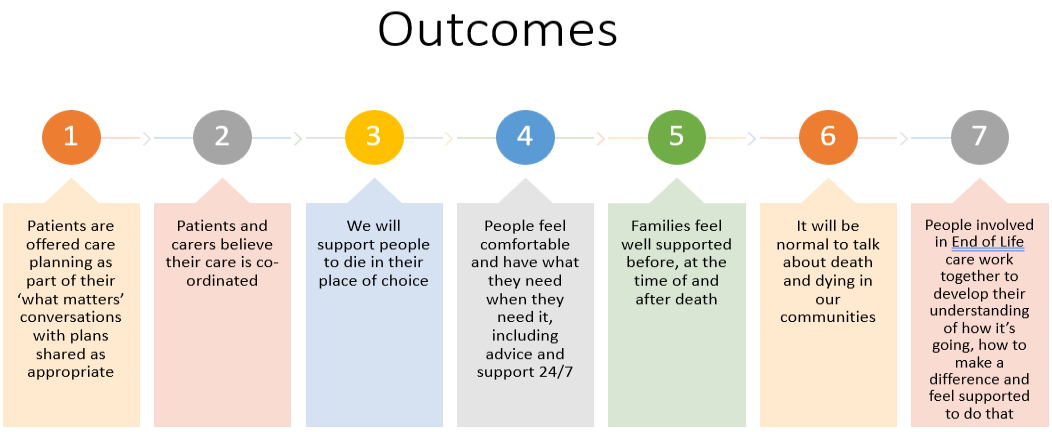
- a screening tool to help everyone to get to know their legs and feet, how to help themselves and when to seek professional advice.
- a full assessment all healthcare professionals will use so there is a consistent approach.
- staff skills and ability standards required to provide each level of care.

Our plan is to continue working with people and healthcare professionals to establish the new model and look at areas that will support such as taking pictures, access to information for people so they know what to look for and continually making sure our medicines, dressings and compression socks list is kept updated.

Palliative End of Life Care

NHS Dorset has published and launched an All Age Strategy for Palliative and End of Life Care with agreed priorities for adults, children and young people recognising the area of transition for young people. Prioritisation and timescales are being developed for delivery. The strategy was supported and compiled by a partnership of health care providers and hospices across Dorset with input from a wide range of stakeholders including the public and voluntary and community sector.

A partner-led workshop has been held focusing on transition with stories from loved ones and from young people directly. This was followed by a system-wide workshop for adult services with agreement on outcomes and the universal model of care for Dorset.



Urgent and Emergency Care Programme

Our Urgent and Emergency Care Programme is responsible for setting the strategy and improvement plans that support the delivery of a high quality, safe and effective unplanned care pathway. There is a strong partnership in place between all health and care organisational with a collective focus on:

- Improving access to care and support in people's own homes or community settings that reduce the need for hospital attendance.
- Getting ambulances to people more quickly when they are needed.
- Treating people more quickly when they do have to go to hospital.
- Supporting people to return home safely and without delay once they no longer require acute hospital care.

Achieving this for all Dorset residents has continued to be challenging in 2023/24 due to the sustained high levels of demand for urgent care services and the disruption linked to multiple periods of industrial action.

Our focus continues to be on how we can improve the consistency of our response and to reduce delays across every step of the urgent care pathway which will ensure people can access the treatment and care they need, when they need it.

Over the last 12 months we have made progress in the following areas:

- Introduction of a pan-Dorset Discharge to Assess pathway that has enabled more people to continue their recovery in a community setting. This has reduced the volume and length of delays in an acute setting. This has been enabled by investment in both homecare and bedded care, and in additional discharge co-ordinator and trusted assessor roles that are intended to reduce hospital discharge delays.
- Establishment of a seven-day System Co-ordination Centre to strengthen our system resilience response and management of system operational risks.
- Sustained delivery of the Category 2 ambulance response times target (40 minutes) and 111 call response remains consistently good and the best in country.
- Strong emerging partnerships with voluntary and community sector partners supporting both admission prevention and supported discharge. This includes the launch of the High Intensity Users service in the East of the county and enhanced on-site support at both acute trusts to

improve connection with voluntary and community services than can enable people to return and/or remain at home safely.

- Good partnership working with local authority colleagues to tackle system flow issues with progress made in increasing reablement capacity and long-term market sustainability. This was in addition to targeted work in emergency departments to support front-door turnaround.
- Expansion of Same Day Emergency Care services in hospital and step-down virtual wards to provide safe and effective alternatives to hospital admission and support people to move forward more quickly.
- Worked with Healthwatch Dorset to get further insight from the people who use our urgent care services about how well the different services are understood and how easy they are to access. The results are being used to help shape our programme delivery for 2024/25.

Our work in 2023/24 has laid the foundations for our 2024/25 delivery programme which will focus on:

- How we can build better connections between our urgent and emergency care services to support more people to remain safe and cared for at home and reduce the need for people to attend hospital unless it is clinically necessary.
- How we can reduce delays for people leaving hospital by working with health and care partners to starting planning for discharge earlier and working with service users and their families to better understand and enable their recovery goals.

Maternity

Our Dorset local Maternity and Neonatal System (LMNS) is committed to assuring safe and high-quality services for the women, birthing people and families of Dorset. Our core functions include the statutory delivery of the national Perinatal Quality Surveillance Model (2020) and the implementation of the Maternity Transformation Programme. In April 2023 NHSE launched the Three Year Delivery Plan for Maternity and Neonatal Services which brings together Better Births (2016), the NHS Long term Plan (2019), the Neonatal Critical Care Review (NCCR, 2019) and recommendations following the Independent Reviews at Shrewsbury and Telford and East Kent (Kirkup, 2022; Ockenden, 2022).

To ensure we can meet the ambitious aims within these documents our LMNS has gone through its own phase of transformation this year including:

- a review of LMNS governance processes to ensure it is fully integrated within the ICB and Trust governance frameworks and is assured by the appropriate sources of intelligence internally and externally to the system.
- an ongoing workforce review as part of ‘fit for the future’ to ensure we have the right skills, expertise and capacity within the LMNS.
- an essential review of our Maternity and Neonatal Voices Partnership (MNVP) model to meet the national MNVP Guidance, 2023 to ensure we are able to put the voices of women and birthing people at the heart of all we do.
- a shared understanding with system partners of aspirations, expectations and requirements to ensure we work collaboratively to meet the needs of the population of Dorset and we are able to meet and exceed the required national ambitions.

The changes we have made to date have been positively recognised within NHS Dorset, the Dorset Integrated Care System and by our NHS England (NHSE) regional maternity and neonatal colleagues. The changes provide the foundation required in the LMNS to support the transformation in maternity and neonatal services in Dorset following a challenging year of CQC inspections.

Care Quality Commission (CQC) Inspections

In March 2023 the CQC published their inspection of maternity services at University Hospitals Dorset (UHD). The services were rated as inadequate overall with ratings for both safe and well-led going down. A Section 29A was issued requiring them to make significant improvements to the processes for staff to summon help in an emergency. As a result of the CQC rating the Trust is formally entered onto the NHSE Maternity Safety Support Programme (MSSP) and in September the Trust received their diagnostic report including the improvement plan and exit criteria from the programme. NHS Dorset meets regularly with the MSSP lead and the Regional Chief Midwife and oversees progress with the maternity improvement plan through the LMNS Board.

In November 2023 the CQC published their inspection report of maternity services at Dorset County Hospital (DCH). The service was rated as requires improvement overall with ratings of requires improvement for safety and inadequate for well-led. A Section 29A was issued regarding governance processes and audit in maternity. The Trust commissioned a Maternity Improvement Advisor (MIA) prior to the report being published, who is following MSSP methodology. The diagnostic report was completed in November. As they are not formally entered onto the NHSE MSSP a rapid quality review had been organised by NHS Dorset in March as per the national guidance on Quality Risk Response and Escalation in ICS (NQB, 2022) to discuss progress and the next steps. NHS Dorset meets regularly with the MIA and the Chief Nursing Officer at DCH and progress is monitored through the LMNS Board.

Safer Maternity Care

In 2015 the Health Secretary announced a new national ambition to halve the 2010 rates of stillbirths, neonatal and maternal deaths and brain injuries that occur soon or after birth by 2030 with an expected 20% reduction by 2020. In 2017, the government brought forward the ambition to 2025 and included a reduction in the preterm birth rate from 8% to 6% by the same year. Key to achieving this ambition is the implementation of Saving Babies Lives, of which the third version was published this year. Below summarises our progress to date:

- Maternal deaths are thankfully rare, the last case in Dorset was in 2018. Data from the Maternity Newborn Safety Investigations show referrals for maternal deaths in Dorset are below the national average: 2% compared to 8%.
- There is a time lag for national data analysis on stillbirths and neonatal deaths. 2021 national data shows the annual stillbirth rate in Dorset has remained largely static since 2017 at approximately 3.48 per 1,000 in 2021 and within 5% of the national average (MBRRACE- UK, 2021). Crude local data for 2023 suggests Dorset's current stillbirth rate is now 2.5 per 1000 which meets the national 2025 ambition; this data needs to be validated nationally.
- National data for the neonatal mortality rate in Dorset shows a steady decline from 1.8 per 1,000 in 2017 to 1.4 per 1,000 in 2021; and was 5-15% below the national average (MBRRACE-UK, 2021). Crude local data for 2023 suggests Dorset's neonatal death rate is now 0.6 per 1000; below the national ambition of 1 per 1,000 live births in 2025.
- It is nationally recognised that the data set and definitions for serious brain injury makes monitoring this progress challenging. We have data for one type of brain injury (hypoxic ischaemic encephalopathy (HIE)) from the regional neonatal operational delivery network (ODN) dashboard. In 2023 there were 6 cases of HIE in Dorset which gives a rate of 1.17 per 1,000 live births and comparable to the region. The distribution of these cases was slightly disproportionately higher at DCH accounting for half of the cases (it is important to note that as the numbers are small and there should be caution in interpreting any conclusions from this).
- In 2023 6% of babies were born prematurely at UHD and 4.9% at DCH.
- NHS Dorset undertakes quarterly reviews of the Trusts' implementation of Saving Babies Lives. Quarter 3 reviews showed DCH is now 64% fully compliant and UHD is 70%. Work continues to support 100% compliance.

The Thirlwall Inquiry

The Thirlwall inquiry is a public inquiry into the events at the Countess of Chester Hospital and their implications following the trial, and subsequent convictions, of former neonatal nurse Lucy Letby of murder and attempted murder of babies at the hospital. Dorset LMNS has strengthened its inclusion of senior neonatal membership and neonatal oversight within its governance framework and will provide the foundation for learning from the inquiry:

- We developed strong collaborative relationships with our regional neonatal ODN so that we have the expertise to be assured of the quality and safety of local services.
- We are proud to be supported by two neonatal clinical leads in the LMNS.
- We have been working closely with both Trusts to strengthen local governance processes and oversight and consider how neonatal aligns with maternity in organisational structures to be effective.

The Maternity Transformation Programme

Dorset LMNS have made some significant achievements to reduce inequalities and inequity in Dorset families:

- Dorset LMNS published their five-year equity and equality plan in May 2023.
- A new continuity of carer team launched in UHD and there are plans for two further teams across Dorset in 2024, aligned with the CORE20PLUS5.
- A pathway has been agreed with Somerset local authority to offer tobacco dependence treatment to approximately 30 women who live in Dorset but have maternity care in Somerset after a gap was recognised between the services.
- An interim placenta accreta (serious condition where the placenta grows too deeply into the uterine wall) pathway has been agreed with South East and South West specialist commissioning.

Dorset was a successful early adopter of specialist perinatal pelvic health services. In April 2024 this becomes business as usual, but concerns continue to be raised to NHS England that the funding model is insufficient to meet the service specification.

Dorset LMNS and Public Health Dorset have collaboratively developed an infant feeding strategy. Achieving UNICEF baby friendly initiative (BFI) accreditation is a key deliverable towards supporting pillar 2 in the Joint Five Year Forward Plan. DCH maternity has achieved stage one with positive feedback from the external assessor and it is hoped UHD maternity and both neonatal services can begin their journey in 2024 subject to financial support.

Nationally there are recruitment and retention concerns across the midwifery, obstetric and neonatal workforce. UHD midwifery vacancy rate has decreased from 20% to being fully appointed and the same is occurring for their maternity support workers. Obstetric workforce is a recognised risk across Dorset with high vacancy rates at UHD and ongoing challenges to fund and recruit to a safe and effective establishment at DCH.

Whilst we have had many successful areas of improvement, some areas remain challenged. Our maternal mental health service has been unable to meet the nationally recommended target and work continues to address this. Governance and oversight are only effective with high quality data and despite this being an area of focus in both CQC reports and part of the national perinatal quality surveillance model, we have been unable to develop and implement a systems dashboard. This is now being escalated to systems leaders as an area of priority.

Service User Voices

We are proud to have the voices of service users represented by the Maternity and Neonatal Voices Partnerships (MNVP) and their 2023 survey demonstrated a positive improvement in feedback. In addition:

- 14 out of 49 UHD CQC survey responses showed a statistically significant increase compared to 2022 with no results that decreased. Only two areas were 'somewhat worse than expected' in comparison to other Trusts: antenatal information on infant feeding and doctors being aware of medical history during pregnancy.
- DCH CQC survey continues to show a positive response with their overall positive score being 4th of all organisations who take part. A third of responses were significantly better than other organisations. An area identified as having declined since 2022 is the provision of partners being able to stay post birth however this is still significantly above the average score for the survey nationally.

The voices of women, birthing people and families identified LMNS priorities for 2024 which include personalised care, infant feeding support, postnatal care and mental health access.

Awards and recognition

- The Director of Midwifery at UHD received the prestigious Silver Chief Midwifery Officers national award at the Southwest Regional Perinatal Conference and Awards.
- A maternity support worker at DCH received the prestigious Maternity Support Worker Excellence Award for her vital role in developing and delivering continuity of carer team.
- The LMNS MVP team received the runner up award for service user engagement at the South West Regional Maternity and Perinatal awards.
- The UHD maternity research team received media recognition as they recruited their 1,000th infant to a feasibility study regarding early diagnosis of spinal muscular atrophy.
- The UHD International Midwife Recruitment lead won the 'trailblazer leadership award'. She was nominated by the international midwives she had been supporting.

Vaccinations

COVID-19 Spring/Summer 2023 Booster Campaign

The Spring/Summer campaign 2023 was delivered between 3 April and 30 June and included all adults aged 75 years and over, residents in an Older Adult Care Home (OACH), and people aged 5 years and over with a weakened immune system. During this phase, the evergreen offer to anyone who had not previously received a first or second dose (primary course) of the vaccine was offered to anyone to come forward by 30 June when this offer ended. From May 2023 the offer was extended to at risk babies and infants aged 6-months to 4-years up to 31 January 2024.

The South West region achieved the highest performing region in the country with Dorset ranked 7th of all 42 ICBs nationally for overall uptake across all eligible cohorts. Dorset vaccinated 73.52% of its eligible population through a mixed model of provision comprising Foundation Trusts, Primary Care Networks and Community Pharmacies and ranked 6th in the country.

The OACH programme was extremely successful in Dorset with 100% of eligible care homes visited and a Spring Booster uptake of 90.32%. Dorset surpassed the national and regional average for OACH uptake and ranked 3rd in the country. Housebound delivery was a big success in the Spring/Summer phase and Dorset achieved 81% uptake for this cohort.

COVID-19 Autumn/Winter 2023/24 Campaign

The Autumn/Winter 2023/2024 campaign commenced on 11 September and ended on 31 January 2024. The South West region achieved the highest uptake across all cohorts in the country. Dorset ranked second in the country for delivery to housebound residents and 5th in the country for Care Home delivery.

The numbers eligible for COVID vaccinations in Autumn/Winter is significantly higher than in Spring/Summer and included all adults aged 65 and over, carers, pregnant women, and frontline health and social care staff and anyone with underlying health conditions or who are considered at higher risk of severe illness from COVID-19.

In 2023/2024, Dorset achieved a 67% uptake rate with a similar delivery model to the spring programme, with 32% of vaccinations co-administered with flu. We recognise there is more we can do in future campaigns to encourage uptake for eligible people with learning disabilities and severe mental health and health and care frontline workers.

Seasonal Flu Programme 2023/24

The seasonal flu campaign commenced 1 September 2023 and ran through to 31 March 2024. Eligibility for flu vaccination matched the cohorts for COVID-19 vaccinations as outlined above to increase opportunities for co-administration. As at 3 March 2024, 63% of the eligible population had been vaccinated.

Reducing Health Inequalities

The Dorset System COVID-19 and Flu Vaccination Inequalities workstream has continued to support the mainstream delivery of COVID-19 vaccination during the Spring/Summer and Autumn/Winter 2023/24 campaigns.

Informed by priorities set by a multi-agency task and finish group, 14 projects were funded to enable equitable access to vaccination and to develop a local understanding of how best to maximise uptake in seldom heard and marginalised communities – together with wider health promotion offers ('making every contact count'). The interventions were Dorset-wide and targeted, as follows:

- A roving vaccination team - for housebound residents and those in care homes (10,384 COVID-19 vaccinations delivered).
- 32 pop-up clinics - in areas of high deprivation, for homeless persons, and for unpaid carers; in partnership with voluntary and statutory agencies, which also offered signposting to wider support e.g. wound care, health checks (264 COVID-19 vaccinations delivered).
- Targeted promotional campaigns for ethnic minority asylum seekers and refugees with 79 COVID-19 vaccinations delivered since March 2023.
- A targeted case finding pilot in Purbeck Primary Care Network for unvaccinated persons with chronic obstructive airway disease (8 COVID-19 vaccinations delivered).
- Delivery of COVID-19 vaccinations to children with learning disabilities in their school environment (awaiting final numbers of COVID-19 vaccinations delivered).

Funding has also enabled local communications initiatives including an enhanced campaign for persons with learning disability and/or severe mental illness targeted to GP practices with lower uptake; a 13-week radio advert; the provision of health and wellbeing information stations in large vaccination sites; and a sensory room providing a calming environment at two large vaccination sites.

A full evaluation will inform recommendations for the Spring/Summer 2024 campaign and the Dorset plan to deliver the NHS vaccination strategy.

Medicines Optimisation

Supporting Better Medicines Commissioning

In Dorset, pharmacy leaders are intensifying their joint efforts to devise a strategy aimed at enhancing the health outcomes derived from prescribed medications. The role of NHS Dorset's Chief Pharmacist is collaboratively held by the Chief Pharmacists of Dorset HealthCare and Dorset County Hospital. Together with other leaders in pharmacy and various professions, they are spearheading advancements in medication optimisation, safety, cost-effectiveness, and efficiency. This is achieved through the revised Integrated Medicines Optimisation Committee and the adoption of a unified formulary.

Dedicated groups overseeing formulary governance, value, medication safety, and quality are entrusted with executing strategies to achieve our objectives of improved health outcomes from medicines in Dorset. These groups co-ordinate the medication aspects of our operational plans, aiming to predict and achieve financial efficiencies in medications, foster innovation, adjust to medication pathway changes, alert to medication risks, and assist in resolving issues as they arise.

With the ongoing adoption of a national medicine procurement initiative this year, we have managed to treat an additional 1,200 individuals with oral anticoagulants to lower stroke risk, without extra costs. Despite supply disruptions, improved procurement and prescribing have yielded £1.8 million in efficiencies for 2023/24.

Our efficiency plans for this year will focus on medications that offer the greatest benefits to our communities, which includes the increased use of generic and biosimilar medicines and promoting self-management of minor conditions through digital NHS resources and community pharmacies.

The Dorset formulary undergoes frequent updates through a transparent and stringent decision-making process involving doctors, specialists, pharmacists, and pharmacy technicians. This ensures that NHS Dorset fulfils its mandatory duties to make twenty-one medicines approved by NICE technology appraisals available to commissioned services this year.

Increasing access to medicines through appropriate services

NHS Dorset has stepped up work with community pharmacies to broaden the availability of guidance and treatments for minor ailments and self-managed conditions. This initiative aligns with NHS England guidance on prescribing over-the-counter medicines, taking into account the varying socioeconomic backgrounds of patients. The Community Pharmacist Consultation Service (CPCS) transitioned into a more comprehensive Pharmacy First Service on 30 January 2024. Currently, 96% of pharmacy contractors are participating in the Pharmacy First services, reflecting a national effort to facilitate the Primary Care Access Recovery Plan.

Additionally, Dorset is actively involved in the National Independent Prescribing in Community Pharmacy Pathfinder programme. This programme aims to establish a framework that will inform future national commissioning strategies. In Dorset, there are four registered sites where the commissioned service will focus on the treatment of acute minor illnesses.

Table 02: Community Pharmacist Consultation Service Referrals
Verified data is available up to the end of November 2023.

Total CPCS referrals April-November 2023	111 CPCS referrals April-November 2023	GP CPCS referrals April-November 2023
13,756	11,817	1,939

Improving collaboration for population health

The Medicines team, in partnership with the Population Health and Business Intelligence teams, has conducted an analysis of the differential use of medicines and its impact on various communities. The findings have informed discussions on prescribing quality, highlighting unmet needs and potential hazards, especially in communities experiencing inequalities.

To address disparities in medicine resource availability in Dorset, we have unified our approach to medicines research and developed models for general practice prescribing budgets that are in line with identified needs. This modelling assists Primary Care Networks in strategically investing in medicines to enhance health outcomes for their populations.

We have established improvement plans with general practices, focusing on reducing disparities in cardiovascular health diagnosis and treatment. This includes working with community pharmacies to improve access to hypertension diagnosis and management services.

The Hypertension Case Finding Service is provided by 84% of community pharmacies in Dorset who are registered to provide the service.

Table 03: Blood Pressure Monitoring
Verified data is available up to the end of November 2023.

Number of patients seen April-November 23	Number of patients receiving clinic blood pressure tests April-November 23	Number of patients receiving ambulatory blood pressure monitoring April-November 23
14,894	14,452	543

Greener Medicines

The Medicines team has focused on elimination of medication waste as a key facet of delivering medicines sustainability in primary care.

February 2024 saw the launch of the 'Only Order What You Need' campaign. A patient facing campaign aimed at empowering the Dorset population to have confidence with repeat prescription ordering, and specifically to understand that repeat items do not have to be collected every month. This programme was multi-faceted and encompassed traditional and digital media, radio campaigns, patient messages by GP teams and discussions with Carer and Patient Participation Groups across the county.

After six weeks, repeat prescription ordering had fallen by 2% across Dorset. A change associated with a reduction of £370,000 in waste.

This campaign will be followed by the promotion of digital engagement with the NHS App to reorder medicines, promotion of self-care to make best use of our NHS medicines resources and improved working together in NHS services to support a greener approach to medicines use.

Improving safety

This year we agreed a targeted approach to helping people receiving ten or more repeat prescriptions and those taking medicines likely to cause dependence. This has seen 75% of all 20,000+ reviews completed with people with the greatest need. Access to reviews have most notably increased in areas with higher inequalities in Weymouth and Portland and Poole Central locations.

Reviews have helped continue the decline in opioid prescribing, reducing the risk of accidental overdose. Work progressing with secondary care teams to improve the safety of pain relief issued after visiting hospital will further reduce the risk of harm from these drugs.

Children and Young People

Special Educational Needs and Disabilities (SEND)

The Health and Care Act (2022) transferred all relevant statutory duties from Clinical Commissioning Groups to Integrated Care Boards (ICBs). As part of this ICBs must continue to deliver the commissioner duties set out in Part 3 of the Children and Families Act 2014 and the SEND Code of Practice (2015) statutory guidance. This includes jointly commissioning services with local authorities for children and young people with Special Educational Needs and Disabilities (SEND).

We endeavour to work in partnership across the system, to ensure that services commissioned for SEND meet the statutory requirements, as set out in the Children and Families Act (2014), Code of Practice (2015) and are relevant to the identified health needs of the local area and population to deliver an effective, high quality integrated pathway. We have committed to our statement of intent during the period July 2023 to March 2024 by:

- Supporting local SEND improvement plans and working to implement as agreed in the improvement plans.
- Supporting a joined plan that enables system partners to work openly and honestly with each other so that partnerships are strengthened.
- Working in partnership with Parent Carer Forums, support groups representing young people with SEND, Healthwatch, the voluntary sector and community groups.
- Ensuring there is health care provision as specified in the Education, Health, and Care Plan (EHCP) as part of our commissioning role.

Co-production is at the heart of our work as reflected by our Dorset Partnership Agreement with Dorset Council (DC) and Dorset Parent Carer Council (DPCC). We have also worked with Bournemouth, Christchurch and Poole Council (BCP), Parent Carers Together (PCT) and wider community groups to develop Co-Production Charters for parent carers and children and young people as well as wider resources and workforce development opportunities.

NHS Dorset is working to improve partnerships and collaboration within the BCP SEND partnership following a ministerial direction outlining ongoing concerns regarding the lack of progress in relation to the written statement of action received following the last SEND inspection in 2021. NHS Dorset is committed to building on current partnership working arrangements to improve the experience of children and young people with SEND and their families. Specific effort is focused on challenged areas including neurodiverse presentations which have grown beyond available commissioned capacity. SEND remains a key priority area for the integrated care system with strong engagement across health providers.

Joint Commissioning for SEND

A Joint Commissioning Plan with Bournemouth, Christchurch and Poole Council (BCP) was developed for 2023/24, this will be refined for 2024/25. This is outcome focused and acknowledges the need for us to build on joint commissioning opportunities. The priorities for 2023/24 included Emotional Health and Wellbeing, Speech and Language, and Autism Spectrum Condition, all of which will carry forward into 2024/25.

We have also continued to work with Dorset Council. Their SEND Strategy has six clear priority areas for attention. Each priority has associated supporting actions. These actions, in the first instance, are focused on the first year of delivery. The six strategic priorities are:

1. Early Identification and Support
2. Inclusion
3. SEND Pathway
4. SEND Sufficiency and Provision

5. Transitions and Preparation for Adulthood
6. Managing Money and Resources.

Children and Young People (CYP) Transformation Programme

Our work to deliver on the national CYP Transformation Programme and the ambitions in the Long Term Plan, has been progressed as part of a developing local landscape as an Integrated Care Board and our role as part of the Integrated Care Partnership.

Encompassing a system-based approach, our areas of focus have been to:

- Ensure that we have a clear understanding of the needs and priorities of children and young people in Dorset and develop integrated care approaches that is based upon their voice and involvement.
- Deliver the outcomes within the national bundle of care for children and young people with asthma.
- Reduce variation in access and care for children with diabetes, in particular around access to technology and supporting young people to manage their diabetes as they move into adulthood.
- Development of a whole system approach to healthy weight for children.
- Ensure that the urgent care needs of children and young people are part of local system remodelling and design to access care in the right place.
- Recognise opportunities to support both the physical and mental health needs of children and young people as part of a holistic and integrated model of support.
- Understand where transition for children and young people works well, where there is need for improvement and develop recommended approaches to ensure that the experience is positive for all.

Speech, Language and Communication Needs (SLCN)

The speech, language and communication transformation programme has continued to implement the new whole system speech, language and communication pathway for early years and children and young people in mainstream educational settings. The ongoing additional commissioning investment has resulted in more rapid access to speech and language therapists for families with under 5s when concerns are first identified via the new “Readi Steadi Chat” service. This has ensured parents and carers do not experience lengthy wait times to access specialist advice and supports early identification of need.

The Balanced System for speech and language in Dorset enables parents/carers of children and young people who may be worried about their communication to access the support they need at the right level. The SLCN online resource pathway is now fully operational and offers cohesive support to professionals working with children and young people, ensuring they have access to online resources, training, coaching to best support the CYP they are working with from the earliest point. Following consultation with education and childcare providers, this pathway now also includes ongoing support sessions with the Speech and Language Team offered in evenings to facilitate professionals’ access. There is a continued focus on the new ways of working and pathways on enabling wider teams, settings and staff to be able to support speech, language and communication needs at a universal and targeted level. More specialist resource is then available for those children and young people who need it most.

Children and Young People Safeguarding

We have continued to fulfil our statutory responsibilities providing clinical, professional and strategic leadership in safeguarding, promoting the health needs of children in care and care leavers, and reducing child mortality. Our annual safeguarding report explains how we follow the assurance processes set out in the NHS England Safeguarding Accountability and Assurance Framework.

We have worked in collaboration with our key local partnerships including the Pan-Dorset Safeguarding Children Partnership, the Dorset and Bournemouth, Christchurch and Poole (BCP) Safeguarding Adults Boards, the Community Safety Partnerships in the Dorset and BCP local authority areas, the Corporate Parenting Boards of the Dorset and BCP local authorities, and the Pan-Dorset and Somerset Child Death Overview Panel.

During the year, we launched innovative safeguarding programmes in our Dorset and Bournemouth, Christchurch and Poole (BCP) places. We were instrumental in the design and publication of a new pathway of care that helps nurses, social workers, and midwives coordinate the care they provide to children in care who become young parents. We worked with care-experienced young people to develop a new Health Passport which helps care-leavers to better understand their health history and to understand how to use their health information when accessing healthcare. We helped launch the ICON programme which helps professionals to reduce the risk of infants suffering abusive head trauma by being shaken by parents trying to cope with infant crying.

We have improved our understanding of safeguarding risks through better analysis of information this year. We looked back at previous Safeguarding Adults Reviews undertaken in Dorset and BCP to get a better understanding of themes which linked the experiences of adults who had come to harm. We noted that self-neglect was a theme, and the Safeguarding Adults Boards are now carrying out work to see how partners can better work together to reduce risk for those who self-neglect. We have worked closely with the Dorset Intelligence and Insight Service to develop new data reports which help us and our system partners to understand and analyse the impact of serious violence.

During the year, our safeguarding team has undertaken safeguarding insight visits to NHS, education, and community settings in Dorset and BCP. This has given us the opportunity to talk with frontline staff and better understand their needs and the needs of those they safeguard.

Learning Disability and Autism

All Age Neurodevelopmental Review

The mental health and learning disability team along with other system partners have completed the all-age autism neurodevelopmental review and has continued to make progress towards developing a model of care that will result in service improvements delivered by the system.

We continue to work closely with our system partners to take forward the options which emerged from co-design workshops. In 2023 work has focused on designing and understanding the workforce skills required to support the proposed future model of a care for assessment and diagnosis in Dorset.

We have continued to work with system partners to progress and deliver our plan to improve the care and treatment of people with a learning disability and/or autism. Key highlights include:

Care and Treatment Reviews

We provide oversight and ongoing facilitation of Care and Treatment Reviews (CTR) for individuals at risk of hospital admission or placed in specialist hospital settings. These reviews focus on ensuring care is personalised and delivered to a high standard, with the overarching aim of enabling individuals to be cared for in community-based settings closer to their home setting. The Dorset Dynamic Support Register has continued to evolve as we work towards ensuring wider system adoption and understanding of the register. Further work is planned to consider options for a dynamic system to manage the register which currently relies on manual processes which are time consuming and less productive. The Dynamic Support Register will form a key element of the revised pathways of care for autism. Details of Care and Treatment Reviews (CTRs) are provided below:

	2023/24	2022/23	2021/22	2020/21	2019/22
Total number of CTRs where admissions avoided	17	26	35	37	28
Total number of CTRs with adult admissions avoided	12	17	15	16	7
Total number of CETRs where children and young people's admission avoided	5	9	20	21	21
Number of adults admitted	22 (2 admitted twice)	23 (1 admitted twice and 1 admitted 3 times)	18 (1 admitted three times and 2 admitted twice)	10	8
Number of children and young people admitted	4	13 (2 young people admitted twice)	8	6	8
Number of discharges	32 (3 discharged twice each)	28 (3 discharged twice)	29 (1 discharged four times, 1 discharged three times, 4 discharged twice)	12	14 adults 10 children

Dorset Keyworker Service

In the first procurement exercise providers were not successful in being awarded a contract to deliver the keyworker project. This has provided NHS Dorset with an opportunity to revisit next steps to engage with potential providers who did not bid during the first round and seek other providers with an interest with support from NHS England. NHS Dorset is also taking stock of other potential opportunities in respect of this new service following the introduction of the Provider Selection Regime in January 2024.

We continue to support the priorities against the Learning Disability and Autism Long Term Plan.

Mental Health

Table 04: NHS Constitution standards performance as at 31 March 2023

Financial Years	2022/23 £	2023/24 £
Mental Health Spend	129,591,766	141,667,908
ICB Programme Allocation	1,332,440,000	1,410,960,000
Mental Health Spend as a proportion of ICB Programme Allocation	10%	10%

The mental health and wellbeing of local communities has been a key area of focus for NHS Dorset with noticeable increases in demand for support across a range of services. Lower life expectancy associated with severe mental illness is also a key health inequality that we are striving to address. Service improvement and mental health transformation programmes have continued to progress.

Co-production with our statutory and non-statutory partners, communities and people with lived experience remains at the heart of all this work. Key developments over the last 12 months have included the following.

We have developed and implemented part of the integrated primary and community model of care for the management of adult mental health needs. This has seen strong partnership work across the system involving our statutory mental health service provider, primary care, local authorities, local voluntary and community sector and people with lived experience come together to re-imagine how services can be provided in a way that puts the individual at the heart of their own wellbeing and recovery plans.

This has culminated in an opportunity to test out a new way of working at a local neighbourhood/ primary care network level that seeks to remove historical barriers between services. Two Access Wellbeing Hubs have opened in February 2024 and have been used by local people from the very outset.

Aligned to this we have expanded the number of primary mental health workers based in GP practices, enabling people to access more timely support at the time of need.

We have continued to improve the uptake of physical health checks for those with a serious mental illness by building on previous years' developments with the addition of dedicated outreach to engage with individuals who traditionally are less likely to engage with the programme. This continues to be a key workstream to support a reduction in heath inequalities.

Improving the level of support our children and young people's mental health services can provide is a key priority for NHS Dorset. As this is a priority, children and young people have been a focus with a transformation programme fully developed and progressed through view seeking and design. We are now at the point where we can see how the co-produced concept can be operationalised at place level. The pathway and workforce modelling are in progress. Business case completion has been delayed to account of completion of more detailed operational modelling in partnership with each of our local authorities. A revised timescale for completion of a business case outlining requirements for each place (BCP and Dorset Council) is now November 2024.

Priorities for the next financial year are:

- Continue the implementation of the Community Mental Health Transformation with new cohort of Open Dialogue practitioners to be trained and Access Wellbeing hubs open and being tried using a test and learn approach.
- Develop the community mental health service offer in the context of local neighbourhoods which is part of the Mental Health in Community Care (MHICC) and part of the community and neighbourhood transformation. This will have to inform how Community Mental Health teams and services are re-shaped.
- Continue to develop the model for Children and Young People's mental health transformation at place, to commence from September 2024 onwards. This model focuses on integration and care and support around the family. There will be two slightly different operational models because of the way the two places work. The overall ambition though is the same for any young person in Dorset and BCP to access the right type of support to meet there presenting need.
- Continue to deliver on Health Checks for people who experience serious mental illnesses.
- A review of the Mental Health Crisis provision (Access Mental Health) which has been in place since 2018. The pathway needs to be reviewed in part because it is a crucial part of the whole offer of support but also because of contractual arrangements with one of the key providers.
- Improve the quality of inpatient settings to ensure that they are fit for purpose and current patient need.
- Develop provision for supporting young people and young adults who present with a wide range of complexity. This might include the development with system partners of a residential options that will tie into the Children and Young People's mental health transformation along with the key worker service and dynamic support register for Learning Disabilities and Autism. These are interdependent programmes of work.

Research and Strategic Partnerships

Our vision for research is for every person in Dorset to have the opportunity to take part in research by harnessing the collective assets, skills and expertise across the Dorset Integrated Care System, working in a collaborative and co-ordinated way. Our aim is to deliver outstanding research fully aligned to the needs of the people of Dorset and to clinical services, and to continue delivering excellent research within our institutions, focusing on condition-led research and trials.

To ensure that Dorset's current research activity supports and delivers outcomes for the people of Dorset, we have focused on the following five key holistic areas of research:

- Tackling health inequalities
- Empowering patients and communities
- The wider determinants of health
- Public health
- Technological solutions to workforce shortages.

In 2023/24 we have focused on delivery on four main areas:

- The people of Dorset – delivering research required to support Dorset's people, in a space close to their homes and communities.
- Our workforce – creating research opportunities for all our staff, empowering our staff to use and embed research into practice.
- Working in partnership – fostering a research ecosystem with partners where diverse and transformative people and ideas can thrive.
- Management of research – creating an efficient approach to managing research in Dorset across all our health and care organisations, including improving the understanding of research in line with the government's Future of UK Clinical Research Delivery paper.

In 2022 NHS Dorset along with Bournemouth University, University Hospitals Dorset and Dorset County Hospital joined Wessex Heath Partners. Wessex Heath Partners also bring together Bournemouth University, the Universities of Portsmouth and Southampton, the two Integrated Care Systems covering Dorset and Hampshire and the Isle of Wight, most of the NHS providers in the two Integrated Care Systems and the Health Innovation Wessex HIW (formerly known as the Academic Health Science Network). As Wessex Heath Partners develops it is envisaged that other partners will join.

The commitment from health and care systems in Dorset and Hampshire and the Isle of Wight to build stronger partnerships with local universities will allow Wessex Heath Partners to continue to develop, with the ambition of becoming an Academic Health Science Centre.

This will improve health and care services by translating early scientific research and innovation into benefits in healthcare at local and regional level, linking with local authorities and industry. The bridge between Wessex Health Partners and Health Innovation Wessex remains key to realising research (Discovery) and the innovation and adoption (Develop and Deploy) to improve or transform the delivery models for health and social care in Dorset.

Highlights during the reporting period include:

- The signing of the collaboration agreement with Wessex Health Partners.
- Colleagues from across Wessex in academia, health and local authorities with expertise and interest in air quality came together to share knowledge and explore where research could help address challenges and improve the health of individuals and communities in Hampshire and the Isle of Wight, Dorset and wider society.
- Health and care system leaders gathered at a workshop in November to explore the challenges and opportunities presented by delivery of the UK's 2020 genomic strategy. The workshop, jointly hosted by Wessex Health Partners (WHP), Health Innovation Wessex (HIW) and the NHS Central and South Genomic Medicine Service Alliance, brought together more than 80 people from the NHS, universities, and the local research and innovation ecosystem to review the government's 10-year ambition to make the UK the most advanced genomic healthcare system in the world.
- Increasing knowledge and expertise in the role of Health Economics. Health Innovation Wessex hosted a webinar delivered by the NICE Technology appraisal team, with over 50 health and social care colleagues to further understand how NICE use health economics and the increasing need to use this within systems.

Supporting the people of Dorset to undertake research in a space close to their homes and communities has been the cornerstone for direction of travel in 2023/24. Dorset's population is unique, it has one of the oldest average life expectancies of 84.6 years, with 28.6% of its residents aged 65+ years, compared to the national average of 18.3%. This, along with a higher proportion of population aged 50-64 years, has a significant impact on the health and care system and wider economy. Understanding this remains key to understanding the wider determinants of health.

We will increase access to research for the population of Dorset through increased awareness of research as well as enabling participation in research studies. We want to take research to communities and under-served groups through community hubs.

We also aim to establish research hubs closer to home. The aspiration was for development of four research hubs within our Health Villages, to be co-located with community diagnostic centres and community wellbeing hubs. Initial locations have now been established and we added the Lindon Unit in Weymouth as an additional site. These fixed sites in the community were extended with the addition of two Research Buses to further extend our reach into the community and work with all the people of Dorset to participate in Research. You can find out more by visiting our site here at Wessex Research Hubs | Take part in research.

These living labs, both fixed and mobile, give agility and reach across the community of Dorset.

We are working to create the appropriate large-scale physical infrastructure to aid research as an extension of the living labs, as a future international exemplar research and development space. This will act as a magnet for attracting leading edge industry research companies to locate in Dorset creating wealth and employment. Engagement work commenced and students at Arts University Bournemouth began to explore the design concepts. This has included working with stakeholders to inform this work and benchmarking against other models worldwide.

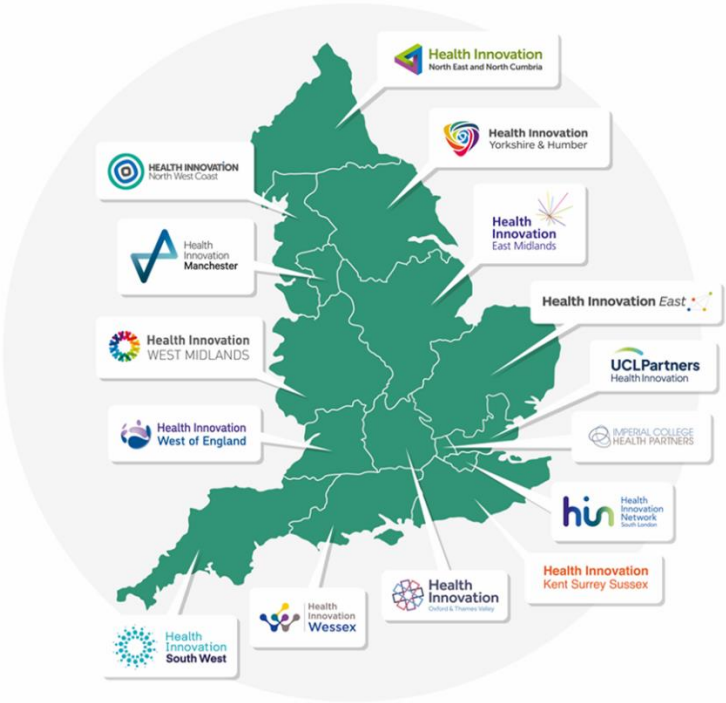
We are also aiming to expand the Patient Research Ambassadors and Patient programme across working with our academic partners in Dorset and Wessex, Promoting Inclusive and Equitable Research (PIER) plans. Dorset County Hospital established volunteer Patient Research Ambassadors in 2018, their role includes raising awareness of research and informing the design of research at the hospital. The creation of the Dorset-wide Voluntary and Community Sector Assembly (VCS Assembly) in 2022 has allowed us to engage the Third Sector as active partners in Research. The REN programme was one such success in 2023/24 that allowed us to increase diversity in research working with HealthBus and Lantern, and the homeless community to engage them and understand how they would support our journey of discovery in communities, to hear their voice.

NHS Dorset is actively working to build upon the opportunity that the Integrated Care System can offer: a change of culture but with a unique selling point to focus on people and community, with prevention and partnership at the heart of our change initiative in research. Our aim is to continue aligning research as a key component of system working, and to remain curious.

Innovation

NHS Dorset in 2023/24 has continued to strengthen its partnership with what is now Health Innovation Wessex (HIW). The Health Innovation Network is the innovation arm of the NHS and the collective voice of the 15 health innovation networks across England. They were formerly known as Academic Health Science Networks (AHSNs) until they underwent a change of name back in October 2023. You can read more here at About Health Innovation Wessex: who we are.

The network was established by NHS England in 2013 to spread innovation at pace and scale – improving health and generating economic growth. Each HIN works across a distinct geography serving a different population in each region as shown in the map below.



HINs connect NHS and academic organisations, local authorities, charities and industry and provide a range of practical support to facilitate change across health and social care economies, with a clear focus on improving outcomes for patients. HINs are uniquely placed to identify and spread health innovation at pace and scale; driving the adoption and spread of innovative ideas and technologies across large populations.

At a local level, they work to:

- Identify innovation and improvements to specific problems, whether that be within a healthcare, academic or business setting, creating an innovation pipeline.
- Empower innovators and those developing improvements to further their ideas and get them in front of the right people.
- Advance the uptake and spread of innovation and improvements by delivering national programmes and initiatives within the NHS and social care.

At a national level, the goal of the HINs is to bring individual health innovation networks together to create a collaborative network with an authoritative voice and greater impact, highlighting successes and sharing best practice so that we can achieve change on a wider scale.

All NHS bodies in Wessex and the Universities of Bournemouth, Portsmouth, Winchester and Southampton are members of Health Innovation Wessex. Where members' system priorities extend to working with other bodies such as Local Authorities and the voluntary sector, Health Innovation Wessex is very happy to provide support.

Health Innovation Wessex

Health Innovation Wessex (HIW) is the regional Health Innovation Network (HIN) that supports NHS Dorset. HIW in common with the other regional HINs will deliver national, regional and local programmes. The split between these is 50% on national/regional and 50% on local.

The annual cost is £13,000 per year, which represents our membership fee to HIW. In return for this fee, HIW co-develop an annual delivery plan with ICB colleagues on local focus areas which align with the

system priorities and strategies and this allows HIW to target their resources to these areas for innovation adoption.

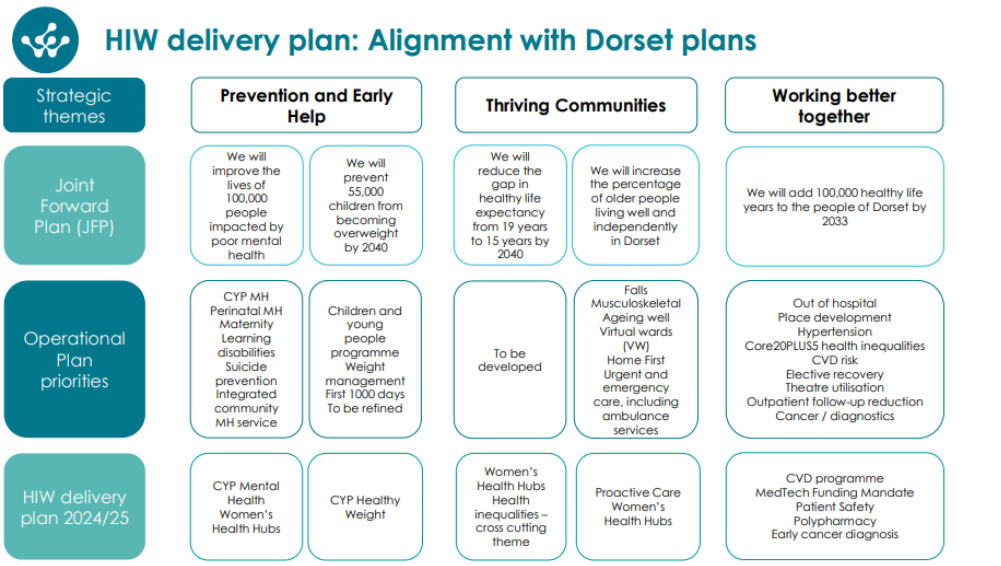
During 2023/24, HIW had three local focus areas which were Cardiovascular Disease, Place Based Partnerships and Virtual Wards and Technology enabled care. During 2023/24, this work has delivered some key outcomes for the Dorset system, which includes:

- Cardiovascular Disease Familial Hypercholestermia (FH) process mapping and pilot of Proactive care frameworks to support the Primary care networks with identifying patients with FH and enable genetic testing for diagnosis and management
- Cardiovascular Disease – BP@Home project and HIW have supported with a case study to compare a practice and PCN approach to help with other PCNs and onboarding of patients to identify and manage hypertension
- Frailty Virtual wards – HIW led a translator tool workshop and mapping exercise and produced a recommendation report to support the system team with progressing the Frailty Virtual wards
- Hosted a Health Economic webinar to support the Dorset system with understanding the basics for health economics, how NICE use health economics and why it is important within the Dorset system.

During 2024-2025, it is likely that HIW will be supporting the Dorset system, building on the Place based partnership work from 2023-24, with a focus on the neighbourhood teams and development within the local communities. This will include specific work on Children and Young People's Healthy Weight and the prevention of obesity and Children and Young people's mental health in terms of a support offer to the 'waiting well' and pathways for access to care relating to neurodiversity. Our focus will be on enabling faster adoption of innovation which improves the outcomes for these populations.

There will also be a focus on proactive care looking at how the system can identify and support patients with long term conditions as well as continuing other work in the system. These works includes the completion of local Cardiovascular Disease work for prevention, Oral health access and innovation for all ages, Women's health hubs and Point of care testing to aid diagnostics and care pathways.

The HIW focus will be on the identification and adoption of suitable innovation to improve outcomes. We know that adoption at scale and sustainability are challenges in the system at the moment and HIW aim to support by setting the right conditions for innovation adoption at scale and systematically. This will also support the workforce with capacity and capability to adopt impactful innovation.



2024/25 will build on learning from 2023/4 and has been co-developed with more stakeholders within the ICB to ensure the local focus areas reflect where HIW can add most value and impact to the priorities in the Dorset system.

In quarter 2 of each financial year HIW engages with their two Integrated Care Systems (Hampshire and the Isle of Wight, and Dorset) to start the process of adopting new local programmes that will enable each ICS's own Change Programmes and also informing them on any changes to national and regional programmes which are commissioned nationally.

The next round of engagement with Health Innovation Wessex will start in September 2024 for the Business Plan 2025/26.

The Dorset Innovation Hub Programmes are co-ordinated with HIW ensuring that we have the ability to increase capacity in Dorset, and not duplicate Regional or National Programmes led and delivered by the HINs.

The Dorset Innovation Hub is one of four Health Foundation Adoption of Innovation Hubs and is currently hosted by University Hospitals Dorset. The Dorset Innovation Hub is a partnership of all Dorset health and care organisations (see below) that provide expertise to spread and adopt innovation across Dorset. Further information on the work of the DIH is available at: [Innovation – Our Dorset ICS Innovation]

Funded for two and a half years to establish and embed a sustainable innovation impact and culture in Dorset, the Dorset Innovation Hub works within system partners' objectives and work programmes to embed a culture of innovation and sustainable adoption of prioritised evidence-based innovation within Dorset. The Dorset Innovation Hub has benefited from significant in-kind funding from partners over past 2.5 years. This includes collaborative working with Health Innovation Wessex and National Institute for Health and Care Research Applied Research Collaborative Wessex and their wider programmes. The Dorset Innovation Hub framework includes:

- A simplified prioritised Dorset Integrated Care System partners model and approach including health learning system through innovative cultural approach, co-designing with communities, benefits realisation, training and development, community of practice, case studies and communications.
- Integration into the Dorset Integrated Care System, enabling innovation to connect with the detail of Dorset system priorities and supporting communities across Dorset to live their best lives.

- Governance from the Dorset Innovation Hub programme group, made up of voting members of Integrated Care System partner organisations that span Dorset including health and care, councils, and academia.
- An Innovation core team providing facilitative innovation advice and support, working with the project sponsor and clinical teams, and to support work towards the strategy including education programme, governance, provide practical support including learning from experience.
- Established prioritised yearly work programmes agreed by the Dorset Innovation Hub programme group and in line with NHS Dorset priorities. The work programme has been developed to ensure our work is focused on improving people's care, outcomes or experience. The plan covers both national and local priorities.
- The Dorset Innovation Hub works with partner organisations to 'develop the impact'. Utilising established NHS Dorset governance processes, we work as a system team with staff from partner organisations to facilitate innovation within organisations. Our partners work with us to take forward priority innovation projects and embed innovation in their organisations. Developing the impact, enables ownership by partner organisations, with a focus on national and local priorities whilst developing the culture, capability, capacity and adoption, implementation, and sustainability of prioritised innovation.

Environmental Matters

Under the Health and Care Act 2022, the NHS must exercise its functions in line with both the Climate Change Act 2008 and the Environment Act 2021, setting out national targets for carbon, biodiversity, air and water pollution. The 'Delivering a net zero NHS' report provides the NHS with a national-level framework for action on climate change and sustainability. This sets out net zero targets that exceed the UK national targets. Every NHS organisation has an essential role to play in meeting this ambition.

In Dorset, we and our partner organisations have been working together to consider and plan how we can meet this NHS ambition together. Each NHS organisation in Dorset has a Green Plan. Together, we have produced an NHS Dorset Green Plan.

This annual report reflects our shared mission and the work we have started with our NHS partners in Dorset towards the national ambitions for sustainability in health and care.

NHS Dorset Green Plan

As NHS organisations in Dorset, our ambition is set out in our shared mission:

> To offer excellent health care for our patients and the wider community in ways which matter to the people we serve, and to do so in a manner that respects the needs of this generation and future generations. The size of this challenge will require all NHS organisations to acknowledge and take ownership of this mission, working together with partners and the community across Dorset's Integrated Care System. Our ambition is to agree a clear and sustainable direction for Dorset.

To deliver this shared mission shared priorities, delivered locally and together were set.

Progress against Green Plan shared ambitions

Ambition	Progress
Shift to 100% renewable energy for all electricity supplies.	All Trusts achieved (the ICB occupies rented premises where the supplier is controlled by the landlord)
Apply a minimum 10% social value weighting to all contracts	Yes
Switch to 100% recycled paper	All Trusts achieved (ICB when price is comparable)
Address single use plastics	All catering is compliant
Share learning on driving sustainable procurement	Yes
To reduce the use of desflurane –	All Trusts removed or significantly reduced
To prescribe lower carbon inhalers. –	Yes – see graph below
To increase virtual outpatients and primary care appointments -Yes	Achieved
Develop plans to support active travel Achieved/ In development	Achieved/ in development
To embed carbon reduction principles in the way all care is delivered	In progress

Our shared challenges with these priorities are:

- Achieving the NHS carbon footprint plus on plan.
- Collaboration as one Integrated Care System.
- Championing and driving culture changes across the system.
- Ensuring local ownership to deliver on agreed actions.
- Reducing the emissions caused by staff and patients.

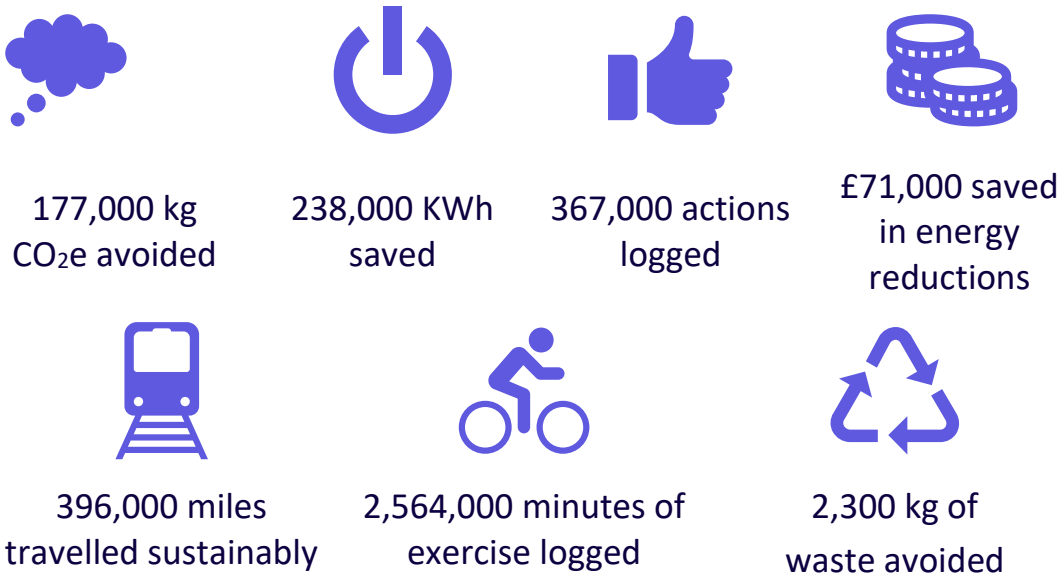
The NHS Dorset Green Plan sets out in more detail what we have all achieved to date, within Trusts and across partners.

Further details of action to deliver the Green Plan in 2023/24:

NHS partners in Dorset utilise Dorset NHS Liftshare. Any NHS employee in the catchment is able to access the scheme; register the journeys they wish to make and find other staff members that would like to share the journey. Staff have the choice to travel only with members of their own site or anyone in the wider NHS community. The service is easy to use, and shared journeys can be acknowledged just by touching smart phones together. This service is helping staff to save money, reduce congestion, and reduce green-house gas emissions and other pollutants, helping to improve air quality.

All NHS partners in Dorset are using the EcoEarn platform as a core component of their sustainability work. This staff engagement platform helps to promote net zero carbon reduction activities and other sustainability and wellbeing behaviours. It is a digital platform easily accessible through a bespoke app and website. EcoEarn has the facility to track the environmental difference made and can provide individual, team, Trust-wide and Dorset-wide impact data. The system supports wider sustainability and wellbeing initiatives also, rewarding users for lift-sharing and for undertaking health and wellbeing activities such as taking physical exercise and logging it with Strava.

EcoEarn data staff in all NHS organisations in Dorset since inception (includes action in work and at home)



As part of Dorset's Integrated Care System, we regularly meet with partners to collaborate on sustainability and are seeking to work more closely on a range of challenges including climate change mitigation and adaptation. Our ambition is to produce a Green Plan for the Dorset Integrated Care System during 2024/25.

NHS Dorset has appointed a Deputy Director to lead on the Sustainability agenda as part of a portfolio including Health Inequalities and Population Health Management. This post reports to the organisation's Chief Medical Officer who provides Board level leadership. The sustainability agenda will be overseen by the Dorset Health Inequalities Group.

We have returned to a hybrid working model and continue to look at ways we can keep travel to a minimum. Where staff do need to travel, we will be promoting and encouraging sustainable ways of travelling and continue to hold meetings virtually where appropriate to reduce travel.

Our Medicines Optimisation Team are embedding the principles of sustainable healthcare across all their work. For example:

The NHS Dorset Pharmacy Medicines Optimisation Team have focused sustainability initiatives on identification and elimination of medicines waste, a core principle of Medicines Sustainability (Centre of Sustainable Healthcare).

February 2024 saw the launch of the 'Only Order What You Need' (OOWYN) campaign, a patient focused campaign designed to give patients in Dorset the confidence to order medicines based on personal stock holding. OOWYN used a multi-faceted approach to reach patients, including traditional & digital media, campaign materials in GP surgeries and Community Pharmacies, personal interaction via GP practice teams, Community Pharmacy teams and Patient Participation Groups, and use of GP text messaging. In the 6 weeks following the launch (time period for which data is currently available), prescription requests fell by 2% across Dorset, resulting in medication saving of approximately £350,000 and a carbon reduction of 248, 400 kg$CO2$e.

Carbon savings associated with a shift to the use of lower carbon inhalers

Paper

As most staff worked from home during the pandemic the use of digital technology was increased, and this consequently lessened the need for paper at all levels. This reduces the environmental impact of paper, reducing cost of paper to the NHS and can help improve information security.

Paper usage increased slightly in 2022/23 as staff began to spend more time back in the office but remained below levels in 2019/20. Paper usage in 2023/24 has fallen again and is now below 2021/22 levels.

Table 05: Paper Usage - figures for 23/24

	2019/20	2020/21	2021/22	2022/23	2023/24
A4 reams	595	0	250	335	220
Boxes	119	0	50	67	44

Confidential wastepaper

In line with overall paper usage, confidential wastepaper has reduced significantly in 2023/24, this has resulted in both an environmental and cost saving.

Table 06: Confidential wastepaper - calculated by volume

	2019/20	2020/21	2021/22	2022/23	2023/24
Confidential waste (coving both sites)	260 bins @ 140 litres	110 bins @ 140 litres	36 bins @ 140 litres	32 bins @ 140 litres 25 bins @240 litres	18 bins @ 140 litres 2 bins @240 litres
	36,400 litres (21.84 tonnes)	15,400 litres (9.24 tonnes)	5,040 litres (3.02 tonnes)	10,480 litres (6.28 tonnes)	3000 litres (1.8 tonnes)
Cost @ £12 per 140 litre bin Cost @ £17 per 240 litre bin	£3,120	£1,320	£432	£384 £425	£216 £34

Single use plastics

NHS Dorset does not purchase any single use plastics.

Water, gas and electricity usage

The utilities relate to our two offices, our headquarters in Dorchester and a site office in Poole for the period 1 April 2023 to 24 February 2024. The Poole office has no gas supplied.

We also assist our partners in providing office space at both sites to relieve the impact of works being undertaken on the transformation on the hospitals' sites.

Part of our Vespasian House site is currently being used as an Outpatient Assessment Centre.

Table 07 Water, gas and electricity

	2019/20	2020/21	2021/22	2022/23	2023/24
	m3	m3	m3	m3	m3
Water *	2,034	2,122	1,911	1,615	2,523
	kWh	kWh	kWh	kWh	kWh
Gas	205,453	178,193	292,734	230,181	154,262
Electricity	350,850	327,475	295,656	254,402	201,997

Improve Quality

One of our key functions is to secure continuous improvement in the quality and safety of the clinical services commissioned in Dorset to drive better outcomes and experiences for our patients. Central to our quality improvement function is the assurance processes relating to the quality-of-care provision that is implemented through the contract monitoring framework, quality assurance schedule and quality reviews ensuring attention to value for money and enhanced productivity. Since the establishment of our Integrated Care Board in Dorset our ways of working have been defined in line with the new landscape for oversight within Dorset, which now includes the oversight of services such as Pharmacy, Optometry and Dentistry. The embedding of the new Patient Safety Incident Reporting Framework (PSIRF) is strengthening ways we can drive quality improvement in Dorset with identification of learning from themes identified from service reviews.

Our focus for the year ahead is to work towards our quality improvement priorities working in collaboration with all system partners to achieve shared quality goals, with improved patient outcomes across services commissioned in Dorset. We will also continue to work together with agencies such as the Care Quality Commission (CQC) to ensure we have an overview of quality of all services in Dorset, alongside our contract monitoring and system priorities to help us identify areas of focus for quality improvement initiatives to support improving outcomes for our patients in Dorset.

Our Quality Framework – System based Approach to Quality

During 2023/24, the NHS Dorset Quality Framework was reviewed with its foundations set around the National Quality Board's Shared Commitment to Quality, focussing on quality improvement using a strengths-based approach to 'System Wide Quality Improvement' and assurance as we developed our Integrated Care System. The framework set out a vision for the system wide quality improvement approach which relied on all partners agreeing shared quality priorities and then places all partners equally responsible and accountable for their delivery.

We have identified five indicators of success that are key functions in Dorset. Before all major decisions the four dimensions of quality are discussed and recorded, bringing a joint vision of the whole ICS improving together including the acknowledgement of voices from the grassroots are systematically heard. Thus, demonstrating a culture that incorporates reflection, appreciation and shared learning and

therefore resulting in Dorset ICS delivering high quality services, that best meet the needs of our population.

Monitoring Quality

Since becoming an ICB, the quality and safety of commissioned health and care services is monitored through a more collaborative arrangement for governance. Our Dorset System Quality Group (SQG) which provides a strategic forum at which partners from across health, social care, public health and wider within the ICS can join up around common priorities (linked to the ICP strategy). By routinely and systematically sharing insight and intelligence, it enables identification of opportunities for improvement and concerns/risks to quality & safety. The development of system responses enables ongoing improvement in the quality & safety of care and services across the ICS. Strengthening our monitoring of quality, are our place-based quality groups (PBQG) which collectively drive quality improvement to meet the needs of a defined population by:

- promoting safety and excellence in patient care.
- identifying, prioritise and manage risk arising from care on a continuing basis.
- ensuring the effective and efficient use of resources through evidence-based
- practice.

In 2023/24 we have moved towards these two (BCP and Dorset) PBQGs which complement already established individual Quality Meetings held with each provider, providing an opportunity to seek assurance first hand and to be part of the quality improvement journey with our providers. The PBQGs review and monitor progress against key agreed indicators for quality and performance and over 2023/24 the approach to quality has matured into a population health approach enabling community-based discussions rather than discussions focused on traditional quality measures and metrics. Overall governance is defined through both PBQGs reporting into the ICB Quality Experience & Safety Committee and Dorset System Quality Group (SQG) through a Chair's report.

Infection Prevention and Control

Infection prevention and control continues to play a vital role in patient safety across all health and social care settings. The value of its importance as a specialism, generating collective skills and experience allows us to shape and influence our whole system approach to support services in Dorset. Infection prevention and control is paramount in delivering safe joined-up care to ensure that people who use health and social care services receive safe and effective care.

We work collaboratively with all partners across Dorset integrated care system as well as colleagues across the Southwest, building on existing relationships, shared learning, efficient decision making and ensuring that effective prevention and control of infection is embedded as part of everyday practice and applied consistently by everyone. We deliver quality improvement initiatives to support people to enable the best possible outcome, better experience and reduce and prevent healthcare associated infections.

Primary Care & Independent Care Sector

We continue to offer support to Primary Care Services Independent care sector, offering support when a level of risk is identified through quality assurance processes. With particular attention on areas such as infection prevention and control and supporting practices with CQC compliance. The support offer is a collaborative approach between the commissioning teams at NHS Dorset working as required with other organisations which could include, the local authorities (BCP & Dorset), the Local Medical Committees (LMC), the Dorset GP Alliance and the CQC.

National programme for learning from lives and deaths – people with a learning disability and autistic people

We have continued to implement the Learning from Lives and Deaths: People with a Learning Disability and Autistic People Policy (formerly known as the Learning from Deaths Review Programme or LeDeR) and to work with our system partners to identify learning and gain assurance that changes in practice

are implemented as a result. An example of this is enabling a family to work with a trust delivering training to all staff as a result of the learning identified from their loved one's death.

The future delivery of the LeDeR programme is currently under review with the possibility of aligning the programme with PSIRF.

Personal Health Commissioning (PHC)

The service continues to strive to meet all NHS England standards for Continuing Healthcare. The market remains fragile with an increase in costs of care and people presenting with increasing complexity of need presenting an ongoing challenge.

The service continues to explore all opportunities to realise greater efficiencies in its operating model and in the commissioning of services to support people's care needs.

Personalised care is based on 'what matters' to people and their individual strengths and needs, working alongside health and care professionals. It provides a positive shift in power and decision making that enables people to have a voice, to be heard and be connected to each other and their communities. A Personal Health Budget (PHB) is one of the ways NHS Dorset makes personalised care a reality for Continuing HealthCare (CHC) and Children & Young People's Continuing Care (CYPCC) eligible residents. It is an amount of money which is set aside to support a person's identified health and well-being needs, planned and agreed between the person and NHS Dorset and enables people to have greater choice and control over the healthcare and support they receive. Further information on how NHS Dorset is supporting eligible residents to access a PHB is available via the following link: Personal-Health-Budget-Policy.pdf (nhsdorset.nhs.uk)

Complaints

NHS Dorset is dedicated to enhancing the standard of local healthcare services, and we understand that any form of feedback, whether positive or negative, is an invaluable resource that helps us monitor performance and identify opportunities for improvement.

2023/24 saw a full review of NHS Dorset's complaints handling processes, which incorporates the principles of the Parliamentary Health Service Ombudsman's NHS Complaints Standards programme. This has led to a more patient centric approach to handling concerns, with a focus on striving to achieve early resolution for complainants to improve patient experience.

From July 2023, there was an increase in the number of complaints processed due to the ICB taking on responsibility for pharmacy, optometry, dental and GP services. The highest number of complaints in this grouping was relating to GP Practices accounting for 58% of the 244 total figure.

During the period 1 April 2023 to 31 March 2024, 342 complaints were received in total. Of these 291 related to NHS Dorset and 51 to providers of services. The trends of complaints received relating to NHS Dorset only are demonstrated in the table below.

Table 08: Complaints received by NHS Dorset

Complaints Received by NHS Dorset	2022/23 Recognising that Quarter 1 was *as Dorset Clinical Commissioning Group*	2023/24
Personal Health Commissioning	25	20
Individual Patient Treatment	0	3
Pharmacy, Optom, Dental and General Practice	n/a	244
General	17	24

Friends and Family Test

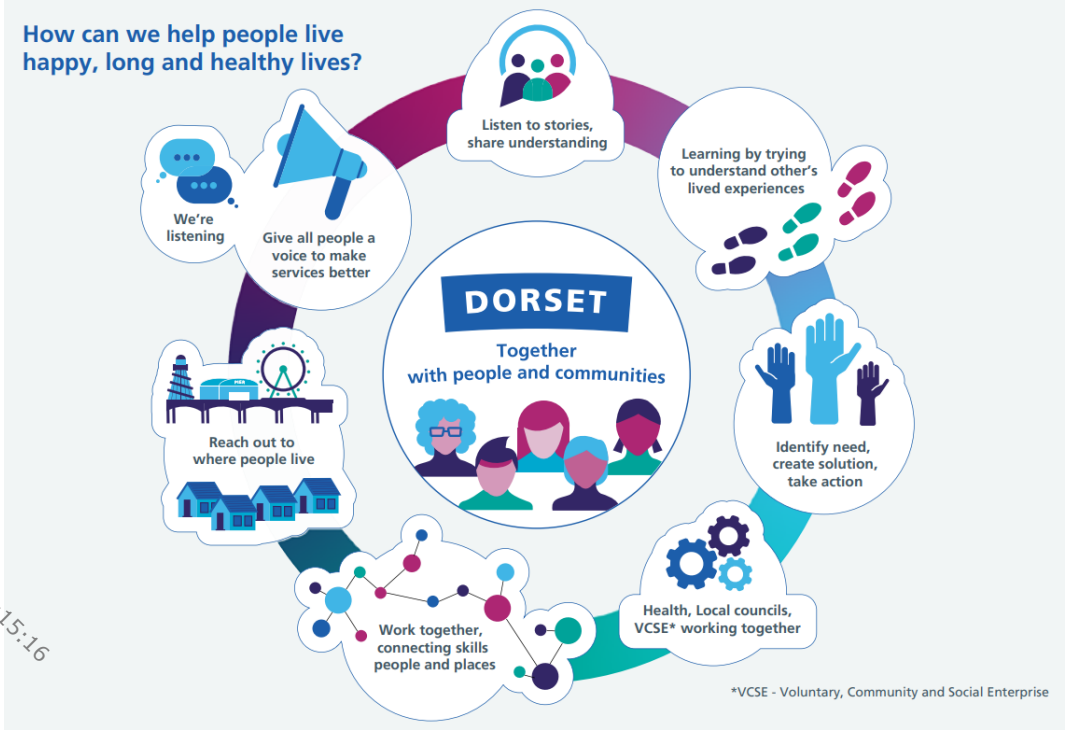
Friends and Family Test (FFT) gives patients the opportunity to submit feedback to providers of NHS funded care or treatment using a simple question which asks how likely, on a scale ranging from extremely unlikely to extremely likely, they are to recommend the service to their friends and family if they needed similar care or treatment. Data on all these services is published on a monthly basis.

Table 09: Friends and Family Data to February 2024

	Provider	Percentage likely to recommend
A&E responses	Dorset County Hospital	87%
	University Hospitals Dorset	84%
Inpatients	Dorset County Hospital	94%
	University Hospitals Dorset	94%
Outpatients	Dorset County Hospitals	96%
	University Hospitals Dorset	96%
Community providers	Dorset HealthCare University	93%
Maternity	Dorset County Hospital	93%
	University Hospitals Dorset	88%
Mental health	Dorset HealthCare University	90%

Engaging People and Communities

We have a clear vision in Dorset – working together to achieve the best possible improvements in the health and wellbeing of our communities. This vision can only be achieved by collectively listening to and working with people and communities.



Creating a culture of listening helps us to:

- Build trust and relationships, which is essential for creating positive change.
- Increase our awareness, helping us to understand people's needs and aspirations.
- Identify common goals and work together towards achieving them.
- Empower people and communities to help shape the future or their community, finding innovative ideas and solutions together.

Lasting change only happens when people and communities are part of creating that change.

This section describes an overview of our commitment to working in partnership with people and communities and shows how we meet our duty to involve under Section 14Z45 of the Health and Social Care Act 2006 (as amended by the Health and Care Act 2022). We work in line with the NHS England statutory guidance on working in partnership with people and communities.

Further detail is provided in our Working in Partnership with People and Communities Annual Report 2023-24: Working-with-people-and-communities-2024.pdf (nhsdorset.nhs.uk)

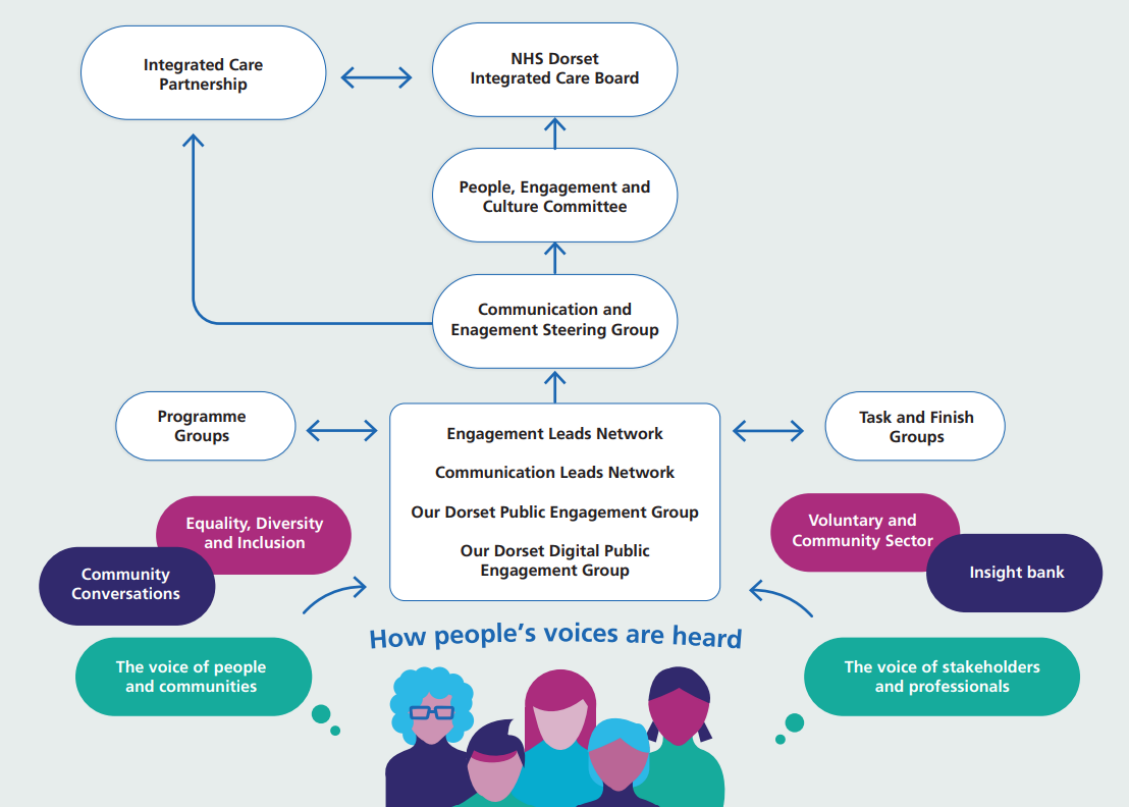
NHS Dorset believes that working with people and communities helps us to:

- better understand people's needs, beliefs, behaviours, culture, experiences and aspirations
- reduce health inequalities, reaching out to identify people's unique and diverse needs
- improve services and safety and help people to live healthier lives
- meet our duty to involve and work in line with national guidance.

We work closely with our partners and have put processes in place to help us work better together with people and communities. Dorset has a well-established engagement leads network, with representatives from the NHS, local councils, Healthwatch Dorset, the Voluntary and Community Sector (VCS), Public Health, Wessex Academic Health Science Network and Community Resilience. This network meets monthly to collaborate, avoid duplication and share good practice.

The integrated care partnership's membership includes representatives from Healthwatch and the VCS Assembly, (who also attend the NHS Dorset Board), as well as the Integrated Care System Public Engagement Group Chair (PEG), and the Digital PEG Chair.

An Integrated Care System Engagement and Communications Steering Group guides the network and provides assurance to NHS Dorset's People and Culture Committee, and the Board.



NHS Dorset is committed to working in line with the ten principles for working with people and communities as included within the national guidance, our NHS constitution and strategic approach to working with people and communities.

To enable this, we:

- have a public engagement and communications team.
- provide advice, guidance, and support on public engagement to teams across NHS Dorset
- have clear engagement guidance for staff, in line with national guidance
- maintain an engagement planner to manage and track engagement
- carry out stakeholder analysis and equality impact assessments to help inform our plans, who we reach out to and how we do so
- promote opportunities for involvement and co-production and let people know how their views have informed service provision ('you said – we did')
- work closely with the Dorset Public Engagement Group (PEG) and Digital PEG, which advise and challenge our approaches to public engagement
- work closely with engagement teams across the NHS, local councils, Healthwatch and the voluntary and community sector
- support the newly established Dorst Voluntary and Community Sector Assembly (VCSA)
- facilitate a Dorset Youth Representatives Networking Group
- provide clear and accessible public information
- work closely with our local research network and university partners
- work closely with our Maternity and Neonatal Voice Partners
- support a network of Patient Participation Groups in primary care
- continue to strengthen our relationships with a wide variety of people, groups and communities across Dorset's geography, demography and diversity
- support the Dorset Race Equality Council (DREC) community health ambassadors network, with 42 ethnically diverse communities
- work collaboratively with national and regional NHS England teams.

- co-designed and are implementing our approach to working with people and communities and progress is highlighted throughout our detailed report: Working-with-people-and-communities-2024.pdf (nhsdorset.nhs.uk)

Some highlights from the reporting period include:

- **Community Conversations** – we have continued our work listening to people and communities by reviewing existing conversational techniques being used across Dorset. Together we are developing an online content to share information about the range of conversation-based listening approaches. This will help all partner organisations to select and adopt conversational approaches suited to their project or programme of work and help to further encourage and support our listening culture across Dorset.
- **Insight Library -** we are co-designing an insight library or what we have heard, working with NHS, local council, VCS and research colleagues.
- **Keyworker project –** working with local people to inform models of service which work best for children and young people with a learning disability and/or autism and their families.
- **Working with Healthwatch** – this year we commissioned them to seek views of children and young people who don't always have a strong voice to inform mental health service development and to do some behavioural insights work to help improve access to urgent care services.
- **Hypertension** – our engagement and communications team rolled out a 'Know Your Numbers' hypertension toolkit in partnership with Blood Pressure UK and NHS England. This toolkit was adopted by integrated care boards across the South-West region.
- **Little Things, Big Difference** – our winter campaign focused on encouraging people to spread kindness, make connections and offer support to the people around them. It highlighted the incredible work being carried out by our voluntary and community partners and has been extended to run all year.
- **Marketplace events** – we held 'marketplace' events, with information and engagement stalls run by integrated care partners and stakeholders. These stalls provided lots of information on health, wellbeing and voluntary support in the local area. Covid vaccinations and blood pressure checks were offered. Feedback from both stallholders and members of the public was excellent.
- **NHS Dorset Neurodiversity Hub website** – as part of our All-Age Neurodevelopmental Review, we developed the NHS Dorset Neurodiversity Hub. We worked alongside people with lived experience of ADHD and autism, as well as experts from the NHS and local charities. The site was designed to provide an accessible, accurate source of information for everyone in Dorset.
- **Registered Nurse Degree Apprenticeships** – we have continued to support people to learn, earn and make a difference in Dorset with the Registered Nurse Degree Apprenticeship (RNDA). Since the programme's launch in 2018, over 300 people have enrolled in the RNDA course, with the first applicants starting work in March 2023.
- **Community mental health services** – wellbeing hubs in Poole and Weymouth have opened this year, staffed by wellbeing coordinators who can help people access the right support and advice. We supported the programme by developing the visual identity for the hubs to coincide with existing mental health branding.
- **Dorset Maternity and Neonatal Voices** – we have been involved in a wide range of work within the local maternity and neonatal system. We have continued to hold our open MNVP meetings, run our annual survey, and assisted with a number of workstreams and projects including infant feeding, equality and equity pelvic health, family hubs and the women's heath hub project.

Reducing health inequalities

Healthcare inequalities relate to inequalities in the access people have to health services and in their experiences of and outcomes from healthcare. Tackling inequalities in outcomes, experience and access is one of the four core purposes of ICSs, and a priority for NHS Dorset. Difference or variation in access, experience and outcomes from healthcare services is driven by a range of factors. Healthcare inequalities are part of wider health inequalities which are arise because of the conditions in which we are born, grow, live, work and age.

Health inequalities can be measured by differences in how long people live (life expectancy) and how long people live in good health (healthy life expectancy). In the shorter term we can measure healthcare inequalities by looking at differences in who accesses and has good outcomes from our healthcare and preventative services, and looking to see if these differences are in line what we would expect, based on healthcare need in different groups in the population.

Our Joint Forward Plan sets out our ambitious plans to increase life expectancy and reduce the gap in healthy life expectancy, focus our efforts on preventing health conditions from occurring, and enable people to live the best lives that they can if they develop a health condition. It recognises that the NHS needs to work with our partners across local authorities, the voluntary and community sector and academia to deliver the crucial role that we play in addressing the direct and wider causes of health inequalities.

Through our health inequalities work we are focusing on our services, looking at the groups of people that we know from national data and research are more likely to develop health problems earlier, and face more challenges in maintaining good health.

This includes people from the most socially deprived areas of Dorset, community minority populations, people with other life challenges such as homelessness, and people from particular geographical areas where poor health can be more concentrated such as urban and coastal areas, or where rurality affects access to services.

We also focus on whether people who share certain demographic characteristics such as different age groups, ethnicity, gender, disability and other characteristics protected by law have fair access and outcomes from our services. Our Working with People and Communities programme is making sure that we draw in the voices of people who are more likely to experience health inequalities to help us to make sure that our services meet their needs.

We have worked closely with our local authorities to draw on their expertise in understanding the health of our population. The Joint Strategic Needs Assessments undertaken by our local authorities in Dorset ICB area (Bournemouth, Christchurch and Poole Council, and Dorset Council) identify the areas of Dorset and the population groups that are more likely to have poorer health outcomes.

ICBs have specific legal duties to address health inequalities and promote equality.
In Dorset, we are fortunate that our Dorset Intelligence and Insight Service provides a range of data to help understand and take action on health inequalities This includes the ability to analyse by population features and to breakdown our population by household data such as lifestyle, behaviour and location.

NHS England has recently published guidance on the information that ICBs should collect to help to understand health inequalities for their population. This includes analysing information across 24 areas or domains of heath care.

We have produced comprehensive information on our work to address health inequalities, including our position against the 24 new domains in our separate Health Inequalities Report. Information is included at both ICB and Trust level, where available. We have included information for all 24 indicators, but there is more that we want to do to fully build the complete indicator set so that we can use it to pinpoint where we can strengthen our action. Below is a summary of the main findings from our initial analysis.

Summary of findings across all domains

In line with national data, both our local data and analysis of the new indicators identifies that there are differences in access to health care services for some population groups. Examples of the findings from this review include:

Some population groups are less likely to have used hospital healthcare services including planned hospital appointments, urgent care, outpatients and virtual healthcare appointments (e.g. people living in deprived areas); or are less likely to have accessed preventative services such as covid and flu

vaccination (e.g. people from deprived areas and community minorities);tend to present later to services (e.g. males more likely to be diagnosed later with cancer); or experience preventable conditions much earlier in life (e.g. community minorities and girls are more likely to have been admitted to hospital for tooth extraction under the age of 10 years)

There are also differences in access to services which help to ensure that once diagnosed health care conditions are well managed, including for hypertension (people living in deprived areas, women, community minorities) and Type 2 diabetes (community minorities).

For some services, such as Annual Health Checks for people with learning disability, people living in deprived areas appear to have the same levels of access as people living in less deprived areas, and there are opportunities to learn from this.

Challenges

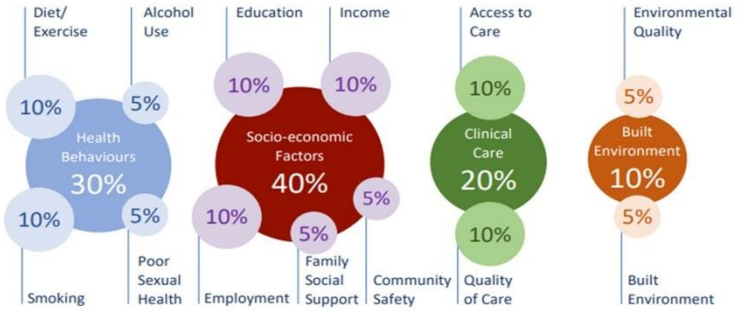
- It can be difficult to interpret the data for some specific groups that national data indicates are more likely to experience health inequalities, because our records are not always as complete as we would like. For example, we can see differences in access and outcomes to some services for community minorities, but we don’t hold information on ethnicity for some patients, which makes comparison difficult.
- For some indicators e.g. waiting times where rates are similar for some populations, more information is needed to understand whether findings are in line with need, or whether adjustment for other factors such as late presentation or variation in how advanced disease is might help to explain difference or highlight inequality that might not be apparent.
- We have not always been able to apply additional tests to check whether differences could be caused by chance.
- It is not always possible to tell whether the differences we see might be expected for some groups e.g. because of the age group, or gender of people who might be more likely to experience particular diseases.

Our analysis to date confirms our understanding of the immediate cross cutting priorities for action to understand variation in access, experience and outcomes from healthcare services, by making the most of the data available to us, and we will continue our work on these. This includes:

- Ensuring that we record and are able to analyse the ethnicity of patients using our services and addressing the challenges of missing data in respect of deprivation for some services, and learning from services where recording is better.
- Setting baselines and ambitions for improvement.
- Continuing to routinely check for differences, and taking action on the causes of poorer access, experience and outcomes from our services.
- Targeted action to improve access at each stage of the healthcare journey including earlier presentation, referral from primary care, addressing or mitigating where possible individual and structural barriers to attending a healthcare appointment (e.g. costs such as lost wages, flexibility of appointments, health literacy etc).
- Prioritising prevention – making sure that we focus our support to prevent people from developing health conditions at those who need it the most.

These actions will be taken forward through our system and ICB health inequalities work programme. Our improvement plans focus on prioritising preventing people from developing diseases, supporting people to be able to manage their health well if they develop a health problem, and making sure that our services are designed, planned and delivered in a way that makes it as easy as possible for everyone to have fair access to healthcare services, in a way that meets their needs.

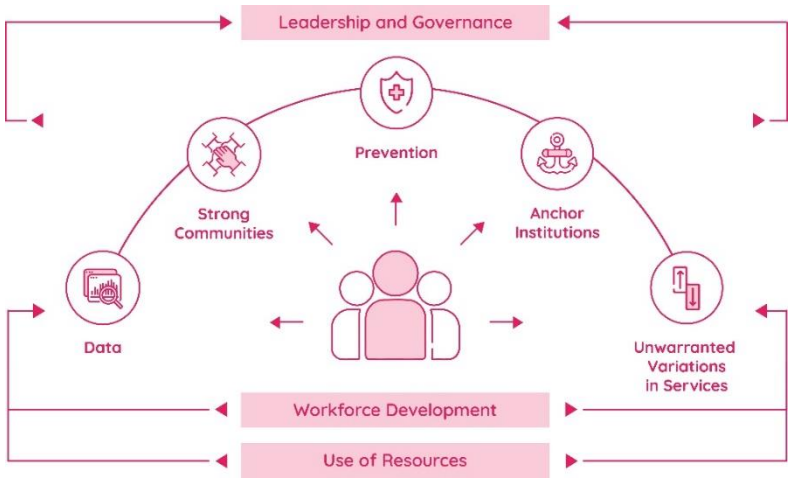
Working with our partners we have identified the range of societal factors which impact on the ability of different population groups to be healthy.



Because the causes of health inequalities are complex, our plans to address them are cross cutting.

We have recently worked with our partners in local authorities, NHS organisations, universities, and the voluntary and community sector to develop areas where we can benefit from co-ordinated action shown in the diagram below:

Areas for action on heath inequalities



Our Health Inequalities report provides detailed information on action we are taking in each of these areas to address healthcare inequalities, and the work we are doing with our partners to embed prevention and tackle the drivers of poor health.

Our priority workstreams bring together all the work that we are currently doing or have planned so that we are better able to track progress. This year we have focused on putting in place the building blocks for rapid at scale action. Examples of action this year, set out against our new priority actions are included below. Further details of our work this year is included in our health inequalities report.

Governance and leadership
Strengthened our internal Governance through a new Prevention, Equity and Outcomes Committee (PEOC) to oversee delivery of our ambitions and invested in a new health inequalities and population health function, led by our Chief Medical Officer (SRO for health inequalities).

Workforce Development
A priority in 2023/24 has been ensuring that we have the skills and capacity to drive forward work on health inequalities at the scale required to make a difference. We have delivered a range of training to support this including a leading for Inclusion Change Agents programme for senior leaders (Deputy Directors) to develop 'pro -equity' cultures across the system and Health inequalities, Population Health Management, and health literacy training to for over 500 people across organisations in Dorset, and

developing a prototype for clinical training starting with junior doctors in their second foundation year (FY2 Doctors).

Data
We are fortunate that our Dorset Intelligence and Insight Service (DiiS) already provide a range of data to help understand and take action on health inequalities. Additional work this year includes developing new dashboards for variation in elective recovery, health inequalities, prevention and the 24 indicators, establishing a cross system analyst group and bringing local authority data sets into DiiS, matching patient records to boost ethnicity recording

Addressing unwarranted variation in healthcare services
We have established delivery groups for each of our Operating Plan priority areas (Planned Care, Urgent Care etc). NHSEs new indicators for health inequalities have been included in the deliverables for the relevant delivery groups ensuring that a Senior Responsible Officer has oversight of variation in their area of work. Work on variation is being undertake across the ICB and NHS partners including for Cancer, CVD, mental health, planned care, maternity, waiting times, mental health and learning disability (including reviewing restrictive practices), and children and young people. Supporting resources and approaches have also been reviewed and the focus on health inequalities in our Population Health Management approach has been strengthened, we have updated our equality and health inequalities impact assessment approach and processes, and work to test methods to embed action on health inequalities in quality improvement methodology has commenced.

Prevention
Embedding action to prevent people from developing disease, or to live as well as they can when they developed disease is a key priority in Dorset. Our new Clinical Strategy includes a strong focus on prevention. We have introduced specific schemes to support earlier diagnosis and/or prevention of diseases such as bowel and lung cancer, strengthened our cardiovascular (CVD) prevention programme, undertaken focused work to increase uptake of vaccinations in underserved populations, and worked with partners to increase access to behaviour change support for priority populations.

Working with our partners and communities
Our approach is underpinned by embedding community voice and the ambitions of people with the poorest health at the centre of all that we do**.** More details on the approach and how this supports our work on health inequalities is included in the engaging people and communities section of this report.

Using all of our Resources
In order to make sure that our health services are fair for everyone, we need to think about how we spend or use all of our resources. We know that prevention is better than cure, and our Joint Forward Plan identifies that historically the NHS has not always had a large enough focus on prevention. We are at the early stages of developing our work to make sure that we are driving fair outcomes for everyone in Dorset through all of our spend. To help us in that we are developing a value-based improvement programme – thinking about how we prioritise action and activity that generates fair and cost-effective outcomes. We have invested a proportion of our dedicated health inequalities resources to developing a staff team to enable rapid at scale action on health inequalities embedded in all that we do, and a senior finance lead has joined the national finance health inequalities ambassador programme.

Anchor Institutions
Our People Plan identifies the action we will take to ensure that our good quality jobs are open to everyone in Dorset. Our partners in Public Health Dorset have undertaken an audit of work to develop the NHS as an Anchor Institution. This is being used alongside the people plan to inform next steps for making most of all the opportunities we have to address health inequalities.

Equality Duties
Details of how we have met duties set out in the Equality Act (2010), including equality of service delivery can be found in our Annual Equality Report and ICB Equality webpages. This includes our Equality Delivery System review, Workforce Race Equality Standard and Disability Equality Standard,

and refreshed equality objectives for 2024/25. A summary of how we have delivered our Equality Objectives in 23/24 is included below.

Equality Objectives Delivery 2023/24

Objective	Action taken
Objective 1: Our commissioned and provided services will meet the needs of our diverse population.	1. Reviewed and refreshed approach to managing the potential for unequal outcomes from our ser launching a new System Quality, Equality, Equity Impact Assessment 2. Embedded equality impact assessment as a core component of our new Gateway process for approving all new projects in the ICB 3. Reviewed our Population Health Management workforce development programme and embedd equality impact assessment, to ensure that everyone undertaking a PHM programme routinely considers the potential for their services to impact differently on groups who share a protected characteristic compared with those who don't (alongside reviewing this for groups more likely to poorer health outcomes). 4. Agreed a new equity and inclusion health post in the health inequalities team structure 5. Undertaken 3 Equality Delivery System reviews
Objective 2: Our workforce will see improvements in health, well-being, and diverse representation.	• Appointed a dedicated workforce Equality, Diversity and Inclusion Business Partner • Established an ICB Equity, Equality, Diversity and Inclusion Steering group. • Established/refreshed three staff networks (Ethnic Diverse Community, Pro-ability and LGBTQ+ • Established a system wide EDI programme group delivering joint EDI activity as per ICS People • Review and launch of the Wellbeing plan and variety of actions delivered • New appointment of two staff level Freedom to Speak up Guardians and variety of actions deliv • Worked with Networks to review a variety of policies including Reasonable Adjustments Policy • Health and Wellbeing passport to capture long term conditions and adjustments should staff mo teams
Objective 3: Our leaders will demonstrate a clear and strong commitment to EDI in all they do.	• Launched system wide commissioned Leading for Equity programme to 25 senior leaders to cre pool change leaders for equality and to support reduction in health inequalities. • System collaborative design of Conscious Inclusion workshop and Inclusive Leadership worksh • Executive sponsors established and active in supporting staff networks • Chief Officer specific objectives linked to EDI • CEO holds specific objective for 2023/24 to implement the regional EDI strategy, prioritising lead development and revision of key people policies

Health and Wellbeing Strategy

This section, which has been produced in consultation with the Chairs of our two Health and Wellbeing Boards, provides details on the ICB's contribution to the development and delivery of the local Health and Wellbeing plans, and plans for future partnership working.

We are members of the Health and Wellbeing Boards which are run by local authorities to develop and monitor the major health and wellbeing priorities for the area. There are two Health and Wellbeing Boards in Dorset – one run by Dorset Council, and one run by Bournemouth, Christchurch and Poole Council. These Boards are made up of representatives from a number of organisations such as the NHS including GPs, the voluntary sector and local authorities. They set the direction for health and wellbeing across the system and work together to ensure that people receive the best possible care.

We engaged with and supported the refresh of the Joint Strategic Needs Assessment narratives for both councils, facilitated by Public Health Dorset. This supports the Health and Wellbeing Boards of Dorset Council and Bournemouth, Christchurch and Poole Council (BCP) in their work.

The overarching reports on the Public Health Dorset website provide a summary of the Joint Strategic Needs Assessment and the current and future strategic health and wellbeing issues for the two local councils. See An introduction to Dorset's JSNA - Public Health Dorset - Dorset Council and Needs assessments and related documents - Public Health Dorset - Dorset Council.

This information is also continuously considered as part of our transformation and strategy work – particularly while developing the Joint Forward Plan this year to ensure there is good strategic alignment between the Health and Wellbeing Strategies, and the NHS Joint Forward Plan.

The assessment was triangulated with engagement work with stakeholders and formed the basis for the development of the Joint Health and Wellbeing Strategies. Due to a change in administration in both

councils during 2023 and 2024, work on refreshed strategies will recommence from summer 2024 onwards. NHS Dorset and ICS partners have made progress in developing place-based working and starting to establish integrated neighbourhood teams this year. This provides a good opportunity for each health and wellbeing strategy to focus on delivery of key outcomes in each place, guided by the system strategies.

NHS Dorset has supported workshops this year with both Health and Wellbeing Boards to discuss and agree the approach to developing refreshed strategies and refresh the priorities for Dorset and BCP Council. There is a new corporate plan for BCP Council, so having the chance to reflect on the ambitions of that plan in the context of health and wellbeing was especially helpful in identifying some issues for place-based working. This is likely to include a focus on establishing neighbourhood teams, development of family hubs and other community assets including the proposed wellbeing hubs, supporting older adults to live well and independently, community mental health services transformation, and work on going smoke free. Health and Wellbeing Board members also noted the importance of cost of living and incorporating the findings and work of the recent Poverty Truth Commission in BCP Council.

For Dorset Council Health and Wellbeing Board there have been close links between its focus on Thriving Communities (a project to strengthen voluntary and community sector infrastructure) and the commitment in the joint forward plan to support more older people to live well and independently. This work will continue to develop during 2024 with a strong link also to developing neighbourhood teams in Dorset.

Both Health and Wellbeing Boards have supported an increasing focus on smoking cessation in the past year, recognising the renewed national ambition to go Smoke Free by 2030. This work has been supported by both Health and Wellbeing Board Chairs and is currently held by the Integrated Care Partnership under the prevention and early help section of our ICS strategy.

Two areas for improvement in next year's partnership working, identified by our Health and Wellbeing Board Chairs, are being more effective as system leaders around the children's agenda, especially the plans for children with special educational needs and disabilities, and accelerating progress on place-based health and social care integration. This should include keeping a strong focus on commissioning for improvements in outcomes and showing progress in tackling some of the most obvious inequalities in access to services.

Financial Review

NHS Dorset delivered a £17.4 million deficit position across the whole of the 2023/24 financial year. This means that its expenditure was £17.4 million more than was funded by its income. Across the Dorset NHS Integrated Care System this was partially offset by surplus in Dorset HealthCare NHS Foundation Trust and leads to a Dorset NHS Integrated Care System in year deficit position of £14.6 million.

The whole system deficit being held within NHS Dorset was a system decision taken to ensure that the New Hospitals programmes of work at our hospitals could continue. Prior to enacting this agreement, the NHS Dorset year end position was a £2.7 million deficit.

Dorset NHS Integrated Care System was issued a fixed financial envelope with a requirement to effectively plan and deliver services within this allocation for the population of Dorset.

The Dorset NHS Integrated Care System comprises:

- NHS Dorset Integrated Care Board
- Dorset County Hospital NHS Foundation Trust
- Dorset HealthCare NHS Foundation Trust
- South Western Ambulance Service NHS Foundation Trust
- University Hospitals Dorset NHS Foundation Trust.

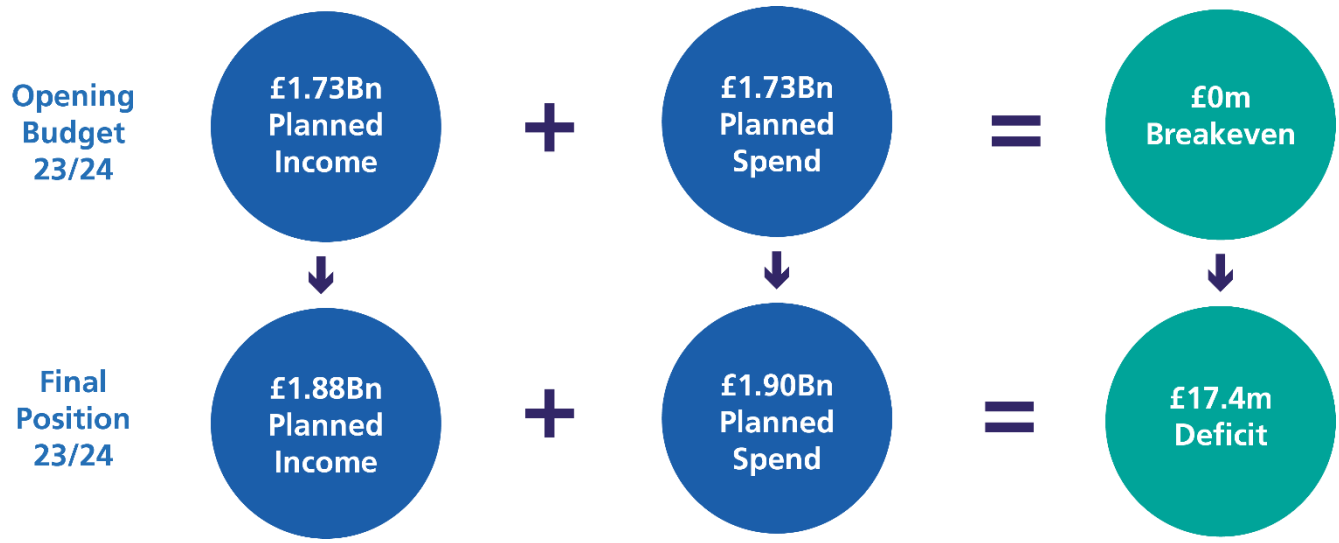
These five NHS bodies received an initial allocation of £1.73 billion for 2023/24 and were required to collectively plan within this envelope. NHS bodies in the Dorset Integrated Care System planned a break-even financial performance across the year. This target was not achieved, with delivery of a collective in year overspend of £14.6 million against the final allocation.

NHS Integrated Care System partners have successfully planned and delivered capital investment projects totalling £180.5 million, this is lower than the planned spend of £297.4 million due to the in-year approved rephasing of major works within University Hospitals Dorset.

The Integrated Care System also encompasses local authority partners (Dorset Council and Bournemouth, Christchurch and Poole Council) plus other partners such as those in the voluntary sector.

The allocations made available for the financial periods ending 31 March 2024 are outlined in the figure below. During the reporting period, additional non-recurrent funding was made available beyond planned income values in including funding for Elective Recovery plus additional targeted funding for specific projects and programmes from NHS England. This is referenced in the final income of £1.88 billion when compared to the planned income of £1.73 billion.

NHS Dorset Financial Performance against plan



NHS Dorset Financial Performance

NHS Dorset has not met all of its statutory and administrative financial duties in its second statutory reporting period ending 31 March 2024. The statutory duties are to remain within its revenue, capital and running costs allocations, and to ensure cash at year end is no more than the mandated threshold. The duty that has not been met in the financial year is the duty to breakeven, detailed on the top line of the table below.

The full results are set out within NHS Dorset's Annual Accounts and notes to the accounts at the end of this document, however the key duties and performance of Dorset ICB is shown below:

Duty	What this means	Dorset ICB Achievement
Expenditure does not exceed sums allotted to the ICB plus other income received.	To keep the amount spent on commissioning and delivering services to or below the amount allocated.	✕ Not achieved Dorset ICB planned for a breakeven balance for the financial year but delivered a £17.4m deficit.
Capital resource use does not exceed the amount specified in our Capital Expenditure Limit.	To not spend more on buying property, plant and equipment than allocated.	✔ Achieved Capital investment was delivered within the limit for both Dorset ICB and the wider NHS Dorset ICS.
Revenue administration resource use does not exceed the amount allocated of £14.9m.	To ensure that ICB efficiently discharges its responsibilities and keeps the spend to or below the amount allocated.	✔ Achieved This was spent on ICB staff and associated costs.
Invest in Mental Health Services in line with the Mental Health Investment Standard.	ICBs are required to invest in Mental Health Services by an amount greater than general allocation growth each year.	✔ Achieved For 2023/24, the target investment in mental health was £141.4m. The ICB achieved £144.7m which is an £12.1m increase from 2022/23 investment levels.
Cash Limits received from NHS England are not exceeded in any one year.	To keep the cash in the bank within acceptable limits.	✔ Achieved The ICB managed its cash resource and achieved a cash balance below the mandated threshold of 1.25% of the cash drawdown in March 2024.

There have been a number of challenges for us as a system in 2023/24, which have not been able to be fully managed to deliver a breakeven position. These included:

- Increasing pressure on Personal Health Commissioning (PHC) expenditure due to pressures in the care market, leading to overspends against plan of £35.0m.
- An emerging pressure on drugs expenditure, particularly No Cheaper Stock Obtainable drugs due to inflation and supply issues, leading to additional expenditure in the reporting period.
- Spend on agency staff being £13.6m higher than planned, driven significantly by escalation beds opened to manage high numbers of patients that were not able to be moved out of a hospital setting at the point at which there was no medical requirement for them to remain.

Whilst the system was able to non-recurrently manage a proportion of the financial challenges, it was not able to fully mitigate them all, leading to the £14.6 million ICS deficit in 2023/24.

Prompt Payments Code

NHS Dorset ICB is a signatory to the Prompt Payment Code.

The Prompt Payment Code sets standards for payment practices and best practice and is administered by the Chartered Institute of Credit Management on behalf of the Department for Business, Energy and Industrial Strategy. Compliance with the principles of the code is monitored and enforced by the Prompt Payment Code Compliance Board. The code covers prompt payment, as well as wider payment procedures, and in signing up we undertake to:

- pay suppliers on time:
  - within the terms agreed at the outset of the contract
  - without attempting to change payment terms retrospectively
  - without changing practice on length of payment for smaller companies on unreasonable grounds.

- give clear guidance to suppliers:
  - provide suppliers with clear and easily accessible guidance on payment procedures
  - ensure there is a system for dealing with complaints and disputes which is communicated to suppliers
  - advise them promptly if there is any reason why an invoice will not be paid within the agreed terms.

- encourage good practice:
  - request that lead suppliers encourage adoption of the code through their own supply chains.

Better Payment Practice Code

In accordance with the Better Payments Practice Code, valid invoices should be paid by their due date or within 30 days of receipt, whichever is later. Our performance is presented below, measured in terms of both the number and value of invoices received, against an NHS administrative target to pay over 95% of non-NHS trade creditors in accordance with the code.

Table 10: Non-NHS Payables

	2023/24		2022/23	
	Number	£'000	Number	£'000
Total bills paid in year	30,794	473,755	23,078	304,323
Total bills paid within target	30,225	467,804	22,393	296,067
Percentage of bills paid within target	98.2%	98.7%	97.0%	97.3%

Table 11: NHS Payables

	2023/24		2022/23	
	Number	£'000	Number	£'000
Total bills paid in year	1,161	1,246,447	863	851,767
Total bills paid within target	1,150	1,246,574	844	851,741
Percentage of bills paid within target	99.1%	100.0%	97.8%	100.0%

2022-23 figures report the first nine months of the ICB, from 1 July 2022 to 31 March 2023 only, whereas 2023-24 figures cover a full twelve-month period. In addition, Pharmacy, Optometry and Dental (POD) delegation to ICBs on 1 April 2023 and the national Elective Recovery Fund (ERF) scheme have resulted in an increase in the value of invoices processed by the ICB in 2023-24.

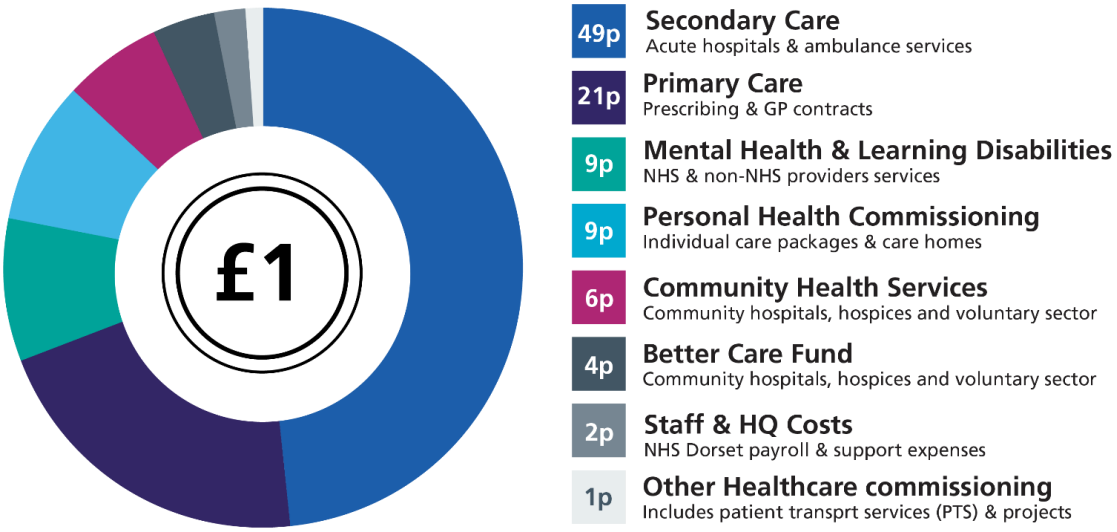
How we spent our budget

NHS Dorset utilises funds to commission (buy) services from a range of NHS and non-NHS organisations including Local Authorities. The charts that follow show how we applied expenditure across the various commissioning areas.

Where were ICB funds spent?

The graphic below shows the total spend for 2023/24:

For every £1 spent on health in Dorset in 2023/24, the amounts spent on our range of services were:



Future financial outlook

The accounts have been prepared on a going concern basis. Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

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. This will align to the NHS England planning priorities announced in its draft 2024/25 priorities and operational planning guidance which are to:

- maintain our collective focus on the overall quality and safety of our services, particularly maternity and neonatal services, and reduce inequalities in line with the Core20PLUS5 approach
- improve ambulance response and A&E waiting times by supporting admissions avoidance and hospital discharge, and maintaining the increased acute bed and ambulance service capacity that systems and individual providers committed to put in place for the final quarter of 2023/24
- reduce elective long waits and improve performance against the core cancer and diagnostic standards
- make it easier for people to access community and primary care services, particularly general practice and dentistry
- improve access to mental health services so that more people of all ages receive the treatment they need
- improve staff experience, retention and attendance
- deliver a balanced net system financial position in 2024/25

For the financial year ending 31 March 2025, the Integrated Care System NHS bodies in Dorset will again receive a fixed financial envelope to deliver all aspects of healthcare.

Additional funding has been made available again in 2024/25 to assist with tackling the growth in numbers of patients waiting for elective procedures, dependant on reaching a level of elective recovery greater than pre pandemic levels. This variable payment mechanism means that providers will only get paid for the elective activity they achieve, therefore there is an additional income risk if recovery is not at the level planned.

NHS Providers are also continuing to manage a number of inflationary pressures including price rises for utilities and drugs. For NHS Dorset the impact of the rise in the National Living Wage on the care market continues to be challenging, along with similar pressures to providers within other non-pay expenditure such as prescribing.

As a result, the Integrated Care System has set itself a challenging and stretching efficiency programme in order to achieve the proposed plan for 2024/25. This plan, as at 31 March 2024 does not yet articulate a route to breakeven. The system is committed to reducing this deficit position whilst still submitting a deliverable plan. The 2024/25 year contains significant financial risk however, and it is likely to require further non-recurrent measures to be achieved.

Dorset NHS Integrated Care System continues to manage an underlying deficit position in future years. Both transformation and increased productivity is needed to continue to tackle this challenge to ensure services continue to be value for money for our population and this is detailed in the 2024/25 operating plan. Delivery of the operating plan will show an improvement equating to one third of the underlying position going into the financial year.

Patricia Miller

Chief Executive Officer

21 June 2024

Accountability Report

Accountability Report

The Accountability Report describes how we meet key accountability requirements and embody best practice to comply with corporate governance norms and regulations.

It comprises three sections:

The **Corporate Governance Report** sets out how we have governed the organisation during the period 1 April 2023 to 31 March 2024 including membership and organisation of our governance structures and how they supported the achievement of our objectives.

The **Remuneration and Staff Report** describes our remuneration polices for executive and non-executive directors, including salary and pension liability information. It also provides further information on our workforce, remuneration and staff policies.

The **Parliamentary Accountability and Audit Report** brings together key information to support accountability, including a summary of fees and charges, remote contingent liabilities, and an audit report and certificate.

Corporate Governance Report

Members' Report

Member profiles

Profiles detailing the professional backgrounds of our Board Members and Chief Officers can be found by following the links below:

- NHS Dorset ICB Board Members
- NHS Dorset ICB Chief Officers

Composition of NHS Dorset Integrated Care Board (ICB) Board

Our NHS Dorset ICB Board is made up of the following members:

- Chair
- Chief Executive
- Two Partner Members – NHS Trust and Foundation Trust (including Mental Health)
- Two Partner Members – Primary Medical Services
- Two Partner Members – Local Authorities
- Six Non-Executive Members
- Chief Finance Officer
- Chief Medical Officer
- Chief Nursing Officer

Table 12: ICB Board composition, term of office and attendance record

Name	Role	Term of Office			Attendance Record (10 meetings held during the period 1 April 2023 to 31 March 2024)
		Date appointed	Re-election/ reappointment date	Date left role (if applicable)	
Jenni Douglas-Todd	Chair	01/07/2022	01/07/2024	N/A	10 of 10
Patricia Miller (to 02/11/23, plus 21/03/24)	NHS Dorset ICB Board Chief Executive Officer	01/07/2022	-	N/A	7 of 7
Rhiannon Beaumont-Wood	NHS Dorset ICB Board Non-Executive Member	01/06/2023	01/06/2026	N/A	8 of 9
John Beswick	NHS Dorset ICB Board Non-Executive Member	01/07/2022	01/07/2025	N/A	10 of 10
Matthew Bryant	NHS Trust and Foundation Trust Partner Member (Mental Health)	27/04/2023	27/04/2026	N/A	9* of 10
Jonathon Carr-Brown	NHS Dorset ICB Board Non-Executive Member	01/07/2022	01/07/2025	18/04/2024	9 of 10
Dawn Dawson	NHS Trust and Foundation Trust Partner Member (Mental Health)	01/07/2022	-	26/04/2023	0 of 0+
Spencer Flower	Local Authority Partner Member	01/07/2022	01/07/2025	N/A	5 of 10
David Freeman (from 22/11/23 meeting)	NHS Dorset ICB Board Acting Chief Executive Officer	20/11/2023 (as Acting CEO)	-	07/04/2024 (as Acting CEO)	4 of 4
Siobhan Harrington	NHS Trust and Foundation Trust Partner Member	01/07/2022	01/07/2025	N/A	7* of 10
Leesa Harwood	NHS Dorset ICB Board Interim Non-Executive Member Non-Executive Member	19/06/2023 20/12/2023	- 20/12/2026	19/12/2023 N/A	5 of 6 2 of 3
Paul Johnson	NHS Dorset Chief Medical Officer	01/07/2022	-	N/A	9* of 10

Robert Morgan	NHS Dorset Chief Finance Officer	01/07/2022	-	N/A	10 of 10
Debbie Simmons	NHS Dorset Chief Nursing Officer	26/09/2022	-	N/A	9 of 10
Vikki Slade	Local Authority Partner Member	02/08/2023	-	25/03/2023	5* of 7
Manish Tayal	NHS Dorset ICB Board Interim Non-Executive Member	01/08/2022	-	31/05/2023	1 of 1
Kay Taylor	NHS Dorset ICB Board Non-Executive Member	01/07/2022	01/07/2025	N/A	8 of 10
Forbes Watson	Primary Medical Services Partner Member	09/12/2022	09/12/2025	N/A	8* of 10
Dan Worsley	NHS Dorset ICB Board Non-Executive Member	01/07/2022	01/07/2025	N/A	7 of 10
***** Figures include attendance by a nominated deputy as allowed for in the Terms of Reference. + Member's term ended during the reporting period, but no Board meetings were held during that time.					

Our Board meetings also have regular attendance by invited participants in order to inform its decision-making and the discharge of its functions. During the course of the year, participants have included:-

- NHS Dorset Chief Strategy and Transformation Officer
- NHS Dorset Chief Commissioning Officer
- NHS Dorset Chief Operating Officer
- NHS Dorset Chief People Officer
- NHS Dorset Chief Digital and Information Officer
- NHS Dorset Associate Non-Executive Members
- Manager, Healthwatch Dorset
- Director of Public Health for Dorset and Bournemouth, Christchurch and Poole Councils
- Chief Executive, Bournemouth, Christchurch and Poole Council
- Chief Executive, Dorset Council
- Acting Chief Executive, Dorset County Hospital NHS Foundation Trust
- Primary Care representative
- Chief Executive, Community Action Need
- Chief Executive, Help and Kindness
- Interim Chair, Dorset VCSE Board

In the preparation of this report each director knows of no information which would be relevant to the auditors for the purposes of their audit report of which the auditors are not aware, and they have taken all the steps required to make themselves aware of any such information and to establish that the auditors are aware of it.

Our Committees

During 2023-24 the ICB undertook a review and refresh of its Board committees. This review considered feedback from the 2022-23 committee self-assessment exercise, the mapping of the ICB's functions and core purposes against the remit of the committees, and examples of best practice from other ICBs. The review also considered the committee memberships as it had become apparent that the original memberships were not necessarily the best alignment with the remits of the committees, and this was being reflected in the attendance rates. The revised structure retained committees regarding quality, finance and performance, and people, as well as the statutory audit and remuneration committees. A Prevention, Outcomes and Equity Committee and a Strategic Objectives Committee were added into the structure. The Terms of Reference (ToR) for all Committees can be found in our Governance Handbook.

As part of the review, the existing committee Terms of Reference were reviewed and Terms of Reference were written for the new committees. These were approved by the ICB Board along with a review of the Governance Handbook. The Terms of Reference and workplans will be reviewed again in 2024-25, and a committee self-assessment exercise will be carried out once the revised committee structure has become embedded. Following their bi-monthly meetings, each committee provides a summary report to the Board covering the main items discussed, decisions made, items for escalation to the Board, and highlighting any items which impact on the Corporate Risk Register or Board Assurance Framework.

Clinical Commissioning Committee

This committee was stood down in December 2023 following the committee refresh, with aspects of the work of the committee being taken on by the Prevention, Equity and Outcomes, Productivity and Performance, and Quality, Experience and Safety committees. The purpose of the Clinical Commissioning Committee prior to this date was to make decisions on the review, planning and commissioning of clinical services and policies under delegated authority from the NHS Dorset ICB Board. It provided clinical leadership to the system, informing the clinical strategy and supporting the Quality and Safety Committee in discharging its responsibility for clinical governance for commissioning services and oversight of the delivery of the clinical strategy.

The committee was chaired by Jonathon Carr-Brown, NHS Dorset ICB Board Non-Executive Member. Other members from 1 April 2023 to 18 October 2023 and their attendance records are detailed below:

Table 13: Clinical Commissioning Committee composition and attendance

Name	Role	Attendance Record (4 meetings held during the period 1 April 2023 to 18 October 2023)
John Beswick	NHS Dorset ICB Board Non-Executive Member	2 of 4
Jonathon Carr-Brown	NHS Dorset ICB Board Non-Executive Member and Committee Chair	3 of 4
Sam Crowe	Director of Public Health for Dorset and Bournemouth, Christchurch and Poole Councils	0 of 4
Dawn Dawson	Chief Nursing Officer, Dorset Healthcare	2 of 4
David Freeman	NHS Dorset Chief Commissioning Officer	3 of 4

Leesa Harwood (co-opted in for 18/10/23 meeting)	NHS Dorset ICB Board Interim Non-Executive Member	1 of 1
Phil Hornsby	Director of Commissioning (People), Bournemouth, Christchurch and Poole Council (Local Authority Lead East)	1 of 4
Jo Howarth	Chief Nursing Officer, Dorset County Hospital	0 of 4
Alastair Hutchison	Chief Medical Officer, Dorset County Hospital	2 of 4
Paul Johnson	NHS Dorset Chief Medical Officer	4* of 4
Patricia Miller	NHS Dorset Chief Executive Officer	1 of 4
Robert Morgan	NHS Dorset Chief Finance Officer	3 of 4
Jon Price	Director, Dorset Council (Local Authority Lead West)	0 of 4
Faisil Sethi	Chief Medical Officer, Dorset Healthcare	4 of 4
Paula Shobbrook	Chief Nursing Officer, University Hospitals Dorset	2* of 4
Debbie Simmons	NHS Dorset Chief Nursing Officer (from 26 September 2022)	2 of 4
Dean Spencer	NHS Dorset Chief Operating Officer	3 of 4
Manish Tayal (to 31/05/23 meeting)	NHS Dorset ICB Board Interim Non-Executive Member	0 of 1
Kay Taylor	NHS Dorset ICB Board Non-Executive Member	4 of 4
Forbes Watson	NHS Dorset Primary Medical Services Partner Member (Chair of the Dorset GP Alliance) (attendance from December 2022)	3 of 4
Ruth Williamson	Interim Chief Medical Officer, University Hospitals Dorset	0 of 4
***** Figures include attendance by a nominated deputy as allowed for in the Terms of Reference.		

During the period when this committee was operational (1 April 2023 to 18 October 2023), the key highlights of the work of the committee included:

- Providing oversight of programmes of work including Home First, Integrated Neighbourhood Teams, Integrated Urgent Care Service, Special Educational Needs and Disabilities (SEND), Diabetes and Mental Health Community Transformation,
- Approving and recommending to the ICB Board the Dorset Support Self-Management Service contract, the 999 Lead Commissioner agreement, and the Specialised Commissioning pre-delegation assessment framework,
- Reviewing and agreeing the arrangements for the ICB committee refresh, including the stepping-down of the committee,
- Reviewing the risks on the Corporate Risk Register relevant to the work of the committee.

People, Engagement and Culture Committee (formerly People and Culture Committee to December 2023)

Since the committee refresh in December 2023, the core purpose of this committee is to provide oversight and seek assurances that NHS Dorset and partner organisations are delivering on commitments regarding:

- the ICS and ICB People Plans
- leadership development and talent management
- workforce - planning, recruitment, retention and training
- equality, diversity and inclusion
- health and wellbeing
- public engagement
- supporting broader social and economic development.

The Committee is currently chaired by Leesa Harwood, NHS Dorset ICB Board Non-Executive Member. Other members from 1 April 2023 to 31 March 2024 and their attendance records are detailed below:

Table 14: People, Engagement and Culture Committee composition and attendance

Name	Role	Attendance Record (6 meetings held during the period 1 April 2023 to 31 March 2024)
Rhiannon Beaumont-Wood (from 20/06/23 meeting)	NHS Dorset ICB Board Non-Executive Member	5 of 5
David Freeman (from 13/12/23 meeting)	NHS Dorset Acting Chief Executive Officer	2 of 2
Siobhan Harrington	Chief Executive, University Hospitals Dorset (Provider Chief Executive)	3 of 6
Dawn Harvey	NHS Dorset Chief People Officer	6 of 6
Patricia Miller (to 18/10/23 meeting)	NHS Dorset Chief Executive Officer	4 of 4
Leesa Harwood (from 20/06/23 meeting)	NHS Dorset ICB Board Non-Executive Member and Committee Chair	5 of 5
Debbie Simmons	NHS Dorset Chief Nursing Officer (from 26 September 2022)	6 of 6
Kay Taylor (to 18/10/23 meeting)	NHS Dorset ICB Board Non-Executive Member	3 of 4
Manish Tayal (to 20/06/23 meeting)	NHS Dorset ICB Board Interim Non-Executive Member	1 of 2

Forbes Watson	NHS Dorset ICB Board Primary Medical Services Partner Member (Chair of the Dorset GP Alliance)	0 of 6
Graham Wilkin	Managing Director, Tricuro	2* of 3
Dan Worsley (from 13/12/23 meeting)	NHS Dorset ICB Board Non-Executive Member	1 of 2
***** Figures include attendance by a nominated deputy as allowed for in the Terms of Reference.		

During the period 1 April 2023 to 30 March 2024, the key highlights of the work of the Committee included:

- Approving and recommending to the ICB Board the Dorset Integrated Care System and NHS Dorset People Plans,
- Proving oversight and assurance on delivery against the people plans for the organisation and the Dorset system, the ICS Staff Survey results, the Primary Care Training Hub, the 100 Voices project, Equality, Diversity and Inclusion work including the Equality Delivery System data and Equality Objectives, Communications and Engagement approach and performance,
- Undertaking deep dives into areas such as recruitment and system-working culture, and considered topics including agency usage and the social care workforce,
- Receiving and reviewing the escalation reports from those groups which sit under the committee, including the NHS Dorset Partnership Forum, the People and Culture Steering Group, and the Communications and Engagement Steering Group,
- Reviewing and agreeing the arrangements for the ICB committee refresh,
- Reviewing the risks on the Corporate Risk Register relevant to the work of the committee.

Prevention, Equity and Outcomes Committee

The core purpose of this new Committee established in December 2023 is to provide oversight and seek assurances that NHS Dorset and partner organisations are delivering on commitments regarding:

- better health outcomes
- the prevention agenda
- reducing inequality and inequity
- social and economic development
- environmental sustainability
- commissioning services which support these principles
- ensuring services are commissioned with measurable objectives and investment outcomes.

The Prevention, Equity and Outcomes Committee is chaired by Jonathon Carr-Brown, NHS Dorset ICB Board Non-Executive Member. Other members and their attendance records are detailed below:

Table 15: Prevention, Equity and Outcomes Committee composition and attendance

Name	Role	Attendance Record (2 meetings held during the period 1 April 2023 to 31 March 2024)
Rhiannon Beaumont-Wood	NHS Dorset ICB Board Non-Executive Member	2 of 2
John Beswick	NHS Dorset ICB Board Non-Executive Member	2 of 2
Kate Calvert	NHS Dorset Acting Chief Commissioning Officer	2 of 2
Jonathon Carr-Brown	NHS Dorset ICB Board Non-Executive Member and Committee Chair	2 of 2
Sam Crowe	Director of Public Health for Dorset and Bournemouth, Christchurch and Poole Councils	1 of 2
David Freeman	NHS Dorset Acting Chief Executive Officer	2 of 2
Alastair Hutchison	NHS Provider Trust representative	0 of 1
Paul Johnson	NHS Dorset Chief Medical Officer	1 of 2
Patricia Miller	NHS Dorset Chief Executive Officer	0 of 0[+]
Debbie Simmons	NHS Dorset Chief Nursing Officer	1 of 2
Kay Taylor	NHS Dorset ICB Board Non-Executive Member	2 of 2
Forbes Watson	NHS Dorset ICB Board Non-Executive Member	2 of 2
***** Figures include attendance by a nominated deputy as allowed for in the Terms of Reference. [+] all meetings held fell within period of absence As at the time of writing, confirmation is awaited regarding member representation from the local authorities and VCS Assembly.		

During the period December 2023 to 30 March 2024, the key highlights of the work of the Committee included:

- Developing the committee's knowledge of prevention, equity, health inequalities and outcomes and agreeing the remit and priorities for the new committee,
- Receiving and reviewing the escalation reports from the Primary Care Strategic Oversight Group, which sits beneath the committee
- Reviewing the risks on the Corporate Risk Register relevant to the work of the committee.

Primary Care Commissioning Committee

This committee stood down in December 2023 following the committee refresh, with aspects of the work of the committee being taken on by the Primary Care Strategic Operating Group, and the Prevention, Equity and Outcomes, Productivity and Performance, and Quality, Experience and Safety committees. Prior to this date the purpose of the Primary Care Commissioning

Committee was to make decisions on the review, planning and procurement of primary care services in Dorset and other direct commissioning under delegated authority from NHS England.

The Primary Care Commissioning Committee was chaired by Kay Taylor, NHS Dorset ICB Board Non-Executive Member. Other members from 1 April 2023 to 18 October 2023 and their attendance records are detailed below:

Table 16: Primary Care Commissioning Committee composition and attendance

Name	Role	Attendance Record (4 meetings held during the period 1 April 2023 to 18 October 2023)
Jonathon Carr-Brown	NHS Dorset ICB Board Non-Executive Member	3 of 4
Sam Crowe	Director of Public Health for Dorset and Bournemouth, Christchurch and Poole Councils	0 of 4
David Freeman	NHS Dorset Chief Commissioning Officer	3 of 4
Dawn Harvey (co-opted for 18/10/23 meeting)	NHS Dorset Chief People Officer	1 of 1
Leesa Harwood (from 21/06/23 meeting)	NHS Dorset ICB Board Interim Non-Executive Member	4 of 4
Paul Johnson	NHS Dorset Chief Medical Officer	2 of 4
Patricia Miller	NHS Dorset Chief Executive Officer	1 of 4
Robert Morgan	NHS Dorset Chief Finance Officer	3 of 4
Andy Purbrick	Chief Executive Local Medical Committees	4 of 4
Debbie Simmons	NHS Dorset Chief Nursing Officer	2 of 4
Kay Taylor	NHS Dorset ICB Board Non-Executive Member and Committee Chair	4 of 4
Forbes Watson	NHS Dorset ICB Board Primary Medical Services Partner Member	3 of 4
Simone Yule	Dorset GP Alliance Deputy Chair	3 of 4
***** Figures include attendance by a nominated deputy as allowed for in the Terms of Reference.		

During the period when this committee was operational (1 April 2023 to 18 October 2023), the key highlights of the work of the Committee included:

- Approving an NHS Dorset procedure for managing changes to existing Primary Care Networks and a contract for a supervised toothbrushing services in Dorset,
- Providing oversight and assurance on the delegation of pharmacy, optometry and dental services, on the performance, quality and risks relating to primary care service provision, and on the sustainability of general practice,
- Reviewing the internal audit reports on general practice and on pharmacy, optometry and dental delegation planning,
- Reviewing and agreeing the arrangements for the ICB committee refresh, including the stepping-down of the committee,
- Reviewing the risks on the Corporate Risk Register relevant to the work of the committee.

Productivity and Performance Committee (formerly Finance and Performance Committee to December 2023)

Since the committee refresh in December 2023, the core purpose of this committee is to provide oversight and seek assurances that NHS Dorset and partner NHS organisations are delivering on commitments regarding:

- financial management
- annual operating plan delivery
- regulatory performance and reporting, including delivery of the National Operating Framework
- capital management and investment including investment/disinvestment decisions, post-evaluation and return on investment
- enhancing productivity.

The committee is chaired by Dan Worsley, NHS Dorset ICB Board Non-Executive Member. Other members from 1 April 2023 to 31 March 2024 and their attendance records are detailed below:

Table 17: Productivity and Performance Committee composition and attendance (formerly Finance and Performance Committee to December 2023)

Name	Role	Attendance Record (7 meetings held during the period 1 April 2023 to 31 March 2024)
Neil Bacon	NHS Dorset Chief Strategy and Transformation Officer	7 of 7
John Beswick	NHS Dorset ICB Board Non-Executive Member	6 of 7
Matthew Bryant	NHS Trust and Foundation Trust Partner Member (Mental Health)	4 of 7
Jonathon Carr-Brown	NHS Dorset ICB Board Non-Executive Member	6 of 7
David Freeman (from 14/12/23 meeting)	NHS Dorset Acting Chief Executive Officer	2 of 3
Patricia Miller (to 19/10/23 meeting)	NHS Dorset Chief Executive Officer	3 of 4
Robert Morgan	NHS Dorset Chief Finance Officer	7 of 7
Dean Spencer	NHS Dorset Chief Operating Officer	7 of 7
Kay Taylor (from 14/12/23 meeting)	NHS Dorset ICB Board Non-Executive Member	2 of 3
Dan Worsley	NHS Dorset ICB Board Non-Executive Member and Committee Chair	6 of 7
***** Figures include attendance by a nominated deputy as allowed for in the Terms of Reference.		

During the period 1 April 2023 to 31 March 2024, the key highlights of the work of the Committee included:

- Approving and, where necessary recommending to the ICB Board, the Dorset ICB Operational Plan and Opening Budgets 2023-24; contract awards and uplifts including urgent ambulance services and Personal Health Commissioning, and awards of contract under the new Provider Selection Regime; the Dorset system's Winter Plan; and amendments to the ICB's Standing Financial Instructions,
- Providing oversight and assurance on system financial and operational performance including mental health, cancer and No Criteria to Reside; Personal Health Commissioning; the System Oversight Framework; and prescribing performance,
- Considering discussion topics including 'what does a good system Finance and Performance Committee look like' and 'how do we define productivity' to support the effectiveness of the committee,
- Reviewing the risks on the Corporate Risk Register relevant to the work of the committee.

Quality, Experience and Safety Committee (formerly Quality and Safety Committee to December 2023)

Since the committee refresh in December 2023, the core purpose of this committee is to provide oversight and seek assurances that NHS Dorset and partner organisations are delivering on commitments regarding:-

- delivery and effectiveness of quality and safety across the system
- delivery and effectiveness of the ICS Clinical Strategy
- quality governance including quality planning, quality control, quality improvement and assurance
- patient/people experience
- capacity and capability to drive a quality improvement culture.

The Quality and Safety Committee is currently chaired by Rhiannon Beaumont-Wood, NHS Dorset ICB Board Non-Executive Member. Other members from 1 April 2023 to 31 March 2024 and their attendance records are detailed below:

Table 18: Quality, Experience and Safety Committee composition and attendance

Name	Role	Attendance Record (6 meetings held during the period 1 April 2023 to 31 March 2024)
Rhiannon Beaumont-Wood (from 22/06/23 meeting)	NHS Dorset ICB Board Non-Executive Member and Committee Chair	5 of 5
Matthew Bryant	NHS Trust and Foundation Trust Partner Member (Mental Health)	1 of 6
David Freeman (from 14/12/23 meeting)	NHS Dorset Acting Chief Executive Officer	2 of 2

Leesa Harwood (from 22/06/23 meeting)	NHS Dorset ICB Board Non-Executive Member	3 of 5
Paul Johnson	NHS Dorset Chief Medical Officer	6 of 6
Patricia Miller (to 19/10/23 meeting)	NHS Dorset Chief Executive Officer	4 of 4
Debbie Simmons	NHS Dorset Chief Nursing Officer (from 26 September 2022)	6* of 6
Manish Tayal (to 20/04/23 meeting)	NHS Dorset ICB Board Interim Non-Executive Member and Committee Chair	1 of 1
Kay Taylor (co-opted for 20/04/23 and 22/06/23 meetings)	NHS Dorset ICB Board Non-Executive Member	2 of 2
Dan Worsley	NHS Dorset ICB Board Non-Executive Member	3 of 6
***** Figures include attendance by a nominated deputy as allowed for in the Terms of Reference.		

During the period 1 April 2023 to 31 March 2024, the key highlights of the work of the Committee included:

- Approving the Patient Safety Incident Response Plans for NHS partners and recommending the Clinical Strategy to the ICB Board for approval,
- Providing oversight and assurance all aspects of quality and patient safety through the Dorset Quality Report, and also on Infection Prevention and Control, medicines optimisation and patient safety, safeguarding, Learning Disabilities Mortality Reviews, Freedom to Speak Up, the Dorset Local Maternity and Neonatal System (LMNS), Children in Care and Care Experienced Young People and customer care,
- Considering the system approach to quality improvement,
- Receiving escalation reports from the System Quality Group, Dorset Place Based Groups West and East, and the Mortality Group,
- Reviewing the full Corporate Risk Register from a quality and safety perspective.

Remuneration Committee

The core purpose of the Remuneration Committee is to support the Board to exercise the functions of the ICB in the Health and Care Act 2022 regarding appointments, remuneration and allowances. Its key responsibilities are to:

- make decisions in relation to the appointment of the Chief Executive and Chief Officers
- make decisions on remuneration of the Chief Executive and Chief Officers
- have oversight of any special payments to the Chief Executive and Chief Officers
- make recommendations to the ICB Board on the executive team composition, balance and skill mix
- ensure adequate succession planning arrangements are in place for the executive team.

The Remuneration Committee is chaired by Leesa Harwood, NHS Dorset ICB Board Non-Executive Member. Other members from 1 April 2023 to 31 March 2024 and their attendance records are detailed below:

Table 19: Remuneration Committee composition and attendance

Name	Role	Attendance Record (6 meetings held during the period 1 April 2023 to 31 March 2024)
Rhiannon Beaumont-Wood (from 17/08/23 meeting)	NHS Dorset ICB Board Non-Executive Member and Committee Chair	5 of 5
John Beswick (to 07/11/23 meeting)	NHS Dorset ICB Board Non-Executive Member	3 of 5
Jonathon Carr-Brown	NHS Dorset ICB Board Non-Executive Member	6 of 6
Jenni Douglas-Todd (member from 07/11/23 meeting)	NHS Dorset ICB Board Chair	2 of 2
Manish Tayal (to 26/05/23 meeting)	NHS Dorset ICB Board Non-Executive Member (interim) (from 1 August 2022)	0 of 1
Kay Taylor	NHS Dorset ICB Board Non-Executive Member	5 of 6
Dan Worsley	NHS Dorset ICB Board Non-Executive Member	3 of 6

During the period 1 April 2023 to 30 March 2024, the key highlights of the work of the Committee included:

- Determining matters of pay for NHS Dorset Chief Officers, including the remuneration for the interim chief executive arrangements,
- Receiving the appraisal summaries for NHS Dorset Chief Officers.

Risk and Audit Committee

The core purpose of this committee is to provide oversight and seek assurances on the adequacy of governance, risk management and internal control processes within the ICB including financial governance, corporate governance, risk management and internal and external audit.

The committee is chaired by John Beswick, NHS Dorset ICB Board Non-Executive Member. Other members from 1 April 2023 to 31 March 2024 and their attendance records are detailed below:

Table 20: Risk and Audit Committee composition and attendance

Name	Role	Attendance Record (7 meetings held during the period 1 April 2023 to 31 March 2024)
Rhiannon Beaumont-Wood (from 19/06/23 meeting)	NHS Dorset ICB Board Non-Executive Member	5 of 6
John Beswick	NHS Dorset ICB Board Non-Executive Member and Committee Chair	7 of 7
Paul Johnson (to 14/12/23 meeting)	NHS Dorset Chief Medical Officer	4 of 6
Robert Morgan (to 14/12/23 meeting)	NHS Dorset Chief Finance Officer	6 of 6
Debbie Simmons (to 14/12/23 meeting)	NHS Dorset Chief Nursing Officer	6 of 6
Dean Spencer (to 14/12/23 meeting)	NHS Dorset Chief Operating Officer	6 of 6
Manish Tayal (to 19/06/23 meeting)	NHS Dorset ICB Board Interim Non-Executive Member	1 of 2
Kay Taylor	NHS Dorset ICB Board Non-Executive Member	6 of 7
Dan Worsley	NHS Dorset ICB Board Non-Executive Member	6 of 7
***** Figures include attendance by a nominated deputy as allowed for in the Terms of Reference.		

During the period 1 April 2023 to 30 March 2024, matters reviewed by the committee in the discharging their duty have included:

- Approving and recommending to the ICB Board for approval the revised Board Assurance Framework and strategic Risk Appetite Statement, the revised ICB Standards of Business Conduct Policy and the Annual Report and Accounts 2022-23,
- Approving the work plans from the external auditors, internal auditors and the anti-crime service, and receiving regular progress reports on their work plus the internal audit reports from the internal auditors,
- Approving the actions taken regarding failure to declare an interest by a Chief Officer, noting that these were in line with the Standards of Business Standards Policy,
- Noting the decision taken outside the Board to accept the delegation of pharmacy, optometry and dental service and the mechanism used to make this decision which was in line with the ICB Constitution,
- Providing oversight and assurance regarding Declarations of Interest and Gifts, Hospitality and Sponsorship, the Emergency Preparedness, Resilience and Response Framework, Awards of Contracts without Competition, Freedom to Speak Up

arrangements, Data Security and Protection, and all year end reporting including the Value for Money assessment plus year-end key judgments and risk assessments,
- Reviewing the full Corporate Risk Register, noting that all committees review the risks relating to their remits and the Quality, Safety and Experience Committee review the full risk register from a quality and safety perspective.

The committee has wide powers to establish special investigations in the event that any wrongdoing is brought to its notice, in particular, in the case of embezzlement, fraud or theft. There were no cases requiring the exercise of these powers during the reporting period.

Strategic Objectives Committee

The core purpose of this new committee established in December 2023 is to provide oversight and seek assurances that NHS Dorset and partner organisations are delivering on commitments regarding the Joint Forward Plan, transformation, research and innovation, digital, data and technology, inward investment, income generation and strategic partnerships.

The Strategic Objectives Committee is chaired by Kay Taylor, ICB Board Non-Executive Member. Other members and their attendance records are detailed below:

Table 21: Strategic Objectives Committee composition and attendance record

Name	Role	Attendance Record (2 meetings held during the period 1 April 2023 to 31 March 2024)
Neil Bacon	NHS Dorset ICB Chief Strategy and Transformation officer	2* of 2
Jonathon Carr-Brown	NHS Dorset ICB Board Non-Executive Member	2 of 2
Sam Crowe	Director of Public Health for Dorset and Bournemouth, Christchurch and Poole Councils	0^{x} of 2
David Freeman	NHS Dorset ICB Acting Chief Executive Officer	2 of 2
Tim Goodson	Dorset GP Alliance member	2 of 2
Leesa Harwood	NHS Dorset ICB Board Non-Executive Member	1 of 2
Paul Johnson	NHS Dorset Chief Medical Officer	2 of 2
Patricia Miller	NHS Dorset ICB Chief Executive	0 of 0^{+}
Robert Morgan	NHS Dorset ICB Chief Finance Officer	2 of 2
Richard Renaut	NHS Provider representative	1 of 2
Stephen Slough	NHS Dorset ICB Chief Digital Information Officer	1 of 2
Kay Taylor	NHS Dorset ICB Board Non-Executive Member and Committee Chair	2 of 2
Dan Worsley	NHS Dorset ICB Board Non-Executive Member	0 of 2
***** Figures include attendance by a nominated deputy as allowed for in the Terms of Reference.		

[+] all meetings held fell within period of absence [X] due to prior commitments As at the time of writing, member representation from the local authorities, VCS Assembly and Local Enterprise Partnership are awaiting confirmation.

During the period December 2023 to 30 March 2024, the key highlights of the work of the Committee included:

- Approving and recommending to the ICB Board the approach to the Five Year Forward Plan refresh,
- Reviewing and recommending the inclusion in the Board Assurance Framework of the strategic risks relevant to the remit of the committee,
- Providing oversight and assurance on inward investment, the Strategic Portfolio Management Office and the gateway process for transformation projects.

Register of Interests

In line with our values of openness and honesty and statutory guidance, it is a requirement that all members of the NHS Dorset ICB Board, its Committees, Sub-Committees and all NHS Dorset staff including agency, seconded and contractual, should declare any interests that they have that may conflict with the interests of NHS Dorset itself. These can be found on our website

Personal data related incidents

A personal data breach is a breach of security leading to the accidental or unlawful destruction, loss, alteration, unauthorised disclosure of, or access to, personal data.

If we experience a personal data breach at NHS Dorset, we need to consider whether this poses a risk to people and the likelihood and severity of the risk to people's rights and freedoms following the breach. Once this assessment has been made by the Data Protection Officer, if it is likely there would be a risk then we would notify the Information Commissioner's Office (ICO). If it is unlikely, then the breach would be dealt with according to NHS Dorset policies, without reporting to the ICO.

There have been no data breaches this year that have met the threshold for reporting to the ICO.

Modern Slavery Act

NHS Dorset fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement is published on our website at NHS-Dorset-Modern-Slavery-and-Human-Trafficking-statement.pdf (nhsdorset.nhs.uk).

Statement of Accountable Officer's Responsibilities

Under the National Health Service Act 2006 (as amended), NHS England has directed each Integrated Care Board to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of NHS Dorset and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and,
- Prepare the accounts on a going concern basis; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

The National Health Service Act 2006 (as amended) states that each Integrated Care Board shall have an Accountable Officer and that Officer shall be appointed by NHS England.

NHS England has appointed the Chief Executive Officer to be the Accountable Officer of NHS Dorset. The responsibilities of an Accountable Officer, including responsibility for the propriety and regularity of the public finances for which the Accountable Officer is answerable, for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Integrated Care Board and enable them to ensure that the accounts comply with the requirements of the Accounts Direction), and for safeguarding the NHS Dorset assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Accountable Officer Appointment Letter, the National Health Service Act 2006 (as amended), and Managing Public Money published by the Treasury.

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that NHS Dorset's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Governance Statement

Introduction and context

NHS Dorset is a body corporate established by NHS England on 1 July 2022 under the National Health Service Act 2006 (as amended).

NHS Dorset's statutory functions are set out under the National Health Service Act 2006 (as amended).

The ICB's general function is arranging the provision of services for persons for the purposes of the health service in England. NHS Dorset is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its population.

Between 1 April 2023 and 31 March 2024 the Integrated Care Board was not subject to any directions from NHS England issued under Section 14Z61 of the of the National Health Service Act 2006 (as amended).

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Dorset's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in the NHS Dorset's Accountable Officer Appointment Letter.

I am responsible for ensuring that NHS Dorset is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the ICB as set out in this governance statement.

Governance arrangements and effectiveness

The main function of the ICB Board is to ensure that the organisation has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically, and complies with such generally accepted principles of good governance as are relevant to it.

As part of the Annual Assessment for the last financial year, ICB Board members underwent interviews facilitated by Healthwatch Dorset which resulted in rich, qualitative data about the performance of the ICB Board in its initial year. An action plan was developed resulting from the Annual Assessment, to which this feedback contributed, which has helped shape and develop the work of the ICB Board this year. The ICB Board will be undertaking a self-assessment exercise on the Board's effectiveness in the first quarter of 2024/25 and the resulting feedback will be used to further develop the ICB Board. In addition to these annual exercises, the ICB Board undertake a verbal review at the end of each ICB Board meeting. This feedback helps support working practices, future agendas, identifying areas for improvement and highlighting good practice or areas of achievement for celebration.

At each Board meeting, the ICB Board receives a range of reports which support its oversight, assurance and decision-making. These include an update from the Chief Executive Officer, plus reports on quality, finance and performance. The Board also received reports from each of the Board committees and the Integrated Care Partnership on the work undertaken at their last meeting.

At each meeting the ICB Board receive a Board Story, which brings the voice of the community into the Board meeting. This year stories have covered:

- the experience of a local man with learning difficulties
- the impact of the availability of affordable housing for the health and care workforce
- the support received by a young person during an inpatient stay relating to an eating disorder
- the ICB Freedom to Speak Up Group's experience of supporting an individual to raise concerns
- University Hospitals Dorset's paediatric virtual ward
- BCP Council's Family Hubs and Early Help service.

In addition, the ICB Board has discussed a broad range of topics throughout the reporting period, relating to both the work of the ICB and the wider Dorset system. Subjects have included the Hewitt Review, access to services, infection prevention and control, operational planning, BCP Council's corporate vision, data security, equality, diversity and inclusion, customer care, the ICB's revised governance arrangements, health inequalities, integrated neighbourhood teams, the Joint Forward Plan and the Clinical Plan.

Papers for all the ICB's Board meetings in public can be found on our website: NHS Dorset Board – NHS Dorset along with details of how to ask a question at the Board and how to access livestreaming and recordings of our Board meetings.

Every other month the ICB Board holds a Development Session for Board members and attendees. These sessions support the Board in the development of its knowledge, skills and behaviours. Sessions are varied and have included safeguarding training for Board members, presentations from partners on aspects of their work including the voluntary and community sector, Dorset County Hospital and Dorset HealthCare, Dorset Council and BCP Council, and discussions on health inequalities, forward planning and the Dorset ICS's operating model.

Details are provided in the Members Report above on:

- membership of the ICB Board and its attendance
- our Board committees, including our Risk and Audit Committee, and their responsibilities, membership, attendance records and highlights of their work.

UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance however this annual report sets out our corporate governance arrangements and the steps NHS Dorset has taken to ensure that corporate governance best practice is followed. More information can be found in our Governance Handbook on our website.

Discharge of Statutory Functions

NHS Dorset has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislation and regulations. As a result, I can confirm that the ICB is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the ICB's statutory duties.

Risk management arrangements and effectiveness

The NHS Dorset Risk Framework is the procedural document which describes the organisation's risk management arrangements and was approved by the Risk and Audit Committee in November 2023.

The document provides guidance on how the organisation:-

- Manages risk and describes the approach used in identifying, analysing, evaluating, managing and controlling risks that threaten the delivery of our strategic objectives.
- Ensures that risk management is part of our culture and is a primary concern for all staff and stakeholders.
- Assures the public, patients and their carers/representatives, staff, and partner organisations that we are committed to managing risk appropriately.

This documented approach to managing risk helps us achieve agreed standards, maintain oversight and improve the quality of services provided.

Our new Board Assurance Framework, which was approved by the ICB Board in March 2024, assesses and manages the risks associated with achieving the strategic objectives. It demonstrates how we are meeting the strategic objectives as set out in the Joint Forward Plan through outcomes, benefits as well as the statutory functions.

The risk management process allows each project, programme or directorate area to consider their risks and how to they affect the organisation. Where these are scored high, they are escalated from the local and programme risk registers to the Corporate Risk Register, via the relevant governance group. Therefore, the Corporate Risk Register is a culmination of the locally considered higher risks.

These risks are recorded and managed via a Risk Management System and are mapped, where applicable, to the strategic objectives of the organisation within the Board Assurance Framework. It is important to match the balance between the two approaches and ensure there are assurances against both to demonstrate controls are working effectively and risks managed to below the desired level, in line with our risk appetite statement.

The risk appetite of the ICB is influenced by a range of factors including organisational culture, current, historical, external, and internal factors. A clearly documented 'risk appetite statement' is essential to ensure that staff and stakeholders understand the level of risk that the ICB is prepared (or not prepared) to accept in achieving its goals. The ICB risk appetite is periodically reviewed to take account of any local decisions, changes in national guidance and/or fundamental system structures.

The risk management approach enables the Board and its Committees to focus on moderate to high risks with the assurance that lower graded risks have oversight at local directorate levels and consider the risks that may affect the strategic objectives through top-down assessment of the Chie Officer team.

Risk management is embedded in all aspects of the organisation's work through a range of methods including:

Counter fraud methodology: There is a robust programme of counter fraud and anti-bribery activity, supported by the accredited Anti-Crime Specialist whose annual proportionate proactive work plan to address identified risks is monitored by the Chief Finance Officer and the Risk and Audit Committee. The Chief Finance Officer is the first point of contact for any issues to be raised by the Anti-Crime Specialist.

Equality Impact Assessments: we are committed to ensuring a reduction in health inequalities and place the needs of people and communities at the heart of all commissioning functions. Equality analysis is undertaken when reviewing services, making changes to services, commissioning services, and using information within services and within the policies that are used. We work with an independent Lay Assessor to ensure high quality and comprehensive Equality Impact Assessments (EIAs) are conducted.

Incident reporting: Incident reporting is openly encouraged from all staff, GP practices and the provider organisations (both NHS and non-NHS) that are commissioned by us. This information is analysed and used to identify any risks which may impact the business of NHS Dorset.

Stakeholder engagement: Communication and consultation with appropriate stakeholders assists the understanding of the risks faced, the basis for decision-making and the reasons why particular actions are required. Communication and consultation bring together different functions and areas of professional expertise in the management of risk in the ICB to ensure that different views are appropriately considered. It also provides sufficient information and evidence to support oversight and decision making, building a sense of ownership and inclusion among those affected by risk

NHS Dorset holds a quarterly System Quality Group for Integrated Care System partner quality and safety leads, which is joined by representatives of Healthwatch Dorset and the Dorset Public Engagement Group. NHS Dorset also has active involvement of Maternity Voices Partners and Patient Safety Partners in key safety meetings where risks are regularly reviewed.

The Voluntary and Community Sector (VCS) Assembly brings together the voices of the VCS, engaging with thousands of voluntary and community groups and community members, building on existing networks, strengthening community partnerships and embedding the sector as partners in system level governance and decision-making arrangements.

Capacity to Handle Risk

Risk management is conducted systematically, iteratively and collaboratively. To support effective risk management there is appropriate communication and consultation with internal and external stakeholders along with promoting awareness and understanding of risks.

NHS Dorset has assurance of the effectiveness of the risk management processes through:

- Adherence to the Risk Management Framework.
- Adherence to the organisation's governance arrangements, Committee structure including Terms of Reference, and reporting framework.
- Scrutiny and oversight by the Risk and Audit Committee, ahead of authorisation by the Board.

Leadership for the organisation's risk management process is provided via the Board, with responsibility delegated to the Risk and Audit Committee. The organisational structure has been established to assist with this process and is described in the following paragraphs.

The organisation's Chief Officers are the designated leads for risk in their portfolio areas with delegated responsibility and authority regarding the management of risks. This includes compliance with the Risk Management Framework and for ensuring that remedial action is taken wherever key risks are identified including:

- Demonstrating leadership, active involvement and support for risk management.
- Ensuring a Local Risk Register is established and maintained that relates to their areas of responsibility and to involve staff in this process to promote ownership of the risks identified.
- Identifying and adding risks to the Corporate Risk Register in a timely manner.
- Co-ordinating the application of resources to minimise, manage and control the likelihood and/or impact of the risk.
- Ensuring staff undertake mandatory and statutory training.

NHS Dorset has clear governance structures with delegation of responsibility clearly articulated in the Terms of Reference for Committees and Groups. Once a risk is identified for escalation from the local risk register it is submitted to one of the following governance groups for approval to be added to the corporate risk register:

- Quality, Experience and Safety Committee
- Productivity and Performance Committee
- People, Engagement and Culture Committee
- Risk and Audit Committee
- Prevention, Equity and Outcomes Committee
- Strategic Objectives Committee
- System Executive Group
- Ambulance Partnership Board

Oversight of the organisations risks is maintained through the reporting arrangements to the ICB Board which has a duty to assure itself that the organisation has properly identified the risks it faces, and that it has processes and controls in place to mitigate those risks and the impact they have on the organisation and its stakeholders. The Board is supported by the System Executive Group (SEG), and ICB Committee, including the Risk and Audit Committee, to achieve this.

The SEG has representatives from the ICB Chief Officers, Local Authority Executives, Provider organisation Chief Executive Officers and the Director of Public Health for Dorset. This group reviews the Board Assurance Framework to align known risks in the system and inform decision making.

The Strategic Objectives Committee provides oversight and seeks assurance that NHS Dorset and partner organisations are delivering on commitments regarding the Joint Forward Plan objectives, transformation, research, innovation, inward investment, income generation and strategic partnerships.

Risk and Audit Committee provide the ICB with an independent and objective view of the ICB's compliance with statutory responsibilities including whether it has an effective system of integrated governance, risk management and internal control.

The Patient Safety and Risk team supports the consistent identification, assessment, and management of risk across the organisation and, as a team, are central to the dissemination and application of best practice.

New staff to the organisation receive information on risk management as part of their NHS Dorset induction and all Board members receive annual risk training. To support a consistent approach across the organisation the Patient Safety and Risk team are working with the Programme Management Office to develop a training resource to support staff that are involved in the various stages of risk management. Risk training in relation to data protection and information governance is provided to information asset owners and assistants to support best practice.

The approach to risk management across the system is continually evaluated with partners to learn from each other and adopt good practice as it is identified.

The current information security landscape

Dorset ICB manages its information systems in broad alignment with the international standard - Information Security Management Systems (ISMS) - Requirements (ISO/IEC 27001:2013) which specifies that controls implemented within the scope, boundaries and context of the ISMS are risk-based. Information risk management follows the international standard – Information Security Risk Management (ISO/IEC 27005:2018) and uses quantitative risk analysis to communicate and escalate any information security risks to the Corporate Risk Register. Where appropriate, controls (countermeasures) are put in place to mitigate identified risks and their effectiveness is monitored to ensure that the deployed controls are effective in managing the risks. Consideration is also given to information risks that may affect the organisation's business partners.

The healthcare sector globally continues to be a high value target for cyber criminals. This seems mainly for financial gain through ransomware/blackmail attacks due to the sensitive nature of data held in healthcare systems but also to potentially cause disruption to critical national infrastructure. Ransomware-as-a-service has been offered by some crime groups over the last few years and has badly affected some healthcare organisations. Recent international law enforcement takedowns of major cyber crime gangs has improved the situation.

The most prevalent threat the ICB faces is identity theft through phishing email leading to credential harvesting sites. Phishing emails containing malware or links to malware sites are also common but well defended against. Each of these two methods are frequently used by crime gangs to steal data, commit fraud and/or introduce ransomware for financial gain. We see many and varied attempts to gain credentials, but through good user awareness and technical controls, we do not see many (if any) successful attacks. Monitoring and alerting means we are aware of issues early on in any attack and contain any threat activity to single devices.

Supply chain attacks remain a source of concern and there have been disruptive breaches in the South West in the last 12 months. The ICB takes all measures possible to gain assurance from its suppliers, minimise access into its networks and harness resilience in cloud-based services to reduce these risks.

Emergency Preparedness, Resilience and Response

NHS Dorset ICB has spent the last year continuing to strengthen and embed the Emergency Preparedness, Resilience and Response (EPRR) function. This has supported improved compliance with EPRR Core Standards and the ability to meet the Category One responder duties, within the Civil Contingencies Act 2004.

The Accountable Emergency Officer reorganised the EPRR resources within the refreshed System Co-ordination Centre (SCC). The EPRR part of the SCC function is responsible for ensuring the organisation meets its planning responsibilities and provides specialist advice during incidents.

The ICB's emergency alerting process has been strengthened, with the introduction of a three tier on-call scheme. This details clear responsibilities and processes for the director, manager and communications lead. Support to these roles has been provided via the on-call training programme and through routine checks and briefings, relating to individual's periods of on-call cover.

Improvements to the organisation's approach to Business Continuity Management was one of several improved standards that put the ICB in a strong position going into the annual EPRR Core Standards Assurance Process. Following a confirm and challenge meeting with NHS England Southwest colleagues, NHS Dorset was approved as being substantially compliant with the EPRR core standards (over 95%). In addition to the annual assurance processes the EPRR team have completed an internal audit and provided information to the national COVID Inquiry.

The principal focus of incident response planning for 2023/24 has been in the preparation for the frequent periods of industrial action, which has required command structures and links with national and regional partners.

The ICB continues to fulfil its active role in the Dorset Local Resilience Forum and acts as the co-chair and facilitator of the Local Health Resilience Partnership.

NHS Dorset aspires to reach full compliance with the EPRR Core Standards and maintain the most robust emergency response procedures in 2024/25.

Risk Assessment

NHS Dorset continues to develop and embed its approaches to risk management both internally in the organisation and as a partner within the Integrated Care System. The organisation views integrated risk management as a key element in the successful delivery of both NHS Dorset and Integrated Care System business and remains committed to ensuring staff are equipped to assess, manage, escalate, and report risks.

The risk management process allows each directorate or programme area to prioritise the risks as they are identified and how they affect the organisation. There is alignment with the Board Assurance Framework, which assesses and manages the risks associated with achieving the strategic objectives, and assurance is sought to ensure a balance between the two processes to demonstrate controls are working effectively and risks are managed to the desired level according to the risk appetite.

The Board Assurance Framework and the Corporate Risk Register have identified no governance, risk management, internal control risks or lapses of protective security. Between 1 April 2023 and 31 March 2024, the process to record operational risks associated with development projects continued, with a clear route to escalate any of the risks identified to the Corporate Risk Register.

During this twelve-month period six risks were added to the Corporate Risk Register, and three risks were closed. At the end of the reporting period, nine risks remain open.

Of the nine open risks as at 31 March 2024 seven are assessed as high. These relate to:

- Financial challenges
- The challenges of current demand for acute mental health inpatient beds
- National target of zero 65 week waits to be achieved by March 2024
- Failure to achieve the Special Educational Needs and Disabilities Written Statement of Action plan with Bournemouth, Christchurch and Poole Council
- Meeting the national target for starting the Autism Spectrum Disorder assessment process within three months of referral in Dorset.

More information on risks relating to the ICB can be found in the Key Issues and Risks section of the Performance Report.

Our risk profile will be subject to on-going in-year revision as the local and corporate registers are presented at the relevant committees for review, challenge and assessment of effectiveness of controls. Risk owners provide updates on progress with actions, re-evaluate the risk score and give realistic timescales for risk reduction on a monthly, quarterly or bi-monthly basis in line with the current risk score.

Over the last year, the ICB developed a new Board Assurance Framework (BAF) to support the management of its strategic risks. In March 2024, following review and input from the Chief Officer team and the Risk and Audit Committee, the ICB Board approved a revised BAF and a Strategic Risk Appetite Statement. The BAF reports on the most significant risks to the achievement of the four core purposes of the Dorset Integrated Care System, which have been adopted as its strategic aims, along with the greatest risks to achieving our vision.

To support the BAF, the ICB Board agreed a Strategic Risk Appetite Statement. The Risk Appetite Statement articulates the levels and types of risk we are prepared to accept in pursuing our objectives. This then informs planning and objective setting, as well as underpinning the threshold used when determining our tolerance to individual risks.

The revised BAF comprises five strategic risks and each of which is linked to one of the four core purposes of the ICS.

Digital Maturity - Improve Outcomes to Population Healthcare
Failure to improve and develop digital maturity, infrastructure and resilience could lead to an inability to fully drive change in clinical pathways, Integrated flexible workforce, access to services and community integration. This will lead to unsafe services and potentially worsening health inequalities in Dorset.

Strategic Partnerships - Improve Outcomes to Population Healthcare
NHS Dorset failure to build and sustain successful partnerships will lead to the failure to deliver strategic outcomes for the population. This may result in continued disparities in healthcare delivery and suboptimal experiences. The ICB will not be able to achieve its strategic objectives: enhancing productivity, tackling inequalities, improving access, and contributing to broader social and economic development.

Workforce and Culture - Tackle Inequalities in Outcomes and Access
The ability of all partners to recruit and retain a health and care workforce to deliver the immediate and longer-term models of care for our population may continue to be compromised due to national shortages of health and care workforce. This leads to insufficient capacity to deliver services, impede transformation, drive agency spend and puts more pressure on the existing workforce resulting in higher staff sickness and leaver rates and negatively affecting the overall performance of health and care services.

Additionally, the failure to implement a culture of system working poses a significant risk to the successful implementation of the ICB's four purposes, and our overall transformation plans for the ICS which include sustainable workforce models across health, care and the VCS.

Financial performance and value - Enhance Productivity and Value for Money
The failure to release funding from high-cost acute provision to invest in community, primary care, and prevention. Leading to a deficit position and limits the ability to get back to sustainable financial balance and invest in the essential future services required in Dorset.

Ability to Transform - Broader Social and Economic Development
There is a potential risk that our system faces capacity challenges and ability to focus on the long-term transformation that could jeopardise the successful execution of our strategic transformation initiatives, leading to a failure to recognise the benefits outlined in the ICP Strategy and 5 year forward plan. The risk is attributed to multiple factors, including surges in demand, ageing population and long lengths of stay.

Each of the risks are assigned an executive risk owner and the Board committees review the strategic risks within their remit. In addition, the Quality, Experience and Safety Committee reviews the full BAF from a quality and safety perspective. Each risk has been assigned an initial risk score, a target risk score and a risk tolerance. Risks are regularly reviewed for progress against these targets. Through the BAF the organisation monitors the assurances and controls relating to each risk, any gaps in assurance and the mitigating actions required to reduce the risk. The Risk and Audit Committee has oversight of the full BAF and it is reviewed regularly by the ICB Board.

Other sources of assurance

Internal Control Framework

A system of internal control is the set of processes and procedures in place in NHS Dorset to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

Primary responsibility for providing oversight and seeking assurances on the adequacy of governance, risk management and internal control processes within the ICB rests with the Risk

and Audit Committee.

The Risk and Audit Committee provides assurance to the Board.

The internal control framework comprises the following elements:

- Control environment – the set of standards, processes and structures set by the ICB. The Chair, Non-Executive Members, Chief Executive, Chief Officers and senior management establish the tone at the top regarding the importance of internal control including expected standards of business conduct as set out in the Governance Handbook.
- Risk assessment – as described above.
- Control activities – the ICB has a comprehensive suite of corporate policies which are available to all staff. The Governance Handbook on the ICB website brings together key documents which support the Constitution and promote good governance.
- Information and communication – governed by various NHS and internal information technology systems, with a strong track record of information governance and security, together with a team of communications specialists.
- Monitoring – robust monitoring is ensured via reporting in line with governance structures, together with staff and management activity.

In particular, the internal control framework is underpinned by the finance system, the Integrated Single Financial Environment (ISFE) which is mandated for all Integrated Care Boards by NHS England. The system is set up to reflect the delegated financial limits laid down in the Standing Financial Instructions and forces access control and segregation of duties which reduces the risk of fraud and error. Other key components include:

- budgetary control
- management checks, authorisations, and oversight
- control account reconciliations
- internal audit and counter fraud activity.

The Strategic Objectives Committee which was introduced in December 2023, provides specific oversight and assurance to the Board to ensure the active development, implementation and measurement of the strategic objectives.

The Health and Care Act 2022 places responsibility on ICBs to manage conflicts of interest and to publish their own Conflicts of Interest Policy. NHS Dorset's has robust processes in place to manage conflicts of interest and our policy is contained within its Governance Handbook. NHS England has provided nationally-commissioned specifically designed e-learning modules on managing conflicts of interest which explains how NHS-wide conflicts of interest rules should be applied within Integrated Care Boards. Module 1 has been released for completion by all ICB staff, board members and committee members. The remaining modules will be made available to ICBs by NHS England in early 2024/25.

Data Quality

The data used by our Board, committees and groups is obtained from various sources, the majority of which are national systems and official NHS data sets. Provider data is quality assured through a number of mechanisms including contract and performance monitoring but also through system control center and other system resilience processes.

The specific governance of data quality and consistency across the Integrated Care System providers is owned by the system-wide Operations and Finance Reference Group. NHS Dorset

maintains good close working relationships with the local providers and addresses any data quality issues in a timely and productive way.

The Board regularly receive and welcome the benefits of using Statistical Process Control (SPC) over other statistical methodologies, especially for understanding impact when implementing change. In line with many NHS organisations, the use of SPC has been adopted for much of our reporting, and this can be seen in the regular Board papers on quality and performance. In addition, the positive uses of the data from the Dorset Intelligence and Insight Service (DiiS) have been discussed regularly by the ICB Board, including in relation to targeting prevention and treatment, and in addressing health inequalities. More information regarding the DiiS and health inequalities can be found in the Reducing Health Inequality section above. The Board has raised no concerns about the quality of data they receive.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to NHS Dorset, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

We place high importance on ensuring there are robust information governance (IG) systems and processes in place to manage data security risks and the protection of patient and corporate information.

Responsibility for Information Governance rests with the Chief Executive Officer, as the Accountable Officer, and this authority is delegated to the Information Asset Owners' Group (IAOG). A range of measures are used to manage and mitigate information risks, including annual mandatory staff training, physical security, data encryption, access controls and departmental spot checks.

The organisation's IG status is regularly reviewed by the IAOG which is a standing group that reports to the Board via the Risk and Audit Committee. Its purpose is to support and drive the broader IG agenda and provide assurance to the ICB Board that effective IG best practice mechanisms are in place. Risks to information, including data protection, data security, confidentiality, integrity, and availability, are managed and controlled via this group which meets quarterly.

The Senior Information Risk Owner (SIRO) has responsibility for leading and implementing the information asset risk assessment and management processes within NHS Dorset in addition to advising the Board on the effectiveness of information risk management throughout the organisation.

As part of the annual Data Security and Protection toolkit (DSP) publication, a comprehensive assessment of information security is undertaken. The effectiveness of this assessment is reported to, and monitored by, the IAOG. This includes details of any personal data related serious incidents, NHS Dorset's annual DSP toolkit publication and reports of other IG incidents and audit reviews. Regular reports are received in relation to policies, the Caldicott risk register, information assets and records management.

There is a staff handbook in place to ensure that staff are aware of their roles and responsibilities under IG and the Data Protection Act 2018.

We are making good progress towards our aim to publish 'standards met' for the DSP toolkit for 2023/24 and confirmation of the outcome is expected in July 2024.

There are processes in place for incident reporting and investigation of serious incidents.

Information risk assessment and management procedures have been established via the IAOG, the SIRO and the risk management team. Work continually takes place to ensure that these are embedded throughout the organisation. All incidents which have a data protection element are investigated with lessons learnt shared via the IAOG.

Business Critical Models

As Accountable Officer I can confirm that there is an appropriate framework and environment in place to provide quality assurance of business-critical models, in line with the recommendations in the Macpherson Report for government departments and their arm's length bodies.

Having reviewed the guidance around business-critical models and the detail held by HM Treasury, although ICBs make use of the models, we do not own them, and are unable to change their content. For example, the models include the ICB allocations formula and the modelling for the national tariff; we receive the outputs of these models but have no control or input to their use.

Third party assurances

NHS Dorset contracts for goods and services using the recommended or statutorily mandated contract forms which contain robust provisions around third party (sub-contracting) rights and assurances. These are scrutinised through the contract review process.

Control Issues

The ICB highlighted to NHS England through the Month 9 Governance Statement Report that there were two areas of concern in relation to control issues. These were in relation to finance, and access to services and capacity.

The original financial plan for 2023/24 showed that the ICB planned to break even, within an overall break even planned position across the whole of the Dorset Integrated Care System. Due to financial pressures in Personal Health Commissioning and Prescribing, the eventual financial performance for the year was a deficit of £17.4m against a whole ICS deficit of £14.6m.

This deficit was experienced despite the following control measures, which were agreed with NHS England and implemented in the final quarter of the financial year:

- Review of all investments made since 2019/20
- Vacancy and workforce controls in place and operating effectively
- Improvement towards full compliance with the Healthcare Financial Management Association (HFMA) standards set out in 'Improving Financial Sustainability'
- 'System lock' investment controls overseen by the System Recovery Group
- All insourcing and outsourcing assessed against financial position and only retained where contractually committed or related to cancer targets.

The financial planning process for 2024/25 is in progress and at year end the ICB (and therefore the wider ICS) was facing serious difficulties in formulating a break-even plan. There is a significant underlying deficit to be tackled and efforts are underway to take action to move the system back into financial balance.

In their work on the value for money arrangements at the ICB, the external auditors, KPMG, have identified a risk to financial sustainability, but no significant weaknesses. The in year deficit necessitates KPMG issuing a qualified opinion on regularity and a Section 30 (1) b letter to the Secretary of State, as required by the Local Audit and Accountability Act 2014.

In relation to access to services/capacity, the ICB agreed a revised 'H2' plan with NHS England, which included a revised year end figure for the number of people waiting over 65 weeks for treatment. Details of the mitigations and actions that have been in place to attain the operational standards, and information on the operational performance position at year end, are included in the Performance Report above.

Review of economy, efficiency & effectiveness of the use of resources

The Scheme of Reservation and Delegation sets out the routes for all NHS Dorset decisions, including those relating to economy, efficiency and effectiveness of the use of resources.

Alongside this, the Standing Financial Instructions and Detailed Delegation Limits ensure that we fulfil our statutory duty to carry out our functions effectively, efficiently and economically.

As part of our control measures for managing the organisation's financial affairs, the Standing Financial Instructions define our purpose, responsibilities, legal framework and operating environment. They enable sound administration, lessen the risk of irregularities and support commissioning and delivery of effective, efficient and economical services.

Our Chief Executive Officer is the Accountable Officer for NHS Dorset and is personally accountable to NHS England for the stewardship of our allocated resources. The Standing Financial Instructions set out the financial responsibilities that are delegated from our Chief Executive Officer to our Chief Finance Officer, who has a key role in supporting a strong culture of public accountability, probity and governance.

Our Board and the Board Committees provide assurance and oversight on the economy, efficiency and effectiveness of our use of resources.

Details of the work of the Board Committees are set out in the Accountability Report above. This includes the work of the Risk and Audit Committee, whose functions include oversight of the internal audit programme.

Each year, the Head of Internal Audit must provide an opinion on the overall adequacy and effectiveness of our framework of governance, risk management and internal control, and this can be read below.

The ICB continues to participate in and lead the Integrated Care System which is allocated a financial envelope for the ICB and the three Foundation Trusts in Dorset. Working within this shared financial envelope requires a collaborative and co-ordinated approach to ensure that the use of resources is optimised.

South Western Ambulance Services NHS Foundation Trust is also funded via the Dorset ICS financial envelope. However, where there are issues relating to the quantum of funding for ambulance services, this is picked up through the Ambulance Joint Commissioning Committee on a regional footprint.

NHS Dorset receives a specific allocation in each financial year to cover its administration costs. This amount was £16,578,000 in 2023/24 and administrative functions (as defined in NHS guidance) were delivered within this total amount, as required by statute.

The NHS System Oversight Framework 2022/23 describes NHS England's approach to NHS oversight for 2023/24. Further information on this framework is given above in the Performance Synopsis section of this report.
During 2024/25 we will continue to enhance our performance reporting by implementing an integrated performance report which will provide a holistic overview of the performance of the Dorset system, encompassing safety, quality, and outcomes, operational performance, financial

performance, and workforce. This report will play a crucial role in highlighting areas of success and areas which may require improvement to the ICB Board.

Information on our financial performance can be found in the Financial Review section above. 2023/24 has seen the implementation of two cross system decision and governance groups, the System Recovery Group and the System Investment Group. The System Recovery Group was established to deliver the revised deficit plan for Dorset ICS and also provides assurance of the delivery of the operational plan, including all efficiency schemes required to be delivered across the system, whether workforce reductions, productivity or transformation. The System Investment Group ensures that any new investments have a robust case for approval, that they have both system and regional support to make investment, and that benefits are appropriately identified for all new investments.

Delegation of functions

The Scheme of Reservation and Delegation sets out those matters that are reserved for NHS Dorset ICB Board and which are delegated to the Board committees and Chief Officers. The Scheme of Reservation and Delegation is available as part of our Governance Handbook which is available on our website. Board committees submit a report on their activities to the Board after each committee meeting. The remit of each committee, and their attendees, are detailed in the Corporate Governance Report above.

The Risk and Audit Committee, in line with our Scheme of Reservation and Delegation, monitors the financial stewardship of the organisation and is responsible for scrutinising the end of year financial accounts and recommending approval to the Board.

The Risk and Audit Committee retains oversight of all operational and strategic risks and are responsible for ensuring that relevant mitigating actions are undertaken. There have been no significant internal control failures identified during the reporting period.

Internal Audit has found no significant lapses in key controls tested in any of the audits that have been undertaken in this financial period.

NHS Dorset commissions support services from other NHS organisations under the NHS contract for goods and services for the provision of back-office functions such as payroll and occupational health. The contract form provides the framework under which assurance on performance can be monitored and managed.

Freedom to Speak Up: raising concerns (whistleblowing) effectiveness

In 2015 Sir Robert Francis published his Freedom to Speak Up Report, which laid out an independent review into creating an open and honest reporting culture in the NHS. Since its establishment, the ICB has been committed to promoting and developing this approach.

In October 2023 the newly appointed Freedom to Speak Up Guardians launched ‘Breaking Barriers’ month which aimed at empowering all ICB staff to step forwards and raise any known or perceived barriers there may be to speaking up. The engagement from staff throughout the ICB was excellent, with forty-three separate feedback points being raised for consideration. Between October 2023 and March 2024 seventeen speak up cases have been recorded. This increase of recorded cases since October 2023 has resulted in the emergence of some common themes:

- The need to increase trust in speaking up, including the need for leaders to listen and follow up on concerns without fear of detriment to the individual raising concern.
- The awareness of the Freedom to Speak Up channel needs to increase.

- The need for greater visibility of the evidence of speaking up making a difference within NHS Dorset.

In response to the common themes, NHS Dorset has given the Freedom to Speak Up Guardian a formal seat on the Equity, Equality and Diversity Steering Group to raise the profile of speaking up and to create a formal channel for emerging themes to be raised. The Risk and Audit Committee provides oversight and assurance of the Freedom to Speak Up arrangements for the organisation, whilst reporting is also received by the Quality, Experience and Safety Committee where cases relate to patient safety. NHS Dorset is aiming to mandate Speak Up training for all staff in early 2024, with further training for managers and leaders. NHS Dorset has also updated it's speak up policy to reflect national guidance, implemented phycological safety training within the organisation, and has supported the roll out of the national freedom to speak up reflective tool which will support the next steps and ambitions of NHS Dorset.

Counter fraud arrangements

NHS Dorset is required, under the terms of the Standard NHS Contract and in accordance with the 'Government Functional Standard 013: Counter fraud – management of counter fraud, bribery and corruption activity' to ensure that appropriate counter fraud measures are in place.

NHS Dorset's accountable officer for fraud, bribery and corruption is the Chief Finance Officer, who is responsible for authorising investigations, including the arrest, interviewing and prosecution of subjects and the recovery or proposal to write-off any sums lost to fraud.

The organisation has an accredited local counter fraud specialist (LCFS) who is nominated and responsible for the investigation of any allegations of fraud, bribery, and corruption and for the delivery of a programme of proactive counter fraud work, as detailed in the annual risk-based work-plan approved by the Risk and Audit Committee.

The LCFS attends each Risk and Audit Committee meeting to report progress against the agreed counter fraud work plan and advise the outcome of any completed investigations or proactive exercises.

Where fraud is established or improvements to systems or processes identified, the LCFS will recommend appropriate action to the organisation.

The LCFS collaborates closely with the workforce team when investigating cases involving members of staff and provides evidence to our investigating officer for disciplinary matters.

NHS Dorset has a nominated in-house Counter Fraud Champion whose role is to support the LCFS in promoting awareness of fraud across the organisation.

Monitoring of the organisation's counter fraud arrangements is undertaken by the Risk and Audit Committee.

NHS Dorset is required to submit an annual counter fraud functional standard return against 'Government Functional Standard 013: Counter fraud – management of counter fraud, bribery and corruption activity' which provides assurance of compliance with the requirements of the standard. For 2023/24, compliance has been assessed as 'green' for each of the 13 component elements of the standard and for the return overall.

Head of Internal Audit Opinion

Following completion of the planned audit work for the period 1 April 2023 to 31 March 2024 for the ICB, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the ICB's system of risk management, governance and internal control. The Head of Internal Audit concluded that:

The role of internal audit is to provide an opinion to the Board, through the Risk and Audit Committee, on the adequacy and effectiveness of the internal control system to ensure the achievement of the ICB's objectives in the areas reviewed. The annual report from internal audit provides an overall opinion on the adequacy and effectiveness of the ICB's risk management, control and governance processes, within the scope of work undertaken by our firm as outsourced providers of the internal audit service. It also summarises the activities of internal audit for the period. The basis for forming my opinion is as follows:

- An assessment of the design and operation of the underpinning Board Assurance Framework and supporting processes
- An assessment of the range of individual opinions arising from risk-based audit assignments contained within internal audit risk-based plans that have been reported throughout the year, taking account of the relative materiality of these areas and management's progress in addressing control weaknesses
- Any reliance that is being placed upon third party assurances.

Overall, we provide **moderate** assurance that there is a sound system of internal control designed to meet the ICB's objectives and that controls are being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk.

In forming our view we have taken into account that:

- The ICB has achieved its agreed control total which was a variance to budget of £17.4m (subject to external audit) for the year April 2023 to March 2024.
- The ICB has displayed strong controls in relation to data security and information and routine key financial system controls. However, there are improvements required for the forecasting and cost improvement plan reporting.
- The ICB has risk management processes in place, however, the new format of the Board Assurance Framework was finalised in March 2024. As a result, this has not been in place since the inception of the ICB.
- Good progress has been made during the year with the implementation of the actions arising from our audit work

During the period, Internal Audit issued the following audit reports:

Area of Audit	Level of Assurance Given	
	Design	**Operational effectiveness**
Data security and protection toolkit	Substantial	Substantial
Key financial systems	Moderate	Moderate
Primary Care Commissioning – PCN service assurance	Moderate	Moderate
Cyber Security	Moderate	Moderate
ICB Governance arrangements	Moderate	Moderate
Business Continuity and Emergency Planning	Substantial	Moderate
EDI maturity	Audit is in progress	Audit is in progress
Dorset ICS System audit	Audit is in progress	Audit is in progress

Review of the effectiveness of governance, risk management and internal control

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within NHS Dorset who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me.

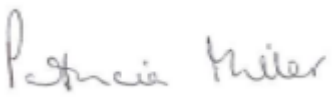
My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to NHS Dorset achieving its principles objectives have been reviewed.

This review is supported by:

- The assurance work of the Board committees, especially the Risk and Audit Committee.
- The oversight work of the Board.
- The work of the internal auditors.
- The Risk Framework, Internal Control Framework, Corporate Risk Register and the work on creating and launching the new Board Assurance Framework and as detailed in the Governance Statement above, which provide evidence of the effectiveness of governance, risk management and internal controls.

In conclusion, I can confirm that other than the two areas highlighted in the Month 9 Governance Statement (as detailed in the Control Issues section above) no significant internal control issues have been identified.



Patricia Miller

Chief Executive Officer

21 June 2024

Remuneration and Staff Report

Remuneration Report

Remuneration Committee

Membership of the ICB's Remuneration Committee is set out in the Accountability Report above.

Percentage change in remuneration of highest paid director

Table 22: Percentage change in remuneration of highest paid director

	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	8.1%	0.0%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	6.5%	0.0%

Pay ratio information (subject to audit)

As at 31 March 2024, remuneration ranged from £22,816 to £209,378 based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff). Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Table 23: Remuneration of NHS Dorset's ICB staff

	25th Percentile (£'000)	Median (£'000)	75th Percentile (£'000)
All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	35	43	57
Salary component of 'all staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	34	43	55

Table 24: Ratios of staff remuneration against the mid-point of the banded remuneration of the highest paid director

Year	25th Percentile pay ratio	Median pay ratio	75th Percentile pay ratio
2023/24	6.9:1	5.5:1	4.2:1

The banded remuneration of the highest paid director/member in NHS Dorset ICB in the financial year 2023/24 was £205k-210k and the relationship to the remuneration of the organisation's workforce is disclosed in the below table.

Table 25: Ratio – staff against highest paid director

Year	25th Percentile total Remuneration ratio	25th Percentile salary ratio	Median total Remuneration ratio	Median salary ratio	75th Percentile total Remuneration ratio	75th Percentile salary ratio
2023/24	6.9:1	6.0:1	5.5:1	4.9:1	4.2:1	3.6:1

In 2023/24, 0 employees received remuneration in excess of the highest-paid director/member.

The median pay ratio, is reflective of the ICB's policies, reflecting the nationally mandated Agenda for Change pay progression and the move within the ICB to additional higher banded staff roles.

Policy and the Remuneration of Very Senior Managers

At NHS Dorset, we have actively recruited a Chief Officer leadership team with the skills, experience, values and behaviours to lead our organisation. We are satisfied that for those earning above £150,000, as with all the Chief Officer team, that their remuneration reflects the wealth of experience they bring. Each appointment has been in line with national guidance and the very senior manager pay framework.

Senior manager remuneration (including salary and pension entitlements)

Table 26: Senior manager remuneration
(including salary and pension entitlements) 2023/24 (subject to audit)

	2023/24					
Name and Title	Salary (bands of £5,000) £'000	Expense payments (taxable)[2] to nearest £100 £	Annual Performance related bonuses (bands of £5,000) £'000	Long term performance related bonuses (bands of £5,000) £'000	All pension related benefits £'000	TOTAL (bands of £5,000) £'000
Executive Directors						
Mrs Jenni Douglas-Todd, Chair	65 - 70	0	0	0	0	65 - 70
Mrs Patricia Miller, Chief Officer **	230 - 235	0	0	0	0	230 - 235
Mr Rob Morgan, Chief Finance Officer	160 - 165	0	0	0	45 - 47.5	205 - 210
Mr Paul Johnson, Chief Medical Officer **	165 - 170	0	0	0	0	165 - 170
Mrs Debbie Simmons, Chief Nursing Officer (to 15 March 2024)	145 - 150	0	0	0	7.5 - 10	155 - 160
Mrs Debra Simmons, Chief Nursing Officer (from 18 March 2024)	5 - 10	0	0	0	0	5 - 10
Mr Stephen Slough, Chief Information Officer	135 - 140	0	0	0	35 - 37.5	170 - 175
Mr David Freeman, Chief Commissioning Officer	160 - 165	0	0	0	75 - 77.5	235 - 240
Mr Kathryn Calvert, Interim Chief Commissioning Officer (from 1 November 2023)	50 - 55	0	0	0	40 - 42.5	95 - 100
Mrs Dawn Harvey, Chief People Officer	140 - 145	0	0	0	147.5 - 150	290 - 295
Mr Neil Bacon, Chief Strategy and Transformation Officer	150 - 155	0	0	0	30 - 32.5	180 - 185
Dr Dean Spencer, Chief Operating Officer **	150 - 155	0	0	0	0	150 - 155

Name and Title	2023/24 Salary (bands of £5,000)	Expense payments (taxable)[2] to nearest £100	Annual Performance related bonuses (bands of £5,000)	Long term performance related bonuses (bands of £5,000)	All pension related benefits	TOTAL (bands of £5,000)
	£'000	£	£'000	£'000	£'000	£'000
Non Executive Members						
Ms Rhiannon Beaumont-Wood, ICB Non-Executive Director and Chair of Quality, Experience & Safety Committee (from 1 June 2023)	10 - 15	0	0	0	0	10 - 15
Mr John Beswick, ICB Non-Executive Director and Chair of Risk & Audit Committee	15 - 20	0	0	0	0	15 - 20
Mr Jonathan Carr-Brown, ICB Non-Executive Director and Chair of Prevention, Equity & Outcomes Committee	15 - 20	0	0	0	0	15 - 20
Ms Leesa Harwood, ICB Non-Executive Director and Chair of Remuneration Committee (from 16 June 23)	10 - 15	0	0	0	0	10 - 15
Dr Manish Tayal, ICB Non-Executive Director (to 7 July 2023)	0 - 5	0	0	0	0	0 - 5
Mrs Kathleen Taylor, ICB Non-Executive Director and Chair of Strategic Objectives Committee	15 - 20	0	0	0	0	15 - 20
Mr Dan Worsley, ICB Non-Executive Director and Chair of Productivity & Performance Committee	15 - 20	0	0	0	0	15 - 20

* Note: Taxable expenses and benefits in kind are expressed to the nearest £100.

** These individuals are affected by the Public Service Pensions Remedy and their membership between 1 April 2015 and 31 March 2022 were moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted for a zero.

Notes:

1 Taxable Benefits relate to on-call and mileage above taxation threshold.

2 The listed Chief Nursing Officers (Debbie Simmons and Debra Simmons) are the same individual, with the split in pay record reflecting retirement and subsequent return.

Pension benefits

Table 27: Pension benefits as at 31 March 2024 (subject to audit)

Senior Manager	Role	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at	Lump sum at pension age related to accrued pension at	Cash Equivalent Transfer Value at	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at	Employer's contribution to stakeholder pension
				31-Mar-2024	31-Mar-2024	01-Apr-2023	31-Mar-2024	31-Mar-2024	
		(bands of £2,500)	(bands of £2,500)	(bands of £5,000	(bands of £5,000				
		£000	£000	£000	£000	£000	£000	£000	£000
Patricia Miller	Chief Officer	0	55 - 57.5	60 - 65	160 - 165	1,114	227	1,482	0
Rob Morgan	Chief Finance Officer	2.5 - 5	0 - 2.5	30 - 35	0	335	88	478	0
Paul Johnson	Chief Medical Officer	0	20 - 22.5	35 - 40	95 - 100	664	67	821	0
Debbie Simmons	Chief Nursing Officer	0 - 2.5	22.5 - 25	45 - 50	125 - 130	937	0	0	0
Stephen Slough	Chief Information Officer	2.5 - 5	0	15 - 20	0	160	53	248	0
David Freeman	Chief Commissioning Officer	0 - 2.5	52.5 - 55	45 - 50	120 - 125	649	277	1,014	0
Kathryn Calvert	Interim Chief Commissioning Officer	0 - 2.5	0 - 2.5	15 - 20	0	197	38	262	0
Dawn Harvey	Chief People Officer	7.5 - 10	50 - 52.5	25 - 30	0	237	177	458	0
Neil Bacon	Chief Strategy and Transformation Officer	2.5 - 5	0 - 2.5	15 - 20	30 - 35	247	54	346	0
Dean Spencer	Chief Operating Officer	0	40 - 42.5	65 - 70	185 - 190	1,268	191	1,614	0

Notes

1 Full details of the accounting policy regarding pension costs can be found within Note 4 of the full set of audited financial statements.

2 '0' is shown above where a Senior Manager is part of the 2008 NHS Pension Scheme, which does not have a Lump sum entitlement.

3 The factors used to calculate the Cash Equivalent Transfer Value (CETV) increased by 10.1% for 2023/24. CETV figures are calculated using the guidance on discount rates for calculating unfunded public service pension contribution rates that was extant at 31 March 2024. HM Treasury published updated guidance on 27 April 2023; this guidance was used in the calculation of 2023 to 24 CETV figures.

4 Where partial or full benefits have been taken the NHS Pension Agency can no longer provide CETV figures and '0' is shown above.

Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Pension Liabilities

For more information regarding pension benefits and costs please see the Financial Statements section on page 11 (see Note 1.5.2 Accounting Policies, Note 4 Employee Benefits and Note 14 Trade and Other Payables).

Compensation on early retirement or for loss of office

There were no ill-health retirements in 2023/24.

Losses and special payments (subject to audit)

There were no special payments in 2023/24 and one in 2022/23 totalling £3,500. In 2023/24 there were 7 losses totalling £9,834, and none in 2022/23.

Payments to past directors (subject to audit)

There were no payments to past directors in 2023/24.

Staff Report

Number of senior managers

The table below shows the number of senior managers by band, excluding Governing Body members within NHS Dorset Integrated Care Board.

Table 28: Number of senior managers by band

NHS Dorset ICB	Number
Very Senior Manager	**5**
Band 9	**6**
Band 8d	**14**
Band 8c	**29**
Band 8b	**44**
Band 8a	**49**
Total	**147**

Staff numbers and costs

Table 29: Average staff numbers by whole-time equivalent (wte) (subject to audit)

Average staff Numbers	2023/24		
	Permanently employed	Other	Total
	No.	No.	No.
Other	444	35	479
Total	**444**	**35**	**479**

Table 30: Staff costs

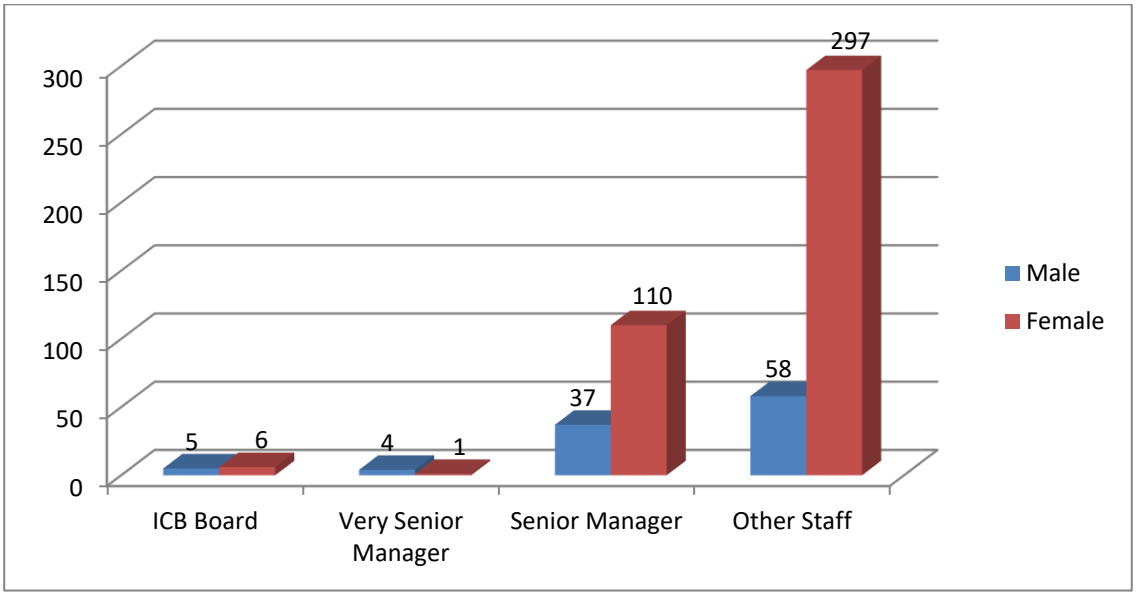
2023/24			
	Permanent Employees	Other	Total
	£'000	£'000	£'000
Salaries and wages	21,688	2,014	23,703
Social security costs	2,385	0	2,385
Employer contributions to the NHS Pension Scheme	4,127	0	4,127
Apprenticeship levy	101	0	101
Termination benefits	320	0	320
Gross admin employee benefits expenditure	28,622	2,014	30,636
Less: Recoveries in respect of employee benefits	(648)	0	(648)
Net admin employee benefits expenditure including capitalised costs	27,974	2,014	29,988
Less: Employee costs capitalised	0	0	0
Net admin employee benefits expenditure excluding capitalised costs	27,974	2,014	29,988
Total average number of people employed	444	35	479
Of above number of whole time equivalent people engaged on capital projects	0.00	0.00	0.00

Staff composition

The table below shows the gender distribution of our Board, senior managers and all other employees as at 31 March 2024 by headcount.

Table 31: Staff composition

	Number		
	Male	Female	Total
ICB Board	5	6	11
Very Senior Manager	4	1	5
Senior Manager	37	110	147
Other Staff	58	297	355
Total	104	414	518



Sickness absence data

Table 32: Staff sickness absence

	%
Monthly Sickness Absence Rates for English NHS bodies - October 2023	5.32 %
Monthly Sickness Absence Rate for NHS Dorset Integrated Care Board - October 2023	2.76 %
Monthly Sickness Absence Rate for NHS Dorset Integrated Care Board - Average for 2022-23	2.85 %

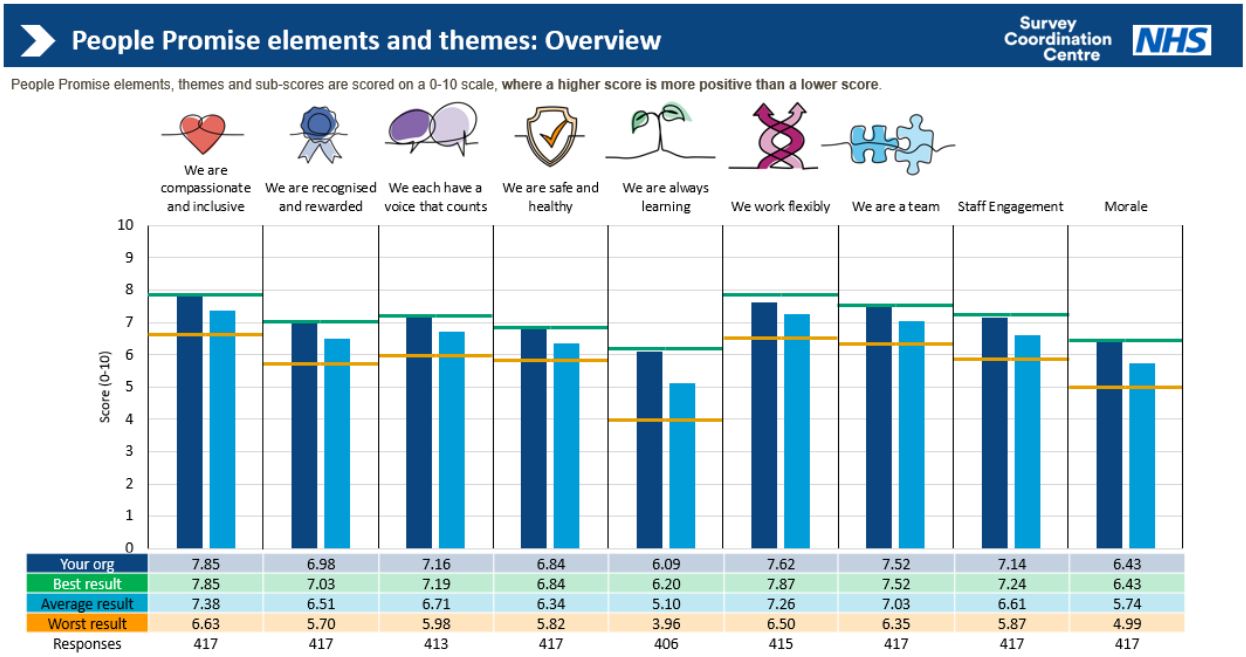
The above figures are provided by NHS Digital and can be found on the website below.
NHS Sickness Absence Rates - NHS England Digital

Staff turnover percentages

For the period 1 April 2023 to 31 March 2024, NHS Dorset employee turnover was 16.60%. For the period 1 July 2022 to 31 March 2023, NHS Dorset employee turnover was 13.93%

Staff engagement percentages

In the 2023 NHS Staff Survey, NHS Dorset's engagement score was 7.14. This compared favourably to the average score for Integrated Care Boards which was 6.61.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.85	6.98	7.16	6.84	6.09	7.62	7.52	7.14	6.43
Best result	7.85	7.03	7.19	6.84	6.20	7.87	7.52	7.24	6.43
Average result	7.38	6.51	6.71	6.34	5.10	7.26	7.03	6.61	5.74
Worst result	6.63	5.70	5.98	5.82	3.96	6.50	6.35	5.87	4.99
Responses	417	417	413	417	406	415	417	417	417

The results of the NHS staff survey are themed by the NHS People Promise elements. In each of these elements, plus Staff Engagement and Morale, NHS Dorset recorded the most positive responses of any Integrated Care Board nationally.

Staff policies

NHS Dorset has policies in place to provide guidance to all employees. All human resource policies have been written to ensure equality and diversity is upheld in the workplace.

From October 2022 to March 2023, we undertook a review of all human resource policies which was completed jointly with a working group of employees and our trade union partners. This work was concluded in March 2023 with all policies approved by our Chief Officers and the trade union partnership. Policies were then noted at the People and Culture Committee.

NHS Dorset has now agreed with TU partners, and the HR Policy Review Group, to look to adopt national HR policies as they are published. This has started with Freedom to Speak Up, Menopause and Flexible Working. This will ensure fairness and consistency for NHS staff across all employing bodies.

Trade Union Facility Time Reporting Requirements

Table 33: Trade Union Facility Time Reporting Requirements

Number of employees who were relevant union officials during 1 April 2023 to 31 March 2024	Full-time equivalent employee number
4	3.60

Number of employees who were relevant union officials employed during the relevant period spent their working hours on facility time	
Percentage of time	**Number of employees**
0%	0
1% - 50%	4
51% - 99%	0
100%	0

Pay bill spent on facility time	
Total cost of facility time	£6,076.76
Total pay bill	£28,621,560
Percentage of the total pay bill spent on facility time	0.02%

The time spent on paid trade union activities as a percentage of total paid facility time hours is 100%.

Other employee matters

Staff health and wellbeing

We are committed to the health and wellbeing of our staff and in addition to the work we do to support absence management, we continued to develop our wider offering during 2023/24.

The result of our work can be seen in our staff survey results:-

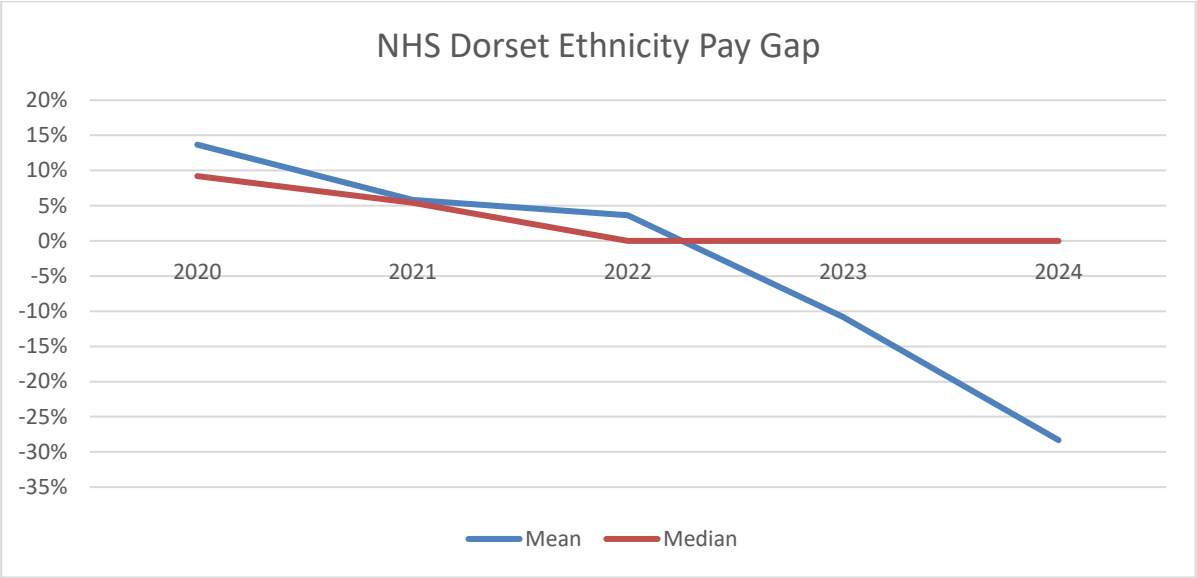
Organisation takes positive action on health and wellbeing

* NHS Dorset 80.6%
* Average of Integrated Care Boards nationally 60.6%

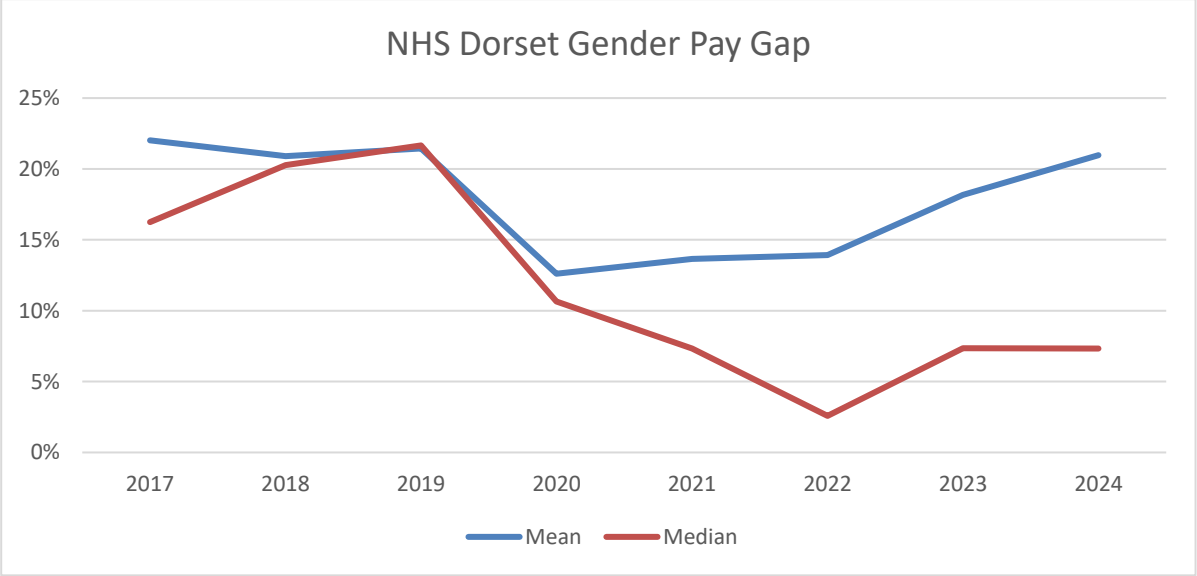
Diversity and inclusion

Since the formation of NHS Dorset, we have established three staff networks around Sexuality, Ethnicity and Disability. Each is independently chaired by an employee of the organisation. Administration support is provided by the organisation, but each network runs independently. We have supported Black History Month, Disability History Month and LGBTQ+ History Month.

We are committed to reporting annually on ethnicity pay gap, in line with gender pay gap report.



The median ethnicity pay gap has remained at 0% for the last three years. This means that the median white employee is paid the same as the median employee from a minority ethnic community. The mean ethnicity pay gap is now below zero. This means that, on average earnings, employees from a minority ethnic community are higher paid than white employees within NHS Dorset.



The most recognised measure of gender pay gap is the median figure. This number dropped consistently from 2019 to 2022 but has risen to a level of 7.35% in the last two years.

We have seen an increase of staff reporting diverse sexualities in 2023-24 as well as year on year increases in the number of staff from black minority ethnic (BME) backgrounds and staff reporting long term health conditions.

<u>Disabled employees</u>

The NHS staff survey asks the question ‘Disability: organisation made adequate adjustment(s) to enable me to carry out work’. NHS Dorset scored 84.1% against the national average for ICBs of 78.3%.

We continue to be proactive in our recruitment of disabled employees and remain committed to the national disability confident scheme (previously ‘Two Ticks’). We achieved disability

confident employer status which means we have committed to:

- interview all disabled applicants who meet the minimum criteria for a job vacancy and to consider them on their abilities,
- make every effort when employees become disabled to make sure they stay in employment,
- take action to ensure that all employees develop the appropriate level of disability awareness needed to make these commitments work.

We also trained a number of workstation assessors on both of our sites to allow more informal assessments to be undertaken ahead of any occupational health referrals.

Expenditure on consultancy

Table 34: Expenditure on consultancy

Supplier	Details	£'000
2023/24		
DELOITTE LLP	VAT Recovery related to Prior Year	(71)
PRICE WATERHOUSE COOPERS	VAT Recovery related to Prior Year	(10)
Total for Year		**(81)**

Off-payroll engagements

For all new off-payroll engagements between 1/4/24 and 31/3/24, for more than £245 per day and that last longer than six months:

Table 35: Length of all highly paid off-payroll engagements as at 31 March 2024

	Number
Number of existing engagements as of 31/3/24	8
Of which:	
• No. that have existed for less than one year at the time of reporting	3
• No. that have existed for between one and two years at the time of reporting	5
• No. that have existed for between two and three years at the time of reporting	0
• No. that have existed for between three and four years at the time of reporting	0
• No. that have existed for four or more years at the time of reporting	0

Table 36: All highly paid off-payroll workers
engaged at any point during the year ended 31 March 2024, earning £245 per day or greater

	Number
Number of new engagements, between 1/4/24 and 31/3/24	3
Of which:	
• Not subject to off-payroll legislation	0
• Subject to off-payroll legislation and determined as in-scope of IR35	0
• Subject to off-payroll legislation and determined as out-of-scope of IR35	3
Number of engagements reassessed for compliance or assurance purposes during the year	15
Of which: number of engagements that saw a change to IR35 status following review	11

For any off-payroll engagements of Board members and/or senior officials with significant financial responsibility, between 1 April 2023 and 31 March 2024. Although included on the ICB's payroll, GP leads are deemed to have a contract for service and any pension payments are 'Practitioner' contributions, paid via the NHS Pension Scheme's GP SOLO route. Therefore, whilst not off-payroll for the purposes of the above tables, GP leads are treated separately to other individuals on the ICB payroll. All individuals, including GP leads, added to the ICB payroll system and all members of the GP SOLO scheme are checked to ensure compliance with Income Tax and National Insurance obligations.

There is one off-payroll engagement that falls outside of the GP leads group, requiring assurance to be sought, and obtained, in relation to Income Tax and National Insurance obligations for that individual.

Table 37: For any off-payroll engagements of board members and/or, senior officials with significant financial responsibility, between 1 April 2023 and 31 March 2024

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	-
Number of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both on payroll and off-payroll engagements.	16

Exit packages, including special (non-contractual) payments

Table 38: Exit Packages 2023/24 (subject to audit)

Exit package cost band (inc. any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Numbers	**£s**	**Numbers**	**£s**	**Numbers**	**£s**	**Numbers**	**£s**
Total	**3**	**62,492**	**3**	**68,742**	**6**	**131,234**	**0**	**0**

Redundancy and other departure cost have been paid in accordance with the provisions of the terms of the individual contracts of employment. Exit costs in this note are accounted for in full in the year of departure. Where NHS Dorset ICB has agreed early retirements, the additional costs are met by NHS Dorset ICB and not by the NHS Pensions Scheme. Ill-health retirement pension costs are met by the NHS Pensions Scheme and are not included in the table.

Table 39: Analysis of other agreed departures 2023/24 (subject to audit)

	2023/24	
	Other agreed departures	
	Number	£s
Voluntary Redundancies	1	46,667
Contractual payments in lieu of notice*	2	22,076
Total	**3**	**68,742**

As a single exit package can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note 4.4 which will be the number of individuals.

*any non-contractual payments in lieu of notice are disclosed under “non-contracted payments requiring HMT approval” below.

Zero non-contractual payments were made to individuals where the payment value was more than 12 months of their annual salary.

The Remuneration Report includes disclosure of exit packages payable to individuals named in that Report.

Parliamentary Accountability and Audit Report

NHS Dorset is not required to produce a Parliamentary Accountability and Audit Report but has opted to include disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges in this Accountability Report here. An audit certificate and report is also included in this Annual Report at page 130.

Independent Auditor's Report

Independent Auditor's Report to the Members of the Board of NHS Dorset Integrated Care Board

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of NHS Dorset Integrated Care Board ("the ICB") for the year ended 31 March 2024 which comprise the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers' Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the financial position of the ICB as at 31 March 2024 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State on 22 April 2024 as being relevant to ICBs in England and included in the Department of Health and Social Care Group Accounting Manual 2023/24; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

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 ICB 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 Accountable Officer of the ICB ("the Accountable Officer") has prepared the financial statements on the going concern basis, as they have not been informed by the relevant national body of the intention to either cease the ICB's services or dissolve the ICB without the transfer of its services to another public sector entity. 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 Accountable Officer's conclusions, we considered the inherent risks associated with the continuity of services provided by the ICB over the going concern period.

Our conclusions based on this work:

- we consider that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified, and concur with the Accountable Officer's assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the ICB'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 ICB 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 management, the Audit Committee and internal audit and inspection of policy documentation as to the ICB's high-level policies and procedures to prevent and detect fraud, as well as whether they have knowledge of any actual, suspected, or alleged fraud.
- Assessing the incentives for management to manipulate reported expenditure as a result of the need to achieve statutory targets delegated to the ICB by NHS England.
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.

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, and taking into account possible pressures to meet delegated statutory resource limits, we performed procedures to address the risk of management override of controls, in particular the risk that ICB management may be in a position to make inappropriate accounting entries.

On this audit we did not identify a fraud risk related to revenue recognition because of the nature of funding provided to the ICB, which is transferred from NHS England and recognised through the Statement of Changes in Taxpayers' Equity. We therefore assessed that there was limited opportunity for the ICB to manipulate the income that was reported.

In line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we also recognised a fraud risk related to expenditure recognition, particularly in relation to the completeness of expenditure. We consider this would

be most likely to occur through understating purchase of goods and services, specifically services from foundation trusts and purchase of healthcare from non-NHS bodies.

We performed procedures including:

- Identifying journal entries to test based on risk criteria and comparing the identified entries to supporting documentation. These included unusual postings to cash, unusual postings to expenditure, and journals that move expenditure between programme and administrative expenditure..
- For a selection of cash payments and purchase invoices in the period post 31 March 2024, verify that the expenditure had been recognised in the correct accounting period to which the expenditure related.

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 sector experience and through discussion with the Board and other management (as required by auditing standards), 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 ICB is subject to laws and regulations that directly affect the financial statements including the financial reporting aspects of NHS legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

As described in the section of this report dealing with other legal and regulatory matters, we made a Section 30 (1)(b) referral to the Secretary of State on 20 June 2024 on the basis that the ICB had failed to meet two of its statutory financial duties for the year ended 31 March 2024. We have also qualified our regularity opinion in respect of this matter.

Whilst the ICB 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 fraud 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.

Other information in the Annual Report

The Accountable Officer is responsible for the other information, which comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information 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 other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required by the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the "Code of Audit Practice") to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2023/24. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared, in all material respects, in accordance with the Department of Health and Social Care Group Accounting Manual 2023/24.

Accountable Officer's responsibilities

As explained more fully in the statement set out on page [X], the Accountable Officer of the ICB is responsible for the preparation of financial statements that give a true and fair view. They are also 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; assessing the ICB'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 have been informed by the relevant national body of the intention to either cease

the services provided by the ICB or dissolve the ICB without the transfer of its services to another public sector entity.

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.

Report on Other Legal And Regulatory Matters

Qualified Opinion on regularity

The Accountable Officer is responsible for ensuring the regularity of expenditure and income.

We are required to report on the following matters under Section 21(4) and (5) of the Local Audit and Accountability Act 2014.

Except for the effects of the matter described in the basis for qualified opinion on regularity section of our report set out below, in our opinion, in all material respects, the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Basis for qualified opinion on regularity

On 20 June 2024 we made a Section 30 (1)(b) referral to the Secretary of State, and notified NHS England of the matter, on the basis that the ICB's draft financial statements for the year ended 31 March 2024 disclosed that it had failed to meet two of its statutory financial duties. Expenditure incurred by the ICB in the year ended 31 March 2024 exceeded its Revenue Resource Limit by £17.4 million and total expenditure exceeded its income by £17.4 million.

We conducted our work on regularity in accordance with Statement of Recommended Practice - Practice Note 10: *Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2022)* issued by the FRC. We planned and performed procedures to obtain sufficient appropriate evidence to give an opinion over whether the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them. The procedures selected depend on our judgement, including the assessment of the risks of material irregular transactions. We are required to obtain sufficient appropriate evidence on which to base our opinion.

Report on the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the ICB to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on pages 96/97, the Accountable Officer is responsible for ensuring that the ICB exercises its functions effectively, efficiently and economically. We are required under section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We planned our work and undertook our review in accordance with the Code of Audit Practice and related statutory guidance, having regard to whether the ICB had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if we refer a matter to the Secretary of State and NHS England under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the ICB, or an officer of the ICB, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

On 20 June 2024 we made a referral under Section 30(1)(b) to the Secretary of State, and notified NHS England of the matter, on the basis that expenditure incurred by the ICB and recorded in its draft financial statements for the year ended 31 March 2024 exceeded its Revenue Resource Limit by £17.4 million and that total expenditure exceeded its income by £17.4 million.

The Purpose of our Audit Work and To Whom We Owe Our Responsibilities

This report is made solely to the Members of the Board of NHS Dorset Integrated Care Board, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Members of the Board of the ICB, as a body, 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 [Members of the Board of the ICB, as a body, for our audit work, for this report or for the opinions we have formed.

Certificate of Completion of the Audit

We certify that we have completed the audit of the accounts of NHS Dorset ICB for the year ended 31 March 2024 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Rees Batley
for and on behalf of KPMG LLP
Chartered Accountants
66 Queen Square
Bristol
BS1 4BE
June 2024

Annual Accounts

Statement of Comprehensive Net Expenditure for year ended 31 March 2024

	NOTE	2023-24 Total £000	2022-23 (Jul-Mar) Total £000
Revenue from sale of goods and services	2	(37,723)	(12,756)
Other operating revenue	2	13	(64)
Total Operating Revenue		**(37,710)**	(12,820)
Staff costs	4	30,636	23,227
Purchase of goods and services	5	1,906,344	1,278,432
Depreciation and impairment charges	5	664	417
Provision expense	5	(1,516)	2,203
Other operating expenditure	5	1,876	1,402
Total Operating Expenditure		**1,938,004**	1,305,681
Net Operating Expenditure		**1,900,294**	1,292,861
Financing			
Finance expense	7	(33)	131
Net financing costs for the financial year		**(33)**	131
Total Comprehensive Net Expenditure for the financial year		**1,900,261**	1,292,992

The notes on pages 5 to 22 form part of this statement.

The purpose of this statement is to summarise, on an accruals basis, the net operating costs of the Integrated Care Board. The statement identifies gross operating costs, less miscellaneous income, to arrive at the net operating costs of the Integrated Care Board.

Statement of Financial Position at 31 March 2024

	NOTE	31 March 2024 £000	31 March 2023 £000
Non-Current Assets			
Property, plant and equipment	9	396	461
Right-of-use assets	9a	821	1,107
Intangible assets	10	179	87
Total Non-Current Assets		**1,396**	1,655
Current Assets			
Inventories	11	1,870	1,831
Trade & other receivables	12	22,336	3,783
Cash & cash equivalents	13	267	41
Total Current Assets		**24,473**	5,655
Total Assets		**25,868**	7,310
Current Liabilities			
Trade & other payables	14	(116,929)	(123,363)
Lease liabilities	9a	(370)	(1,063)
Provisions	15	(1,072)	(3,346)
Total Current Liabilities		**(118,371)**	(127,772)
Total Assets less Current Liabilities		**(92,503)**	(120,462)
Non-Current Liabilities			
Lease liabilities	9a	(393)	0
Provisions	15	(418)	(922)
Total Non-Current Liabilities		**(811)**	(922)
Total Assets less Liabilities		**(93,314)**	(121,384)
Financed by Taxpayers' Equity			
General fund		(93,314)	(121,384)
Total Taxpayers' Equity		**(93,314)**	(121,384)

The notes on pages 5 to 22 form part of this statement.

The financial statements on pages 1 to 4 were approved by the ICB Board on 20 June 2024 and signed on its behalf by: -

Patricia Miller

Accountable Officer: Patricia Miller
Date 21 June 2024

Statement of Changes In Taxpayers' Equity for the year ended 31 March 2024

	General Fund £000	Total £000
Balance at 01-April-2023	**(121,384)**	**(121,384)**
Net operating costs for the financial year	**(1,900,261)**	**(1,900,261)**
	(2,021,645)	**(2,021,645)**
Net funding	1,928,331	1,928,331
Balance at 31 March 2024	**(93,314)**	**(93,314)**

	General Fund £000	Total £000
Changes in taxpayers' equity for 2022-23 (Jul-Mar)		
Balance at 01-July-2022	0	0
Net operating costs for the financial year	(1,292,992)	(1,292,992)
Transfers by absorption to/(from) other bodies	(77,281)	(77,281)
	(1,370,273)	(1,370,273)
Net funding	1,248,888	1,248,888
Balance at 31 March 2023	(121,384)	(121,384)

Changes in an entity's equity between the beginning and the end of the reporting period reflect the increase or decrease in its net assets during the period. The Statement has been interpreted to include figures for net operating costs for the year and funding for the year.

Statement of Cash Flows for the year ended 31 March 2024

	NOTE	2023-24 £000	2022-23 (Jul-Mar) £000
Cash Flows from Operating Activities			
Total net expenditure for the financial year	2 & 5	(1,900,261)	(1,292,992)
Depreciation and amortisation	5, 9, 9a & 10	664	417
Movement due to transfer by Modified Absorption		0	(74,120)
Finance costs	5 & 15	(126)	(175)
Unwinding of discounts	15	(42)	127
Increase in inventories	11	(38)	(1,831)
Increase in trade & other receivables	12	(18,553)	(3,783)
Decrease in trade & other payables	14	(6,473)	123,363
Provisions utilised	15	(1,409)	(1,726)
Decrease in provisions	15	(1,200)	2,378
Net Cash Outflow from Operating Activities		**(1,927,439)**	(1,248,343)
Cash Flows from Investing Activities			
Interest paid	7	8	4
Payments for property, plant and equipment	9 & 9a	(153)	(239)
Payments for intangible assets	10	(150)	(65)
Net Cash Outflow from Investing Activities		**(295)**	(300)
Net Cash Outflow before Financing		**(1,927,734)**	(1,248,642)
Cash Flows from Financing Activities			
Net funding received		1,928,331	1,248,888
Repayment of lease liabilities	9a	(372)	(205)
Net Cash Inflow from Financing Activities		**1,927,959**	1,248,683
Net Increase in Cash & Cash Equivalents	13	**226**	41
Cash & Cash Equivalents at the Beginning of the Financial Year		41	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year	13	**267**	41

The Statement of Cash Flows provides information on Integrated Care Board liquidity, viability and financial adaptability.

NOTES TO THE ACCOUNTS

The notes to the accounts provide additional details on the entries on the primary statements as well as additional disclosures, such as the accounting policies that the organisation follows when preparing its accounts.

1. ACCOUNTING POLICIES

NHS England has directed that the financial statements of Integrated Care Boards shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the financial statements have been prepared in accordance with the Group Accounting Manual 2023-24 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Integrated Care Boards, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Integrated Care Board for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Integrated Care Board are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on a going concern basis.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

The financial statements for ICBs are prepared on a Going Concern basis as they will continue to provide the services in the future.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.3 Operating Segments

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the Integrated Care Board.

1.4 Revenue

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows: -

• As per paragraph 121 of the Standard the Integrated Care Board will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less;

• The Integrated Care Board is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date;

• The HM Treasury published Financial Reporting Manual (FReM) has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the Integrated Care Board to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the Integrated Care Board is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received. There is also revenue from other Integrated Care Boards.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.
Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

Payment terms are standard reflecting cross-government principles. Significant terms include payment within 30 days, more details can be found in Note 6 - Better Payment Practice Code, to the Accounts.

The value of the benefit received when the Integrated Care Board accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.5 Employee Benefits

1.5.1 Short-term Employee Benefits

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

The Integrated Care Board allows a maximum of five days to be carried forward, but only in exceptional circumstances.

1.5.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the ICB commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.6 Other Expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.7 Grants Payable

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the Integrated Care Board recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.8 Property, Plant & Equipment

1.8.1 Recognition

Property, plant and equipment are capitalised if: -

• It is held for use in delivering services or for administrative purposes;
• It is probable that future economic benefits will flow to, or service potential will be supplied to the Integrated Care Board;
• It is expected to be used for more than one financial year;
• The cost of the item can be measured reliably; and,
• The item has a cost of at least £5,000; or,

• Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
• Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.8.2 Measurement

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at valuation.
Land and buildings used for the Integrated Care Board's services or for administrative purposes are stated in the Statement of Financial Position at their re-valued amounts, being the fair value at the date of revaluation less any impairment.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.8.3 Subsequent Expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.9 Intangible Assets

1.9.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Integrated Care Board's business or which arise from contractual or other legal rights. They are recognised only: -
• When it is probable that future economic benefits will flow to, or service potential be provided to, the Integrated Care Board;
• Where the cost of the asset can be measured reliably;
• Where the cost is at least £5,000; or
• Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised but is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated: -
•The technical feasibility of completing the intangible asset so that it will be available for use;
•The intention to complete the intangible asset and use it;
•The ability to sell or use the intangible asset;
•How the intangible asset will generate probable future economic benefits or service potential;
•The availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and
•The ability to measure reliably the expenditure attributable to the intangible asset during its development.

1.9.2 Measurement

Intangible assets acquired separately are initially recognised at cost. The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost or the value in use where the asset is income generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances. Revaluations and impairments are treated in the same manner as for property, plant and equipment.

1.10 Depreciation, Amortisation & Impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Integrated Care Board expects to obtain economic benefits or service potential from the asset. This is specific to the Integrated Care Board and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the Integrated Care Board checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.11 Government Grants

The value of assets received by means of a government grant are credited directly to income. The Integrated Care Board has no deferred income.

1.12 Leases

A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration. The ICB assesses whether a contract is or contains a lease, at inception of the contract.

1.12.1 The Integrated Care Board as Lessee

The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.

The HM Treasury incremental borrowing rate of 3.51% is applied for leases commencing, transitioning or being remeasured in the 2023 calendar year; and 4.72% to new leases commencing in 2024 under IFRS 16.

The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.

The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.

The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.

1.12.2 The Integrated Care Board as Lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Integrated Care Board's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the Integrated Care Board's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease.

1.13 Inventories

Inventories are valued at the lower of cost and net realisable value.

1.14 Cash & Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Integrated Care Board's cash management.

1.15 Provisions

Provisions are recognised when the Integrated Care Board has a present legal or constructive obligation as a result of a past event, it is probable that the Integrated Care Board will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows: -

All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date: -

• A nominal short-term rate of 4.26% (2022-23: 3.27%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date;

• A nominal medium-term rate of 4.03% (2022-23: 3.20%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date;

• A nominal long-term rate of 4.72% (2022-23: 3.51%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date;

• A nominal very long-term rate of 4.40% (2022-23: 3.00%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

1.16 Clinical Negligence Costs

NHS Resolution operates a risk pooling scheme under which the Integrated Care Board pays an annual contribution to NHS Resolution which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases the legal liability remains with the Integrated Care Board.

1.17 Non-clinical Risk Pooling

The Integrated Care Board participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Integrated Care Board pays an annual contribution to NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.18 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Integrated Care Board, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Integrated Care Board. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.19 Financial Assets

Financial assets are recognised when the Integrated Care Board becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories: -

• Financial assets at amortised cost;

• Financial assets at fair value through other comprehensive income; and

• Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.19.1 Financial Assets at Amortised cost

The Integrated Care Board holds no financial assets at amortised cost.

1.19.2 Financial Assets at fair value through other comprehensive income

The Integrated Care Board holds no financial assets at fair value through other comprehensive income.

1.19.3 Financial Assets at fair value through profit and loss

The Integrated Care Board holds no financial assets at fair value through profit and loss.

1.19.4 Impairment

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the Integrated Care Board recognises a loss allowance representing the expected credit losses on the financial asset.

The Integrated Care Board adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The Integrated Care Board therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally DHSC provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the Integrated Care Board does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.
The Integrated Care Board holds no Loans, only Receivables.

1.20 Financial Liabilities

Financial liabilities are recognised on the Statement of Financial Position when the Integrated Care Board becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are derecognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.20.1 Financial Guarantee Contract Liabilities

Financial Guarantee Contract Liabilities are subsequently measured at the higher of: -

• The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and

• The amount of the obligation under the contract, as determined in accordance with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.

The Integrated Care Board holds no Financial Guarantee Contract Liabilities.

1.20.2 Financial Liabilities at Fair Value Through Profit and Loss

The Integrated Care Board holds no Financial Liabilities with embedded derivatives.

1.20.3 Other Financial Liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.21 Value Added Tax (VAT)

Most of the activities of the Integrated Care Board are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.22 Foreign Currencies

The Integrated Care Board's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Integrated Care Board's surplus/deficit in the period in which they arise.

1.23 Losses & Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Integrated Care Board not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.24 Critical Accounting Judgments & Key Sources of Estimation Uncertainty

In the application of the Integrated Care Board's accounting policies, management is required to make judgments, 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.

1.24.1 Critical Judgments in Applying Accounting Policies

No critical judgments with a significant effect on the amounts recognised on the financial statements were required.

1.24.2 Key Sources of Estimation Uncertainty

No key sources of estimation uncertainty with a significant effect on the amounts recognised on the financial statements were required.

1.25 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value. The Integrated Care Boards Gifts, Hospitality Sponsorship register can be found on our website www.nhsdorset.nhs.uk/about/constitution/#gifts.

1.26 New and revised IFRS Standards in issue but not yet effective

● IFRS 14 Regulatory Deferral Accounts – Not UK-endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore, not applicable to DHSC group bodies.

● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2025: early adoption is not therefore permitted.

● IFRS 18 Presentation and Disclosure in Financial Statements - Issued in April 2024 and applies to periods beginning on or after 1 January 2027. The standard has not yet been adopted by FRAB for inclusion within the FREM and therefore it is not yet possible to confirm how this will impact on our accounts in the future.

2. Other Operating Revenue

	2023-24 Total £000	2022-23 (Jul-Mar) Total £000
Revenue from sale of goods and services (contracts)		
Education, training and research	**0**	(206)
Non-patient care services to other bodies	**(11,595)**	(11,185)
Prescription fees and charges	**(9,450)**	0
Dental fees and charges	**(10,809)**	0
Other Contract revenue	**(5,222)**	(145)
Recoveries in respect of employee benefits	**(648)**	(1,220)
Total Revenue from sale of goods and services	**(37,723)**	(12,756)
Other Operating Revenue		
Charitable and other contributions to expenditure: non-NHS	**(30)**	(62)
Other revenue	**43**	(2)
Total Other Operating Revenue	**13**	(64)
Total Operating Revenue	**(37,710)**	(12,820)

This note discloses the revenue that relates directly to the operating activities of the Integrated Care Board, it excludes cash received from NHS England by the Integrated Care Board, which is credited directly to the General Fund.

3. Disaggregation of Revenue - revenue from sale of good and services (contracts)

Source of Revenue	NHS £000	Non NHS £000	2023-24 Total £000
Education, training and research	0	0	**0**
Non-patient care services to other bodies	(6,486)	(5,109)	**(11,595)**
Prescription fees and charges	0	(9,450)	**(9,450)**
Dental fees and charges	0	(10,809)	**(10,809)**
Other contract revenue	(722)	(4,500)	**(5,222)**
Recoveries in respect of employee benefits	(221)	(427)	**(648)**
Total	**(7,429)**	**(30,295)**	**(37,723)**

Revenue received is totally from the supply of services. The Integrated Care Board receives no revenue from the sale of goods.

4. Employee Benefits

Please refer to the Annual Report for details of Employee Benefits and Staff Numbers.

4.1 Pension Costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

4.1.1 Accounting Valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2024, is based on valuation data as 31 March 2023, updated to 31 March 2024 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.1.2 Full Actuarial (funding) Valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from April 2024. The Department of Health and Social Care has recently laid Scheme Regulations confirming that the employer contribution rate will increase to 23.7% from 1 April 2024 (previously 20.6%).

	2023-24 £000	2022-23 (Jul-Mar) £000
Employers' contributions payable to the NHS Pensions Scheme	**4,127**	2,725
	%	%
Payable to the NHS Pension Scheme of pensionable pay, at the rate of	**20.60**	20.60

4.2 Staff Costs

	2023-24 Permanent Employees	2023-24 Other	2023-24 Total
	£'000	£'000	£'000
Salaries and wages	21,688	2,014	23,703
Social security costs	2,385	0	2,385
Employer contributions to the NHS Pension Scheme	4,127	0	4,127
Apprenticeship levy	101	0	101
Termination benefits	320	0	320
Gross admin employee benefits expenditure	**28,622**	**2,014**	**30,636**
Less: Recoveries in respect of employee benefits	(648)	0	(648)
Net admin employee benefits expenditure including capitalised costs	**27,974**	**2,014**	**29,988**
Less: Employee costs capitalised	0	0	0
Net admin employee benefits expenditure excluding capitalised costs	**27,974**	**2,014**	**29,988**
Total average number of people employed	444	35	479
Of above number of whole time equivalent people engaged on capital projects	0	0	0

	2022-23 (Jul-Mar) Permanent Employees	2022-23 (Jul-Mar) Other	2022-23 (Jul-Mar) Total
	£'000	£'000	£'000
Salaries and wages	16,463	1,964	18,427
Social security costs	1,752	0	1,752
Employer contributions to the NHS Pension Scheme	2,725	0	2,725
Apprenticeship levy	68	0	68
Termination benefits	255	0	255
Gross admin employee benefits expenditure	**21,264**	**1,964**	**23,227**
Less: Recoveries in respect of employee benefits	(1,220)	0	(1,220)
Net admin employee benefits expenditure including capitalised costs	**20,044**	**1,964**	**22,007**
Less: Employee costs capitalised	0	0	0
Net admin employee benefits expenditure excluding capitalised costs	**20,044**	**1,964**	**22,007**
Total average number of people employed	434	47	481
Of above number of whole time equivalent people engaged on capital projects	0	0	0

4.3 Exit packages agreed in the financial year

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.

Agreed exit package banding	2023-24 Compulsory Redundancies	2023-24 Compulsory Redundancies	2023-24 Other Agreed Departures	2023-24 Other Agreed Departures	2023-24 Total	2023-24 Total
	Number	£	Number	£	Number	£
Less than £10,000	0	0	1	9,338	1	9,338
£10,001 to £25,000	2	31,731	1	12,738	3	44,469
£25,001 to £50,000	1	30,761	1	46,666	2	77,427
Total	**3**	**62,492**	**3**	**68,742**	**6**	**131,234**

Agreed exit package banding	2022-23 (Jul-Mar) Compulsory Redundancies	2022-23 (Jul-Mar) Compulsory Redundancies	2022-23 (Jul-Mar) Other Agreed Departures	2022-23 (Jul-Mar) Other Agreed Departures	2022-23 (Jul-Mar) Total	2022-23 (Jul-Mar) Total
	Number	£	Number	£	Number	£
Less than £10,000	0	0	2	10,228	2	10,228
£10,001 to £25,000	5	71,455	0	0	5	71,455
£25,001 to £50,000	3	114,835	0	0	3	114,835
£50,001 to £100,000	1	58,969	0	0	1	58,969
Total	**9**	**245,259**	**2**	**10,228**	**11**	**255,487**

5. Operating Expenses

	2023-24	2022-23 (Jul-Mar)
	Total	Total
	£000	£000
Purchase of Goods and Services		
Services from other ICBs and NHS England	**2,473**	(59)
Services from foundation trusts	**1,253,308**	850,129
Services from other NHS trusts	**4,336**	3,256
Services from other WGA bodies	**24**	5
Purchase of healthcare from non-NHS bodies	**266,860**	179,398
Purchase of social care	**4,646**	3,320
General dental services and personal dental services	**34,794**	0
Prescribing costs	**158,500**	116,793
Pharmaceutical services	**27,252**	0
General ophthalmic services	**7,010**	181
GPMS/APMS and PCTMS	**135,674**	114,987
Supplies and services – clinical	**8**	0
Supplies and services – general	**5,914**	2,014
Consultancy services	**(81)**	457
Establishment	**2,282**	5,898
Transport	**16**	22
Premises	**1,248**	542
Audit fees	**235**	96
Other non statutory audit expenditure		
• Other services	**21**	15
Other professional fees (excluding statutory audit)	**586**	337
Legal fees	**242**	231
Education and training	**996**	812
Total Purchase of Goods and Services	**1,906,344**	1,278,432
Depreciation and Impairment Charges		
Depreciation	**606**	388
Amortisation	**58**	28
Total Depreciation and Impairment Charges	**664**	417
Provision Expense		
Change in discount rate	**(126)**	(175)
Provisions	**(1,390)**	2,378
Total Provision Expense	**(1,515)**	2,203
Other Operating Expenditure		
Chair and lay membership body and governing body members	**301**	333
Grants to other bodies	**474**	141
Clinical negligence	**11**	12
Research and development (excluding staff costs)	**25**	20
Expected credit loss on receivables	**30**	(26)
Inventories consumed	**1,025**	918
Other expenditure	**10**	3
Total Other Operating Expenditure	**1,876**	1,402
Total Operating Expenses	**1,907,369**	**1,282,453**

GPMS/APMS and PCTMS - shows costs related to primary care services.

External Audit The figures in the 'Audit fees' line above include VAT. The net figure is £172,993 for 2023-24. The Audit liability for KPMG is restricted to £1,000,000.

'Other services' were for the external assurance on the Mental Health Investment Standard (MHIS), as procured by NHS England relating to 2021-22.

Internal Audit - As Internal Audit is carried out by a different organisation to our Statutory Audit, the Department of Health and Social Care guidance is to show Internal Audit costs in 'Other professional fees'.

6. Better Payment Practice Code

	2023-24		2022-23 (Jul-Mar)	
	Number	**£000**	Number	£000
Non-NHS Payables				
Total Non-NHS trade invoices paid in the year	30,794	473,755	23,078	304,323
Total Non-NHS trade invoices paid within target	30,225	467,804	22,393	296,067
Percentage of Non-NHS trade invoices paid within target	**98.15%**	**98.74%**	97.03%	97.29%
NHS Payables				
Total NHS trade invoices paid in the year	1,161	1,246,447	863	851,767
Total NHS trade invoices paid within target	1,150	1,246,574	844	851,741
Percentage of NHS trade invoices paid within target	**99.05%**	**100.01%**	97.80%	100.00%

Where the percentage of invoices paid within target is greater than 100%, this is due to the effect of credit notes.

This note shows the Integrated Care Board's performance against its administrative duty to pay all creditors within 30 calendar days of receipt of goods or valid invoice, whichever is later, unless other payment terms have been agreed. There is a performance target of 95% for each measure.

7. Finance Costs

	2023-24	2022-23 (Jul-Mar)
	£000	£000
Interest on lease liabilities	8	4
Provisions - unwinding of discount	(41)	127
Total Finance Costs	**(33)**	131

This note identifies the Integrated Care Board's interest costs, including the unwinding of discounts on provisions, and corresponds with the amount shown on the Statement of Comprehensive Net Expenditure.

8. Net gain/(loss) on transfer by absorption

	2023-24		2022-23 (Jul-Mar)	
	Total £'000	**NHS England Group Entities (non parent) £'000**	Total £'000	NHS England Group Entities (non parent) £'000
Transfer of property plant and equipment	-	-	452	452
Transfer of Right of Use assets	-	-	653	653
Transfer of intangibles	-	-	50	50
Transfer of inventories	-	-	1,738	1,738
Transfer of cash and cash equivalents	-	-	3,187	3,187
Transfer of receivables	-	-	3,595	3,595
Transfer of payables	-	-	(82,639)	(82,639)
Transfer of provisions	-	-	(3,665)	(3,665)
Transfer of Right Of Use liabilities	-	-	(651)	(651)
Net loss on transfers by absorption	**-**	**-**	(77,281)	(77,281)

In line with the Government Financial Reporting Manual, issued by HM Treasury, previous Clinical Commissioning Group balances that are attributable to the Integrated Care Board need to be accounted for through absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of balances required when functions transfer within the public sector.

9. Property, Plant and Equipment

2023-24	Buildings excluding £000	Plant & Machinery £000	Information Technology £000	Furniture & Fittings £000	Total £000
Cost or Valuation at 01-April-2023	0	150	1,290	322	**1,761**
Additions Purchased	0	0	142	50	**192**
Disposals other than for sale	0	0	(263)	0	**(263)**
Transfer (to) from other public sector body	0	0	0	0	**0**
Cost or Valuation at 31 March 2024	**0**	**150**	**1,168**	**372**	**1,690**
Depreciation at 01-April-2023	0	150	931	219	**1,300**
Disposals other than for sale	0	0	(263)	0	**(263)**
Charged during the Year	0	0	217	40	**257**
Transfer (to) from other public sector body	0	0	0	0	**0**
Depreciation at 31 March 2024	**0**	**150**	**885**	**259**	**1,294**
Net Book Value at 31 March 2024	**0**	**0**	**283**	**113**	**396**
Purchased	0	0	283	113	**396**
Total at 31 March 2024	**0**	**0**	**283**	**113**	**396**

9.1 Economic Lives

	Minimum Life (Years)	Maximum Life (Years)
Information Technology	3	3
Furniture and Fittings	3	3

This note records the range of remaining useful economic lives of property, plant and equipment employed by the Integrated Care Board.

9a Leases

9a.1 Right-of-use assets

2023-24	Buildings excluding dwellings £'000	Plant & Machinery £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2023	1,319	0	0	0	1,319
Additions	0	0	63	0	63
Cost/Valuation at 31 March 2024	**1,319**	**0**	**63**	**0**	**1,382**
Depreciation 01 April 2023	212	0	0	0	212
Charged during the year	348	0	2	0	349
Depreciation at 31 March 2024	**559**	**0**	**2**	**0**	**561**
Net Book Value at 31 March 2024	**759**	**0**	**61**	**0**	**821**

9a Leases

9a.2 Lease liabilities

2023-24	2023-24	2022-23 (Jul-Mar)
	£'000	£'000
Lease liabilities at 01 April 2023	(1,063)	0
Additions purchased	(63)	(613)
Interest expense relating to lease liabilities	(8)	(4)
Repayment of lease liabilities (including interest)	372	205
Transfer (to) from other public sector body	0	(651)
Lease liabilities at 31 March 2024	**(763)**	**(1,063)**

9a.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	2023-24	2022-23 (Jul-Mar)
	£'000	£'000
Within one year	(376)	(1,063)
Between one and five years	(462)	0
After five years	(14)	0
Balance at 31 March 2024	**(852)**	**(1,063)**
Effect of discounting	89	(0)
Included in:		
Current lease liabilities	(370)	(1,063)
Non-current lease liabilities	(393)	0
Balance at 31 March 2024	**(763)**	**(1,063)**

The majority of lease liability amounts relate to intra group lease, with £706k attributable to NHS Property Services Ltd. The remaining £57k is non-NHS.

9a.4 Amounts recognised in Statement of Comprehensive Net Expenditure

2023-24	2023-24	2022-23 (Jul-Mar)
	£'000	£'000
Depreciation expense on right-of-use assets	349	159
Interest expense on lease liabilities	8	4

9a.5 Amounts recognised in Statement of Cash Flows

	2023-24	2022-23 (Jul-Mar)
	£'000	£'000
Total cash outflow on leases under IFRS 16	372	205

Future cash outflows to which the lessee is potentially exposed that are not reflected in the measurement of lease liabilities. This includes exposure arising from
* Variable lease payments
* Extension and termination options
* Residual value guarantee
* Restrictions or covenants imposed by leases
* Leases not yet commenced to which the lessee is committed
* Sale and leaseback transactions

10. Intangible non-current assets

2023-24	Computer Software: Purchased £000	Total £000
Cost or valuation at 1 April 2023	202	202
Additions purchased	150	150
Disposals other than by sale	(105)	(105)
Cost / Valuation at 31 March 2024	**247**	**247**
Amortisation 1 April 2023	116	116
Disposals other than by sale	(105)	(105)
Charged during the year	58	58
Amortisation at 31 March 2024	**69**	**69**
Net Book Value at 31 March 2024	**179**	**179**

10.1 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Computer software: purchased	2	5

Intangible non-current assets are defined as brand value or some other right, which although invisible is likely to derive financial benefit for its owner in the future, and for which you might be willing to pay.

11. Inventories

	Loan Equipment	Total
	£000	**£000**
Balance at 01-April-2023	1,831	**1,831**
Additions	1,063	**1,063**
Inventories recognised as an expense in the period	(1,025)	**(1,025)**
Balance at 31 March 2024	**1,870**	**1,870**

	Loan Equipment	Total
	£000	£000
Balance at 01-July-2022	1,011	1,011
Additions	(918)	(918)
Reversal of write-down previously taken to SoCNE	1,738	1,738
Balance at 31 March 2023	1,831	1,831

The Integrated Community Equipment is managed by Bournemouth, Christchurch and Poole Council.

The total value of inventories corresponds with the amount shown on the face of the Statement of Financial Position. Finished processed goods is the value of stocks after completion of manufacture or processing and where the goods concerned are to be sold or consumed in a future accounting period.

This note does not include the provision of health care services under partially completed contracts; or assets in the course of construction.

12. Trade and Other Receivables

	Current	
	31 March 2024	31 March 2023
	£000	£000
NHS receivables: revenue	998	1,205
NHS accrued income	2,668	1,784
Non-NHS and other WGA receivables: Revenue	4,120	220
Non-NHS and other WGA prepayments	1,218	78
Non-NHS and other WGA accrued income	1,712	250
Non-NHS and Other WGA contract receivable not yet invoiced/non-invoice	11,355	0
Expected credit loss allowance - receivables	(29)	(9)
VAT	293	250
Other receivables	1	6
Total	**22,336**	3,783
Total Current and Non-current	**22,336**	3,783
Included in NHS receivables are pre-paid pension contributions	**0**	0

The great majority of trade is with NHS England. As NHS England is funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary. The level of trade with non-NHS organisations is immaterial and is covered by contractual terms, therefore no credit scoring of them is considered necessary.

This note analyses the amounts owing to the Integrated Care Board at the Statement of Financial Position date.

12.1 Receivables Past Their Due Date But Not Impaired

	31 March 2024 DHSC Group Bodies	**31 March 2024 Non DHSC Group Bodies**	31 March 2023 DHSC Group Bodies	31 March 2023 Non DHSC Group Bodies
	£000	**£000**	£000	£000
By up to three months	**22**	**167**	463	117
By three to six months	**0**	**0**	0	0
By more than six months	**203**	**94**	0	56
Total	**225**	**261**	463	173

£28,714.09 (as at 5 June 24) of the amount above has subsequently been recovered post the Statement of Financial Position date.

This note analyses the length of time beyond their due date the amounts owing to the Integrated Care Board at the Statement of Financial Position date have been outstanding.

12.2 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies	**Total**
	£000	**£000**
Balance as at 01-April-2023	(9)	(9)
Lifetime expected credit losses on trade and other receivables - Stage 2	(20)	(20)
Lifetime expected credit losses on trade and other receivables - Stage 3	(10)	(10)
Amounts written off	10	10
Total	**(29)**	(29)

This is an estimate linked to expected credit losses on a financial asset that is applied to reduce the carrying amount of the financial asset in the Statement of Financial Position.

13. Cash and Cash Equivalents

	31 March 2024	31 March 2023
	£000	£000
Opening balance	41	0
Net change in year	226	41
Closing balance	**267**	41
Made up of:		
Cash with Government Banking Service	253	28
Cash in hand	14	13
Cash and cash equivalents as in Statement of Financial Position	**267**	41
Bank overdraft - Government Banking Service	0	0
Cash and cash equivalents as in Statement of Cash Flows	**267**	41
Patients' money held by the Integrated Care Board, not included above	**0**	0

14. Trade and Other Payables

	Current	
	31 March 2024	31 March 2023
	£000	£000
NHS payables: revenue	(780)	(402)
NHS accruals	(19,477)	(5,289)
Non-NHS and other WGA payables: revenue	(10,617)	(4,401)
Non-NHS and other WGA payables: capital	(39)	0
Non-NHS and other WGA accruals	(60,909)	(58,780)
Social security costs	(312)	(308)
Tax	(447)	(393)
Other payables and accruals	(24,348)	(53,791)
Total	**(116,929)**	(123,363)
Total Current and Non-current	**(116,929)**	(123,363)

	31 March 2024	31 March 2023
	£000	£000
Included above are liabilities, due in future years under arrangements to buy out the liability for early retirement over 5 years.	**0**	0
Other payables include outstanding pension contributions. The increase in outstanding pension contributions is due to the Integrated Care Board taking on the devolved primary care co-commissioning role from NHS England.	**1,820**	1,203
Other payables also includes accruals for invoices registered on the finance ledger, but not approved.	**1,972**	4,426
Other payables also includes primary care accruals, which is due to the Integrated Care Board taking on the devolved primary care co-commissioning role from NHS England.	**20,597**	46,695

This note analyses the amounts owed by the Integrated Care Board at the Statement of Financial Position date.

15. Provisions

	Current	Current	**Non Current**	Non-Current
	31 March 2024	31 March 2023	**31 March 2024**	31 March 2023
	£000	£000	**£000**	£000
Redundancy	(189)	0	0	0
Legal claims	0	(574)	0	0
Continuing care	(883)	(2,772)	(67)	(555)
Other	0	0	(351)	(368)
Total	**(1,072)**	(3,346)	**(418)**	(922)
Total Current and Non-Current	**(1,491)**	(4,269)		

Comprising:

	Redundancy	**Continuing Care**	**Legal Claims**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**
Balance at 01-April-2023	0	(3,327)	(574)	(368)	**(4,269)**
Arising during the year	(189)	(690)	0	0	**(879)**
Utilised during the year	0	1,409	0	0	**1,409**
Reversed unused	0	1,528	551	0	**2,079**
Unwinding of discount	0	31	0	11	**42**
Change in discount rate	0	99	22	5	**127**
Transfer (to) from other public sector body	0	0	0	0	**0**
Balance at 31 March 2024	**(189)**	**(950)**	**0**	**(351)**	**(1,491)**
Expected Timing of Cash Flows:					
No Later than One Year	(189)	(883)	0	0	**(1,072)**
Later than One Year and not later than Five Years	0	(67)	0	(351)	**(418)**
Balance at 31 March 2024	**(189)**	**(950)**	**0**	**(351)**	**(1,491)**

Amount Included in the Provisions of NHS Resolution in Respect of Clinical Negligence Liabilities:

	£000
As at 31 March 2024	118
As at 31 March 2023	0

Finance costs on the Statement of Cash Flows refers to the change in discount rate, shown above.

The balance of the Continuing Care provision is reversed out of the Ledger in March and shows here as 'Reversed unused' and then the new provision is created and this is shown as 'Arising during the year'. This approach is taken because the provision is calculated case by case during March.

15. Provisions continued

Critical accounting judgments and key sources of estimation uncertainty:

The provisions shown under the heading 'Other' relates to dilapidation costs associated with leases for Vespasian House, and the future costs are uncertain.

A provision has been made against applications for continuing healthcare support where a panel has not yet met to determine whether the application is approved. The provision is calculated on a named basis for the period that continuing healthcare may be eligible, at the probability rate of the application being awarded.

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the Integrated Care Board. However, the legal liability remains with the Integrated Care Board.

This note analyses the amounts recorded as provisions by the Integrated Care Board at the Statement of Financial Position date.

16. Contingencies

	31 March 2024 £000
Contingent liabilities	
Continuing Healthcare	712
Net Value of Contingent Liabilities	**712**

There are no contingent Assets

The contingent liability above relates to continuing care claims, and is directly linked with the continuing care provision included in the Provisions Note. An estimation has been made of the value based upon the amounts claimed. The uncertainties relate to the eligibility of the claims.

The purpose of this note is to disclose material contingent liabilities or assets, if there is more than a remote possibility that there will be a transfer of 'economic benefit' as a result of events that existed before the Statement of Financial Position date.

17. Commitments

17.1 Other financial commitments

The Integrated Care Board has entered into non-cancellable contracts (which are not leases or PFI contracts or other service concession arrangements), for information management and technology equipment and support. The payments to which the Integrated Care Board are committed are as follows: -

	31 March 2024 £000
Not later than one year	3,696
Later than one year and not later than five years	678
Total	**4,374**

The Integrated Care Board have no contracts that exceeds one million pounds.

This note discloses undertakings that have been committed at a future date.

18. Financial Instruments

18.1 Financial Risk Management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because the Integrated Care Board is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Integrated Care Board has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Integrated Care Board in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the Integrated Care Board's Standing Financial Instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the Integrated Care Board's internal auditors.

Only where the Integrated Care Board is exposed to material risk should the appropriate IFRS 7 disclosures be made. The headings in IFRS 7 should be used to the extent that they are relevant.

18.1.1 Currency Risk
The Integrated Care Board is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Integrated Care Board has no overseas operations. The Integrated Care Board therefore has low exposure to currency rate fluctuations.

18.1.2 Interest Rate Risk
The Integrated Care Board borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Integrated Care Board therefore has low exposure to interest rate fluctuations.

18.1.3 Credit Risk
Because the majority of the Integrated Care Board's revenue comes from parliamentary funding, the Integrated Care Board has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

18.1.4 Liquidity Risk
The Integrated Care Board is required to operate within resource allocations agreed with NHS England, which are financed from resources voted annually by Parliament. The Integrated Care Board draws down cash to cover expenditure, from NHS England, as the need arises, unrelated to its performance against resource limits. The Integrated Care Board is not, therefore, exposed to significant liquidity risks.

18.2 Financial Assets

	Financial Assets measured at amortised cost 2023-24 £000	Total 2023-24 £000
Trade and other receivables with NHSE bodies	1,863	1,863
Trade and other receivables with other DHSC group bodies	3,414	3,414
Trade and other receivables with external bodies	15,577	15,577
Cash and cash equivalents	267	267
Total at 31 March 2024	**21,121**	**21,121**

18.3 Financial Liabilities

	Financial Liabilities measured at amortised cost 2023-24 £000	Total 2023-24 £000
Trade and other payables with NHSE bodies	956	956
Trade and other payables with other DHSC group bodies	19,900	19,900
Trade and other payables with external bodies	96,076	96,076
Total at 31 March 2024	116,932	116,932

Due to the short-term nature of these transactions, the fair value of these financial assets and liabilities approximate the carrying amounts at the balance sheet date.

Financial instruments are a broad range of assets and liabilities that arise from contracts and result in a financial asset being created in one entity and a financial liability in another. This note discloses the interest rate risks arising from the Integrated Care Board's financial assets and liabilities, which largely comprise items due after more than one year, such as long-term debtors and creditors, and provisions made under contract.

19. Operating Segments

The Integrated Care Board has only one operating segment, that of commissioning healthcare services for the population of Dorset.

An operating segment is a component of an entity:
* that engages in business activities from which it may earn revenues and incur expenses,
* whose operating results are regularly reviewed by the entity's chief operating decision maker to make decisions about resources to be allocated to the segment and assess its performance, and
* for which discrete financial information is available.

20. Related Party Transactions

The Department of Health is regarded as a related party. During the year the Integrated Care Board has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. For example: -

- NHS England (including commissioning support units);
- NHS Foundation Trusts;
- NHS Trusts;
- NHS Resolution; and
- NHS Business Services Authority.

In addition, the Integrated Care Board has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Dorset Council and Bournemouth, Christchurch & Poole Council in respect of Better Care Fund arrangements.

The Integrated Care Board has received revenue grant monies from Macmillan Cancer Support. No capital payments have been received from charitable funds.

Dorset Integrated Care Board is a body corporate established by order of the Secretary of State for Health.

		Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
1	John Beswick - ICB Non-Executive Director and Chair of Risk & Audit Committee, Chief Finance Officer (CFO) at Great Ormond Street Hospital. **Transactions disclosed for Great Ormond Street Hospital.**	34	0	0	0
2	John Beswick - ICB Non-Executive Director and Chair of Risk & Audit Committee, Bournemouth University non-exec director. **Transactions disclosed for Bournemouth University.**	28	0	0	0
3	John Beswick - ICB Non-Executive Director and Chair of Risk & Audit Committee, Divisional Chief Finance Officer, BT Group Plc. **Transactions disclosed for BT Group Plc.**	37	0	0	0
4	Matthew Bryant - Dorset HealthCare University NHS Foundation Trust and Dorset County Hospital NHS Foundation Trust, Joint Chief Executive, **Transactions disclosed for Dorset Healthcare University NHS Foundation Trust.**	300,844	3,762	0	266
5	Matthew Bryant - Dorset HealthCare University NHS Foundation Trust and Dorset County Hospital NHS Foundation Trust, Joint Chief Executive, **Transactions disclosed for Dorset County Hospital NHS Foundation Trust.**	221,590	296	9,663	3
6	Jenni Douglas-Todd - Chair, NHS Dorset, University Hospital Southampton NHS Foundation Trust Chair. **Transactions disclosed for University Hospital Southampton NHS Foundation Trust.**	10,675	5	130	14
7	Spencer Flower - Dorset Council, Leader, **Transactions disclosed for Dorset Council.**	31,915	1,263	7,636	1,454
8	Siobhan Harrington - University Hospitals Dorset NHS Foundation Trust, Chief Executive, **Transactions disclosed for University Hospitals Dorset.**	581,611	667	9,048	630
9	Vikki Slade - Bournemouth, Christchurch & Poole Council, Leader, **Transactions disclosed for Bournemouth, Christchurch & Poole Council.**	28,191	1,455	4,188	3,603
10	Stephen Slough - Chief Information Officer, CIO and Executive Director at Dorset County Hospital NHS Foundation Trust. **Transactions disclosed for Dorset County Hospital NHS Foundation Trust.**	221,590	296	9,663	3
11	Dr Forbes Watson - Governing Body, Clinical Commissioning Group Chair, Remuneration Committee. Principal GP, Lyme Bay Practice. **Transactions disclosed for Lyme Bay Medical Centre.**	417	0	0	0
		1,396,932	**7,744**	**40,328**	**5,973**

The Department of Health and Social Care has identified a number of individuals and entities as meeting the definition of Related Parties set out in IAS 24 (Related Party Transactions) and these are also deemed to be related parties of entities within the Departmental Group. Of these individuals and entities, Dorset Integrated Care Board has had no transactions in 2023/24.

In formulating this note the Integrated Care Board has considered all declarations of interest for Governing Body Members. Under IAS 24, related party transactions have only been disclosed where they meet the following criteria:
(i) have control or joint control over the reporting entity;
(ii) have significant influence over the reporting entity; or
(iii) are a member of the key management personnel.
The Declaration of Interest register can be found on our web site www.nhsdorset.nhs.uk/about/constitution/#doi

21. Events after the end of the Reporting Period

The Integrated Care Board has no Events after the end of the Reporting Period.

This note discloses the financial consequences of events (both favourable or unfavourable) that occur between the Statement of Financial Position date and the date on which the financial statements are approved by the Board, if appropriate. Two types of events can be identified: -
* those that provide evidence of conditions that existed at the end of the reporting period (adjusting events); and
* those that are indicative of conditions that arose after the reporting period (non-adjusting events).

22. Financial Performance Targets

Integrated Care Boards have a number of financial duties under the NHS Act 2006 (as amended).
The Integrated Care Board's performance against those duties was as follows:

Duty	2023-24 Target	2023-24 Performance	Duty Achieved?
	£'000	£'000	
Expenditure not to exceed income	**1,920,943**	**1,938,377**	**No**
Capital resource use does not exceed the amount specified in Directions	**405**	**405**	**Yes**
Revenue resource use does not exceed the amount specified in Directions	**1,882,828**	**1,900,261**	**No**
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	**0**	**0**	**Yes**
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	**0**	**0**	**Yes**
Revenue administration resource use does not exceed the amount specified in Directions	**16,578**	**16,556**	**Yes**

The Revenue Resource Allocation Directions for 2023-24 are based on in-year funding, excluding any historic surplus, which for the ICB was £24,334k (£23,879k as at 31 March 2023 plus £455k in year adjustment). In-year, expenditure exceeded income, resulting in an in-year deficit of £17,433k.

The purpose of this note is to disclose the Financial Performance of the Integrated Care Board. Where an Integrated Care Board breaches, or plans to breach, one of the statutory financial provisions, even if this is agreed with NHS England (e.g. setting a deficit budget) local auditors are under a duty to make a report to the Secretary of State for Health under Section 28 of the Audit Commission Act 1998.

23. Other

The Integrated Care Board has considered the following areas and has no details to disclose under these headings: -

- The Late Payment of Commercial Debts (Interest) Act 1998
- Income Generation Activities
- Investment Revenue
- Impairments & Reversals
- Investment Property
- Other Financial Assets
- PFI & LIFT Contracts
- Other Current Assets
- Non-Current Assets Held for Sale
- Analysis of Impairments and Reversals
- Other Financial Liabilities
- Other Liabilities
- Borrowings
- Other Gains & Losses
- NHS LIFT Investments
- Finance Lease Obligations
- Finance Lease Receivables
- Third Party Assets
- Impact of IFRS Treatment
- Analysis of Charitable Reserve

GLOSSARY OF FINANCIAL TERMS

Accruals	An accounting concept. In addition to payments and receipts of cash, adjustment is made for outstanding payments, debts to be collected and inventory. This means that the accounts show all of the income and expenditure that related to the financial year.
Assets	An item that has a value in the future. For example, a debtor (someone who owes money) is an asset, as they will in future pay. A building is an asset, because it houses activity that will provide a future income stream.
Assurance	Process through which accurate and current information is provided to stakeholders about the efficiency and effectiveness of policies and operations, and the status of compliance with statutory obligations.
Audit	The process of validation of the accuracy, completeness and adequacy of disclosure of financial records.
Capital	Land, buildings, equipment and other non-current assets owned by the Integrated Care Board, the cost of which exceeds £5,000 and has an expected life of more than one year.
Cash limit	A limit set by the NHS England which restricts the amount of cash drawings that the Integrated Care Board can make in the financial year. There is a combined cash limit for both revenue and capital.
Co-Commissioning	Refers to the process whereby the Integrated Care Board can directly commission primary medical services and performance manage practices but not individuals. This role was transferred from NHS England on the 1 April 2016.
Commissioning	Purchase of healthcare from external service providers (NHS, other public sector, private and voluntary) to meet the needs of the population.
Current Assets	Trade receivables, inventories, cash or similar, whose value is, or can be converted into, cash within the next twelve months.
Deep dive	A technique to rapidly immerse a group or team into a situation for problem solving or idea creation. It is often used for brainstorming product or process development.
Governance	The framework of rules and practices by which a board of directors ensures accountability, fairness, and transparency in relationships with its stakeholders. Corporate governance should underpin all that an organisation does. This means it must encompass clinical, financial and organisational aspects in the NHS.
Gross Operating Costs	This is the total revenue expenditure, including accruals and provisions, incurred in the course of performing all aspects of the Integrated Care Board's functions during the year.
Intangible Assets	Brand value or some other right (for example, a software licence), which although invisible is likely to derive financial benefit for its owner in the future, and for which you might be willing to pay.
Locality	In general meaning a community in which people live. Specifically to the Integrated Care Board this refers to the 13 different geographical areas in Dorset for which we commission services.
Locality Cluster	This refers to the 3 clusters made up of the 13 geographical localities in Dorset.
Miscellaneous Income	Income that relates directly to the operating activities of the Integrated Care Board. This excludes cash from NHS England, which is credited to the general fund.
NHS Constitution	The constitution brings together in one place details of what staff, patients and the public can expect from the NHS.
Non-Current Assets	Land, buildings, equipment and other long term assets that are expected to have a life of more than one year.
Procurement	The act of obtaining or buying goods and services. The process includes preparation and processing of a demand as well as the end receipt and approval of payment.
Quality Premium	Is intended to reward Integrated Care Boards for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities.
Remuneration	Reward for employment in the form of pay, salary, or wage, including allowances, benefits (such as company car, medical plan, pension plan), bonuses, cash incentives, and monetary value of the noncash incentives.
Resource limit	Expenditure limits are determined for each NHS organisation by NHS England for both revenue and capital, which limit the amount that may be expended on revenue purchases, as assessed on an accruals basis (that is, after adjusting for receivables and payables).
Transformation	A process of profound and radical change that orients an organisation in a new direction and takes it to an entirely different level of effectiveness.
Safeguarding	Protecting from harm or damage with an appropriate measure.
Stakeholders	A person, group or organisation that has interest or concern in an organisation.
Sustainability	An approach that creates long-term strategy aimed toward the natural environment and taking into consideration every dimension of how a business operates in the social, cultural, and economic environment.
WGA	Whole of Government Accounting (WGA) are organisations such as Local Authorities, Scottish and Welsh NHS bodies, NHS Property Services and NHS Resolution, etc.

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If you need this report in an alternative format or language then please email communication@nhsdorset.nhs.uk

Public Health Dorset

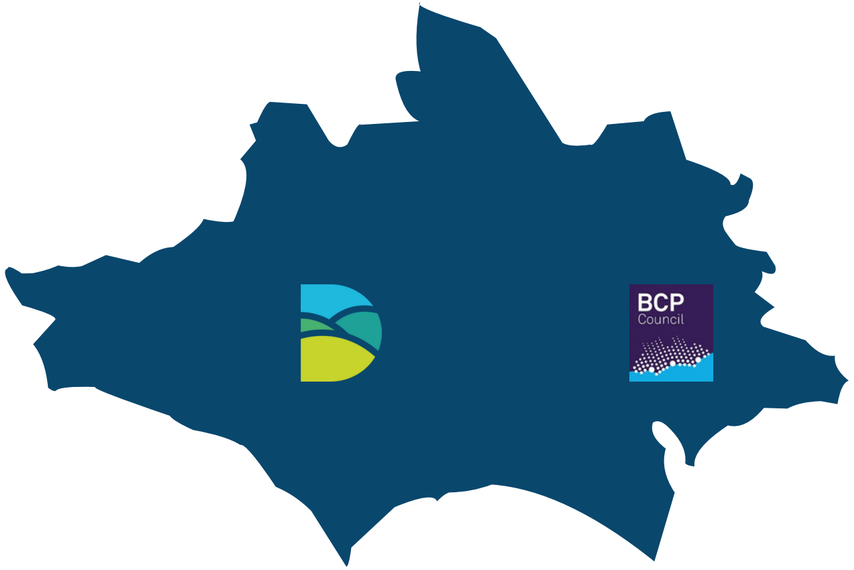
Part of BCP and Dorset Councils

Annex 3

Annual Director of Public Health Report

Dorset Council and Bournemouth, Christchurch and Poole Council

2022/2023



Celebrating ten years in local government

Sam Crowe
Director of Public Health for Dorset and Bournemouth, Christchurch and Poole Councils

Welcome to our annual public health report. This year's report is focused on understanding the difference we make through our public health services. With ongoing complex challenges to health it feels timely to focus on who we are helping through our shared services by improving and protecting the health of residents in both Dorset and Bournemouth, Christchurch and Poole Councils, and tackling inequalities.

Ten years ago, public health moved from the NHS into local government in one of the biggest shake-ups to the public health system in recent history. We decided to provide public health through a shared service in 2013 – supporting the three councils at the time, before local government reorganisation formed two unitary authorities.

There were clear reasons for this. Being able to provide services at scale – delivering value for money, efficiency and effectiveness. We used the pooled public health grant to develop new services such as our integrated health improvement service, LiveWell Dorset. We stopped smaller support services, and invested in evidence-led behaviour change, embracing digital delivery to reach people most in need. Since 2015 LiveWell Dorset has helped around 50,000 Dorset and BCP Council residents to lose weight, quit smoking, reduce their drinking and move more.

Sharing services and pooling the public health grant has meant we have been able to provide advice and guidance at scale to many different partners over the years. We retain a strong team, able to provide specialist communications, intelligence and evidence to partners and the public to improve health. Having strength in depth meant that when the COVID-19 global emergency hit, we were able to lead the local outbreak response, stepping in to provide vital health protection and infection prevention and control support to our local communities.

Over the past year, we've stepped back from health protection, focusing back on communities, health improvement and our work with partners in the health system. We led a diverse team to deliver the system's first integrated care strategy focused on prevention, as well as healthy places policy work with councils to improve walking and cycling, make homes warmer, reduce food insecurity and improve access to high quality green spaces.

I hope you enjoy this year’s report, and through it gain a clear understanding of the way the public health shared service has supported residents not just in the past year, but also through a decade’s work in local government.

> **One of my proudest achievements was supporting the creation of the first Poverty Truth Commission in the south of England, in BCP Council. The Commission brings together people with living experience of poverty to sit with local leaders, working together to find ways to involve people fully in decisions that affect them about services. Over time this approach will help tackle inequality in our local areas, and support service providers to better understand the difference they can make to people living with poverty.**
>
> **Sam Crowe, Director of Public Health**

2022-23: The year in review

This section shows some of the highlights and achievements from our programmes during 22-23. We report on progress through the Joint Public Health Board, and our key programmes and services are set out in our annual business plan.

Recovering services

During the pandemic, many of our public health services were paused or revised when face-to-face contact was stopped in lockdown. Recovering services has been the main ambition in the past year.

We have now taken the opportunity to relaunch our NHS Health Checks service. This is a national service that provides people aged 40-74 with a check to find out their risk of stroke and heart disease. Performance has not always been strong, especially in disadvantaged areas. We redesigned the service, and are now offering checks in-house through LiveWell Dorset, who will focus on communities with the highest needs.

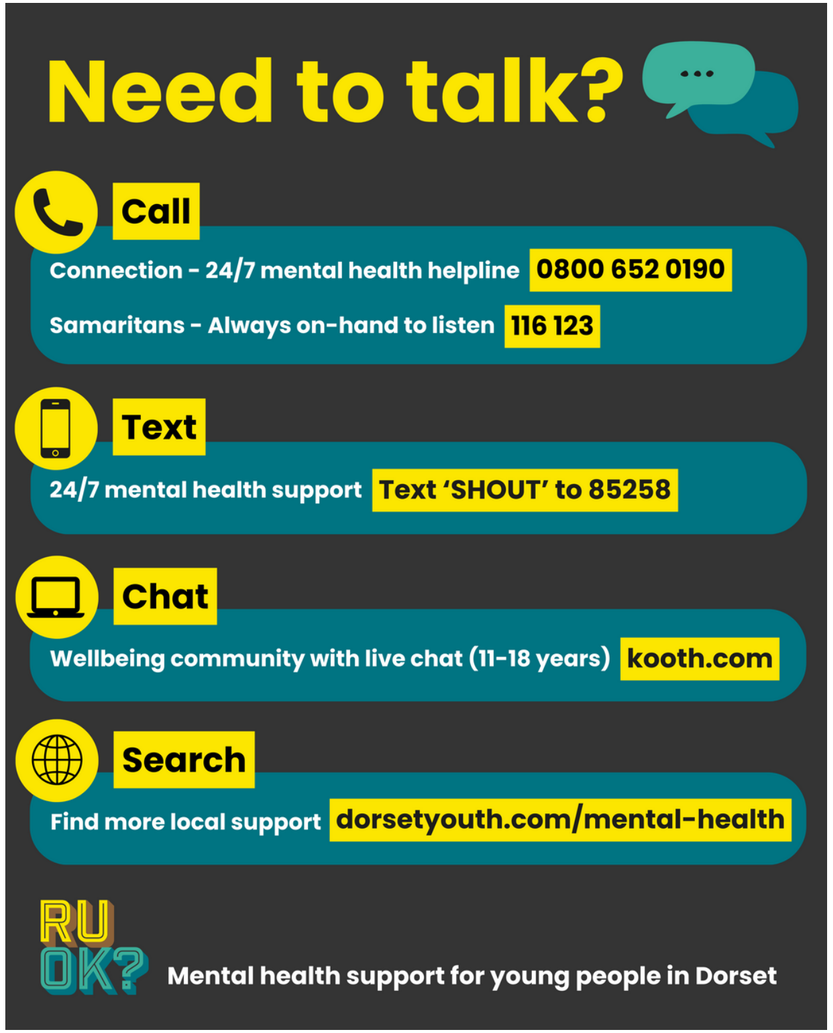
Recovery of services for people with drug and alcohol problems was also a key feature. We supported a new partnership – the Combating Drugs Partnership – to deliver the national strategy, supported by new funding to restore services.

Our largest area of spend in public health goes on delivery of the healthy child programme. This provides health visiting to families with very young babies, supporting the vital early years, as well as children and young people through public health work in schools. In the past year, we saw successful recovery of these services, with face-to-face contact restored and performance above regional and national comparisons.

Our mental health prevention work continued, responding to an increase in people locally who are struggling. Sadly in January we declared a cluster of suspected deaths by suicide, and set up a response team to ensure access to bereavement support and identify people affected who may need more support to reduce the risk of further deaths.

We continued to provide suicide awareness and prevention training to around 250 people working in frontline services. Building confidence in people to talk about suicide is one small step in helping some people share how they are feeling, which can make a difference in getting help. We also ran a large communications campaign aimed at young people, to raise awareness of how to seek help when struggling with their mental health.

In our work with the health and care system, we developed the first integrated care strategy for Dorset, and continue to lead its implementation. This includes developing new ways of engaging with people and communities, through the 100 Conversations community engagement programme. We supported both councils to play an active role in the new integrated care system and are working to ensure local plans align and can deliver on priorities set out in the strategy.



Key service performance

0-19 public health service	Performing well
Sexual health	Performing well
Drugs and alcohol	Performing well
LiveWell Dorset	Performing well
NHS Health Checks	Behind target

Public health had a brand refresh led by our communications team. Having a visual identity that reflected the partnership between the two unitary councils involved a subtle change to our colours and strapline. This is supported by changes in the team to enable us to work in a more integrated way in both councils.

The theme of greater integration continued through the public health intelligence team, who have completed the transition of our data and information platform from Tableau to PowerBI. This will help share understanding of our data as it is now the common platform across the system. We also have a new joint intelligence role working with Dorset Council and NHS Dorset, to enable more integrated working.

Finally, it was great to be recognised nationally for our partnership work. LiveWell Dorset has been working closely with local clinicians in the Dorset Health Villages - outpatient assessment centres in Dorchester town centre and Beales in Poole Dolphin Centre. They provide people preparing for surgery for joint problems with advice on losing weight, stopping smoking and getting more active. This way of working is reducing the need for surgery in some cases, and instead people are able to manage and improve their condition through changing their health behaviour, and undergoing rehabilitation through physiotherapy. The service was highly commended in the Health Services Journal awards this year. Thanks to our partners Active Dorset in helping deliver this new way of working in Dorset.

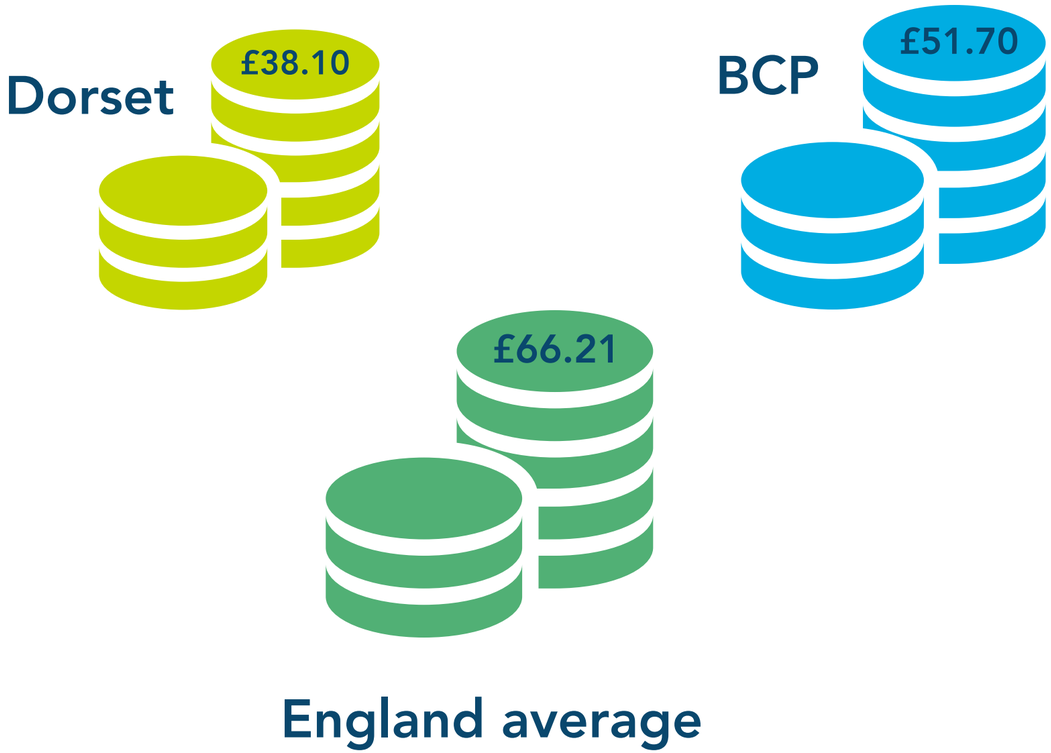
Our finances

Public Health Dorset is funded from a public health grant received by both councils from central government. In total we receive around £25million each year. The graphic on the next page shows where this was spent last year.

The grant is ring-fenced for use on public health functions. Overall, around 87% of our grant is used to directly commission or provide public health services. The remainder goes on our team and hosting costs.

The grant received by each council varies based on underlying population need and historic allocations. BCP Council received £51.70 per head of population in 22-23 (£20.6m in total), compared with £38.10 per head for Dorset (£14.6m). The Dorset allocation is the 13th lowest in the country, and BCP Council 55th of 152 councils. At the top end, Kensington and Chelsea receive around £140 per head, and Blackpool £138 per head for comparison.

Funding allocation per head of population



How we spent the grant in 22-23

0-19 services

- £11.2m - Dorset HealthCare
- £260k - Best Start in Life and breastfeeding

Sexual health services

- £5.17m - Dorset HealthCare
- £801k - GPs, pharmacies and out of area

Drugs and alcohol (Dorset Council only)

- £2.58m - Reach (EDP)
- £168k - Pharmacies, waste, detox and rehab

Team costs

- £2.5m - Main staffing costs
- £477k - Hosting and operational costs

LiveWell Dorset

- £1.02m - In-house provision

Smoking cessation

- £697k - Hospitals, pharmacies, GPs and other

Adult obesity

- £236k - Fixed term support and tier 2

NHS Health Checks

- £132k - GPs and pharmacies

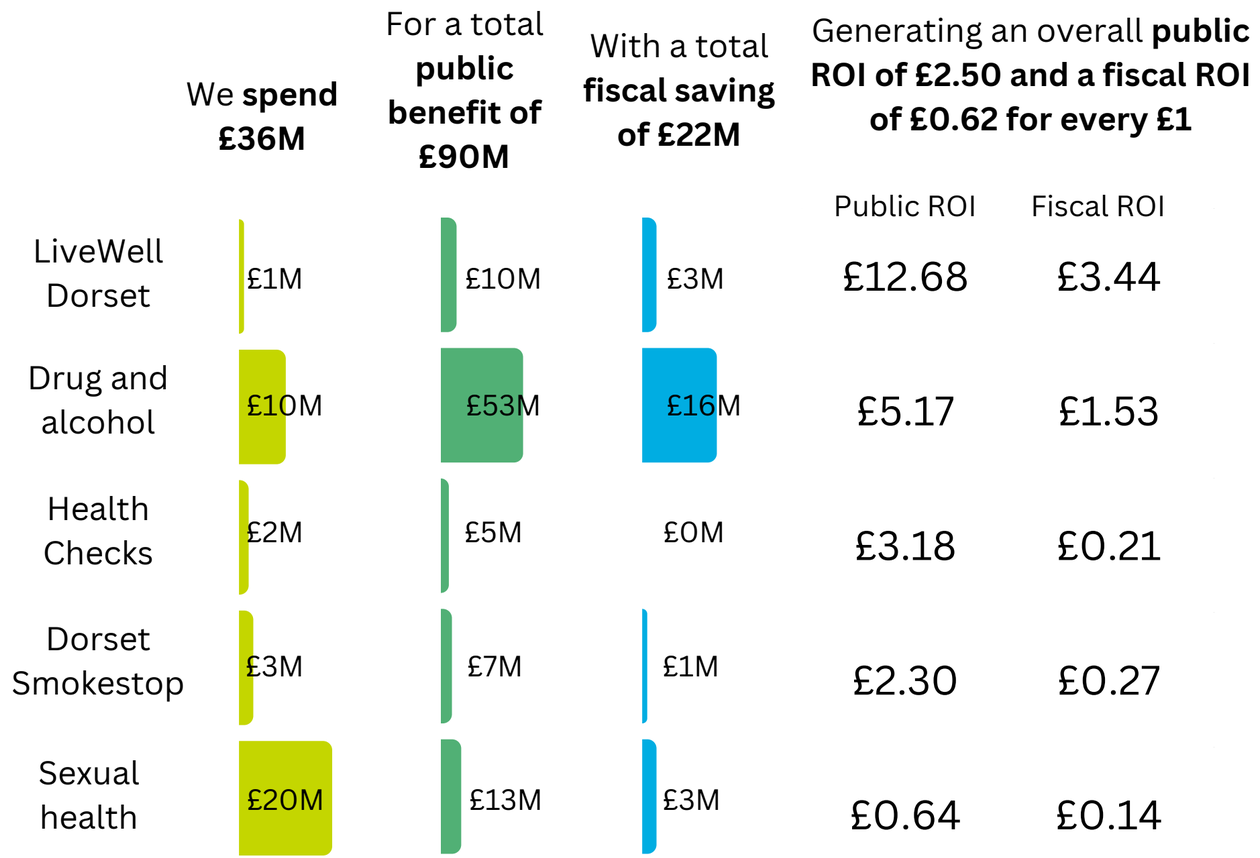
Public health intelligence

- £137k - Joint posts and software

Measuring value for money

We carry out studies to assess the value for money in the way the public health grant is invested. In 2016-18 we used an economic model (New Economy, Manchester) to understand the costs and benefits of public health services locally.

This found that the greatest return on investment was through health improvement services, like LiveWell Dorset. For every £1 spent through the service, a public return of £12 was generated in prevented ill health. However, the fiscal return was greatest to the NHS, not local government. Fiscal return measures benefits to local public sector organisations, like the NHS or councils.



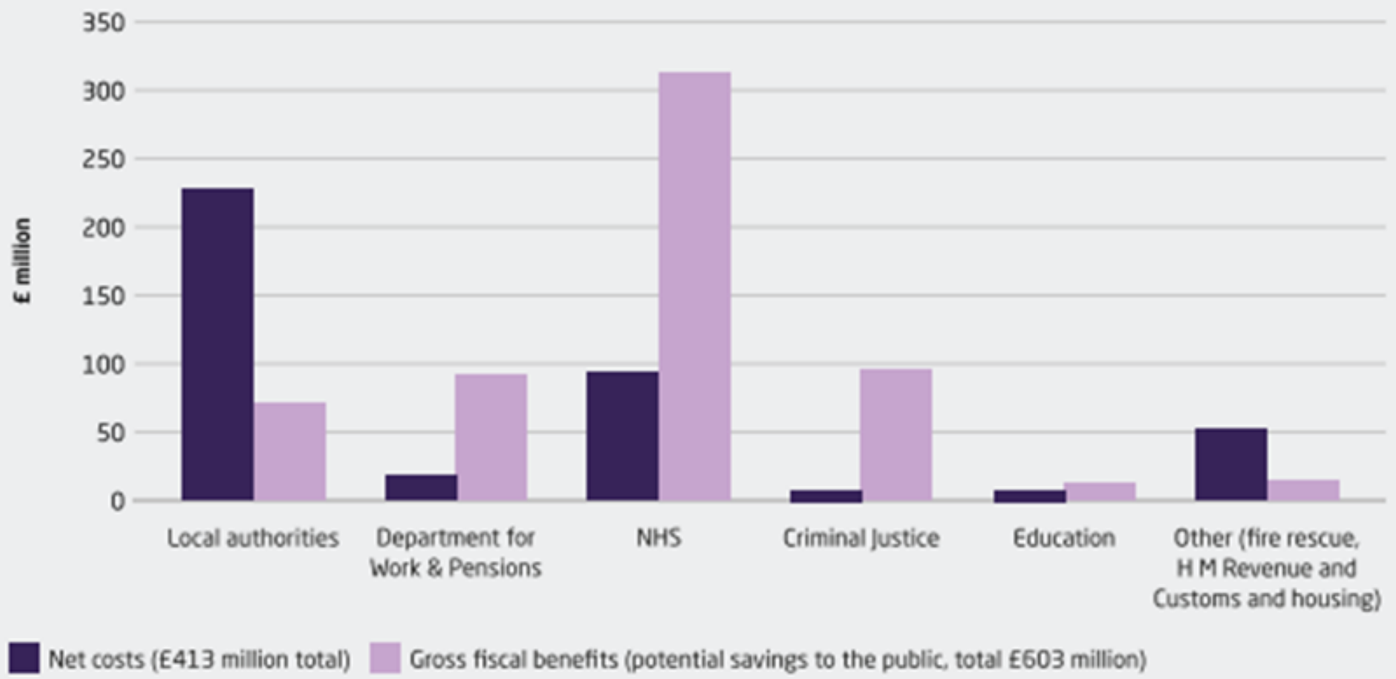
Graphic showing benefits arising from 3 year spend on common public health services in Dorset between 2013/14 and 2015/16. The costs (spend) of some of these services are considerably lower today, resulting in improved value for money.

This is supported by a larger analysis of public health commissioning by local government, see Figure 5. Overall, public health services remain a good investment and offer good return at system level, but this is harder to evidence directly back to councils.

The second greatest return on investment after health improvement was from spend on drug and alcohol services.

The chart to the right shows use of the same model applied to 13 areas in England, looking at the costs and benefits of the public health grant.

Figure 5 How costs and benefits are shared across the public sector



Source: Public Service Transformation Network analysis of 33 ex-ante Cost Benefit Analyses (from 13 places working with the Public Service Transformation Network) – New Economy, Manchester

From King's Fund 2020: An Independent Assessments of the English local government public health reforms.

Our service performance

0-19 Public Health Service

We commission Dorset Healthcare, a local NHS provider, to deliver the Children and Young Person's Public Health Service to families in BCP Council and Dorset Council.

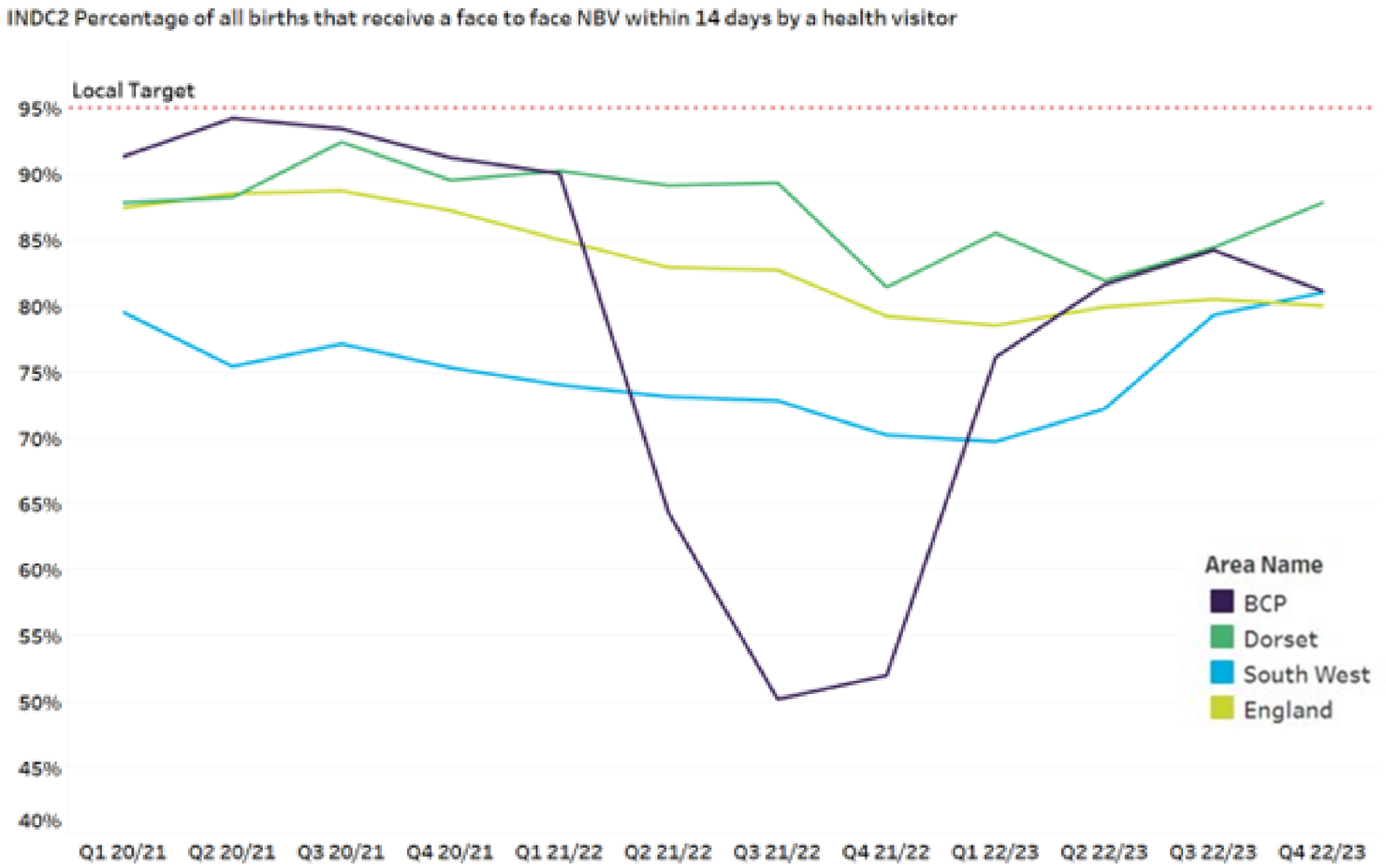
The overall aim is to support the next generation to have the best possible start in life. The service offers a number of face to face visits, assessments and checks at important early years stages, as well as working to deliver better health through schools. Each year they will visit around 4,500 families with newborn babies.

They provide support and advice to parents, carers and families of children and young people working closely with other children's services. They have an important role in safeguarding and in identifying issues early to provide help, including for depression following childbirth.

The service works to deliver a range of national activity targets. However, in recent years we have also asked for evidence of impact on improving public health outcomes at a universal level in the first two years of life. We ask the service to focus on reduction of smoking, through smoke free homes work, increased physical activity, readiness for school, and family mental health.

The service has faced challenges in the past few years. This includes not being able to carry out face-to-face visits during the pandemic, workforce challenges and vacancies, and juggling safeguarding responsibilities and working with complex families whilst providing a universal service to all families with young children.

All new births should receive a visit from a health visitor within the first 2 weeks. The chart above shows local performance. In 22-23 we have seen significant recovery of the timeliness of visits in BCP Council – and they are consistently above the average for South West England, and similar to England in both council areas.



Smoking

Smoking at time of delivery is a key national measure that is collected by the NHS. In Dorset, around 10% of women giving birth are smoking at delivery, slightly higher than England at 9.1%. Midwives offer support to quit for women who are smoking, and this work is continued by our CYPPHS service when they are working with families with new babies. Carbon monoxide monitoring of the smoking status of parents is now routinely recorded at visits, and those smoking offered support to quit. Around 2 in 3 are given health advice about smoking, and 1 in 3 referred for stop smoking support.

Achievements and challenges

The service is delivering broadly above the national average for all mandated contacts despite continued workforce challenges. Quarterly highlight reports show strong evidence of successful work around the four key outcomes - reducing smoking, school readiness, physical activity and family mental health. ChatHealth and Parentline are providing innovative digital support to children and families and use is increasing steadily.

Specific safeguarding posts have been introduced to ease system pressures around increased need and responsibilities, allowing the service to focus on universal contact and support. We have continued to collaborate well with the service managers and leadership on addressing challenges this year, including task groups to work on key challenges, such as cost pressures due to pay awards and rising complex needs, workforce challenges including recruitment and retention, and data quality and reporting.

Our service performance

Sexual health services

We commission an integrated, community based sexual health service that operates from two main clinical hubs in Dorset, in Weymouth and Bournemouth. The hubs are supported by smaller community services in Blandford, Poole, Bridport and Portland. Around 3,500 people attend each month. The main aims of the service are to diagnose and treat sexually transmitted infections including HIV, provide contraceptive health advice, behaviour change and prevention, and enable access to online testing for a range of conditions. The service is skilled at working with and reaching core groups who experience increased sexual health risks including men who have sex with men, the trans community, and some ethnic minority groups.

The most recent data on new STI diagnoses shows an increase, although during the pandemic the number of new diagnoses dropped. In BCP rates are now similar to pre-pandemic at 464 per 100,000 (compared to 457 per 100,000 in 2019). In Dorset, the increase has been smaller, currently at 300 per 100,000 (compared to 430 per 100,000 in 2019).

Sexual Health Dorset

Achievements and challenges

The service continues to develop a fully integrated sexual health and HIV community model with improved access to online testing services including for HIV. They are developing strong quality improvement approaches, including a behaviour change skills development plan for employees.

They are successfully providing new services such as pre-exposure prophylaxis for HIV, and developing a zero HIV programme. They continue to adopt new service delivery approaches, including using online tools like ChatHealth to provide support on sexual health for children and young people.

This year Sexual Health Dorset has worked through the challenge of keeping the service functioning during the recovery from COVID and the national Mpox outbreak. An ongoing challenge is engaging groups at higher risk of risky sexual behaviours, and re-establishing work with schools following the pandemic.

Our service performance

Addiction treatment and recovery

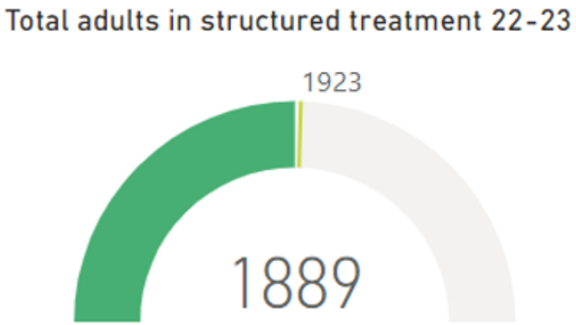
Public Health Dorset commissions treatment for people with problematic drug and alcohol use in the Dorset Council area. The service, called Reach, is provided by Humankind and is an integrated, all-age model. We no longer commission treatment services for residents in the BCP Council area, this is carried out by a separate team in the council.

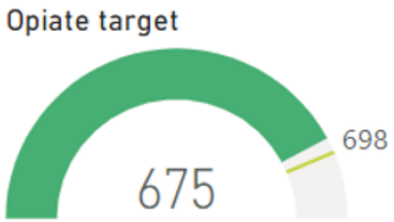
Drug and alcohol services are an important public health service. Investment in treatment and recovery has been shown by numerous studies to provide a good level of return on investment. People and families benefit from recovery from addictions on an individual level, but there are also wider benefits to communities through reduction of acquisitive crime, improved community safety, and reduced use of health and social care services. Effective treatment reduces demand for illegal drugs too and is one of the main aims of the new national drug strategy, From Harm to Hope.

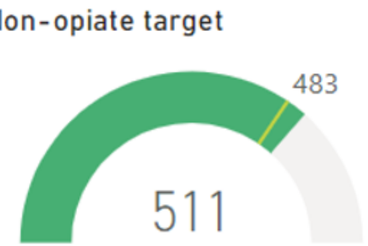
In the past year, the public health team has been working with the service providers to plan for new investment to increase the number of adults in treatment through new grant funding in addition to our existing local funding. The team has also been preparing to re-tender for the service as the contract expires shortly.

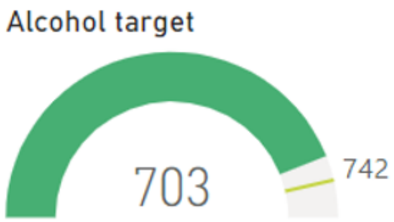
Achievements and challenges

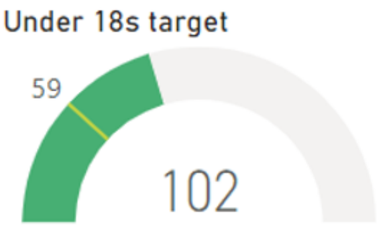
The service has performed well against national targets in 2022-23, only marginally below the target for number of adults in structured treatment by 34. The target for adults in treatment for non-opiates was exceeded, as was the target for young people in treatment. Dorset Council had higher successful completions than the national average in all four drug categories in 22-23. It also had a higher proportion of people in treatment showing substantial progress, compared with national targets.











One of the most improved outcomes is continuity of care following release from prison, which rose from 43% to 67% through the year. This measures the proportion of adults with a need for substance misuse treatment who successfully engage with treatment in the community on release from prison. The national proportion is 41% on this performance measure.

There has also been a reduction in the number of drug related deaths in the county in 2022. Although the figures are provisional, depending on coroners inquest findings, deaths fell from 59 in 2021 to 51 in 2022.

Challenges for the treatment and recovery of adults with problematic substance use include meeting national expectations around performance following the additional investment. Re-tender can sometimes lead to temporary loss of performance due to uncertainty and change. With the new grant funding due to end in March 2025, there remain risks around continuity of service as without additional funding, the level of performance will be difficult to maintain.

Our service performance

LiveWell Dorset is our in-house integrated health behaviour change service. It offers support to adults who live in the Dorset Council and BCP Council areas who want to quit smoking, lose weight, reduce their alcohol consumption and move more. What makes this service different is that it combines support for different lifestyle issues with evidence-based behaviour change support, all in a simple to access service with digital, telephone and some face to face support.

It's public health importance is because lifestyle risk factors underpin many of the diseases and conditions that lead to early death and years spent living in poor health, such as cancer, heart disease, strokes and diabetes. Supporting people so they are motivated to make positive changes to improve their health can have a big impact on their quality of life, as well as being one of the most cost-effective prevention investments in our local system.

LiveWell Dorset also focuses on primary prevention in our integrated care system working collaboratively in to deliver innovative, effective, and evolutionary local services at scale.

Achievements in numbers:

- Almost 50,000 registrations since the service started in 2015
- 40% of all clients are from most deprived areas, helping to tackle health inequalities
- Nearly 13,000 coaching sessions delivered for 3,500 clients
- Almost 40% of weight management clients lose 5% bodyweight by 3 months
- Over 1,700 clients supported to stop smoking through nicotine replacement therapy and e-cigarette offer

Our service performance

NHS Health Checks

The NHS Health Check is commissioned and delivered through public health in local authorities under our mandate to provide a cardiovascular risk assessment to adults aged 40-74 years old. Adults who are not being treated for known heart problems, stroke or diabetes are invited once every five years to receive a check on their risk factors.

Anyone at an increased risk is asked to see their GP for a fuller assessment and possible treatment. Around 3% of people in Dorset having a check are usually asked to see their GP due to raised risks, but this rises to more than 15% in some communities with greater underlying risk factors.

Performance locally has not been strong in recent years. We have delivered a lower number of invitations, and a lower number of checks in each council area compared with national averages. This has been due to a combination of inconsistent delivery by primary care and pharmacy, interruption due to the pandemic and current workforce pressures. Performance on this programme has been lower than the average for England across the wider South West region too.

But there are also problems with ‘the inverse care law’. The lowest provision of checks has been in areas with the highest underlying risk factors for cardiovascular disease, and the greatest provision has been in more affluent areas in Dorset, with lower risk factors.

Because of this, we spent time in 22-23 relaunching the programme following consultation and engagement with service users, providers and members of the Joint Public Health Board.

In April 2023 a new programme went live, with a mixture of primary care providers, and a new outreach service provided by LiveWell Dorset, aiming to work with groups harder to reach. They have a target to achieve delivery of around 2,000 additional checks in 23-24.

Achievements and impact in 2023

The programme did not achieve its targets in 2023. In the BCP Council area, 6.5% of the eligible population were invited for a check, but only 1.6% took up the offer (7,312 offered, 1,768 delivered). The CIPFA benchmarking data for nearest neighbours shows an average of 17.6% of the population being invited each year, with 6.7% taking up the offer. To match this performance, an increase of around 5,500 checks delivered each year is required. The outlook and activity improved in the final quarter of 2022-23, and will be closely monitored this year.

For Dorset Council performance was similar with 5.3% receiving an invitation, and 2.2% of the eligible population having a check (6,247 invited, 2,628 delivered). The number of checks delivered in the final quarter of 22-23 improved, and again will be monitored this year. The CIPFA benchmark for neighbouring authorities is for 12.1% of the eligible population to be invited per year, with 4.8% of the population receiving a check. To match this performance, an increase of around 3,000 health checks delivered is required.

Spotlight: BCP Council

One of our key links in the BCP area has been the Access to Food Partnership, where we have taken a holistic approach to address the wellbeing of people experiencing food insecurity. We have supported local food projects and worked towards ensuring that vulnerable populations have access to nutritious food.

The public health team has closely worked with Community Development Officers on programmes with links to population health outcomes, such as the ASPIRE project, Boscombe Soup events and the cost of living response.

We have collaborated with the Resettlement Team on asylum seekers' health and wellbeing. In particular, we have focused on supporting the health needs of hotel residents, providing Mental Health First Aid training for support staff.

We've worked with BCP colleagues on joint public engagement, through the 100 Conversations project which ensured residents' voices were heard as part of the development of the Integrated Care Partnership strategy. We've followed on from this by linking in with Age-friendly Communities, fostering a more inclusive and age-friendly environment in Bournemouth, Christchurch and Poole.

Recognising the importance of equality, diversity, and inclusion, we have provided our support to the Strategic Equality Leadership Group.

We have also provided support to Children's Services in developing the Special Educational Needs and Disabilities (SEND) Joint Strategic Needs Assessment (JSNA) process.

Spotlight: Dorset Council

Through Dorset Together, we've supported the Ukrainian refugee programme and work to support residents through the cost of living crisis. Our intelligence team has contributed to modelling work, providing valuable insights and data to provide help to those who need it most.

We have taken a lead role in the Dorset Food Security Network, which has made remarkable progress in improving the infrastructure for food security across the area. We are particularly focused on extending the provision of affordable, healthy food options while establishing strong links with a wider wellbeing offer.

Our locality link workers have worked with Dorset Council and town council colleagues in towns across Dorset to support health and wellbeing initiatives, including wellness events and parkrun in Shaftesbury and new orienteering courses in Gillingham and Blandford. In Weymouth, we conducted a survey to understand young people's use of outdoor space, with the aim of understanding barriers and improving access.

For children and families, we have undertaken a thorough review to improve the uptake of the Healthy Start Programme and are supporting the development of Family Hubs, collaborating with other local initiatives. We've also worked with the Early Help Engagement team to create physical activity opportunities for young people who are on risk registers or have anti-social behaviour orders.

In line with the council's commitment to equality, diversity, and inclusion, we have provided support to the council's EDI Strategic and Operational Groups.

Other programmes: Mental health

In 2022-23 the team recognised mental health was an increasing priority, based on understanding the level of need that was presenting to services, supported by national surveys showing an increased prevalence especially in children and young people. We have begun developing a programme of public mental health work, aiming to support partners in the wider system. The work falls into the following categories for the public health team:

- Understanding need – contributing to the Joint Strategic Needs Assessment and developing our integrated care system strategy with partners
- Support to NHS service improvement and transformation – under our healthcare public health programme (child and adolescent mental health services, community integrated care)
- Suicide prevention – communications campaigns, awareness raising, and training of professionals working in the system to better support people in need
- Response work – developing real time surveillance of suspected deaths by suicide, and offering timely bereavement support working closely with affected groups and settings

2022/23 achievements

The past year saw the creation of a new statutory body, NHS Dorset, to lead the integrated care system which went live on 1 July. Public health has been supporting the development of the integrated care strategy. Mental health featured strongly in the strategy, recognising that as a system we could do more to support people at an earlier stage when they experience problems with their mental health.

This included developing a case study on children's emotional health and wellbeing, and their experiences of support through child and adolescent mental health services. This was used with both Health and Wellbeing Boards as part of our joint strategic needs assessment process, to highlight priorities we believe the system should focus on in the coming years.

Work is now progressing on a major change programme for CAMHS, which we will support under our healthcare public health agreement. To support the work, a series of in-depth panels on mental health are taking place this year, to understand what prevents people from seeking support at an early stage, and what we can do differently.

The public health team has experience of responding to clusters of suicides, and actively worked with partners to improve access to timely bereavement support, improve understanding of what to do in response to a suspected death, and getting more timely data and intelligence, working with partners.

The Director of Public Health established a sector led improvement programme for the South West Region in 22-23 specifically looking at barriers to timely local data. The improvement work will continue during 23-24, aiming to ensure that every area in the South West has access to timely surveillance data, to enable a timely response.

We have delivered two targeted suicide prevention campaigns this year - one focusing on rural communities and the other for young people. Suicide rates are higher in rural communities, and agricultural workers and farmers have an increased risk of suicide. We delivered a hyper-local suicide prevention campaign called Within Reach in two rural communities in North Dorset and West Dorset to empower people to support others and encourage those struggling to reach out for help. This included mental health first aid training, radio and print advertising and distribution of hundreds of cards signposting to support.

Research by Dorset Youth showed that young people don't always know where to go to get mental health support, so we aimed to tackle this problem with our integrated campaign 'RUOK?'. Our focus was on a shareable graphic that young people and their families and friends can screenshot, save and share on their phones so information about mental health services is always to hand. It has been shared with a wide range of partners including all schools and colleges, youth groups, libraries, town and parish councils, and NHS and mental health partners. Our advertising campaign in March and April targeted young people in Dorset on Snapchat, Instagram and Youtube, and generated over 1.5million views, with 13,500 click throughs to signposting information.

We have also been working to train our workforce in Dorset to have the skills to provide support to people who may be thinking about suicide. Last year, we provided suicide first aid training to 225 people in a range of frontline roles including in the NHS, fire service and drug and alcohol services, with 99% saying it increased their confidence in recognising the signs and being able to help people. We also have 12 Mental Health First Aid trainers delivering courses each year across our system.

Prevention in the Integrated Care System

As part of our mandate from the Department of Health and Social Care, the public health team provides advice and guidance to the NHS as part of its efforts to improve population health, increase the value and effectiveness of health and care services, and reduce inequalities in health outcomes.

This section highlights some of the work in the past year. In our business plan, the work we do alongside NHS colleagues is set out in an agreement on healthcare public health advice. This ensures we have clear programmes where we provide support helping us plan where our capacity can make a difference, in support of clear outcomes and priorities.

The integrated care strategy

The Director of Public Health led a system team during 2022-23 to undertake research, engagement and development of the first integrated care strategy for Dorset. The strategy was published in January 2023 and sets a framework for how all organisations within the integrated care system should work together to tackle ill health and inequality. The DPH is continuing to lead the implementation of the strategy in the system, including work with both Health and Wellbeing Boards, the two councils, NHS Dorset, and the main health and care providers.

Case study: Treating Tobacco Dependency

The public health role in this work is to highlight where there are opportunities to work differently to prevent ill health and premature death. For example, due to the impact of smoking on health, we lead the Treating Tobacco Dependency programme in the NHS. This provides everyone admitted to hospital or having a baby at a hospital trust with support to quit smoking, if they are identified as a current smoker. It is an evidence based way of reaching smokers in addition to our public health services like LiveWell Dorset.

All of our hospital trusts offer an in-house smoking in pregnancy service under the programme. The target in 2022-23 was to offer 75% of pregnant smokers referral to the service, including direct supply of nicotine replacement therapy and vapes. Services exceeded this target during 22-23, and also ensured all pregnant women at the time of booking their antenatal care were asked for smoking status. This links to the national target to reduce smoking at time of delivery to 6%, with Dorset currently on par with England, at 8.6%.

In Dorset 46,164 hospital inpatients were screened for smoking in 22-23, and 8.1% were identified as smokers (compared with 16.1% nationally). In Dorset, this has fallen from 16.5% when the pathway for acute inpatients first launched in 2020. Compared with national data we are exceeding performance: 70% of smokers were referred to our in house acute service compared to 45% nationally, and 67.2% were seen by our inhouse acute service compared with 63.2% nationally.

Dorset is also one of the early adopters in the country to fully roll out the NHS Advanced Smoking Cessation Service which ensures people can be referred direct from hospital to community pharmacy for smoking cessation support on discharge. This addresses the gap in the handover between secondary and primary care on discharge, as well as creating additional smoking cessation capacity in the community.

Case study: Dorset Health Villages

Since 2021 we've been working with system partners to develop a new model of care at Dorset's Health Villages. These sites bring together Outpatient Assessment Centres with health behaviour change services LiveWell Dorset and Active Dorset in convenient town centre locations in Poole and Dorchester.

LiveWell Navigators have been providing a service at the Outpatient Assessment Centres since November 2021. The Navigators are a partnership of staff from LiveWell Dorset, Active Dorset and volunteers, some of whom have been trained to become Wellbeing Champions. The team provide non-clinical preventative health and wellbeing support alongside the clinical care pathways on site.

The team welcome and engage with patients when they arrive at the Outpatient Assessment Centres, and are on hand to provide 1-2-1 brief interventions, sign-ups to the LiveWell Dorset service and further support on a range of issues including alcohol, physical activity, smoking cessation, weight loss, and signposting to other services where needed like Help & Care and Steps2Wellbeing.

The service has been welcome and valued by clinicians, particularly for the potential to improve pre- and post-operative outcomes.

> **As an orthopaedic surgeon I've seen the enormous impact lifestyle changes can have on my patients' health and happiness. Although these changes might not reverse the underlying orthopaedic condition, they can help reduce the symptoms, delay the need for surgery and improve the safety and outcomes of the surgery itself. That is why it is so important that LiveWell Dorset is embedded within our outpatient clinics.**
>
> **Mr James O. Smith, Consultant Surgeon - Trauma and Orthopaedics**

Key take-aways from 2022-23

This annual report deliberately focused on the services commissioned and provided by Public Health Dorset, through our public health grant. This is because during the pandemic many services ceased face to face delivery. And since the end of the pandemic, workforce challenges are still impacting some of our providers, particularly primary care.

There has also been substantial change in our health and care system, and the elected members with responsibility for public health have also changed. This felt like a good time to put the focus on how well our services are performing, and to identify areas for improvement.
There is more scrutiny nationally of performance of drug and alcohol treatment services not least because of additional grant funding to increase access to treatment for addiction. And as we develop our integrated care system, with its longer term focus on prevention, having a close look at the value of public health services can contribute to the debate about how we best use our collective public sector resources to improve health and wellbeing in the longer term.

Overall most of our public health services that we are responsible for are delivering at or above regional and national levels, with the exception of the NHS Health Check programme. I would especially highlight the improved performance in connection to treatment for addiction on release from prison – at 67% this is one of the highest in the country. But we know we can do even better, going forwards. While the 0-19 public health nursing service has recovered post-pandemic, the percentage of families that have a visit following a new baby within 14 days is not yet back to the local target of 95%. Over the next year, we will continue to monitor performance, and work with our services to understand how to support improvement. For the NHS Health Check programme, this will include monitoring take up of checks in primary care, and evaluating the new outreach service through LiveWell Dorset that went live in April 2023.

3 key challenges:

- Health inequalities - This is reflected in our service performance. Our Health Checks programme has higher take up in areas with lower risk of heart disease and stroke, and lower take up in areas where these risk factors are highest. We must change this, working with communities and partners over the next few years.
- Cost of living – This is directly affecting the health and wellbeing of local people, and is being felt in the affordability of public health services. Our uplift to the public health grant was 3.2% this year. Yet inflation is running much higher, and the cost of meeting pay awards exceeds the uplift provided.
- Workforce – pressures affect the ability of key services to make vital visits, and for our community public health services, wider workforce pressure means providing these services is less attractive to providers.

Opportunities in a new system

The integrated care system, and a new strategy about working differently together, provides a real opportunity to re-examine the most effective public health interventions, and make the case for investing in prevention. The opportunity is to move from considering these public health services in isolation, to thinking about how the system could take a consistently preventive approach. A strong example of where this is working well is the smoking cessation support now offered to people admitted to hospital. Our stop smoking services generally reach around 5% of the smoking population each year. Having smoking cessation in hospitals means we can reach a group we would never normally be able to support.

NHS Health Checks is another commissioned service where we could take a different approach in an integrated care system. Joined up campaigns to encourage people to know and take action on their risks from heart disease and stroke would result in a healthier population, fewer heart attacks and strokes, fewer years spent living in ill-health and fewer demands on health and care services. We could do more, working as a system. In sexual health, the ambition to reach zero HIV could be enhanced if we could roll out widespread testing for HIV in places like emergency departments. Early diagnosis and suppression of the virus with modern treatment means it cannot be passed on. This would also tackle inequalities as people most affected by HIV are from some of the most excluded groups in society.

Director's recommendations for 2023-24

- Monitor the NHS Health Check Programme with an ambition to restore the number of health checks delivered each year to that of similar councils (using CIPFA benchmarking). This would see around 8,000 extra checks delivered each year.
- Carry out a check on the equity of provision of health checks, focusing on communities where we know heart disease and stroke risks are highest.
- Continue to improve performance of new birth visits through the 0-19 service to the local target of 95% by Q4 of 23-24.
- Carry out a check on the equity of timely visits by health visitors to families with new babies ensuring they are reaching families fairly and in response to need.
- Continue to establish LiveWell Dorset support to outpatient assessment centres by ensuring this is sustainable and affordable in the public health grant. If not, seek additional funding from partners.
- Improve the number of adults in treatment in our drug and alcohol services.
- Ensure that smoking cessation services provided in our hospital trusts and maternity services are funded on a sustainable basis, embedded as business as usual in the integrated care system.

Dorset NHS

Consolidated Green Plan

Contents

Introduction

Dorset

The county of Dorset is situated on the South-West coast of England and is 2,653 sq. km in area.

The county is predominately rural, with the exception of Bournemouth and Poole which total more than half of the Dorset population.

Due to its warmer climate Dorset is a renowned tourist destination, with our tourists wanting to visit our blue flag beaches and famous Jurassic coastline, thus dramatically increasing the county's population during the summer months.

Our Population

We currently have 810,00 patient registered with a GP in Dorset. People in Dorset generally live healthier and longer lives than the average for England, but this does vary on where people live.

We have a higher population of older people with long-term health conditions, which results in increased demand for health and care services.

We have unacceptable variation in the life expectancy of different groups, including those with mental health problems. We need to improve the health and wellbeing of our current and future population.

We have some of the most affluent areas within the country , also some of the most deprived. In comparison both men and women from the deprived areas have a lower life expectancy of 11 years.

Our Dorset Integrated Care System

Dorset Integrated Care System includes Bournemouth, Christchurch and Poole Council, Dorset Council and Public Health Dorset and the NHS partners comprise of 5 partner organisations and the primary care network who work together as anchor institutions to address our health, wellbeing, quality and financial challenges. Whilst SWASFT covers the whole south west region, it sits as part of Dorset ICS for commissioning and sustainability services. **Dorset NHS Partners are:**

- Dorset Clinical Commissioning Group (CCG) to become NHS Dorset integrated Care Board (ICB) as of 1st July 2022
- Primary Care Network
- Dorset County Hospital NHS Foundation Trust
- Dorset HealthCare University NHS Foundation Trust
- South Western Ambulance Service NHS Foundation Trust
- University Hospitals Dorset NHS Foundation Trust

This consolidated Green Plan relates to Dorset NHS Trusts as highlighted above. The sustainability Executive lead for Dorset is Nick Johnson - Acting CEO Dorset County Hospital Foundation Trust with local sustainability leads for Dorset NHS trusts.

Purpose

Each of the Dorset NHS Trusts has a separate Sustainable Development Strategy or "Green Plan".

This documents consolidates the separate Green Plans, capturing the good work being undertaken by Dorset NHS partners and frames our sustainability plans for the future.

As a partnership, we recognise our responsibilities to current and future generations and we are committed to the good that we can achieve within our communities, relating to environmental, economic and social value factors - the "three pillars" of sustainability.

Through it's operations, the NHS currently has adverse impacts upon the environment including significant greenhouse gas emissions and air pollution emissions. The NHS is candid in it's assessment that these impact directly and adversely effect health and wellbeing of current and future generations.

That is why the NHS has pledged to be Net Zero carbon by 2040 for the emissions we control and by 2045 for the emissions we can influence.

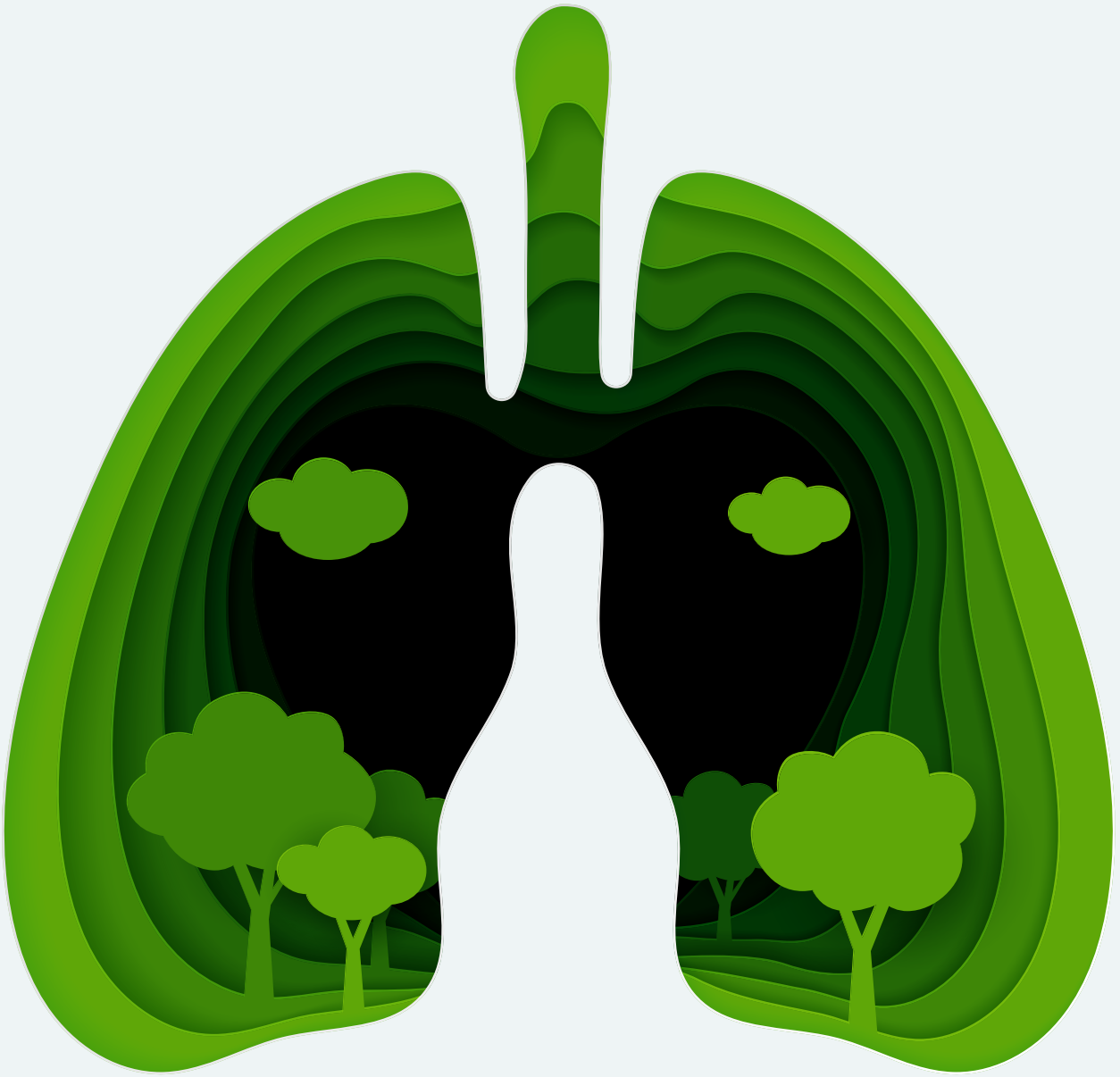
The NHS is also committed to air pollution reduction measures, tackling single use plastic, addressing health inequalities, adding social value, and adapting for climate change.

Through our Green Plans, Dorset NHS Partners will continue to work with NHS England to reduce our negative impacts on the environment, and deliver against our obligation to have a positive effect on the communities we serve; building health and resilience within Dorset and beyond.

Climate emergency *is a* health emergency

"That is why the NHS became the worlds first health service to commit to reaching net zero carbon. Air pollution alone contributes to 1 in 20 deaths in the UK. Reducing emissions would support the reduction of cases of Asthma, Cancer, and heart disease."

Dr Nick Watts – Chief Sustainability Officer NHS
31 October 2021 (In-post October 2020 to present)



Our Mission:

To offer excellent health care for our patients and the wider community in ways which matter to the people we serve, and to do so in a manner that respects the needs of this generation and future generations.

The size of this challenge will require all NHS organisations to acknowledge and take ownership of this mission, working together with partners and the community across Dorset's Integrated Care System. Our ambition is to agree a clear and sustainable direction for Dorset.

Local Priorities and Challenges

Overview

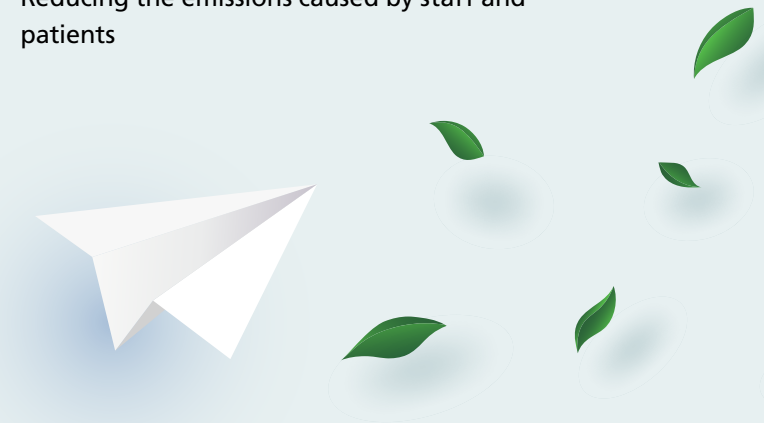
Alongside, and in line with the NHS commitment to become the worlds first NET Zero Carbon National Health service, in Dorset NHS Organisations are committed to the following carbon targets:

Priorities

- Shift to 100% renewable energy for all electricity supplies
- Align with Greener NHS Estates Delivery Plan
- Apply a minimum 10% social value weighting to all contracts
- Switch to 100% recycled paper
- Address single use plastics
- Share learning on driving sustainable procurement
- To reduce the use of desflurane
- To prescribe lower carbon inhalers
- To increase virtual outpatients and primary care appointments
- Develop plans to support active travel
- To embed carbon reduction principles in the way all care is delivered

Challenges

- Achieving the NHS Carbon footprint PLUS on plan
- Collaboration as one Integrated Care System
- Championing and driving culture changes across the system
- Ensuring local ownership to deliver on agreed actions
- Reducing the emissions caused by staff and patients



Key Achievements

In Dorset, NHS Organisations are already striving to reach the targets set out in the 'Delivering a Net Zero National Health Service' paper in October 2020 and are proud of the achievements that we have made so far. These achievements will ensure that we will become Net Zero Carbon by 2040 and a Net Zero Carbon Plus by 2045.

- Nominated sustainability lead for the Integrated Care System
- Nominated sustainability leadership for each NHS organisation
- Cycle parking, lockers and showers to encourage active transport
- Significant progress in replacing all lighting to Light-Emitting Diode (LED)
- New builds being built to the Net Zero Carbon Hospital Standard
- Catering services provide seasonable menus high in fruit and vegetables and low in processed foods
- Local gardening clubs to manage our green space
- Digital transformation across Dorset to reduce the need for paper records, printing and postage
- The reduction of Patients conveyed to Hospital by using 'Hear and Treat' [SWASFT]

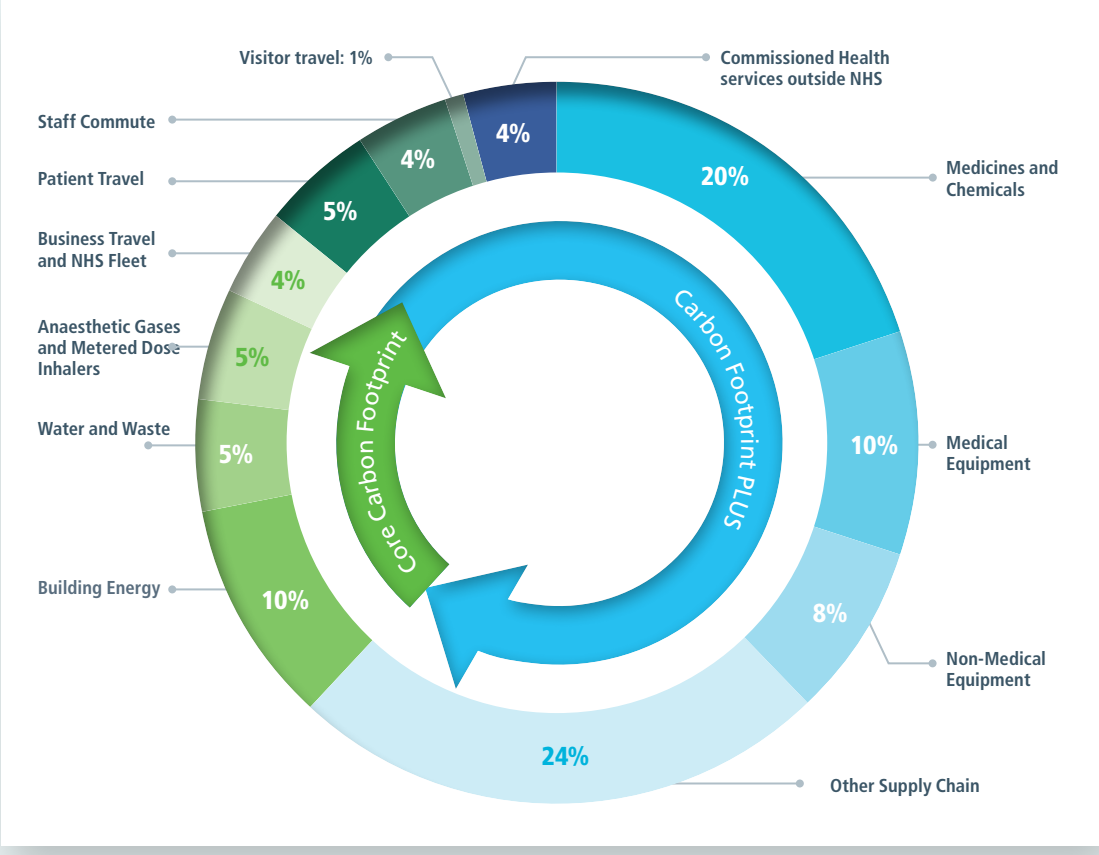
NHS Carbon Footprint Targets

The diagram shows the elements that make up the NHS carbon emissions – the carbon "footprint". "NHS Core Carbon Footprint" (shown by the green arrow) includes carbon emissions that are directly produced through the use of building energy, water, waste processes, anaesthetics and inhalers and business travel."The NHS Footprint PLUS" (shown by the blue arrow) includes the other emissions associated with products and services that we purchase."

In line with the NHS commitment to become the world's first Net Zero Carbon National Health Service, Dorset NHS partners are committed to the following carbon targets:

Core Carbon Footprint:
- Reduced 80% by 2030 (against 1990 baseline)
- Net Zero Carbon by 2040

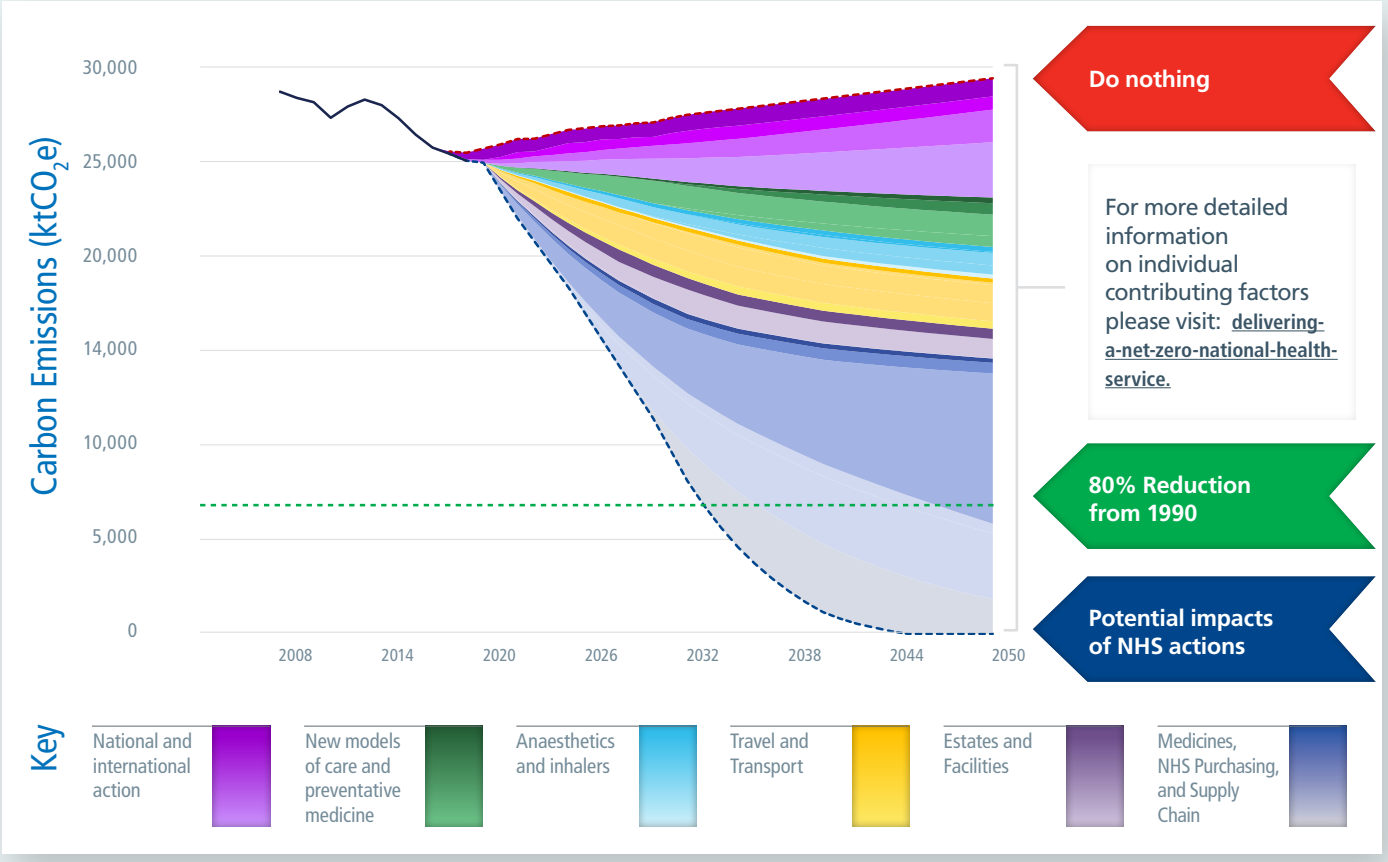
Carbon Footprint PLUS:
Net Zero Carbon by 2045



NHS Carbon Reduction Pathways

Achieving Net Zero Carbon emissions will require efforts by all staff and collaboration with our partners and our entire supply chain.

Measuring and managing the carbon footprint involves the development and application of new tools and processes. These are being developed to form a cohesive approach for NHS Trusts, ICS Partners, Regions and National system.



Biodiversity and Green Space

Overview

Our NHS Organisations in Dorset are committed to protecting our natural environment and reducing the risk of pollution. As part of the Green Plan strategy we all strive to enhance our green spaces and make them areas that protect plant and animal species and provide pleasant outside spaces for our people to enjoy.

This approach, will help support and improve the physical and mental wellbeing of staff, patients and the wider community through access to green space, biodiversity and interactions with nature. Furthermore, help to mitigate climate change and biodiversity loss.

Currently Doing

- Involving volunteers to manage our green spaces
- Consider the environmental impact when embarking on maintenance contracts
- Ensure chemicals are stored correctly
- Each NHS organisation has a Board Level Lead

Planning To Do

- To incorporate green space within new builds and refurbishments
- To start local friendly green space competitions
- To re-purpose unused areas, such as roof space and walls to create wild flower and bee friendly zones
- To install beehives

Case Study
Biodiversity and Green Space

Wellbeing Garden

'Wellbeing garden' space for Blandford Ambulance Station.

A paramedic based at Blandford and her husband, have created a 'wellbeing garden' space for the staff at Blandford Ambulance station. The staff have enjoyed some much needed downtime within the garden. This is also used by colleagues who do not have their own garden and come and use it on their time off to relax. This has proved a great success.

Workforce and System Leadership

Overview

Our ability to deliver on the green plan will be dependant upon all NHS Organisations working together as one team. The nominated leaders will play a crucial part to the success of this by delivering against our strategy, including regular monitoring and reporting, development of detailed action plans and liaison with system partners.

Currently Doing

- Each NHS Organisation has a recognisable sustainability lead
- Connections are being established with wider groups within each NHS organisation
- Enlisting Green Champions
- Communication and engagement with staff

Planning To Do

- Sustainability in all staff induction programmes
- Sustainability as part of all staff objectives
- Sustainability training for all staff
- Deep Dive sustainability training for sustainability leadership team and ambassadors
- Launch an NHS staff engagement and change programme – see case study below
- To embed the sustainability programme as 'business as usual'
- Develop Sustainable Quality Improvement (SUSQI) training and resources for application throughout the Dorset Partnership

Case Study
Workforce and System Leadership

EcoEarn Platform

Dorset NHS Partners have commissioned a staff engagement platform to help promote net zero carbon reduction activities and other sustainability and wellbeing behaviours.

It is a digital platform easily accessible through a bespoke app and website - simple to use for all people at various job roles across the NHS.

Each NHS organisation is set up as a team adding 'friendly competition' through the leader boards. EcoEarn also incentivises participants with individual rewards in the form of vouchers for ethical products and services.

Participants will receive bespoke communications including weekly reminders, monthly newsletters, and quarterly campaigns.

EcoEarn has the facility to track the environmental difference made and can provide individual, team, Trust wide and Dorset wide impact data.

The system is also being integrated with other initiatives so that users will earn rewards for using a Lift-sharing application and for taking physical exercise and logging it with Strava.

Sustainable models of Care

Overview

Embedding net zero principles across all clinical services is critical. All NHS Organisations must aim to deliver the best quality of care while being mindful of its social, environmental and financial impact and take a whole system approach to the way it is delivered. Greater provision of care closer to home reduces carbon emissions, traffic congestion, air quality and can improve patient experience.

Currently Doing

- Dorset Health Village opened in the Dolphin Centre Pool to bring diagnostic services closer to the community
- 'Hear and Treat and See and Treat'[SWAST]
- Triage locations [SWAST]
- Acute hospital at home service
- Health And Nature Dorset – HAND - see case study

Planning To Do

- Introduce further diagnostic services to Health Villages to provide 'one stop shops' within the community
- Getting It Right First Time and Model Hospital action plans being rolled across the Dorset system to improve efficiencies.
- Review the environmental impact on how we deliver patient services
- Introduction of Sustainability Ambassador roles for Trust clinical Directorates to help mainstream sustainability practices
- Use of sustainable Personal Protective Equipment (PPE)

Case Study
Sustainable models of Care

Health and Nature in Dorset (HAND)

How can we maximise collaboration to increase the use of Dorset's natural environment to deliver health and wellbeing benefits?

This collaborative is encouraging people within Dorset to engage in the open green space to help with their health and wellbeing.

Over the last couple of years, we have been working together with the design council 'Ideas to Action' to find new ways to overcome inequalities in physical activity.

The Health and Nature in Dorset (HAND) project which was launched in May 2021 is a collaboration to embed nature-based wellbeing into the health system and to promote the benefits and opportunities engagement in the environment has in supporting and improving health and wellbeing.

The aim is to increase the access to, use of and connection with the natural environment to support and enhance physical and wellbeing in Dorset.

Digital Transformation

Overview

The direct alignments between the digital transformation agenda and a net zero NHS are clear.

Digital technology allows us to deliver appropriate care remotely using video technology to conduct virtual consultations and this concept will allow healthcare professionals to sustain and grow this approach.

Currently Doing

- Use of virtual clinic such as Attend Anywhere, Telecare, BP@home
- Electronic care records to reduce the need for paper and improve patient care
- Remote monitoring of Long condition management such as covid at home, pulse oximetry
- Use of Microsoft Teams, reducing the need for travelling
- Use of Text messaging to communicate to patients and to assist with lowering DNA rates

Planning to Do

- 25% of all outpatient activity to be completed remotely
- Fully implement Patient Initiated Follow Ups (PIFU)
- Virtual wards
- Badger net, digital records within our maternity services
- Patient Portal, so Patients and check and change their upcoming appointments
- Embrace new and existing digital technologies to provide more sustainable Patient pathways for primary and secondary care

Case Study
Digital Transformation

University Hospitals Dorset IT

UHD started an IT replacement project to ensure the Trust was current and compliant with security standards.

A large volume of IT needed to be updated and functional but obsolete equipment was earmarked for Waste Electrical and Electronic Equipment (WEEE) waste disposal. The sustainability manager investigated a more sustainable approach and a stakeholder group was mounted to consider options proposed.

The group found a supplier to refurbish and resell retired equipment, ensuring that data protection requirements were met. The group also had Trust policies amended to ensure that functional peripheral equipment such as keyboards and mice were retained and not replaced.

Approximately 2/3 of the retired equipment was suitable for resale. During the first year of the project, 40 tonnes of equipment was handled and between rebates and avoided waste costs, the Trust saved £75,000.

This case study was presented at the South West Greener NHS COP26 road-show.

Staff were pleased to have found a sustainable solution and save money. The IT team has nominated a sustainability lead and are supporting further sustainability efforts.

Travel and Transport

Overview

Dorset is a predominately rural county which means that staff, patient and visitors often have to travel further, causing relatively high emissions.

To tackle this, we aim to clear the barriers to sustainable travel options and promote the benefits.

Currently Doing

- Secure cycle storage including some of the Primary care sites
- Restrict car-parking permits by location
- Discounted Salary sacrifice schemes for bicycles
- Provide showers and changing facilities
- Installed electricity charging points for Zero Emission Vehicles

Planning to Do

- Enable staff to participate in Park and Ride schemes
- Enable staff to participate in a lift share programme
- Commission trust wide travel plans for staff and service users
- Purchase only Ultra Low Emissions Vehicles (ULEV) or Zero Emission fleet for vehicles under 3.5t
- Facilitate flexible working and working from home policies
- Install more electricity charging points for Zero Emission Vehicles

Case Study
Travel and Transport

Dorset Lift Share

Dorset NHS Partners and SWAST are setting up a "LIFTSHARE" service for staff. Any NHS employee in the catchment will be able to access the scheme; register the journeys they wish to make and find other staff members that would like to share the journey.

Staff will have the choice to travel only with members of their own site or anyone in the wider NHS community.

The service will be really easy to use and shared journeys can be acknowledged just by touching smart phones together.

Better still, we will be recognising staff that use the service by awarding them green credits and rewards.

This service will help staff save money, reduce congestion, and reduce green-house gas emissions and other pollutants, helping to improve air quality.

Air quality is a significant driver of health issues and under our Green Plan, we recognise our responsibility to address this for the benefit of our staff and the wider community.

Estates and Facilities

Overview

Emissions resulting from its buildings, water and waste account for 63% of the emissions the NHS directly controls.

Our aim is to embed sustainability and efficiency, using smart design and emerging technologies across our improvement works including refurbishments and new building works.

Currently Doing

- Use Building Research Establishment Environmental Assessment Method (BREEAM) 'Excellent' in all major capital projects underway
- Use Building Research Establishment Environmental Assessment Method (BREEAM) ' very good' or higher in all refurbishments
- A few GP practices signed up to renewable energy

Planning to Do

- Applying NHS Net Zero Carbon Building standards for all New Hospital Programme and other future major capital projects
- Expansion of Showers and facilities available for staff who cycle to work
- Cycle storage being installed in some GP practices
- Change to Light-Emitting Diode (LED) lighting
- Pilot project for selection of GP surgeries to embark on energy surveys

Case Study
Estates and Facilities

Light Emitting Diode (LED) Project

Dorset Healthcare and South Western Ambulance Service Trust both obtained funding from NHS Improvement for switching to Light Emitting Diode (LED) light-bulbs. Dorset Healthcare were able to this change the lighting at 10 of our large Trust sites and South Western Ambulance trust were able to fit out 11 Dorset ambulance stations This plan will save money and reduce our carbon emissions.

Both projects commenced in late 2019 and were completed by March 2020. The spend deadline and project delivery target set by NHS Improvement was met ahead of schedule.

All the old light fittings were locally recycled and waste transfer notes audited to ensure compliance.

In January 2021, Dorset Healthcare provided Capital funding leading us to once again working with Energy Saving Lighting (ESL) and completing the third phase of Light Emitting Diode (LED) light-bulb replacement scheme and implemented at our remaining larger12 sites.

Safe working protocols were written by the Trust's Health and Safety Team to enable the work to be undertaken. Our Estates Team were very supportive, working in collaboration with Energy Saving Lighting (ESL) despite the ongoing challenges presented by the global pandemic. The working partnership created, ensured that the staff and patient safety was paramount and was embedded within all actions to deliver the project.

Case Study
Estates and Facilities

Solar Photovoltaics (PV) Project

During 2019 Dorset Healthcare sought to install Solar photovoltaics (PV) panels at 3 of their hospital sites Alderney, Blandford and Bridport.

Dorset Community Energy (DCE) is contracted to install Solar PV on public buildings including schools and libraries as a company, with shareholders. These shareholders purchase shares to collectively fund the specific project. The shareholders will receive a dividend and their initial deposit will be renumerated over several years. This scheme is managed by local people installing Solar PV within their local area.

Through a Power Purchase Agreement (PPA) with the non-profit making organisation, Dorset Community Energy (DCE) the Trust would purchase the solar energy it generated from its sites via Dorset Community Energy (DCE) and use it on the sites where it the energy was produced.

Due to the Covid 19 pandemic this project was delayed. In October 2020 the first phase of Solar PV was installed at the Bridport Hospital site followed by Alderney Hospital during February 2021 and then the completion of the scheme was in Blandford Hospital during May 2021.

Dorset Healthcare had to ensure that the emergency generators would be compatible during and on completion of the Solar PV installation, working in collaboration with the trust, Dorset Community Energy (DCE) and Generator maintenance team a proposal was agreed by all.

This project should provide 250MWh and 120tCO_2e of carbon savings per annum.

Medicines

Overview

The prescribing and use of medicines makes up 25% of the NHS's overall carbon footprint. Anaesthetic gases and meter dosed inhaler account for 21% of the emissions the NHS directly control.

Our aim as NHS Organisations is to optimise our use of pharmaceuticals, consider lower carbon alternatives, reduce waste and responsibly capture or dispose of all medicine waste.

Currently Doing

- Reviewed the volume and use of controlled and other drugs
- Centralised collection process for out of date medicines

Planning To Do

- To trial nitrous oxide destruction technology
- Investigate the use of equipment to capture volatile agents
- When treatment pathways are reviewed, ensure that promotion of health and non-pharmacological treatments, including social prescribing, are considered as well as or before medicines
- Incorporate a sustainability assessment into the Dorset Formulary application form
- Educate patients and staff on medicines overuse and waste
- Promote high quality structured medication reviews in primary care networks to promote sustainable prescribing

Case Study
Medicines

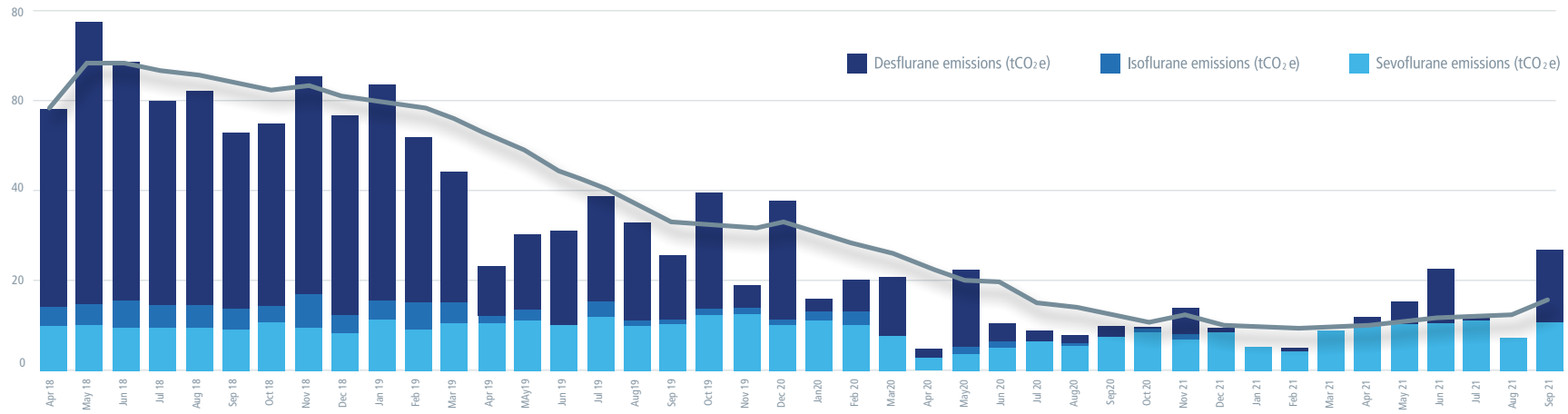
Dorset NHS Pharmacy Environmental Awareness

Dorset NHS pharmacy teams recognise the health implications of the climate and ecological crisis, and the need to urgently decarbonise our societal systems, including that of healthcare provision.

We acknowledge the environmental impact of medicines production, use and disposal but also our capacity to bring about substantive change in the delivery of pharmacy systems.

There are some direct pharmacy actions already underway such as selection of the most environmentally sustainable inhaled anaesthetics (specifically a move away from the most environmentally harmful option, desflurane) and utilisation of dry-powder respiratory inhalers over those using hydrofluorocarbon gases (metered-dose devices). Work is underway to address this where safe to do so without impacting patient care and is being directed by specialist clinical leads. The inhaler review programme is a required element in the updated Direct Enhanced Service (DES) for primary care networks.

Carbon equivalent emissions resulting from volatile anaesthetic gas use (Dorset ICS)



Data from the Greener NHS Dashboard on the Carbon equivalent emissions arising from volatile anaesthetics (Desflurane, Isoflurane, Sevoflurane) use and progress towards the commitment to cut Desflurane use to less than 5%. Accessed 21 Nov 2021.

Desflurane use as a percentage of all volatile anaesthetics (Dorset ICS)

Supply Chain and Procurement

Overview

The NHS supply chain accounts for 62% of the total carbon emissions and is a clear priority for any Green plan.

Our aim as NHS Organisations is to positively influence the sustainability performance of our suppliers and the sustainability of our goods, food consumables and services that we purchase.

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Currently Doing

- Ensuring the Governments procurement standards on environmental and socioeconomic standards policies are followed
- Moved to 100% FSC approved recycled paper
- Minimised the number of hazardous substances used and have clear controls in place
- Where appropriate repairing rather than replace medical devices
- Applying a minimum of 10% weighting to social value in contract awards

Planning to Do

- Provide appropriate sustainability training to all procurement staff
- To develop policies and procedures that promote sustainability
- Reduce single use plastics and adopt the NHS plastic pledge
- Sign up to 'warp-it' reuse network

Case Study
Supply Chain and Procurement

UHD - Recycled Paper

The University Hospital Dorset sustainability group proposed that they purchased 100% recycled paper for printing and copying.

Trials in a couple of areas had shown no quality or equipment compatibility issues.

They group proposed a blanket policy with no exceptions for the use of such paper.

The product trialled was 100% recycled, 80g paper which is Forrest Stewardship Council (FSC), European Union (EU) Ecolabel and Blue angel certified. On conclusion the brightness of the paper was not compromised, and they felt that this product actively promoted environmental benefits. Not only was the product helping achieve the NHS Net Zero plan, but there was also a financial benefit saving the trust approximately £7000 per year.

DCH - Reusable Gowns

PPE shortages during the pandemic highlighted an unsustainable demand on single-use items.

Dorset County Hospital's Clinical, Housekeeping and Procurement Teams sought ways to increase our resilience by working with NHS E&I and our laundry supplier, Salisbury Linen Services, to introduce reusable gowns to the Trust.

In contrast to single-use gowns, our reusable gowns can be used and washed 100 times before being disposed. This has created huge carbon savings.

Thanks to using reusable gowns we diverted 36,200 single-use gowns entering the waste stream in 2021. But not only that, we're saving money and we're enjoying a better and more consistent level of quality. The reusable gowns are a great example of how putting the environment first can increase resilience, save money, and improve quality.

Food and Nutrition

Overview

Our catering departments provides meals for all our in-patients and staff across Dorset.
We provide seasonal menus high in fruit and vegetables and low in heavily processed foods.
All meals are prepared by our trained chefs on the day from fresh ingredients.

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Currently Doing

- Procuring ethically sourced foods
- Using seasonal fruit and vegetables
- Using The Soil Associations accreditation – Food for life

Planning to Do

- To reduce single use plastics and adopt the NHS plastic pledge
- Hospitality to use sustainable disposable products
- Procure locally produced foods
- Procure organic foods where possible

Case Study
Food and Nutrition

Food for Life

Dorset County Hospital and University Hospital Dorset participate in the Soil Association's Food for Life scheme. The scheme aims to encourage and reward caterers who:

- Serve fresh food
- Source environmentally sustainable and ethical food
- Make healthy eating easy, and
- Champion local food producers

University Hospital Dorset have achieved Food for Life Silver whilst Dorset County Hospital has achieved Bronze. Both Trusts ensure there are vegan and vegetarian options on the daily menus. Menus are seasonal and are reviewed by dieticians. Night staff have access to freshly made, hot food. The Soil Association also offer the Green Kitchen Standard accreditation scheme which we will explore to help sustainably manage our catering energy, water and waste.

Adaptation

Overview

In Dorset we are already experiencing the effect of climate change and are experiencing periods of heavy rain and prolonged heat waves. There is also a risk of snowstorms and have in recent years experienced the issues caused by extreme low temperatures. These severe weather events are likely to increase as global temperatures continue to rise.

Currently Doing

- Policies for keeping drugs at correct temperature during extreme temperatures to avoid wastage
- Working together as a system to ensure Business Continuity plans are in place for extreme weather and reviewed regularly

Planning to Do

- Put in place long term adaptation plans by 2025 including stress testing business continuity plans for regional shocks
- Identify Risks
- Support Collaboration
- Action Plans to Mitigate Risk on all ICS function

Case Study
Adaptation

Weather Incidents

There has been an increase in severe weather incidents in recent years which is believed to be related to global warming.

Dorset was specifically affected in 2013/14 from a series of high impact storms, which lead to regional flooding, also during 2018 with Storm Emma, causing freezing ice and very low temperatures.

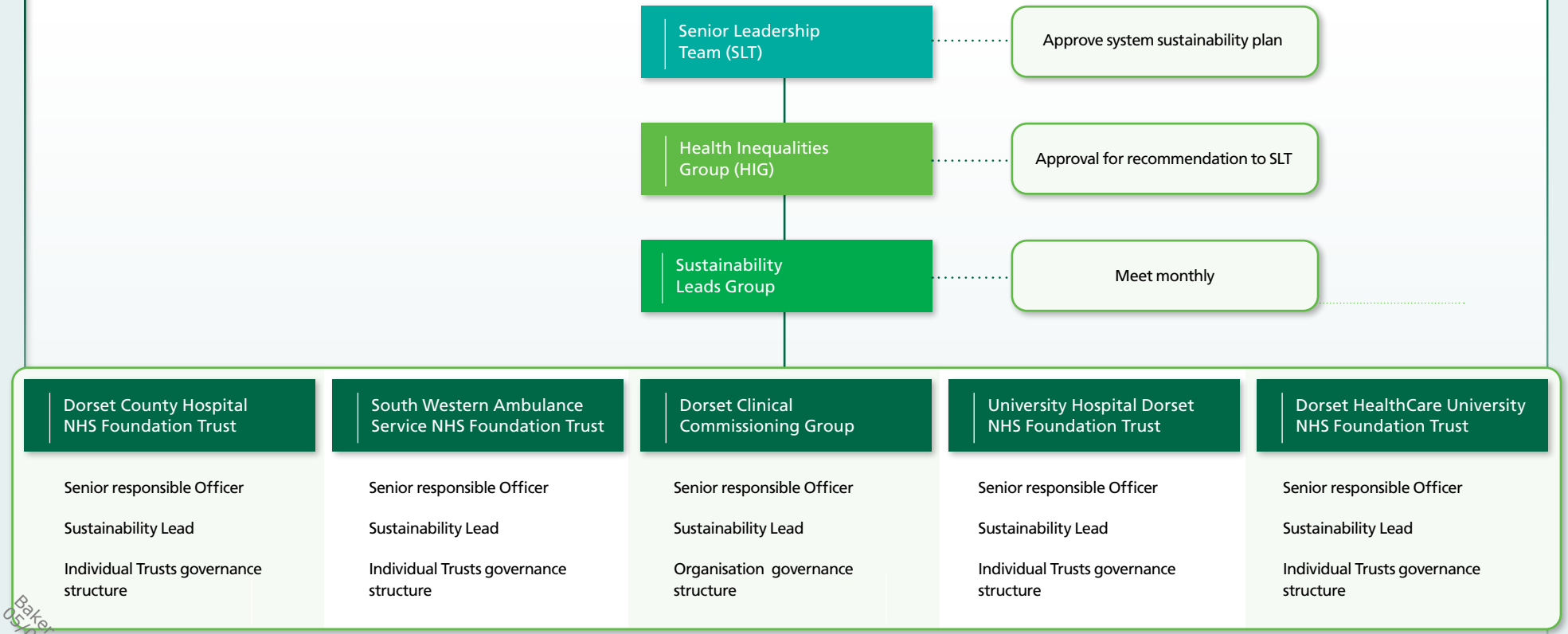
Incidents such as these provide an increased risk to the delivery of health and care services in Dorset.

- Utilities outages
- Staffing challenges
- Exacerbating underlying health condition, and an increase in strokes during heat-waves
- Increased likelihood of multiple casualty incidents

Next Steps

- As NHS organisations in Dorset we are committed to meeting our shared mission and deliver on the NHS pledge to be net zero by 2040.
- As part of the Dorset's Integrated Care System, we want to extend our discussions, our commitment and our actions across Dorset's partners. We want to involve and engage our communities and the local economy to co-produce a plan which we all own and share.
- As NHS organisations, we recognise our responsibilities to current and future generations and we are committed to the good that we can achieve within our communities, relating to environmental, economic and social value factors - the "three pillars" of sustainability.
- We know that by working in partnership we can achieve more, we can involve more people and have a greater impact on the community we serve.
- We will start our commitment to work across the Dorset Integrated Care System now.

Health Governance



Sustainability Leads

Executive Lead for Sustainability	NHS Dorset Clinical Commissioning Group	NHS University Hospitals Dorset NHS Foundation Trust
Nick Johnson	Eleanor Parson	Stuart Lane
NHS Dorset County Hospital NHS Foundation Trust	NHS Dorset HealthCare University NHS Foundation Trust	NHS South Western Ambulance Service NHS Foundation Trust
Isabel Bourne	Patrick McDermott	Emily Bullock

NHS Dorset
Consolidated Green Plan

Dorset Clinical Commissioning Group (CCG) to become
NHS Dorset integrated Care Board (ICB) as of 1st July 2022

University Hospitals Dorset NHS Foundation Trust

Dorset County Hospital NHS Foundation Trust

Dorset HealthCare University NHS Foundation Trust

South Western Ambulance Service NHS Foundation Trust

Strategic context – national drivers

- Provider collaboratives are partnership arrangements involving at least two NHS trusts working at scale across multiple places, with a shared purpose and effective decision-making arrangements.
- When integrated care systems (ICS) were set up, NHS England required all trusts providing acute and mental health services to be part of one or more provider collaboratives.
- Provider collaboratives aim to:
    - reduce unwarranted variation and inequality in outcomes, experience and access to services
    - improve resilience of NHS providers
    - bring services together and develop joined-up, specialised services where that makes sense
    - improve recruitment, retention and development of staff
    - enable efficiencies and economies of scale

Our Dorset

Strategic context – The Dorset perspective

- In 2022 we established Our Dorset Provider Collaborative (ODPC) a single strategic provider collaborative which is governed by a leadership board (Siobhan Harrington – Chair 2024/25)
- The members of the ODPC have agreed on their purpose, values, culture, behaviours, principles, and enablers to work together.
- The goals of the ODPC are:
    - Improving population health and healthcare
    - Tackling unequal outcomes and access
    - Enhancing productivity and value for money
    - Helping the NHS to support broader social and economic development

Provider collaborative local context

- Collective decisions are made through the ODPC Leadership Board on behalf of the member organisations.
- The partner organisations of Dorset ODPC are:
  - Dorset County Hospital
  - Dorset Healthcare
  - University Hospitals Dorset
  - Dorset General Practice Alliance
  - Standing invitations are also sent to NHS Dorset, SWAST, Dorset Local Medical Committee, and a VCS representative
- ODPC's local context includes Joint Forward Plan, Medium Term Financial Plan, Recovery plans for primary care, elective and urgent care, Better Care Fund, 2024/25 Operational Plan

Our Dorset

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.

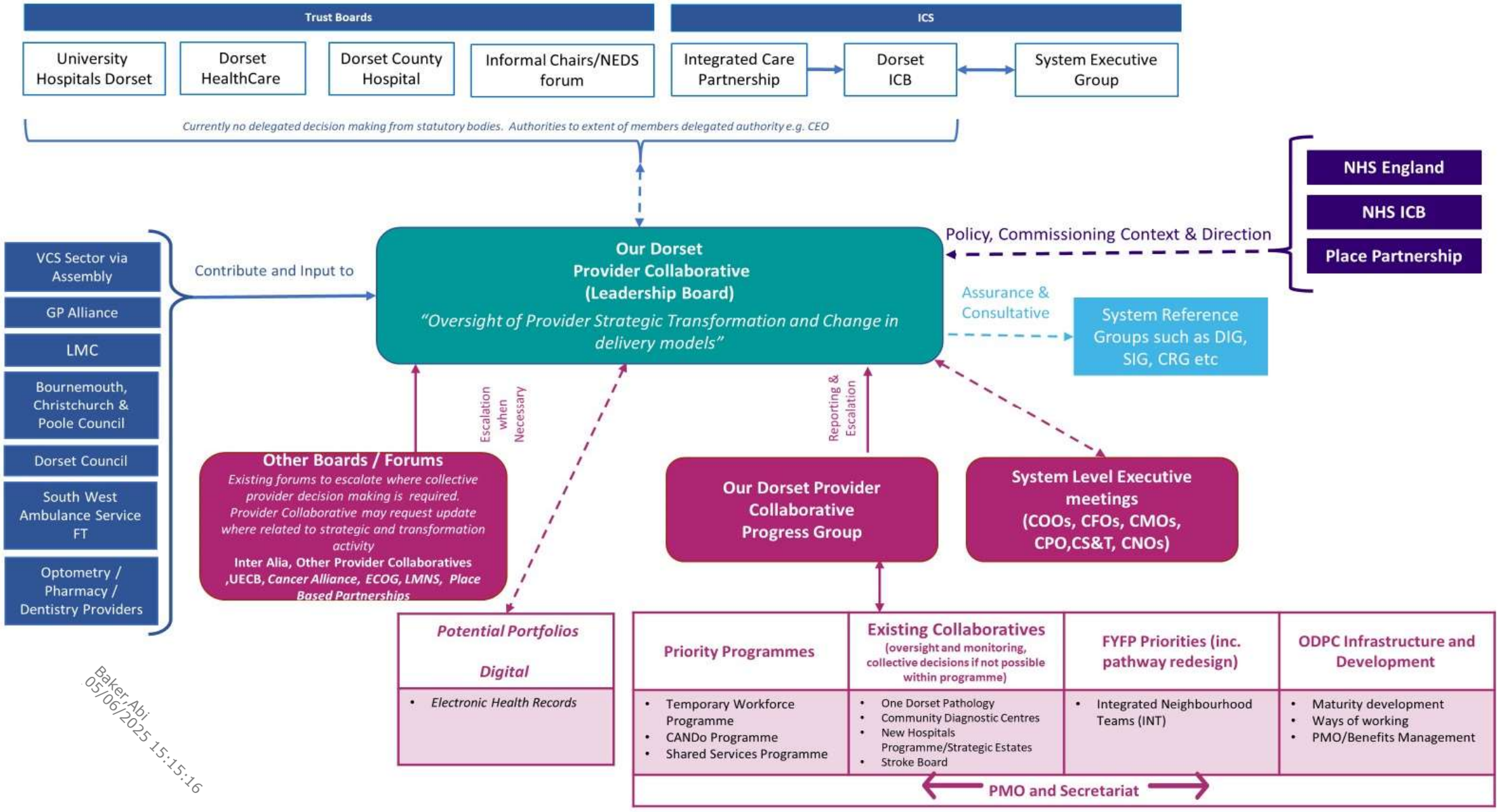
Compassion.
We ensure that compassion is central to the care we provide and respond with humanity and kindness to each person's pain, distress, anxiety or need.

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.



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ODPC priorities 2024/25

ODPC PRIORITY PROGRAMMES 2024/25	
CANDo	**CANDo priority specialties** • Ophthalmology, Dermatology, Respiratory, OMF **CANDo network support** • Orthopaedics, ENT, Urology, Gastroenterology, Gynae, General surgery **CANDo enabling** Shared waiting lists
Temporary Workforce	Nursing and Medical
Shared services	Procurement

Our Dorset

ODPC priorities 2024/25

ODPC EXISTING COLLABORATIVES 2024/25

Community Diagnostic Centres

Integrated Neighbourhood Teams

One Dorset Pathology

Strategic Estates/NHP

Stroke

ODPC DEVELOPMENT AND INFRASTRUCTURE

- 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
- To design and deliver an OD development programme at executive and senior level which increases trust and collaborative working

Our Dorset

DRAFT Briefing Note
January 2025:

Assessing relative merits of a Operatimg Company and a Trust Hosting Arrangement

Our Dorset Provider Collaborative (ODPC) is developing a shared support services business case. Part of this is evaluating options for delivery. Following the first options appraisal workshop further work was requested to assess the hosting arrangement as an option. Eight issues were identified, where the hosting was seen as sub optimal to a OpCo. These are expanded upon here, including the effectiveness of mitigations. There were no specific benefits identified of hosting above an OpCo.

This paper should be read in conjunction with the scoring process briefing paper and the other options in the draft business case.

Key issues identified, are:

1. Dedicated Board focus on services
2. Specialist Board Members
3. Potential conflicts of interest and perceptions of favouritism towards the host
4. Multiple roles lead to less accountability and non-value added "distraction".
5. Ownership of risk and reward needs to be transparent.
6. Due diligence for baseline and differential service levels
7. Incentives for Delivery
8. Strategic Direction

Potential mitigations are assessed. These are how a hosted service could mitigate the disadvantage it faces to an OpCo. These are grouped as "full mitigation," "partial mitigation," "limited mitigation" and "no effective mitigation."

A conclusion to help inform the scoring process is suggested at the end.

1. Dedicated Board focus on services

The OpCo would have its own Board and leadership team to focus 100% on the services that it provides. This will never be the case for a hosted service where time at the main Trust Board, including of executives, would be limited, and priority will always be the frontline clinical services. This is evidenced by the actual board agendas.

In private sector organisations a group structure is common, allowing focus and leadership at the right size, on the right subject matter, to drive greatest value. This allows the group to provide overall direction and gain the benefits, whilst holding to account the organisations within the group. An OpCo would fulfil that purpose and is thus preferrable to hosting.

This issue cannot be mitigated effectively, as there can only be one Board. Other remedies are considered at the end of this section.

Summary: no effective mitigation.

2. **Specialist Board Members**

A dedicated Board would allow for specialist Board members to be appointed. This could include executives and non-executives with experience in running a shared service, or with service expertise in areas like estates & FM, procurement, capital developments. A Trust Board is much less likely to be able to secure such places for specialist like these, as the number of Board members is limited, whilst retaining an effective Board.

In a Trust the services are placed under a Board level executive as part of their portfolio. It is highly unlikely the executive will be a master of all these disciplines. Chief Finance Officers can often be accountable for Estates, Capital Development, Procurement, Digital, for example, yet most will have no formal qualifications in these areas and often limited operational experience. Whilst executive directors can provide leadership, the service level expertise is one or two steps away from the Board table. A dedicated OpCo would change that, as it's much more likely professionals in those disciplines are Board members.

A further benefit is that an OpCo is more likely to attract talent from beyond the NHS, by offering roles that are more professionally focused, comparability to other sectors, and freedom to act. This should lead to a wider number of applicants, at senior levels.

If hosting the only mitigations would be to increase the size of the Board of the host organisation for more executives. As FT Boards need a NED majority, then this means multiple of twos. To have Estates and FM, Capital, and procurement at the Board table, would means 6 more Board members, making Boards c40% bigger. This would be unacceptable as it is unworkable.

Summary: no effective mitigation.

3. **Potential conflicts of interest and perceptions of favouritism towards the host**

Where a Trust provides a service to other Trusts there is a much higher chance of conflicts of interests occurring around the prioritisation of services and developments. There is a real risk of conflicts of interest as the lead Executive can never be totally independent of their host Trust's priorities and accountabilities, as they are answerable and accountable to their FT Board first.

Service Level Agreements (SLAs) can set out the host and customer Trust roles and responsibilities, level of investment and KPIs. However, these are not truly enforceable within the NHS, and the customer Trust has very little leverage in such relationships. Firstly, this is because the host Trust has control of the majority of information and expertise and is likely to see most of the benefits. Secondly there is less transparency on costs, savings and allocation of overheads, when the service is embedded in a much larger organisation. Thirdly the employees of the host service are more likely to be culturally and practically aligned to their host employer and have an unconscious bias towards where they work. This can lead to prioritising the "home" Trust's requirements.

This can often lead to the perceptions of favouritism to the host Trust. Examples include benefits are usually seen as accruing to the host Trust receiving a higher level of service, greater attentiveness to host needs, and greater alignment of future plans with the host Trust values and priorities.

A third reason why conflicts can occur is when a host provider struggles to meet the expectations of the customer Trust(s). This may be real or perceived. It can be partly mitigated through highly professional and well-resourced contract management. Where services are so critical to overall performance of a Trust, (as estates, FM, procurement, digital and capital development are) then this

can become a high stakes risk for a Trust to "surrender" these core support services to a third party over whom there is a "complex" relationship. This complexity comes from many clinical pathways and other relationships existing outside the direct host-customer contract. These can often come into play when Trusts are in dispute over the level of service provided and local examples would evidence this.

Hosting arrangements do exist across the NHS, but many once established have struggled or are unwound. Within Dorset very few support service *hosting* arrangements existing, and ones that have previously been set up (Digital, Audit etc) have been unwound or moved to third party, i.e. no longer hosted by a local Trust. This evidences why a more independent provider such as a OpCo, is more likely to proceed than a hosting arrangement.

Summary: no effective mitigation.

4. **Multiple roles lead to less accountability and non-value added "distraction".**

Any Executive that is accountable for running a shared service will inevitably have to deal with any concerns from other Trust executives buying in that service. That makes for a more complex set of relationships where the host Executive has multiple 'hats' with their counterparts and peers. They would move from being in a peer-to-peer relationship, to one where they are either a customer or a host provider. This could all occur in the same meeting e.g. when looking at causes for any financial under performance as a Trust and system. With the support services in scope, being core to delivery of quality, performance, and financial balance, (as procurement and estates/FM are), this can result in significant stress on relationships.

Where there are split hosted services (e.g. one trust hosts procurement, one hosts Estates, and third capital developments etc) the relationships become ever more complex, and less effective. This is because of lower level of clarity, and therefore accountability. Experience shows a lot of time can then be spent on "transactional" work resolving relatively minor issues (such as allocations of costs, risks and benefits). This is time not spent on improving the services. This non-value add activity is part of why several support services where unwound.

Where there is less transparency and diffused hosting, overlaid with perceptions of favouritism this can lead to lower levels of trust. If services are then not performing in line with expectations, Trusts can start 'blaming' other Trusts, which affects not just the hosted services, but the entire functionality of the Trusts relationships with each other.

The mitigation is to have excellent, high trust relationships and high performing services. However as this cannot be guaranteed to be maintained forever, it is at best a partial mitigation. As this is based upon personal relationships at exec level, and execs can change, and the wider context of the NHS delivery becomes more challenging, this is an ineffective mitigation, and also time consuming. This non-value add time means the core exec role is diminished, overall leading to a negative impact. This is why several Dorset organisations have decided to "unwind hosting" as referenced above.

This can be avoided with the creation of a OpCo where each Trust is a shareholder, but not directly the provider of the services. This gives far greater clarity on roles and responsibilities, without reliance on personal relationships.

Summary: limited mitigation (but difficult to maintain).

5. **Ownership of risk and reward needs to be transparent.**

A hosted service will be a small percentage of the overall Trust turnover, and it can be very difficult to assess the allocation of benefits, and risks, separate from the whole Trust. Also difficult is agreeing where any savings and cost pressures should be distributed. Should the host keep them all, as the one running the service, and holding the risk? Likewise, the customer Trusts will expect those benefits to flow to their way, otherwise why surrender the service to the host in the first place?

A simplistic mitigation could be 50-50 agreements on risk and reward shared between host and customer. However, this is flawed as most issues are more complex. The simplest example is savings from a shared procurement for supplies. Should the largest savings go to the Trust with the lowest volume, and most to gain from pooling, or should it go to the largest volume Trust, as it's their volume that is has probably already got the best prices, but it is critical to getting the best overall price. This could play out over thousands of product lines. In reality most situations are more complex, and benefits often only achieved over several financial years with extensive negotiations.

The result is each benefit, risk, investment needs to be considered individually, to assess allocations between Trusts. This will require a lot of time for analysis and negotiation. The negotiations are largely win-lose, as whether the benefit sits with the host or the customer. This gets ever more complex with multiple Trusts hosting different services. Any time spent negotiating internally is ultimately not value adding.

In comparison the OpCo would have a pre-agreed formula for the overall risks and benefits to flow via their shareholding. It is in everyone's interest to maximise benefits overall and focus attention on delivery. The formula and governance will be agreed as part of the setting up process and then reviewed annually via contract setting. This reduces non-value adding work for the leadership teams of each Trust, and the SubCos.

Summary: limited mitigation (at significant cost of time).

6. **Due diligence for baseline and differential service levels**

A significant difficulty with a hosted service, learnt from experience, is that the services being pooled will inevitably have a different baseline for almost every aspect of what they do. For estates this could be investment in both revenue and capital, the capital backlog, the maturity of their systems of governance and assurance, the expertise of the staff (and any vacancies), as well as less tangible, but very important aspects like culture and morale.

A hosted service and a OpCo will both need to deal with this. Both options will require due diligence and skilful programmes of integration. The differences are:

- It is easier to create a single culture within OpCo, as it is less of a "takeover".
- It is easier for a OpCo to hold multiple service contracts, with differing levels of investment, KPIs and outcomes. A single host Trust's regulators are unlikely to support one service holding such different approaches.
- The transparency on inputs (e.g. investments, assets etc) and clarity for outcomes is harder to show in a host (as the service is "buried" within a larger Trust's overheads)
- Future investment, and benefits realisation is also easier for a OpCo to demonstrate.

The hosted Trust's Board could in theory accept it has different levels of investment, risk, outcomes within the services. Where there are statutory responsibilities e.g. Health and Safety for estates, or IPC this is difficult to defend legally. This would require a rapid investment and alignment process

that is likely to be beyond the affordability of the health system. Or it could lead to one Trust service being degraded to level it to the another. Both these scenarios are unlikely to be acceptable to all the Boards. Based on experience this is likely to be a major source of tension.

In contrast a OPCO can hold three or more contracts (one per Trust). These would allow for transparent service levels, on Day One based upon the current service levels. Over time these may converge, or not, depending upon the customer appetite and conscious decision making around service levels and investment priorities.

In conclusion this is an issue for both a OpCo and a hosted service, but it is easier for the OpCo to address.

Summary: limited mitigation.

7. Incentives and alignment for Delivery

The main purpose of a Trust and its Board/Executives is the delivery of high-quality patient care. The use of the Board members time should be dedicated as much as possible to delivering this objective. The running of a shared service function is by its very nature not the direct delivery of patient care. Time spent by CEOs and other executives running such a service is ultimately taking time away from focussing on direct patient care. What the Board can focus on is the outputs of EFMP services, and how they help patient services, within budget allocated. A Board must ask itself where it wants its top team focussing its attention on.

In comparison the leadership team of the OpCo has its' purpose as delivering the best services to its customers (the Trusts). As they remain wholly NHS, their purpose is not profit maximisation (and commercial risk minimisation), but rather best serving their shareholders – the Trusts, and their patients.

In comparison a hosted service will need to contribute to the host Trust's bottom line, to justify being hosted. This is a fundamental, intrinsic tension. The exec team of the host, as well as needing to lead the services to support the wider Trust also needs to keep the hosted service's customers happy. This is a second intrinsic tension. Neither of these intrinsic issues with hosting have effective mitigations.

Summary: no effective mitigation.

8. Strategic Direction

The outsourcing of support services and more transactional functions to specialist providers of such services is not new. This has been part of the cost savings programme of Trusts for some time. (Examples listed below, some are managed commercial service, others are via SubCos/other NHS providers).

This ad hoc, service by service arrangement can continue. It does though miss the opportunity of having an "at scale approach" for procurement, estates and FM, then over time other services, subject to business case and engagement. Examples from elsewhere include digital, transactional HR, Finance, and other areas like Sterile Services. A second loss from outsourcing is less benefits staying in the Dorset ICS area as some of the cashable benefits would be retained by the external provider. This also undermines some of the local societal benefits, such as local employment and skills development.

A local Host and a OpCo are therefore better options than the ad hoc approach. Taking a single strategic direction, alongside developing deep expertise in managing the market, contracts and staff are all preferrable.

This is less so with the "multiple hosted services" (i.e. each trust hosts a different service). This has many of the disadvantages of 1-7, with multiple decision making and a much slower progress. It is also likely having higher overheads and lack critical mass. It will be difficult to create centres of excellence from combining the contract management expertise in a single organisation. Some of the synergies e.g. in sustainability across estates and procurement, would be lost.

The historic ad-hoc approach in Dorset has resulted in services that were once in-house are now provided by dedicated providers include (this list is not exhaustive):

- East Lancashire Financial Services 'ELFs' for financial service functions,
- Salisbury FT for Payroll,
- KPMG for Internal Audit,
- TIAA Counter Fraud,
- Boots for Outpatient Pharmacy at UHD
- A wholly owned SubCo for Pharmacy at DCH,
- Saba for Car Parking at UHD,
- Mitie for Housekeeping at Poole Hospital,
- One Dorset Pathology with a managed service for IT and equipment,
- Equipment maintenance with a mix of in-house and managed contracts,
- Homecare drug delivery for complex, chronic disease drugs.
- Laundry with Sunlight and other providers

What the above shows is that there is appetite and experience for alternative providers, where these are demonstrably better than in-house. However, some external providers, especially where they can operate at national level, and recover VAT, will almost always be lower cost than three Trusts in-house. The preferred option addresses this.

A further issue has been in-house teams are often not able to bid effectively for work, when it is market tested. This is because of the lack of capacity and skills to develop bids, demonstrate at scale efficiency, and to be separated from the client-side decision making process. This has made it harder to progress market testing and thus to test value for money. It also means when a test is undertaken there is very little chance of a compliant bid by the in-house team. An OpCo would overcome this, by having the skills and capacity to both set up and maintain a professional, commercial contractual relationship. When services are then tendered, this would allow the OpCo to consider responding to tenders. Therefore, some of the above example areas could become part of a business plan for growth in later phases, subject to winning in competitive tenders. Likewise, the OPCO could also compete for other commercial opportunities e.g. supply of services to GP practices, voluntary and public sector organisations.

What the list also shows is that these are mainly non-core services. There is limited track record in Dorset in having entire "core" services provided outside the Trust, in a way that could risk core delivery of performance. With a OpCo, with dedicated management, at scale expertise, and the clarity and transparency, this would allow core support services to improve towards the top quartile productivity and quality, with all the benefits staying within the local NHS, and crucially the control of those services still being aligned with the Dorset strategic direction. Therefore, a OpCo is considerably better placed than a hosted service to deliver the strategic direction.

Summary: limited mitigation.

Can the disbenefits of hosting arrangements be overcome?

	Full mitigation	Partial mitigation	limited mitigation	no effective mitigation
Dedicated Board focus on services				X
Specialist Board Members				X
Potential conflicts of interest and perceptions of favouritism towards the host				X
Multiple roles lead to less accountability and non-value added "distraction".			X	
Ownership of risk and reward needs to be transparent			X	
Due diligence for baseline and differential service levels			X	
Incentives for Delivery				X
Strategic Direction			X	

Further considerations

The panel undertaking the scoring also considered other ways of mitigating hosted arrangements.

a) Why not a sub-Board within a Trust to achieve the same dedication?

A sub-Board within a Trust could also be established to gain specialist members, this would deliver some benefits it terms of expert knowledge and experience of its membership. However, this would still mean a customer and provider relationship between Trusts, with ultimately the accountability still resting with the main Trust Board and members, making it hard to ever separate the services truly from the host. This increases potential conflicts of interest and will inevitably draw the main Board members into challenging decisions at some point where they will have multiple roles as the receiver and provider of services. The OpCo is a much cleaner solution as no one Trust is the host. Therefore, this mitigation was abandoned.

b) Why not have different Trusts hosting different services?

This would mean every Trust Board having to dedicate time to running a shared service function. This is unlikely to result in the services being prioritised by the Board as individually they would still be a minor part of the Trusts business. It would also mean a more complex set of arrangements where every Trust was a provider and receiver of services, and they would end up bidding for capital and revenue investment between themselves. It is also likely that each Host would wish to prioritise the service that they were running. This is unlikely to lead to optimum decision making. This would also result in each Trust having to have a contract manager for each service it was buying in, where this could potentially be shared between the Trust with a OpCo/single provider arrangement. This was considered complex, and distracting. This mitigation option was abandoned.

Conclusion: Benefits of a OpCo over a Trust Hosting Arrangement (even after mitigations)

1.	Dedicated Board focusing on services.	The OpCo would have its own Board and leadership team to focus 100% on the services that it provides.
2.	Specialist Board Members	A dedicated Board would allow for specialist Board members to be appointed. This could include executive and non-executives with experience in running a shared service, or with service expertise in areas like estates, procurement, capital developments.
3.	Conflicts of interest – reducing the risk	By having a OpCo results in less chance of conflicts of interest occurring around the prioritisation of services and developments due to having an independent Board.
4.	Multiple roles lead to less accountability and non-value added "distraction".	With the creation of a OpCo where each Trust is ultimately a shareholder, but not directly the provider of the services. This gives far greater clarity on roles and responsibilities, without reliance on personal relationships.
5.	Risk and Reward	OpCo has a pre-agreed formula for the benefits to flow via their shareholding. It is in everyone's interest to maximise benefits overall and focus attention on delivery. The formula and governance will be agreed as part of the setting up process. This reduces non-value adding work for the leadership teams of each Trust.
6.	Due diligence for baseline and differential service levels	It is easier to create a single culture within OpCo, as it is less of a "takeover". It is easier for a OpCo to hold multiple service contracts, with differing levels of investment, KPIs and outcomes, when there is transparency on inputs (e.g. investments, assets etc) and clarity for outcomes. The service is not "buried" within a larger Trust. Future investment, and benefits realisation, is also easier for a OpCo.
7.	Incentives for Delivery	The leadership team of the OpCo has its' purpose clear: delivering the best services to its customers (the Trusts). As they remain wholly NHS, their purpose is not profit maximisation, and risk minimisation, but best serving all their shareholders – the Trusts, and in turn the patients.
8.	Strategic Direction	OpCo provides the opportunity of having an "at scale approach" for procurement and estates, and over time other services, and potentially other customers. A OpCo can take a single strategic direction, better bid for work, both of which are more difficult with hosting.

Ends.

Annex: Working Paper on PropCo option

Why do the three trusts each need to set up a subsidiary company holding property (Prop Co), to achieve the benefits?

Context: Op Co role

The preferred option (F) has an operating company/ property company split ("Op Co / Prop Co"). This is common within the commercial sector. The operating company focuses on the staffing and service performance. It can also work across several customers. The Prop Co is focused on the asset management and ownership.

The question of whether the *shared services* should be directly hosted by a single Trust as provider, or an Op Co, are considered in a separate paper. The conclusion is there are significant benefits to the Op Co model, and problems with direct hosting. Some of the hosting problems can be partially mitigated, but several are intrinsic and cannot be avoided. For those reasons the conclusion is to prefer the Op Co model, to deliver shared services.

Factors to consider with the prop co model:

Firstly, is setting up *one* Prop Co an option? It is ruled out early on, because:

1. Trusts are against transferring assets. Trusts wish to retain ownership of their assets within their group consolidated accounts. This is because the transfer of significant assets, even to another NHS Trust, is not realistic to expect and does not happen in the NHS outside of a merger. Thus, any if assets are moved, it would only be to a wholly owned subsidiary (subco) within the group accounts, so the Trust retains control. This is a "redline" as Boards are responsible for their property assets and would not transfer this to another Trust.
2. One Subco would almost certainly incur significant legal and taxation costs, for no particular benefit, other than the relatively minor one-off cost of setting up the three SubCos.
3. Each Trust already has group accounts, reflecting the commonality of managing the large and complex business of the Trusts, whose groups turnovers are between £300m and £850m each. Where there are subsidiaries, the cost and management of the Boards and governance and kept small and proportionate.

Thus if a Prop Co model is set up, using the wholly owned subsidiary company (SubCo) approach, the firm conclusion is there would need to be one per Trust.

So moving to the main question:

Can the benefits of the shared service operating company be achieved without the PropCo element, that is the estate and assets remain "as is," owned by the Trusts.

Arguments in favour of the "as is" approach, are:

1. **Simplicity** – the assets stay "as is"
2. **Cost** – there is no need for a Prop Co board and governance, ie reporting in the Trust group accounts. This could be £5-10K per Trust.

Arguments in favour of the Prop Co approach, are:

1. **Focus of a dedicated Board.**

   Having a Prop co board, to manage the assets of each trust, brings this into focus, with the discipline and transparency that separate reporting. It will also allow independent non-execs with specialist expertise in Estates, Facilities and Procurement to bring longterm, objective, support and challenge. Currently Foundation Trust Board time spent looking at the assets and asset management strategy is very small, as there are so many other, pressing calls upon a Board's time. The PropCo would be the effective guardians of the assets.

   To quantify the costs, these are mainly ones that would be provided from within the current cost base eg accounts, existing staff member salaries. The only significant net additional cost would be independent board non-exec membership. This could be 2-3 members at say £2K each, to reflect senior experience, over 4-6 meetings per year. Thus total cost to the NHS Dorset position might be £4-6k per Trust.

   The dedicated Board, and non-exec approach is not possible or practical with the "as is" alternative.

2. **Intelligent client**.

   In the preferred model the PropCo will sub-contract to OpCo for services it requires. It will then provide a single "managed service" to the Trust, combining the operational and asset management. The managed service approach is common practice within the public and private sector, as it works by delivering a unitary service and cost. This approach is the norm, as it is so self-evidently better than multiple contracts, with significant overlaps and grey areas as to where service delivery and asset management starts and finishes. This is also reflected in the tax and accounting regimes (see further points below).

   One way of seeing this is the PropCo as the principal supply chain partner. This requires the PropCo being the "intelligent client," understanding the individual needs of the Trust, and how best to meet these. Being wholly owned by the Trust it's responsible to, its' duty is to ensure the right level of service and value for money to the Trust. The group accounts model reinforces this. Thus the PropCo can be relied upon to undertake the intelligent client function for the service provided.

   In the "as is" alternative, the Trust could provide this, but is less likely to have the focus and expertise. Whilst in theory this could be developed, the experience of decades of Opco/Prop in practice across multiple sectors, is to have the set up as proposed.

3. **Backlog reduction, through transparent, focused contract approach.**

   The assets have significant backlog repairs, and the safety risks and lower productivity that comes from this. A PropCo could be contractually driven to resolve this, in the way that Trusts with separated property management are far more successful in doing (e.g. PFIs, and those with SubCos). This will entail resources, and the Trusts may make the decision not to

pursue this, due to resource constraints. However this would be a far better informed, and more transparent decision than the "as is" now situation.

The speed and cost effectiveness of backlog reduction would be better in the preferred model of Opco/Prop Co for reasons set out below in strategic asset management section.

Context: The Estates Returns Information collection (ERIC) reports £53m of critical and high risk backlog. This is the core cost, and the out turn cost is usually double (as fees, prelims, VAT and contingency are added). This figure is likely to increase significantly in the year ahead. This is because the 5 yearly assets survey is being undertaken across the Dorset Trusts, and because build costs have risen sharply, due to the inflationary pressures of the past few years. More positively some progress in backlog works is being made, by use of New Hospital Programme and other major capital investments. However the annual capital spend remains below the level needed to have a trajectory to remove the critical and high risk backlog estates.

	Total Assets £m	Backlog £m* (Critical & High only, estimated) *Outturn cost double	Is typical annual capital spend sufficient to maintain, & reduce backlog ?
Dorset County Hospital	161	12 (8)	No
Dorset Healthcare	196	29 (14)	No
University Hospitals Dorset	549	62 (31)	No
Total	**906**	**103 (53)**	

In comparison the amount of high and critical backlog in PFI hospitals is much lower, as there is a contractual requirement to maintain estates. For clarity a PFI approach is not proposed, as an objective is to keep services and assets NHS owned. However the benefits of separation for transparency and contractual discipline can be best delivered whilst keeping to this principle, by using the prop co approach. This is better than the "as is" which has demonstrably not worked for the wider NHS, with backlog now reaching £13.8bn.

This argument is especially important for Dorset NHS Trusts which are benefiting from significant investment in new estate, totalling c£750m. This new estate needs maintaining. Thus applying the contractual discipline, and dedicated leadership focus, will reduce the risk of these assets not being fully maintained.

4. Level Playing field vs PFI, outsourced and managed services.

NHS Trust boards have a duty to break even and provide value for money (VFM). Measures for productivity are increasingly becoming a regulatory priority, driving behaviours and decision making. This will include Trusts' reviewing their considerable non-clinical service spend in areas like EFM and procurement to ensure VFM.

Over the years many Trusts have their property and services out sourced, broadly called "managed services." Typically, this is to private, commercial services providers. These offer the economies of scale, focused leadership and flexibility that the at-scale OpCo for Dorset is aiming to achieve. There is one further benefit managed service providers have: Tax

treatment. The Capital Goods Scheme and the ability to reclaim VAT allow commercial companies and SubCos to recover VAT.

This means when comparing the costs and productivity of managed service companies with NHS directly held assets, with all other things being equal, the managed service approach will be lower cost. This is even after the cost of setting up the companies, paying any corporation and other taxes and charges due. This is not a level playing field.

The duty of Boards to deliver best value, will include looking at cost of providing services. Currently the uneven playing field, due to the tax status, would compel a move at some point towards resolving this. The most obvious option being outsourcing. The Boards in Dorset in seeking a shared service are looking to achieve the multiple benefits set out in the Business Case, but without the financial costs and organisational disruption of outsourcing.

Instead they are looking to align with other NHS Trusts that have set up subsidiary companies, and to comply with the legal, tax and guidance issued on the subject, as well as the case law. This includes ensuring the changes isn't for tax purposes, and would still be progressed if the tax situation were neutral. The Boards, in deciding on the Business Case are fully briefed that the case for change needs to stand regardless of the tax status. For example, the tax regime could change at any point.

The 2024 guidance on wholly owned subsidiaries requires the transaction's impact on tax to be assessed. The same regulatory requirement also is clear on keeping the cost of fees and advice to a minimum. To balance these two requirements the following is proposed:

- A high level tax assessment has been taken after the OBC and before the FBC decision (so the decision is not informed by the tax position)
- A very high-level impact assessment is undertaken before the FBC decision making, to give an indication of scale.
- Now the FBC is approved more detailed tax advice, and the full tax assessment will be undertaken. The results of this would be shared with the regulatory team at NHSE when available as part of their assessment and advice.

The OpCo/PropCo option is supported, and the tax status allows VAT recovery, corporation tax to be paid, and the overheads of the governance structure to be estimated, a net position to each Trust can be calculated. This would accord with the Trust fiduciary duties, in following the many other Trusts that have already progressed the option of a managed service approach. The PropCo element is essential for this, as it includes the assets, capital investments and works associated. As the regulators require improved financial performance the "as is" approach, of ignoring this option will become increasing difficult to defend.

5. **Subco provides the managed service, bespoke to the Trust. The speed of convergence will be better manged by the PropCos, and the transparency and equity they bring.**

The share service provider (OpCo) will have three main contracts to provide, one per Trust. There are very different stating points for each service. This comes from different levels of investment, leadership styles, performance management, backlog requirements, and differing strategies and priorities. For this reason, most NHS SubCos that have been set up are one per Trust, as this is simplier. However, the Dorset ambition is to go beyond the

benefits as a standalone. This allows further benefits by a shared using an ICS-wide approach. These are the strategic reasons, listed in the Business Case, which then enable a longer list of benefits.

Over time the level of differentiation may reduce, with the Trusts actively choosing to align, standardise, and to accept the trade off over a lower level of bespoke service. Also choices about levels of investment and allocation of savings (and/or reinvestments) may lead to more convergence. The speed and scale of this will be for the Trusts to set through the managed service agreements. This will be a dynamic dialogue, with the intelligent client role of the PropCo working with the OpCo to provide the optimum level of service within the unitary payment that each Trust sets.

Not having the PropCo could be partially mitigated by having the Shared service contract held directly between the Trust and OpCo. This is sub optimal though. Firstly because reasons 1-4 are absent. Secondly because holding the assets directly at the Trust means less clarity on asset management, and the overlap between OpCo and Trust role. The removal of this layer of governance has the potential to cause tensions in the relationships between the Trusts. Those with the minority share owning of OpCo, would lack the transparency and accountability that separate PropCo brings. This could lead to a sense of priority being given to Trust that consolidates the accounts of the OpCo, due to the direct nature of the contract to the host Trust. This then creates some of the issues listed in the reason why directly hosting was scored as suboptimal. It would also mean it becomes harder, and thus slower, to manage the convergence towards the standardised service offering, especially if that standardisation is perceived to be a win-lose in favour of the hosting Trust. Therefore, it is likely the Trusts would object to not having the subco approach, as removing it creates a sub optimal implementation.

Instead by having all three Trusts having the same managed service contract arrangement, this is open, equitable and contractually puts all three Trusts on the same footing.

6. Strategic asset management (move towards one estate strategy).

The NHS assets within Dorset are considerable, valued at £ 906m in 23/4. They are also very varied. Dorset Healthcare operates from 200+ community locations. Dorset County Hospital from one main site. University Hospitals Dorset from 2 large acute sites, and a range of smaller sites.

The history of competition within the NHS and now collaboration, means there are examples of estates being used between Trusts, collaboratively, but these are slow, complex arrangements. This is because each Trust is held to account individually, especially on issues of quality and performance. This means there is usually significant executive time spent on relatively small transactions between Trusts. This disproportionate effort to benefit means collaborations are less frequent than they could be. From a system viewpoint this results is sub-optimal use of assets.

For example the use of community hospital operating theatres, radiology and endoscopy departments is low. The acute trusts find it difficult to align the financial, governance, workforce and administrative processes, to make ad-hoc usage of empty capacity disproportionally complex. This includes staff being trained to use the kit that differs, have

the right clearances to work, and many, many others “frictions” that are there to ensure patient safety.

By having assets set within each PropCo this could over time allow greater transparency and consistency in asset management. This could then look to utilise assets more effectively, improving productivity. The alternative, absent the PropCo, would be to continue to rely on adhoc arrangements, brokered when there is time available.

The second stage to this would become more strategic with the PropCos developing a Dorset wide estates strategy. This could look beyond utilisation and at asset management, including disposals and acquisitions. Having the property held by each Trust Subco, means the Trust retains control, which is crucial as the Trusts are held to account. Thus the Trust would ultimately approve, reject or amend strategies and proposals. However the SubCos would be expected to work together to develop an asset strategy at both Trust and ICS wide basis, using the dedicated Boards with expertise and focus.

Absent the PropCo this could in theory still happen, but the reality is this is not occurring across the NHS, and when it does it is a slow, executive intensive effort. Thus the “as is” arrangement is severely sub optimal.

Conclusions

The OpCo/PropCo model is preferred way of delivering the benefits.

Removing the PropCo aspect creates a simpler governance and saves a very small cost. This is not recommended as a PropCo has 4 significant advantages over “as is.” These are:

1. Focus of a dedicated Board.
2. Intelligent client.
3. Backlog reduction, through transparent, focused contract approach.
4. Level Playing field vs PFI, outsourced and managed services.

The idea of having one subco for the system is ruled out. The need for Trusts to retain control of their assets, plus the potential significant costs of transfer of assets, means this would not be acceptable to Boards.

In addition to the 4 reasons listed above, there are two further reasons having PropCos at Trust level, benefit the system:

- Subco provides the managed service, bespoke to the Trust. The speed of convergence will be better manged by the PropCos, and the transparency and equity they bring.
- Strategic asset management (move towards one estate strategy).

In conclusion the OpCo/PropCo proposal is common to many public and private sector arrangements, and work with the grain of long standing regulatory, tax and governance approaches. These six reasons for taking this approach far outweigh the reasons for staying as is. Thus the preferred option F is recommended.

ENDS

Annex: Economic Model for Dorset Shared Services

Model Summary

Preferred Option: Financial Appraisal Summary (Real)

Project Lifetime Savings (Hard Pasted)

Live Scenario: Expected

Populate Tables

Heading	Downside	Expected	Upside	Live Scenario
DCH	-29,986,685	-35,542,304	-80,182,726	-35,542,304
DHC	-33,681,380	-40,515,667	-72,996,800	-40,515,667
UHD	-112,162,506	-131,470,607	-259,468,444	-131,470,607
Total	**-175,830,571**	**-207,528,578**	**-412,647,969**	**-207,528,578**

Analysis By Driver:

Heading	Downside	Expected	Upside	Live Scenario
Cash Releasing Benefits (-)	-68,385,274	-94,083,585	-152,293,615	-94,083,585
Baseline CIPs (-)	-50,168,626	-49,158,863	-46,826,758	-49,158,863
Additional Operating Costs (+)	15,909,544	15,909,544	15,909,544	15,909,544
Transitional Costs (+)	983,302	983,302	983,302	983,302
VAT Recovery (-)	-79,330,400	-86,181,400	-235,064,238	-86,181,400
Corporation Tax (+)	5,160,884	5,002,425	4,643,796	5,002,425
Total	**-175,830,571**	**-207,528,578**	**-412,647,969**	**-207,528,578**

Summary Financial Appraisal By Year

Summary Marginal Costs/Savings (Real): Live Scenario

Price Base: 24/25

Active Year Weight: 0.583333333 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 0.416666667

Heading	Mar-26 Year 1	Mar-27 Year 2	Mar-28 Year 3	Mar-29 Year 4	Mar-30 Year 5	Mar-31 Year 6	Mar-32 Year 7	Mar-33 Year 8	Mar-34 Year 9	Mar-35 Year 10	Mar-36 Year 11
Cash Releasing Benefits (-)	-411,708	-4,487,217	-7,675,900	-9,396,218	-11,238,318	-11,238,318	-11,238,318	-11,238,318	-11,238,318	-11,238,318	-4,682,633
Baseline CIPs (-)	-529,700	-1,812,652	-2,670,386	-3,487,656	-4,279,551	-5,045,105	-5,803,004	-6,553,324	-7,296,140	-8,031,529	-3,649,818
Additional Operating Costs (+)	928,057	1,590,954	1,590,954	1,590,954	1,590,954	1,590,954	1,590,954	1,590,954	1,590,954	1,590,954	662,898
Transitional Costs (+)	983,302	0	0	0	0	0	0	0	0	0	0
VAT Recovery (-)	-8,281,473	-9,303,240	-9,303,240	-9,303,240	-9,303,240	-9,303,240	-9,303,240	-9,303,240	-9,303,240	-2,452,240	-1,021,767
Corporation Tax (+)	339,466	551,902	525,964	509,697	492,813	487,905	483,047	478,237	473,476	468,762	191,157
Total	**-6,972,057**	**-13,460,252**	**-17,532,608**	**-20,086,462**	**-22,737,342**	**-23,507,803**	**-24,270,561**	**-25,025,690**	**-25,773,268**	**-19,662,371**	**-8,500,163**

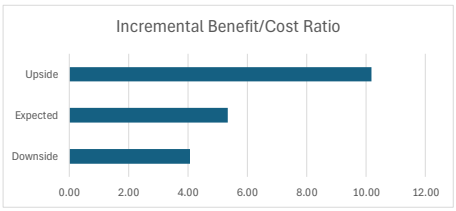
By Trust:

DCH	-889,998	-2,117,974	-2,892,483	-3,378,192	-3,882,354	-4,028,886	-4,173,952	-4,317,568	-4,459,748	-3,770,505	-1,630,642
DHC	-258,274	-1,971,794	-3,047,980	-3,722,877	-4,423,415	-4,627,022	-4,828,593	-5,028,148	-5,225,708	-5,153,292	-2,228,564
UHD	-5,823,785	-9,370,484	-11,592,145	-12,985,393	-14,431,572	-14,851,895	-15,268,015	-15,679,974	-16,087,813	-10,738,573	-4,640,957
Total	**-6,972,057**	**-13,460,252**	**-17,532,608**	**-20,086,462**	**-22,737,342**	**-23,507,803**	**-24,270,561**	**-25,025,690**	**-25,773,268**	**-19,662,371**	**-8,500,163**

Economic Appraisal

Net Present Cost By Scenario (Hard Pasted)

Heading	Downside	Expected	Upside
Do Nothing	724,258,127	724,258,127	724,258,127
Full Shared Service	666,111,857	642,727,770	554,618,056
Incremental Benefit/Cost Ratio	4.08	5.35	10.19
Cost Increase/(Decrease)	-58,146,271	-81,530,357	-169,640,071



Net Present Cost Summary (Live Scenario)

Heading	Costs	Benefits	Net Present Cost
Do Nothing	770,613,733	-46,355,606	**724,258,127**
Full Shared Service	789,370,063	-146,642,293	**642,727,770**

Incremental Benefit/Cost Ratio (Live Scenario)

Incremental Costs	Incremental Benefits	Incremental Ratio
0	0	**0.00**
18,756,329	-100,286,687	**5.35**

Target Ratio = 4.00+

Net Present Cost Summary Analysis (Live Scenario)

Heading	Mar-26 Year 1	Mar-27 Year 2	Mar-28 Year 3	Mar-29 Year 4	Mar-30 Year 5	Mar-31 Year 6	Mar-32 Year 7	Mar-33 Year 8	Mar-34 Year 9	Mar-35 Year 10	Mar-36 Year 11
Do Nothing	52,061,934	85,989,050	82,250,395	78,674,291	75,253,670	71,981,771	68,852,129	65,858,558	62,995,142	60,256,223	20,084,964
Full Shared Service	53,376,818	81,917,345	74,657,795	69,165,154	64,457,880	61,629,437	58,924,846	56,338,693	53,865,801	51,501,216	16,892,785

Economic Appraisal

Summary (Real)

Assumptions

Active Scenario: Expected

Price Base: 24/25

Discount Rate 3.50%

Net Present Cost Summary

Heading	Costs	Benefits	Net Present Cost
Do Nothing	770,613,733	-46,355,606	**724,258,127**
Full Shared Service	789,370,063	-146,642,293	**642,727,770**
			81,530,357

Incremental Costs	Incremental Benefits	Incremental Ratio
0	0	**0.00**
18,756,329	-100,286,687	**5.35**

Target Ratio = 4.00+

Net Present Cost Summary Analysis

Active Year Weight	0.583333333	1	1	1	1	1	1	1	1	1	0.416666667
Discount Factor	1.000	0.966	0.934	0.902	0.871	0.842	0.814	0.786	0.759	0.734	0.709

Heading	Mar-26 Year 1	Mar-27 Year 2	Mar-28 Year 3	Mar-29 Year 4	Mar-30 Year 5	Mar-31 Year 6	Mar-32 Year 7	Mar-33 Year 8	Mar-34 Year 9	Mar-35 Year 10	Mar-36 Year 11
Do Nothing	52,061,934	85,989,050	82,250,395	78,674,291	75,253,670	71,981,771	68,852,129	65,858,558	62,995,142	60,256,223	20,084,964
Full Shared Service	53,376,818	81,917,345	74,657,795	69,165,154	64,457,880	61,629,437	58,924,846	56,338,693	53,865,801	51,501,216	16,892,785

Do Nothing

Undiscounted

Heading	Mar-26 Year 1	Mar-27 Year 2	Mar-28 Year 3	Mar-29 Year 4	Mar-30 Year 5	Mar-31 Year 6	Mar-32 Year 7	Mar-33 Year 8	Mar-34 Year 9	Mar-35 Year 10	Mar-36 Year 11
Costs (+)	52,969,991	90,805,700	90,805,700	90,805,700	90,805,700	90,805,700	90,805,700	90,805,700	90,805,700	90,805,700	37,835,708
Benefits (-)	-908,057	-1,807,033	-2,697,020	-3,578,107	-4,450,383	-5,313,936	-6,168,854	-7,015,222	-7,853,127	-8,682,653	-9,503,883
Net Total Cost	**52,061,934**	**88,998,666**	**88,108,680**	**87,227,593**	**86,355,317**	**85,491,764**	**84,636,846**	**83,790,478**	**82,952,573**	**82,123,047**	**28,331,825**

Discounted

Heading	Mar-26 Year 1	Mar-27 Year 2	Mar-28 Year 3	Mar-29 Year 4	Mar-30 Year 5	Mar-31 Year 6	Mar-32 Year 7	Mar-33 Year 8	Mar-34 Year 9	Mar-35 Year 10	Mar-36 Year 11
Costs (+)	52,969,991	87,734,976	84,768,092	81,901,538	79,131,921	76,455,963	73,870,495	71,372,459	68,958,898	66,626,954	26,822,445
Benefits (-)	-908,057	-1,745,926	-2,517,697	-3,227,247	-3,878,252	-4,474,192	-5,018,366	-5,513,901	-5,963,755	-6,370,731	-6,737,481
Net Total	**52,061,934**	**85,989,050**	**82,250,395**	**78,674,291**	**75,253,670**	**71,981,771**	**68,852,129**	**65,858,558**	**62,995,142**	**60,256,223**	**20,084,964**

Full Shared Service

Undiscounted

Heading	Mar-26 Year 1	Mar-27 Year 2	Mar-28 Year 3	Mar-29 Year 4	Mar-30 Year 5	Mar-31 Year 6	Mar-32 Year 7	Mar-33 Year 8	Mar-34 Year 9	Mar-35 Year 10	Mar-36 Year 11
Costs (+)	55,220,816	92,948,557	92,922,618	92,906,351	92,889,467	92,884,559	92,879,701	92,874,891	92,870,130	92,865,416	38,689,762
Benefits (-)	-1,843,998	-8,164,105	-12,947,321	-16,221,709	-18,922,567	-19,688,121	-20,446,020	-21,196,340	-21,939,157	-22,674,545	-14,860,820
Net Total	**53,376,818**	**84,784,452**	**79,975,297**	**76,684,643**	**73,966,900**	**73,196,438**	**72,433,681**	**71,678,551**	**70,930,973**	**70,190,871**	**23,828,942**

Discounted

Heading	Mar-26 Year 1	Mar-27 Year 2	Mar-28 Year 3	Mar-29 Year 4	Mar-30 Year 5	Mar-31 Year 6	Mar-32 Year 7	Mar-33 Year 8	Mar-34 Year 9	Mar-35 Year 10	Mar-36 Year 11
Costs (+)	55,220,816	89,805,369	86,744,258	83,796,206	80,947,804	78,206,307	75,557,697	72,998,825	70,526,650	68,138,232	27,427,900
Benefits (-)	-1,843,998	-7,888,024	-12,086,463	-14,631,052	-16,489,924	-16,576,870	-16,632,851	-16,660,132	-16,660,849	-16,637,016	-10,535,115
Net Total	**53,376,818**	**81,917,345**	**74,657,795**	**69,165,154**	**64,457,880**	**61,629,437**	**58,924,846**	**56,338,693**	**53,865,801**	**51,501,216**	**16,892,785**

Financial Appraisal

Summary Marginal Costs/Savings (Real)

Active Scenario: Expected

Price Base: 24/25

Active Year Weight	0.583333333	1	1	1	1	1	1	1	1	1	0.416666667

Heading	Mar-26 Year 1	Mar-27 Year 2	Mar-28 Year 3	Mar-29 Year 4	Mar-30 Year 5	Mar-31 Year 6	Mar-32 Year 7	Mar-33 Year 8	Mar-34 Year 9	Mar-35 Year 10	Mar-36 Year 11
Cash Releasing Benefits (-)	-411,708	-4,487,217	-7,675,900	-9,396,218	-11,238,318	-11,238,318	-11,238,318	-11,238,318	-11,238,318	-11,238,318	-4,682,633
Baseline CIPFA (-)	-529,700	-1,812,652	-2,670,386	-3,487,656	-4,279,551	-5,045,105	-5,803,004	-6,553,324	-7,296,140	-8,031,529	-3,649,818
Additional Operating Costs (+)	928,057	1,590,954	1,590,954	1,590,954	1,590,954	1,590,954	1,590,954	1,590,954	1,590,954	1,590,954	662,898
Transitional Costs (+)	983,302	0	0	0	0	0	0	0	0	0	0
VAT Recovery (-)	-8,281,473	-9,303,240	-9,303,240	-9,303,240	-9,303,240	-9,303,240	-9,303,240	-9,303,240	-9,303,240	-2,452,240	-1,021,767
Corporation Tax (+)	339,466	551,902	525,964	509,697	492,813	487,905	483,047	478,237	473,476	468,762	191,157
Total	**-6,972,057**	**-13,460,252**	**-17,532,608**	**-20,086,462**	**-22,737,342**	**-23,507,803**	**-24,270,561**	**-25,025,690**	**-25,773,268**	**-19,662,371**	**-8,500,163**

By Trust:

DCH	-889,998	-2,117,974	-2,892,483	-3,378,192	-3,882,354	-4,028,886	-4,173,952	-4,317,568	-4,459,748	-3,770,505	-1,630,642
DHC	-258,274	-1,971,794	-3,047,980	-3,722,877	-4,423,415	-4,627,022	-4,828,593	-5,028,148	-5,225,708	-5,153,292	-2,228,564
UHD	-5,823,785	-9,370,484	-11,592,145	-12,985,393	-14,431,572	-14,851,895	-15,268,015	-15,679,974	-16,087,813	-10,738,573	-4,640,957
Total	**-6,972,057**	**-13,460,252**	**-17,532,608**	**-20,086,462**	**-22,737,342**	**-23,507,803**	**-24,270,561**	**-25,025,690**	**-25,773,268**	**-19,662,371**	**-8,500,163**

Marginal Costs/Savings By Trust (Real)

DCH

Heading	Mar-26 Year 1	Mar-27 Year 2	Mar-28 Year 3	Mar-29 Year 4	Mar-30 Year 5	Mar-31 Year 6	Mar-32 Year 7	Mar-33 Year 8	Mar-34 Year 9	Mar-35 Year 10	Mar-36 Year 11
Cash Releasing Benefits (-)	-78,301	-853,410	-1,459,855	-1,787,037	-2,137,380	-2,137,380	-2,137,380	-2,137,380	-2,137,380	-2,137,380	-890,575
Baseline CIPs (-)	-100,742	-344,742	-507,872	-663,306	-813,914	-959,512	-1,103,655	-1,246,356	-1,387,630	-1,527,491	-694,147
Additional Operating Costs (+)	203,504	348,865	348,865	348,865	348,865	348,865	348,865	348,865	348,865	348,865	145,360
Transitional Costs (+)	168,109										
VAT Recovery (-)	-1,147,303	-1,373,948	-1,373,948	-1,373,948	-1,373,948	-1,373,948	-1,373,948	-1,373,948	-1,373,948	-543,948	-226,645
Corporation Tax (+)	64,735	105,261	100,328	97,234	94,023	93,090	92,166	91,251	90,346	89,449	35,365
Total Costs/(Savings)	**-889,998**	**-2,117,974**	**-2,892,483**	**-3,378,192**	**-3,882,354**	**-4,028,886**	**-4,173,952**	**-4,317,568**	**-4,459,748**	**-3,770,505**	**-1,630,642**
Analysis:											
Expenditure With Subco	10,035,782	16,312,977	15,543,402	15,060,786	14,559,835	14,414,237	14,270,094	14,127,393	13,986,119	13,846,258	5,711,581
Baseline Costs	-10,074,194	-17,270,047	-17,270,047	-17,270,047	-17,270,047	-17,270,047	-17,270,047	-17,270,047	-17,270,047	-17,270,047	-7,195,853
Net Savings	-38,412	-957,070	-1,726,645	-2,209,261	-2,710,212	-2,855,810	-2,999,953	-3,142,654	-3,283,928	-3,423,789	-1,484,271
Propco Additional Operating Costs	62,873	107,783	107,783	107,783	107,783	107,783	107,783	107,783	107,783	107,783	44,909
Propco Corporation Tax	64,735	105,261	100,328	97,234	94,023	93,090	92,166	91,251	90,346	89,449	35,365
VAT Recovery	-1,147,303	-1,373,948	-1,373,948	-1,373,948	-1,373,948	-1,373,948	-1,373,948	-1,373,948	-1,373,948	-543,948	-226,645
Transitional Costs	168,109										
Less: Share Of Subco Profits	0	0	0	0	0	0	0	0	0	0	0
Total	**-889,998**	**-2,117,974**	**-2,892,483**	**-3,378,192**	**-3,882,354**	**-4,028,886**	**-4,173,952**	**-4,317,568**	**-4,459,748**	**-3,770,505**	**-1,630,642**
Check	0	0	-0	0	0	0	0	0	0	0	0

DHC

Heading	Mar-26 Year 1	Mar-27 Year 2	Mar-28 Year 3	Mar-29 Year 4	Mar-30 Year 5	Mar-31 Year 6	Mar-32 Year 7	Mar-33 Year 8	Mar-34 Year 9	Mar-35 Year 10	Mar-36 Year 11
Cash Releasing Benefits (-)	-108,800	-1,185,820	-2,028,481	-2,483,103	-2,969,908	-2,969,908	-2,969,908	-2,969,908	-2,969,908	-2,969,908	-1,237,462
Baseline CIPs (-)	-139,982	-479,023	-705,693	-921,670	-1,130,941	-1,333,251	-1,533,538	-1,731,822	-1,928,123	-2,122,462	-964,524
Additional Operating Costs (+)	258,281	442,768	442,768	442,768	442,768	442,768	442,768	442,768	442,768	442,768	184,487
Transitional Costs (+)	276,599										
VAT Recovery (-)	-634,165	-895,712	-895,712	-895,712	-895,712	-895,712	-895,712	-895,712	-895,712	-627,712	-261,547
Corporation Tax (+)	89,793	145,992	139,138	134,839	130,377	129,080	127,796	126,525	125,267	124,021	50,481
Total Costs/(Savings)	**-258,274**	**-1,971,794**	**-3,047,980**	**-3,722,877**	**-4,423,415**	**-4,627,022**	**-4,828,593**	**-5,028,148**	**-5,225,708**	**-5,153,292**	**-2,228,564**
Analysis:											
Expenditure With Subco	13,944,805	22,667,022	21,597,691	20,927,092	20,231,016	20,028,706	19,828,419	19,630,135	19,433,833	19,239,495	7,936,292
Baseline Costs	-13,998,179	-23,996,879	-23,996,879	-23,996,879	-23,996,879	-23,996,879	-23,996,879	-23,996,879	-23,996,879	-23,996,879	-9,998,700
Net Savings	-53,374	-1,329,857	-2,399,188	-3,069,787	-3,765,863	-3,968,173	-4,168,460	-4,366,744	-4,563,046	-4,757,384	-2,062,408
Propco Additional Operating Costs	62,873	107,783	107,783	107,783	107,783	107,783	107,783	107,783	107,783	107,783	44,909
Propco Corporation Tax	89,793	145,992	139,138	134,839	130,377	129,080	127,796	126,525	125,267	124,021	50,481
VAT Recovery	-634,165	-895,712	-895,712	-895,712	-895,712	-895,712	-895,712	-895,712	-895,712	-627,712	-261,547
Transitional Costs	276,599										
Less: Share Of Subco Profits	0	0	0	0	0	0	0	0	0	0	0
Total	**-258,274**	**-1,971,794**	**-3,047,980**	**-3,722,877**	**-4,423,415**	**-4,627,022**	**-4,828,593**	**-5,028,148**	**-5,225,708**	**-5,153,292**	**-2,228,564**
Check	0	0	-0	0	0	0	0	0	0	0	0

UHD

Heading	Mar-26 Year 1	Mar-27 Year 2	Mar-28 Year 3	Mar-29 Year 4	Mar-30 Year 5	Mar-31 Year 6	Mar-32 Year 7	Mar-33 Year 8	Mar-34 Year 9	Mar-35 Year 10	Mar-36 Year 11
Cash Releasing Benefits (-)	-224,606	-2,447,988	-4,187,564	-5,126,078	-6,131,030	-6,131,030	-6,131,030	-6,131,030	-6,131,030	-6,131,030	-2,554,596
Baseline CIPs (-)	-288,976	-988,887	-1,456,821	-1,902,680	-2,334,696	-2,752,342	-3,165,811	-3,575,146	-3,980,387	-4,381,576	-1,991,147
Additional Operating Costs (+)	466,271	799,321	799,321	799,321	799,321	799,321	799,321	799,321	799,321	799,321	333,051
Transitional Costs (+)	538,593										
VAT Recovery (-)	-6,500,005	-7,033,580	-7,033,580	-7,033,580	-7,033,580	-7,033,580	-7,033,580	-7,033,580	-7,033,580	-1,280,580	-533,575
Corporation Tax (+)	184,938	300,649	286,498	277,624	268,413	265,735	263,085	260,461	257,863	255,292	105,311
Total Costs/(Savings)	**-5,823,785**	**-9,370,484**	**-11,592,145**	**-12,985,393**	**-14,431,572**	**-14,851,895**	**-15,268,015**	**-15,679,974**	**-16,087,813**	**-10,738,573**	**-4,640,957**
Analysis:											
Expenditure With Subco	28,787,434	46,793,438	44,585,928	43,201,554	41,764,586	41,346,941	40,933,471	40,524,136	40,118,895	39,717,706	16,383,554
Baseline Costs	-28,897,618	-49,538,774	-49,538,774	-49,538,774	-49,538,774	-49,538,774	-49,538,774	-49,538,774	-49,538,774	-49,538,774	-20,641,156
Net Savings	-110,184	-2,745,336	-4,952,846	-6,337,220	-7,774,187	-8,191,833	-8,605,303	-9,014,637	-9,419,879	-9,821,068	-4,257,602
Propco Additional Operating Costs	62,873	107,783	107,783	107,783	107,783	107,783	107,783	107,783	107,783	107,783	44,909
Propco Corporation Tax	184,938	300,649	286,498	277,624	268,413	265,735	263,085	260,461	257,863	255,292	105,311
VAT Recovery	-6,500,005	-7,033,580	-7,033,580	-7,033,580	-7,033,580	-7,033,580	-7,033,580	-7,033,580	-7,033,580	-1,280,580	-533,575
Transitional Costs	538,593										
Less: Share Of Subco Profits	0	0	0	0	0	0	0	0	0	0	0
Total	**-5,823,785**	**-9,370,484**	**-11,592,145**	**-12,985,393**	**-14,431,572**	**-14,851,895**	**-15,268,015**	**-15,679,974**	**-16,087,813**	**-10,738,573**	**-4,640,957**

Cost Summary

Summary

Active Year Weight	0.583333333	1	1	1	1	1	1	1	1	1	0.416666667

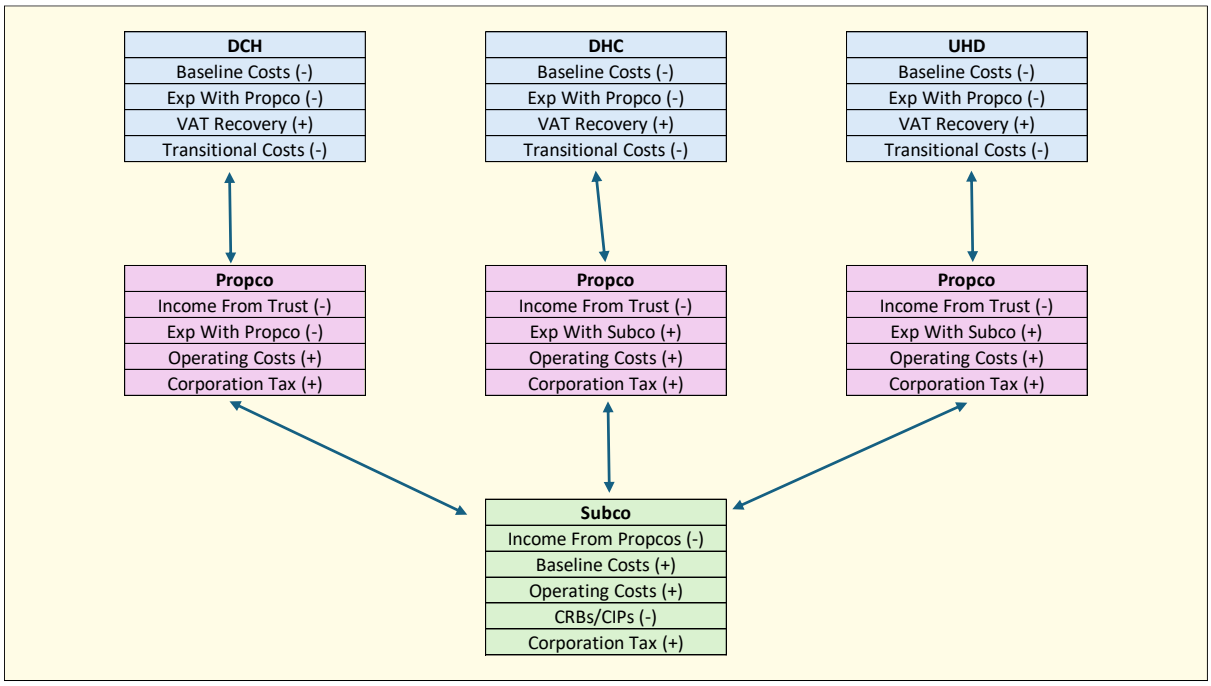
Heading	Mar-26 Year 1	Mar-27 Year 2	Mar-28 Year 3	Mar-29 Year 4	Mar-30 Year 5	Mar-31 Year 6	Mar-32 Year 7	Mar-33 Year 8	Mar-34 Year 9	Mar-35 Year 10	Mar-36 Year 11
Do Nothing	52,969,991	90,805,700	90,805,700	90,805,700	90,805,700	90,805,700	90,805,700	90,805,700	90,805,700	90,805,700	37,835,708
Full Shared Service	55,220,816	92,948,557	92,922,618	92,906,351	92,889,467	92,884,559	92,879,701	92,874,891	92,870,130	92,865,416	38,689,762

Do Nothing

Heading	Mar-26 Year 1	Mar-27 Year 2	Mar-28 Year 3	Mar-29 Year 4	Mar-30 Year 5	Mar-31 Year 6	Mar-32 Year 7	Mar-33 Year 8	Mar-34 Year 9	Mar-35 Year 10	Mar-36 Year 11
Baseline Cost	52,969,991	90,805,700	90,805,700	90,805,700	90,805,700	90,805,700	90,805,700	90,805,700	90,805,700	90,805,700	37,835,708
Additional Operating Costs	0	0	0	0	0	0	0	0	0	0	0
Transitional Costs	0	0	0	0	0	0	0	0	0	0	0
Corporation Tax	0	0	0	0	0	0	0	0	0	0	0
Total	**52,969,991**	**90,805,700**	**90,805,700**	**90,805,700**	**90,805,700**	**90,805,700**	**90,805,700**	**90,805,700**	**90,805,700**	**90,805,700**	**37,835,708**

Full Shared Service

Heading	Mar-26 Year 1	Mar-27 Year 2	Mar-28 Year 3	Mar-29 Year 4	Mar-30 Year 5	Mar-31 Year 6	Mar-32 Year 7	Mar-33 Year 8	Mar-34 Year 9	Mar-35 Year 10	Mar-36 Year 11
Baseline Cost	52,969,991	90,805,700	90,805,700	90,805,700	90,805,700	90,805,700	90,805,700	90,805,700	90,805,700	90,805,700	37,835,708
Additional Operating Costs	928,057	1,590,954	1,590,954	1,590,954	1,590,954	1,590,954	1,590,954	1,590,954	1,590,954	1,590,954	662,898
Transitional Costs	983,302	0	0	0	0	0	0	0	0	0	0
Corporation Tax	339,466	551,902	525,964	509,697	492,813	487,905	483,047	478,237	473,476	468,762	191,157
Total	**55,220,816**	**92,948,557**	**92,922,618**	**92,906,351**	**92,889,467**	**92,884,559**	**92,879,701**	**92,874,891**	**92,870,130**	**92,865,416**	**38,689,762**



Subsidiary P&L Accounts

Contract Pricing Assumptions

Revenue Calibration

Heading	Propco	Subco
Assumed Net Profit Margin	2.50%	0.00%

Notes:
1. Overall subco revenue have been calculated on a cost plus basis, albeit based upon a cost base which will benefit from cash releasing benefits.
2. These assumptions are also required to derive a net profit sum to estimate the corporation tax liability.
3. The pricing mechanism is effectively how the three organisations extract CIPs from the subco.
4. The propco revenue charge to host Trust's works on the same basis. Therefore, propco revenue is a direct contra for Trust expenditure.
5. Similarly, subco income from the propcos should reconcile directly to propco expenditure.

Subco Revenue Apportionment

Recharge Method: Pro-Rata Share (Baseline Costs) — *Use drop down menu to select active recharge method*

Recharge Options:

Heading	DCH	DHC	UHD	Total	
Equal Share	33%	33%	33%	**100%**	
Ownership Share	25%	51%	25%	**100%**	
Pro-Rata Share (Baseline Costs)	19%	26%	55%	**100%**	*Recommended Default Method*
Other Agreed Method *(Please overtype)*	18%	17%	66%	**100%**	
Active Recharge Method	19%	26%	55%	**100%**	

Notes:
1. in order to split subco revenue between the propcos, it is necessary to choose one of the apportionment methods above from the drop-down menu in the recharge method assumption above.
2. Similar assumptions are set out in the Transitional Cost worksheet to apportion pre-operational costs incurred. It is assumed these mirror the revenue, but doesn't necessarily have to.
3. The recharge method above is assumed to apply equally to benefits and costs with the exception of VAT which is shared by actual VAT recovery.

Subco/Propco Income Reconciliation

Active Year Weight	0.583333333	1	1	1	1	1	1	1	1	1	0.416666667

Heading	Mar-26 Year 1	Mar-27 Year 2	Mar-28 Year 3	Mar-29 Year 4	Mar-30 Year 5	Mar-31 Year 6	Mar-32 Year 7	Mar-33 Year 8	Mar-34 Year 9	Mar-35 Year 10	Mar-36 Year 11
Subco Revenue	52,768,021	85,773,437	81,727,020	79,189,432	76,555,437	75,789,883	75,031,984	74,281,664	73,538,848	72,803,459	30,031,427
Aggregate Propco Expenditure	52,768,021	85,773,437	81,727,020	79,189,432	76,555,437	75,789,883	75,031,984	74,281,664	73,538,848	72,803,459	30,031,427
Difference	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Notes:
1. If there is a difference between aggregate propco expenditure and subco income, the difference total above will be shaded red to highlight an error.

Propco Summary

Revenue

Heading	Mar-26 Year 1	Mar-27 Year 2	Mar-28 Year 3	Mar-29 Year 4	Mar-30 Year 5	Mar-31 Year 6	Mar-32 Year 7	Mar-33 Year 8	Mar-34 Year 9	Mar-35 Year 10	Mar-36 Year 11
DCH Propco	10,357,595	16,841,805	16,052,497	15,557,506	15,043,710	14,894,379	14,746,540	14,600,180	14,455,284	14,311,837	5,904,093
DHC Propco	14,366,850	23,358,774	22,262,024	21,574,230	20,860,306	20,652,809	20,447,386	20,244,018	20,042,683	19,843,362	8,185,847
UHD Propco	29,590,058	48,103,816	45,839,703	44,419,833	42,946,020	42,517,665	42,093,594	41,673,763	41,258,131	40,846,655	16,849,706
Total	**54,314,503**	**88,304,395**	**84,154,224**	**81,551,569**	**78,850,036**	**78,064,852**	**77,287,520**	**76,517,961**	**75,756,098**	**75,001,853**	**30,939,646**

Expenditure With Subco

Heading	Mar-26 Year 1	Mar-27 Year 2	Mar-28 Year 3	Mar-29 Year 4	Mar-30 Year 5	Mar-31 Year 6	Mar-32 Year 7	Mar-33 Year 8	Mar-34 Year 9	Mar-35 Year 10	Mar-36 Year 11
DCH Propco	10,035,782	16,312,977	15,543,402	15,060,786	14,559,835	14,414,237	14,270,094	14,127,393	13,986,119	13,846,258	5,711,581
DHC Propco	13,944,805	22,667,022	21,597,691	20,927,092	20,231,016	20,028,706	19,828,419	19,630,135	19,433,833	19,239,495	7,936,292
UHD Propco	28,787,434	46,793,438	44,585,928	43,201,554	41,764,586	41,346,941	40,933,471	40,524,136	40,118,895	39,717,706	16,383,554
Total	**52,768,021**	**85,773,437**	**81,727,020**	**79,189,432**	**76,555,437**	**75,789,883**	**75,031,984**	**74,281,664**	**73,538,848**	**72,803,459**	**30,031,427**

Additional Operating Costs

Heading	Mar-26 Year 1	Mar-27 Year 2	Mar-28 Year 3	Mar-29 Year 4	Mar-30 Year 5	Mar-31 Year 6	Mar-32 Year 7	Mar-33 Year 8	Mar-34 Year 9	Mar-35 Year 10	Mar-36 Year 11
DCH Propco	62,873	107,783	107,783	107,783	107,783	107,783	107,783	107,783	107,783	107,783	44,909
DHC Propco	62,873	107,783	107,783	107,783	107,783	107,783	107,783	107,783	107,783	107,783	44,909
UHD Propco	62,873	107,783	107,783	107,783	107,783	107,783	107,783	107,783	107,783	107,783	44,909
Total	**188,620**	**323,348**	**323,348**	**323,348**	**323,348**	**323,348**	**323,348**	**323,348**	**323,348**	**323,348**	**134,728**

Total Expenditure

Heading	Mar-26 Year 1	Mar-27 Year 2	Mar-28 Year 3	Mar-29 Year 4	Mar-30 Year 5	Mar-31 Year 6	Mar-32 Year 7	Mar-33 Year 8	Mar-34 Year 9	Mar-35 Year 10	Mar-36 Year 11
DCH Propco	10,098,655	16,420,760	15,651,184	15,168,569	14,667,618	14,522,019	14,377,877	14,235,176	14,093,902	13,954,041	5,756,491
DHC Propco	14,007,679	22,774,805	21,705,473	21,034,874	20,338,799	20,136,488	19,936,201	19,737,917	19,541,616	19,347,278	7,981,201
UHD Propco	28,850,307	46,901,221	44,693,710	43,309,337	41,872,369	41,454,723	41,041,254	40,631,919	40,226,678	39,825,489	16,428,463
Total	**52,956,641**	**86,096,785**	**82,050,368**	**79,512,780**	**76,878,785**	**76,113,231**	**75,355,332**	**74,605,012**	**73,862,196**	**73,126,807**	**30,166,155**

Net Profit Before Tax

Heading	Mar-26 Year 1	Mar-27 Year 2	Mar-28 Year 3	Mar-29 Year 4	Mar-30 Year 5	Mar-31 Year 6	Mar-32 Year 7	Mar-33 Year 8	Mar-34 Year 9	Mar-35 Year 10	Mar-36 Year 11
DCH Propco	321,813	528,828	509,095	496,720	483,875	480,142	476,446	472,787	469,165	465,579	192,512
DHC Propco	422,044	691,752	664,333	647,138	629,290	624,103	618,967	613,883	608,850	603,867	249,556
UHD Propco	802,625	1,310,378	1,253,775	1,218,279	1,181,433	1,170,724	1,160,123	1,149,627	1,139,236	1,128,949	466,152
Total	**1,546,482**	**2,530,958**	**2,427,204**	**2,362,137**	**2,294,599**	**2,274,969**	**2,255,536**	**2,236,297**	**2,217,251**	**2,198,394**	**908,220**

Corporation Tax

Heading	Mar-26 Year 1	Mar-27 Year 2	Mar-28 Year 3	Mar-29 Year 4	Mar-30 Year 5	Mar-31 Year 6	Mar-32 Year 7	Mar-33 Year 8	Mar-34 Year 9	Mar-35 Year 10	Mar-36 Year 11
DCH Propco	-64,735	-105,261	-100,328	-97,234	-94,023	-93,090	-92,166	-91,251	-90,346	-89,449	-35,365
DHC Propco	-89,793	-145,992	-139,138	-134,839	-130,377	-129,080	-127,796	-126,525	-125,267	-124,021	-50,481
UHD Propco	-184,938	-300,649	-286,498	-277,624	-268,413	-265,735	-263,085	-260,461	-257,863	-255,292	-105,311
Total	**-339,466**	**-551,902**	**-525,964**	**-509,697**	**-492,813**	**-487,905**	**-483,047**	**-478,237**	**-473,476**	**-468,762**	**-191,157**

Net Profit Before Tax

Heading	Mar-26 Year 1	Mar-27 Year 2	Mar-28 Year 3	Mar-29 Year 4	Mar-30 Year 5	Mar-31 Year 6	Mar-32 Year 7	Mar-33 Year 8	Mar-34 Year 9	Mar-35 Year 10	Mar-36 Year 11
DCH Propco	257,078	423,567	408,767	399,486	389,852	387,052	384,280	381,536	378,819	376,130	157,147
DHC Propco	332,252	545,760	525,196	512,299	498,913	495,023	491,171	487,358	483,583	479,846	199,074
UHD Propco	617,687	1,009,729	967,277	940,655	913,021	904,989	897,038	889,166	881,373	873,657	360,841
Total	**1,207,017**	**1,979,055**	**1,901,240**	**1,852,440**	**1,801,786**	**1,787,064**	**1,772,489**	**1,758,060**	**1,743,775**	**1,729,633**	**717,063**
Cumulative Net Profit After Tax	1,207,017	3,186,072	5,087,312	6,939,752	8,741,538	10,528,602	12,301,091	14,059,151	15,802,926	17,532,559	18,249,622

Corporation Tax

Summary Analysis (Real)

Active Year Weight	0.58333333	1	1	1	1	1	1	1	1	1	0.41666667

Heading	Mar-26 Year 1	Mar-27 Year 2	Mar-28 Year 3	Mar-29 Year 4	Mar-30 Year 5	Mar-31 Year 6	Mar-32 Year 7	Mar-33 Year 8	Mar-34 Year 9	Mar-35 Year 10	Mar-36 Year 11
DCH Propco	64,735	105,261	100,328	97,234	94,023	93,090	92,166	91,251	90,346	89,449	35,365
DHC Propco	89,793	145,992	139,138	134,839	130,377	129,080	127,796	126,525	125,267	124,021	50,481
UHD Propco	184,938	300,649	286,498	277,624	268,413	265,735	263,085	260,461	257,863	255,292	105,311
Subco	0	0	0	0	0	0	0	0	0	0	0
Total	**339,466**	**551,902**	**525,964**	**509,697**	**492,813**	**487,905**	**483,047**	**478,237**	**473,476**	**468,762**	**191,157**

Corporation Tax Assumptions

Main Rate Threshold	250,000
Marginal Relief Threshold	50,000
Marginal Relief Fraction	1.50%
Main Tax Rate (%)	25%
Lower Tax Rate (%)	19%

Notes:
1. For simplicity and prudence, it is assumed that there are no pre-trading costs or capital allowances, although in practice these are likely.

Corporation Tax Calculations (Real)

DCH Propco

Heading	Mar-26 Year 1	Mar-27 Year 2	Mar-28 Year 3	Mar-29 Year 4	Mar-30 Year 5	Mar-31 Year 6	Mar-32 Year 7	Mar-33 Year 8	Mar-34 Year 9	Mar-35 Year 10	Mar-36 Year 11
Revenue (Real)	10,357,595	16,841,805	16,052,497	15,557,506	15,043,710	14,894,379	14,746,540	14,600,180	14,455,284	14,311,837	5,904,093
Expenditure (Real)	10,098,655	16,420,760	15,651,184	15,168,569	14,667,618	14,522,019	14,377,877	14,235,176	14,093,902	13,954,041	5,756,491
Net Profit	258,940	421,045	401,312	388,938	376,093	372,359	368,664	365,005	361,382	357,796	147,602
Net Profit %	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%
Tax Profit/(Loss) B/Fwd		0	0	0	0	0	0	0	0	0	0
Tax Loss Incurred	0	0	0	0	0	0	0	0	0	0	0
Tax Loss Utilised	0	0	0	0	0	0	0	0	0	0	0
Tax Profit/(Loss) C/Fwd	0	0	0	0	0	0	0	0	0	0	0
Taxable Profits	258,940	421,045	401,312	388,938	376,093	372,359	368,664	365,005	361,382	357,796	147,602
Taxation Due At Main Rate	64,735	105,261	100,328	97,234	94,023	93,090	92,166	91,251	90,346	89,449	36,901
Taxation Due At Small Profits Rate	0	0	0	0	0	0	0	0	0	0	0
Less: Marginal Relief	0	0	0	0	0	0	0	0	0	0	-1,536
Tax Payable	64,735	105,261	100,328	97,234	94,023	93,090	92,166	91,251	90,346	89,449	35,365
Calculated Composite Tax Rate	25%	25%	25%	25%	25%	25%	25%	25%	25%	25%	24%

Additional Operating Costs

Summary Analysis (Real)

Active Year Weight	0.583333333	1	1	1	1	1	1	1	1	1	0.416666667

OpCo

Heading	Mar-26 Year 1	Mar-27 Year 2	Mar-28 Year 3	Mar-29 Year 4	Mar-30 Year 5	Mar-31 Year 6	Mar-32 Year 7	Mar-33 Year 8	Mar-34 Year 9	Mar-35 Year 10	Mar-36 Year 11
Additional Staff	500,665	858,282	858,282	858,282	858,282	858,282	858,282	858,282	858,282	858,282	357,618
Other Staff costs	57,939	99,324	99,324	99,324	99,324	99,324	99,324	99,324	99,324	99,324	41,385
Other Pay and banding reserve	145,833	250,000	250,000	250,000	250,000	250,000	250,000	250,000	250,000	250,000	104,167
Non-Pay (Audit, insurance, legal, contingency)	35,000	60,000	60,000	60,000	60,000	60,000	60,000	60,000	60,000	60,000	25,000
Total	**739,437**	**1,267,606**	**1,267,606**	**1,267,606**	**1,267,606**	**1,267,606**	**1,267,606**	**1,267,606**	**1,267,606**	**1,267,606**	**528,169**

Individual Propco

Heading	Mar-26 Year 1	Mar-27 Year 2	Mar-28 Year 3	Mar-29 Year 4	Mar-30 Year 5	Mar-31 Year 6	Mar-32 Year 7	Mar-33 Year 8	Mar-34 Year 9	Mar-35 Year 10	Mar-36 Year 11
Additional Staff	54,123	92,783	92,783	92,783	92,783	92,783	92,783	92,783	92,783	92,783	38,659
Other staff costs	0	0	0	0	0	0	0	0	0	0	0
Other Pay	0	0	0	0	0	0	0	0	0	0	0
Non-Pay (Audit, insurance, legal, contingency)	8,750	15,000	15,000	15,000	15,000	15,000	15,000	15,000	15,000	15,000	6,250
Total	**62,873**	**107,783**	**107,783**	**107,783**	**107,783**	**107,783**	**107,783**	**107,783**	**107,783**	**107,783**	**44,909**

Staff Costs

Price Base Assumptions:

Model Price Base: 24/25

	Pay	Non-Pay
25/26 Inflation	2.80%	2.00%

On-Costs Assumptions

Employer Pension Contribution	14.38%
Employers NIC (New Rate)	15.00%
NIC Threshold (New Rate)	5,000

AfC Pay Rates

24/25 Prices

Band	Scale Point Bottom	Mid	Top
Band 2	23,615	23,615	23,615
Band 3	24,071	24,873	25,674
Band 4	26,530	27,822	29,114
Band 5	29,970	32,324	36,483
Band 6	37,338	39,405	44,962
Band 7	46,148	48,526	52,809
Band 8a	53,755	56,454	60,504
Band 8b	62,215	66,246	72,293
Band 8c	74,290	78,814	85,601
Band 8d	88,168	93,572	101,677
Band 9	105,385	111,740	121,271

Assumed 25/26 Prices

Scale Point Bottom	Mid	Top
24,276	24,276	24,276
24,745	25,569	26,393
27,273	28,601	29,929
30,809	33,229	37,505
38,383	40,508	46,221
47,440	49,885	54,288
55,260	58,035	62,198
63,957	68,101	74,317
76,370	81,021	87,998
90,637	96,192	104,524
108,336	114,869	124,667

Baseline Costs

Summary

Period: 24/25

Heading	DCH	DHC	UHD	Total
Pay	9,792,857	12,942,107	25,297,641	**48,032,605**
Non-Pay	10,239,894	11,516,058	32,071,722	**53,827,674**
Income	-2,762,704	-461,286	-7,830,590	**-11,054,579**
Total	**17,270,047**	**23,996,879**	**49,538,774**	**90,805,700**
% Share	19%	26%	55%	**100%**

Post CIP Baseline

	Do Nothing	Full Shared Service
Assumed Annual CIP (-)		
Years 1-5	-1.0%	-1.0%
Year 6+	-1.0%	-1.0%

Active Year Weight	0.583333333	1	1	1	1	1	1	1	1	1	0.416666667

Cumulative Baseline (Pre-CIP)

Heading	Mar-26 Year 1	Mar-27 Year 2	Mar-28 Year 3	Mar-29 Year 4	Mar-30 Year 5	Mar-31 Year 6	Mar-32 Year 7	Mar-33 Year 8	Mar-34 Year 9	Mar-35 Year 10	Mar-36 Year 11
Do Nothing	90,805,700	90,805,700	90,805,700	90,805,700	90,805,700	90,805,700	90,805,700	90,805,700	90,805,700	90,805,700	90,805,700
Full Shared Service	90,805,700	90,805,700	90,805,700	90,805,700	90,805,700	90,805,700	90,805,700	90,805,700	90,805,700	90,805,700	90,805,700

Cumulative Baseline (Post-CIP)

Heading	Mar-26 Year 1	Mar-27 Year 2	Mar-28 Year 3	Mar-29 Year 4	Mar-30 Year 5	Mar-31 Year 6	Mar-32 Year 7	Mar-33 Year 8	Mar-34 Year 9	Mar-35 Year 10	Mar-36 Year 11
Do Nothing	89,897,643	88,998,666	88,108,680	87,227,593	86,355,317	85,491,764	84,636,846	83,790,478	82,952,573	82,123,047	81,301,817
Full Shared Service	89,897,643	89,554,870	84,915,703	80,909,750	78,397,538	75,789,883	75,031,984	74,281,664	73,538,848	72,803,459	72,075,424

Cumulative CIPs

Heading	Mar-26 Year 1	Mar-27 Year 2	Mar-28 Year 3	Mar-29 Year 4	Mar-30 Year 5	Mar-31 Year 6	Mar-32 Year 7	Mar-33 Year 8	Mar-34 Year 9	Mar-35 Year 10	Mar-36 Year 11
Do Nothing	-908,057	-1,807,033	-2,697,020	-3,578,107	-4,450,383	-5,313,936	-6,168,854	-7,015,222	-7,853,127	-8,682,653	-9,503,883
Full Shared Service	-908,057	-1,812,652	-2,670,386	-3,487,656	-4,279,551	-5,045,105	-5,803,004	-6,553,324	-7,296,140	-8,031,529	-8,759,563

Benefits Summary

Live Scenario: Expected

Summary Analysis (Real)

Active Year Weight	0.583333333	1	1	1	1	1	1	1	1	1	0.416666667

Do Nothing

Heading	Mar-26 Year 1	Mar-27 Year 2	Mar-28 Year 3	Mar-29 Year 4	Mar-30 Year 5	Mar-31 Year 6	Mar-32 Year 7	Mar-33 Year 8	Mar-34 Year 9	Mar-35 Year 10	Mar-36 Year 11
CRB	0	0	0	0	0	0	0	0	0	0	0
NRCB	0	0	0	0	0	0	0	0	0	0	0
SB	0	0	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Full Shared Service

Heading	Mar-26 Year 1	Mar-27 Year 2	Mar-28 Year 3	Mar-29 Year 4	Mar-30 Year 5	Mar-31 Year 6	Mar-32 Year 7	Mar-33 Year 8	Mar-34 Year 9	Mar-35 Year 10	Mar-36 Year 11
Cash Releasing Benefit CRB	411,708	4,487,217	7,675,900	9,396,218	11,238,318	11,238,318	11,238,318	11,238,318	11,238,318	11,238,318	4,682,633
Non-cash releasing benefit NRCB	524,233	1,797,372	2,467,308	3,137,244	3,137,244	3,137,244	3,137,244	3,137,244	3,137,244	3,137,244	1,307,185
Societal Benefits	0	66,864	133,727	200,591	267,454	267,454	267,454	267,454	267,454	267,454	111,439
Total	**935,941**	**6,351,453**	**10,276,935**	**12,734,052**	**14,643,016**	**14,643,016**	**14,643,016**	**14,643,016**	**14,643,016**	**14,643,016**	**6,101,257**

Do Nothing

Cash Releasing Benefits (CRB)

Heading	Mar-26 Year 1	Mar-27 Year 2	Mar-28 Year 3	Mar-29 Year 4	Mar-30 Year 5	Mar-31 Year 6	Mar-32 Year 7	Mar-33 Year 8	Mar-34 Year 9	Mar-35 Year 10	Mar-36 Year 11
1. Dedicated Company Structure	0	0	0	0	0	0	0	0	0	0	0
2. Dedicated Board Leadership	0	0	0	0	0	0	0	0	0	0	0
3. Freedom To Operate	0	0	0	0	0	0	0	0	0	0	0
4. Commercial Drive	0	0	0	0	0	0	0	0	0	0	0
5. Dedicated Workforce	0	0	0	0	0	0	0	0	0	0	0
6. Asset Management	0	0	0	0	0	0	0	0	0	0	0
7. Value For Money	0	0	0	0	0	0	0	0	0	0	0
8. Shared Procurement Service	0	0	0	0	0	0	0	0	0	0	0
9. Services Management	0	0	0	0	0	0	0	0	0	0	0
10.Strategic Focus	0	0	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Non-Cash Releasing Benefits (NCRB)

Heading	Mar-26 Year 1	Mar-27 Year 2	Mar-28 Year 3	Mar-29 Year 4	Mar-30 Year 5	Mar-31 Year 6	Mar-32 Year 7	Mar-33 Year 8	Mar-34 Year 9	Mar-35 Year 10	Mar-36 Year 11
1. Dedicated Company Structure	0	0	0	0	0	0	0	0	0	0	0
2. Dedicated Board Leadership	0	0	0	0	0	0	0	0	0	0	0
3. Freedom To Operate	0	0	0	0	0	0	0	0	0	0	0
4. Commercial Drive	0	0	0	0	0	0	0	0	0	0	0
5. Dedicated Workforce	0	0	0	0	0	0	0	0	0	0	0
6. Asset Management	0	0	0	0	0	0	0	0	0	0	0
7. Value For Money	0	0	0	0	0	0	0	0	0	0	0
8. Shared Procurement Service	0	0	0	0	0	0	0	0	0	0	0
9. Services Management	0	0	0	0	0	0	0	0	0	0	0
10.Strategic Focus	0	0	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Societal Benefits (SB)

Heading	Mar-26 Year 1	Mar-27 Year 2	Mar-28 Year 3	Mar-29 Year 4	Mar-30 Year 5	Mar-31 Year 6	Mar-32 Year 7	Mar-33 Year 8	Mar-34 Year 9	Mar-35 Year 10	Mar-36 Year 11
1. Dedicated Company Structure	0	0	0	0	0	0	0	0	0	0	0
2. Dedicated Board Leadership	0	0	0	0	0	0	0	0	0	0	0
3. Freedom To Operate	0	0	0	0	0	0	0	0	0	0	0
4. Commercial Drive	0	0	0	0	0	0	0	0	0	0	0
5. Dedicated Workforce	0	0	0	0	0	0	0	0	0	0	0
6. Asset Management	0	0	0	0	0	0	0	0	0	0	0
7. Value For Money	0	0	0	0	0	0	0	0	0	0	0
8. Shared Procurement Service	0	0	0	0	0	0	0	0	0	0	0
9. Services Management	0	0	0	0	0	0	0	0	0	0	0
10.Strategic Focus	0	0	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Full Shared Service

Cash Releasing Benefits (CRB)

Heading	Mar-26 Year 1	Mar-27 Year 2	Mar-28 Year 3	Mar-29 Year 4	Mar-30 Year 5	Mar-31 Year 6	Mar-32 Year 7	Mar-33 Year 8	Mar-34 Year 9	Mar-35 Year 10	Mar-36 Year 11
1. Dedicated Company Structure	0	0	0	0	0	0	0	0	0	0	0
2. Dedicated Board Leadership	0	0	0	0	0	0	0	0	0	0	0
3. Freedom To Operate	0	0	0	0	0	0	0	0	0	0	0
4. Commercial Drive	114,844	414,807	632,739	829,614	829,614	829,614	829,614	829,614	829,614	829,614	345,672
5. Dedicated Workforce	0	0	0	0	0	0	0	0	0	0	0
6. Asset Management	0	0	0	0	0	0	0	0	0	0	0
7. Value For Money	0	0	0	0	0	0	0	0	0	0	0
8. Shared Procurement Service	296,864	3,917,284	6,732,908	8,101,225	9,788,199	9,788,199	9,788,199	9,788,199	9,788,199	9,788,199	4,078,416
9. Services Management	0	155,127	310,253	465,380	620,506	620,506	620,506	620,506	620,506	620,506	258,544
10.Strategic Focus	0	0	0	0	0	0	0	0	0	0	0
Total	**411,708**	**4,487,217**	**7,675,900**	**9,396,218**	**11,238,318**	**11,238,318**	**11,238,318**	**11,238,318**	**11,238,318**	**11,238,318**	**4,682,633**

Non-Cash Releasing Benefits (NCRB)

Heading	Mar-26 Year 1	Mar-27 Year 2	Mar-28 Year 3	Mar-29 Year 4	Mar-30 Year 5	Mar-31 Year 6	Mar-32 Year 7	Mar-33 Year 8	Mar-34 Year 9	Mar-35 Year 10	Mar-36 Year 11
1. Dedicated Company Structure	0	0	0	0	0	0	0	0	0	0	0
2. Dedicated Board Leadership	0	0	0	0	0	0	0	0	0	0	0
3. Freedom To Operate	133,438	457,500	457,500	457,500	457,500	457,500	457,500	457,500	457,500	457,500	190,625
4. Commercial Drive	80,393	275,634	413,451	551,267	551,267	551,267	551,267	551,267	551,267	551,267	229,695
5. Dedicated Workforce	144,210	494,436	741,653	988,871	988,871	988,871	988,871	988,871	988,871	988,871	412,030
6. Asset Management	0	0	0	0	0	0	0	0	0	0	0
7. Value For Money	0	0	0	0	0	0	0	0	0	0	0
8. Shared Procurement Service	0	0	0	0	0	0	0	0	0	0	0
9. Services Management	166,192	569,803	854,704	1,139,605	1,139,605	1,139,605	1,139,605	1,139,605	1,139,605	1,139,605	474,835
10.Strategic Focus	0	0	0	0	0	0	0	0	0	0	0
Total	**524,233**	**1,797,372**	**2,467,308**	**3,137,244**	**3,137,244**	**3,137,244**	**3,137,244**	**3,137,244**	**3,137,244**	**3,137,244**	**1,307,185**

Societal Benefits (SB)

Heading	Mar-26 Year 1	Mar-27 Year 2	Mar-28 Year 3	Mar-29 Year 4	Mar-30 Year 5	Mar-31 Year 6	Mar-32 Year 7	Mar-33 Year 8	Mar-34 Year 9	Mar-35 Year 10	Mar-36 Year 11
1. Dedicated Company Structure	0	0	0	0	0	0	0	0	0	0	0
2. Dedicated Board Leadership	0	0	0	0	0	0	0	0	0	0	0
3. Freedom To Operate	0	0	0	0	0	0	0	0	0	0	0
4. Commercial Drive	0	0	0	0	0	0	0	0	0	0	0
5. Dedicated Workforce	0	0	0	0	0	0	0	0	0	0	0
6. Asset Management	0	0	0	0	0	0	0	0	0	0	0
7. Value For Money	0	0	0	0	0	0	0	0	0	0	0
8. Shared Procurement Service	0	0	0	0	0	0	0	0	0	0	0
9. Services Management	0	66,864	133,727	200,591	267,454	267,454	267,454	267,454	267,454	267,454	111,439
10.Strategic Focus	0	0	0	0	0	0	0	0	0	0	0
Total	**0**	**66,864**	**133,727**	**200,591**	**267,454**	**267,454**	**267,454**	**267,454**	**267,454**	**267,454**	**111,439**

2. Dedicated Board Leadership

Benefits Summary

Live Scenario: Expected

Benefit Description	Benefit Number	Benefit Lead	Evidence Base	Benefit Calculation Basis	Economic Case Benefit	Economic Case Benefit Flag	Benefit Type	Annual Benefit Value (£000s)		
								Downside	Expected	Upside
Focus on concentrated business activities enables recruitment of enables recruitment of Executive and Non-Executive Directors with related experience	A	HR Leads	Enabling of benefits below		Yes	1	Enabling			
Greater assurance, less reactive compliance to regulators	B	HR Leads	3 year improvement trajectory measured by ERIC, PLACE, other KPIs		Yes	1	Enabling			
	C				Yes	1				
	D				Yes	1				
	E				Yes	1				
	F				Yes	1				
	G				Yes	1				
	H				Yes	1				
	I				Yes	1				
	J				Yes	1				

Notes:
1. Use the assumption cells shaded in yellow to iterate the benefit type, relative achievement by option and phasing.
2. The underlying benefit value is derived from the individual benefits quantification below.
3. The phasing assumption refers to the run rate and should not be confused with the part-year effect for an in-year operational start which is adjusted in the Global Assumptions worksheet.
4. For simplicity, all phasing is assumed to have reached maturity by year 5.
5. If the Economic case benefit' assumption is set to 'No', this means the benefit is ineligible for inclusion in the economic case (e.g. VAT, capital charges, sunk costs, transfer payments, inflation) but that any cash releasing savings associated with this benefit will carry across to the financial case.
6. All benefits have been calculated on a net return basis rather than gross with offsetting costs being incorporated into the cost model.

2. Dedicated Board Leadership

Benefits Summary

Live Scenario: Expected

Benefit Description	Benefit Number	Benefit Lead	Evidence Base	Benefit Calculation Basis	Economic Case Benefit	Economic Case Benefit Flag	Benefit Type	Annual Benefit Value (£000s)		
								Downside	Expected	Upside
Focus on concentrated business activities enables recruitment of enables recruitment of Executive and Non-Executive Directors with related experience	A	HR Leads	Enabling of benefits below		Yes	1	Enabling			
Greater assurance, less reactive compliance to regulators	B	HR Leads	3 year improvement trajectory measured by ERIC, PLACE, other KPIs		Yes	1	Enabling			
	C				Yes	1				
	D				Yes	1				
	E				Yes	1				
	F				Yes	1				
	G				Yes	1				
	H				Yes	1				
	I				Yes	1				
	J				Yes	1				

Notes:
1. Use the assumption cells shaded in yellow to iterate the benefit type, relative achievement by option and phasing.
2. The underlying benefit value is derived from the individual benefits quantification below.
3. The phasing assumption refers to the run rate and should not be confused with the part-year effect for an in-year operational start which is adjusted in the Global Assumptions worksheet.
4. For simplicity, all phasing is assumed to have reached maturity by year 5.
5. If the Economic case benefit' assumption is set to 'No', this means the benefit is ineligible for inclusion in the economic case (e.g. VAT, capital charges, sunk costs, transfer payments, inflation) but that any cash releasing savings associated with this benefit will carry across to the financial case.
6. All benefits have been calculated on a net return basis rather than gross with offsetting costs being incorporated into the cost model.

3. Freedom To Operate

Benefits Summary

Live Scenario: Expected

Benefit Description	Benefit Number	Benefit Lead	Evidence Base	Benefit Calculation Basis	Economic Case Benefit	Economic Case Benefit Flag	Benefit Type	Annual Benefit Value (£000s)		
								Downside	Expected	Upside
Quicker decision making will reduce exposure to inflation	A	Andrew Monahan	current approval process could be reduce by 1-2 months as dedicated Board and processes are streamlined. Construction bidders typically prefer a faster, reliable bid response. On current capital programme,	Assume reduced slippage which lowers inflation exposure and enables greater output from allocated budgets. See table below.	Yes	1	NCRB	162,667	183,000	203,333
Ability to deploy resources more flexibly will improve the efficiency of capital expenditure	B	Andrew Monahan	Current annual capital programme value. Apply design guide standardisation across this, linked with and faster response time to queries.	Assume an efficiency factor, very prudently 1%, which increase the outputs that can be delivered from a given budget.	Yes	1	NCRB	244,000	274,500	305,000
Freedom to seek out supplementary sources of income	C	Richard Renaut	Greater management independence will enable more focus on developing new sources of income generation and operating more commercially.	See other benefits eg retail income.	Yes	1	Enabling			
Greater adoption of supporting technology such as AI tools, RFID asset tracking, intelligence based prevenative maintenance.	D	David McLaughlin	Enabling for future savings and product developments	Individual business cases more likey to be developed, and sooner	Yes	1	Enabling			
	E				Yes	1				
	F				Yes	1				
	G				Yes	1				
	H				Yes	1				
	I				Yes	1				
	J				Yes	1				

Notes:
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3. The phasing assumption refers to the run rate and should not be confused with the part-year effect for an in-year operational start which is adjusted in the Global Assumptions worksheet.
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6. All benefits have been calculated on a net return basis rather than gross with offsetting costs being incorporated into the cost model.

4. Commercial Drive

Benefits Summary

Live Scenario: Expected

Benefit Description	Benefit Number	Benefit Lead	Evidence Base	Benefit Calculation Basis	Economic Case Benefit	Economic Case Benefit Flag	Benefit Type	Annual Benefit Value (£000s)		
								Downside	Expected	Upside
Reduce contractor expenditure by expanding the inhouse team	A	Bernard Bhukal	Economies of scale enable greater sub-specialisation and reduced need for external contractors through additional recruitment	Assume that contractor premium costs can be saved by substitution	Yes	1	NCRB	490,016	551,267	612,519
Generate additional income by focusing on the under provision of services to primary care and care homes.	B	Steve Killen	Local GPs unable to get quotes, let alone work done, that meets healthcare standards. ICS investment often underspent.	Assume a total market size of £5M from new builds to minor works. 50% market share and a pre-tax margin of 15%	Yes	1	CRB	300,000	337,500	375,000
Generate consultancy income by providing capital project management expertise to other organisations	C	Steve Killen	Commerical project management costs typically have 100% mark up, directly or indirectly charged. NHP & other schemes have significant growth, and major market shortfall in experienced NHS PMs.	Assume potential sales of £1M p.a. at only 30% margin.	Yes	1	CRB	240,000	270,000	300,000
Rationalise the catering offer in the NHS and then expand to other organisations	E	Stuart Willes	Exploit spare capacity following recent investment in Central Production Kitchen, enabling a high marginal profit due to economies of scale	Assume 200,000 additional meals at a £1 margin per meal. (NB above the extra sales already planned).	Yes	1	CRB	160,000	180,000	200,000
Greater focus on investment and service improvement of retail services	D	Stuart Willes	Develop strategy and implementation plan to increase retail margins through in investment facilities, systems and purchasing, and working at scale.	10% up on current incomes, mostly by improving margins	Yes	1	CRB	37,434	42,114	46,793
	F				Yes	1				
	G				Yes	1				
	H				Yes	1				
	I				Yes	1				
	J				Yes	1				

Notes:
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6. All benefits have been calculated on a net return basis rather than gross with offsetting costs being incorporated into the cost model.

5. Dedicated Workforce

Benefits Summary

Live Scenario: Expected

Benefit Description	Benefit Number	Benefit Lead	Evidence Base	Benefit Calculation Basis	Economic Case Benefit	Economic Case Benefit Flag	Benefit Type	Annual Benefit Value (£000s)		
								Downside	Expected	Upside
AfC banding and terms & conditions move to best of legacy Trusts, (funding included in costs), improving recruitment and retention.	A	HR	Enabling of benefits below		Yes	1	Enabling			
Streamlined decision making will enable faster approval of recruitment	B	HR	Enabling of benefits below		Yes	1	Enabling			
Greater focus on the delivery of good workplace culture, & good HR process, will lead to reduced staff turnover and sickness.	C	HR	There is strong evidence (Prof West et al) + improvement methodology (Patient First) of improved staff morale and thus attendance rates	As a proxy assume a % reduction in overall pay costs to reflect composite reduced turnover and sickness levels. See table below. Treat as quality (non-cashable)	Yes	1	NCRB	384,261	432,293	480,326
Economies of scale allows more entry level & development roles which will reduce turnover by lowering average age of workforce	D	David McLaughlin	The current high average age of the workforce will lead to higher turnover through retirement. Vacancies lead to a reduced delivery of benefits.	Entry level and then developed staff expected to lead to reduction in vacancies, improve service quality and better work environment (as less covering for vacancies). Treat as quality gain (non-cashable)	Yes	1	NCRB	187,327	210,743	234,159
Increased use of task allocation and management systems will decrease required staff time and enable greater outputs or savings	E	David McLaughlin	Improved productivity allows higher service quality, (and/or reduce use of contractor or other staff costs). This saving can either be taken as a cash releasing, but assumed as non-cashable.	Apply efficiency improvement factor to pay costs. See table below.	Yes	1	NCRB	307,409	345,835	384,261
	F				Yes	1				
	G				Yes	1				
	H				Yes	1				
	I				Yes	1				
	J				Yes	1				

Notes:
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2. The underlying benefit value is derived from the individual benefits quantification below.
3. The phasing assumption refers to the run rate and should not be confused with the part-year effect for an in-year operational start which is adjusted in the Global Assumptions worksheet.
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6. All benefits have been calculated on a net return basis rather than gross with offsetting costs being incorporated into the cost model.

6. Asset Management

Benefits Summary

Live Scenario: Expected

Benefit Description	Benefit Number	Benefit Lead	Evidence Base	Benefit Calculation Basis	Economic Case Benefit	Economic Case Benefit Flag	Benefit Type	Annual Benefit Value (£000s) Downside	Expected	Upside
Better fill rate of accommodation through improved maintenance and more regular rent reviews	A	Norman Gillespie	Better maintenance and booking of rental properties, plus opening to all Dorset staff, will improve occupancy rates and enable increase in rental rates	Assume an increase in occupancy rates and uplift in rental values (see table). Also wider beenfit in more staff house in lower than market rate accomodation.	Yes	1	CRB	205,818	231,546	257,273
	B				Yes	1				
	C				Yes	1				
	D				Yes	1				
	E				Yes	1				
	F				Yes	1				
	H				Yes	1				
	I				Yes	1				
	J				Yes	1				

Notes:
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3. The phasing assumption refers to the run rate and should not be confused with the part-year effect for an in-year operational start which is adjusted in the Global Assumptions worksheet.
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6. All benefits have been calculated on a net return basis rather than gross with offsetting costs being incorporated into the cost model.

7. Value For Money

Benefits Summary

Live Scenario: Expected

Benefit Description	Benefit Number	Benefit Lead	Evidence Base	Benefit Calculation Basis	Economic Case Benefit	Economic Case Benefit Flag	Benefit Type	Annual Benefit Value (£000s) Downside	Expected	Upside
VAT recovery on revenue expenditure	A	Andrew Monahan	Current VAT paid has been analysed. As the tax regime may change in future, this is left as upside only benefit.	See detailed analysis provided by Colbeck Brighton, summary table below,	No	0	CRB	0	0	14,203,184
VAT recovery on retrospective Capital Goods Scheme(CGS) expenditure	B	Andrew Monahan	Historic VAT paid on CGS for past 9 years estimated. As historic claims unlikley to be changed, even if tax regime changes prospectively, this has been included in base case. It is though a non-recurrent benefit. Default assumption is it would be released over 9 years by HMRC.	See detailed analysis provided by Colbeck Brighton	No	0	CRB	54,808,000	61,659,000	68,510,000
VAT recovery on prospective capital expenditure	C	Andrew Monahan	Medium Term capital programme estimated spend. Improved buying power is a capital benefit (so listed as NCRB). This may improve revenue position e.g. improved productivity following investment, but this will be part of the business case. So assume £0 revenue benefit for this case.	See detailed analysis provided by Colbeck Brighton.	Yes	1	NCRB	0	0	0
Revaluation of buildings to reduce PDC dividends costs	D	Rob Kirkpatrick	Valuations of buildings are understood to be base upon rebuild costs. Therefore, there is potential to reduce valuations on the assumption that VAT will be recovered. This enable a reduction in the PDC dividend.	3.5% PDC dividend saving on the reduced valuation. This benefit might not be relaised and so is only in upside scenario.	No	0	CRB	0	0	2,452,240
	E				Yes	1	CRB			
	F				Yes	1	NCRB			
	G				Yes	1	CRB			
	H				Yes	1	SB			
	I				Yes	1				
	J				Yes	1				

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8. Shared Procurement Service

Benefits Summary

Live Scenario: Expected

Benefit Description	Benefit Number	Benefit Lead	Evidence Base	Benefit Calculation Basis	Economic Case Benefit	Economic Case Benefit Flag	Benefit Type	Annual Benefit Value (£000s) Downside	Expected	Upside
Single purchasing, strategic supply chain management etc	A	Louise Betteridge	Procurement business case, advised by Capita.	Detailed annualised savings per supporting workbook led by Capita	Yes	1	CRB	6,984,867	9,788,199	16,177,398
Investment in inventory control systems to reduce stock levels	B	Louise Betteridge	Better inventory control would enable a one-off reduction in stock levels and thereby generate a non-recurring reduction in expenditure	Assume implemented in Year 3 with the aim of reducing stock levels net off the cost of investment	Yes	1	CRB	444,113	499,627	555,141
Improved career prospects through economies of scale and strengthened leadership	C	Louise Betteridge	Enabled by the procurement business case	Assume unquantified	Yes	1	UB			
	E				Yes	1				
	F				Yes	1				
	G				Yes	1				
	H				Yes	1				
	I				Yes	1				
	J				Yes	1				

Notes:
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9. Services Management

Benefits Summary

Live Scenario: Expected

Benefit Description	Benefit Number	Benefit Lead	Evidence Base	Benefit Calculation Basis	Economic Case Benefit	Economic Case Benefit Flag	Benefit Type	Annual Benefit Value (£000s)		
								Downside	Expected	Upside
Improved comprehensive approach to energy efficiency	A	George Atkinson	Phased progression to median ERIC benchmarks and adoption of NZC energy efficency and generation. Costs post-investment in enabling measures such as insulation, BMS, PVs	Assumed % improvement on 23/24 ERIC return consumption data net of any capex investment. See tbale below.	Yes	1	CRB	444,113	499,627	555,141
					Yes	1	SB	237,737	267,454	297,171
Reduce single use item waste	B	Stuart lane	Green wards and theatre pilots show significant opportunities. Also progress in waste separation, to avoid high cost disposals.	Reduction in purchase costs, plus waste disposal costs. Potential social value of landfill avoidance. See table below for workings.	Yes	1	CRB	107,448	120,879	134,310
Greater focus on the delivery of KPI performance / customer centric culture, leads to saving 2 minutes per week per member of staff but cutting non-value adding E&F or procurement issues	C	Bernard Bhukal /David McLaughlin	3 year improvement trajectory measured by ERIC, PLACE, other KPIs, by redcued staff time requesting or navigating EFMP processes.	Assume a 0.01% reduction in overall pay costs to reflect the composite impact of reduced staff time wasted, but left as non-cashable as no headcount reduction.	Yes	1	NCRB	846,734	952,576	1,058,418
Improved customer focus will enable more effective navigation of hospitals for patients and staff, from parking to wayfinding.	D	Bernard Bhukal /David McLaughlin	See table below, total number of DNAs, and assuming 0.25% improvement. Does not include other activity e.g. scans, procedures etc, and does not count late arrivals that may impact on list productivity.	Very prudent estimate of the potential of improvement in these areas. Left as non-cashable, but easily able to convert via tariff income, or reduced need for extra activity to offset avoidable DNAs.	Yes	1	NCRB	32,327	36,368	40,409
Reduction in food waste	E	Stuart Willes	Reduced food waste due to controlled portion sizes and standardised menu templates	Assumed reduction in inpatient ingredient costs from EIC returns	Yes	1	NCRB	133,921	150,661	167,401
	F				Yes	1				
	G				Yes	1				
	H				Yes	1				
	I				Yes	1				
	J				Yes	1				

Notes:
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6. All benefits have been calculated on a net return basis rather than gross with offsetting costs being incorporated into the cost model.

10.Strategic Focus

Benefits Summary

Live Scenario: Expected

Benefit Description	Benefit Number	Benefit Lead	Evidence Base	Benefit Calculation Basis	Economic Case Benefit	Economic Case Benefit Flag	Benefit Type	Annual Benefit Value (£000s)		
								Downside	Expected	Upside
Sustainablity / Green NHS Dorset single approach strengthens governance through more specialist expertise and systems, increasing impact	A	Stuart Lane	Sustainable Develop Assessment Tool (SDAT) measures impact across all domains (most of which are held by EFMP services)	Enabling benefit for	Yes	1	Enabling			
Other benefits references in Full Business Case, including key worker housing, geothermal energy and other strategic benefits from operating at scale, with dedicated longterm thinking.	B	Richard Renaut	Initial work on Wessex Fields masterplan for key worker housing and green energy.	Enabling as will require separate business case.	Yes	1	Enabling			
	C				Yes	1				
	D				Yes	1				
	E				Yes	1				
	F				Yes	1				
	G				Yes	1				
	H				Yes	1				
	I				Yes	1				
	J				Yes	1				

Notes:
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4. For simplicity, all phasing is assumed to have reached maturity by year 4.
5. If the Economic case benefit' assumption is set to 'No', this means the benefit is ineligible for inclusion in the economic case (e.g. VAT, capital charges, sunk costs, transfer payments, inflation) but that any cash releasing savings associated with this benefit will carry across to th
6. All benefits have been calculated on a net return basis rather than gross with offsetting costs being incorporated into the cost model.

Equality Impact Assessment

This section should refer to the equality impact assessment and the assessment should be attached as an annex to the 'procedural document'.

1. Title of document	**OUR DORSET PROVIDER COLLABORATIVE:** **SHARED SERVICES: Estates, Facilities Management and Procurement** **Equality Impact Assessment**
2. Date of EIA	May 2025
3. Date for review	Recommended 6 months after set up of the company
4. Directorate/Specialty	Estates, facilities management and procurement staff in DHC, DCH and UHD are all impacted by the proposal to set up a wholly owned subsidiary company.

5. Does the document/service affect one group less or more favorably than another on the basis of:

	Yes/No	Rationale	Mitigation
Introduction		In setting up a wholly owned subsidiary (WOS) company for the delivery of Estates, Facilities management and Procurement services all three Trusts have made a firm commitment that pay, terms and conditions will remain the same and aligned to the NHS and Agenda for Change terms and conditions, including continuous service and wider benefits such as salary sacrifice schemes. The Transfer of the EFMP services to a subsidiary wholly owned by the three NHS Dorset Trusts will offer the same employment terms and conditions to all staff regardless of their protected characteristics.	
• Age – where this is referred to, it refers to a person belonging to a particular age or range of ages.	No	· **Impact on pension rights and financial security:** Older employees might have significant concerns regarding how the SubCo structure affects their pension rights and overall financial security. While TUPE generally provides initial contractual protection, any future adjustments or divergences in pension arrangements, terms of service, or	Current guidance from the DHSC indicates that it is highly likely that the WOS can successfully apply for an Open Direction order which will allow transferring and

		financial entitlements could disproportionately impact older workers, who often have fewer alternative employment opportunities and limited time remaining to make alternative financial provisions. · **Loss of seniority or perceived reduction in career stability:** Long-serving employees, typically older staff, might perceive a SubCo transition as diminishing the value of their seniority and accumulated benefits. Even if legal rights are protected, the psychological impact of feeling undervalued or separated from core NHS identity can lead to decreased motivation, reduced engagement, and early retirement decisions. · **Challenges in adapting to organisational change:** Older staff, particularly those who have spent significant portions of their careers within the NHS, may find the cultural shift to a separate SubCo challenging. This could lead to feelings of alienation, reduced morale, and difficulties adapting to new workplace cultures or operational methods. · **Impact of relocation and multi-site working:** If the SubCo involves changes to working locations or an increased requirement to travel between multiple Trust sites, older employees might face greater difficulties due to mobility issues, increased commuting burdens, or reduced flexibility in adjusting routines. This could disproportionately impact those reliant on existing transportation arrangements, car-sharing agreements, or public transport routes. · **Training and technological adaptation pressures:** Any requirement for new skills training, technology adoption or significant process changes might disproportionately affect older workers,	new employees to join the NHS Pension scheme. Further assurances on access to NHS Pensions are being sought from the NHS Pension Services Agency and a recommendation to apply for a 'Letter of Comfort' guaranteeing access to the pension scheme is being sought. The WOS will have a People Plan that will outline the OD initiatives and support for staff to support the transfer and integration of the new company. The vast majority of staff will work in the same location and with the same teams. Full support will be provided to all staff to support with any

		who may require additional support, time, or tailored training approaches. Without specific accommodations, older staff could feel excluded or disadvantaged, potentially resulting in lower retention and diminished job satisfaction. · **Intersectionality with health and disability:** Many older employees might also experience age-related health conditions or disabilities. Changes to physical working conditions, increased commuting distances, altered job roles, or facilities restructuring could exacerbate existing health conditions, thus indirectly discriminating against older workers.	new training requirements. As staff will transfer on their current NHS terms and conditions entitlement to sick pay will remain the same along with access to OH support and wellbeing guidance in their place of work.
• Disability – a person has a disability if they have a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal daily activities.	No	· **Physical accessibility:** Changes in workplace location or the introduction of multi-site working could have implications for staff with physical disabilities. Established accessibility arrangements, commuting logistics, adapted facilities or specialised equipment may be impacted by structural changes or changes in work venues. Any increase in travel demands or changes to accessible infrastructure could disproportionately impact disabled employees. · **Reasonable adjustments continuity:** Employees currently benefiting from reasonable adjustments related to disability or chronic health conditions may experience uncertainty regarding the continuity and administrative responsibility for these adjustments	The vast majority of staff will work in the same location and with the same teams as they do currently. All agreed reasonable adjustments will be maintained and reviewed in the normal way.

		post-transition. Unclear arrangements or procedural changes could lead to a period of disruption or re-assessment, creating anxiety and potential practical barriers.	
		· **Occupational health and support services:** Disabled employees often rely significantly on integrated NHS occupational health and wellbeing services. Changes resulting from the creation of a SubCo might affect access to these established resources, causing concern among staff about the consistency of support structures.	Al staff in the WOS will have access to OH services and wider wellbeing support offered.
		· **Impact on neurodiverse employees:** Organisational changes, including new management structures, operational procedures, or working environments, might disproportionately impact neurodiverse staff. Altered routines or unfamiliar processes could exacerbate anxiety or stress for individuals who depend on stable and predictable work arrangements.	Full support will be provided to all staff transferring and we will work with staff networks to help with this support. Continued access and membership to staff networks for staff in WOS will be encouraged.
		· **Mental health implications:** Employees with mental health conditions may find organisational change processes challenging. The potential uncertainty around new working conditions, support structures, or organisational culture could heighten anxiety, stress, or reduce overall wellbeing.	Full support will be provided to all staff transferring and we will work with staff networks to help with this support. OH advice will also be sought on an as needed basis..
		· **Indirect disability-related impacts:** The establishment of a SubCo could indirectly impact disabled staff through potential changes in flexible working arrangements, travel demands or access to inclusive spaces and practices. These impacts could have subtle yet significant implications for day-to-day work experiences.	The vast majority of staff will work in the same location and with the same teams as they do currently.
		· **Representation and consultation:** Disabled employees may experience uncertainty regarding their representation within the new organisational structure. Changes could affect existing disability networks	Full support will be provided to all staff transferring and we will work with staff networks to help with this support. Continued access

		or advocacy frameworks, potentially altering the visibility and strength of disability-related employee voice and representation.	and membership to staff networks for staff in WOS will be encouraged.
• Gender reassignment – the process of transitioning from one gender to another.	No	· **Risk of forced re-outing:** Staff who are transgender or non-binary and have disclosed their gender identity within their current teams may face renewed anxiety if organisational changes (such as new line management structures, relocation to different sites, or new peer groups) require them to re-explain or reassert their identity in unfamiliar environments. This can increase emotional stress and negatively impact psychological safety. · **Uncertainty about policy continuity:** Staff may be concerned whether existing protections (e.g., policies on gender-neutral facilities, support for trans inclusion, transition-at-work protocols) will be mirrored in the SubCo environment or if new variations will apply, requiring additional disclosures or renegotiations. · **Loss of visibility of LGBTQIA+ support:** If SubCo employees are no longer fully integrated into NHS Trust-wide EDIB initiatives, visibility of LGBTQIA+ champions, networks and policies may diminish, creating a perception of reduced organisational commitment to inclusion. · **Practical risks related to facilities:** Estates and Facilities employees frequently access changing rooms, toilets, and shared spaces. Any inconsistencies across the three Trusts regarding availability of gender-neutral facilities, signage, or inclusive environments could directly affect trans and non-binary staff comfort, dignity and safety. · **Wider reputational risk:** Failing to actively safeguard the inclusion of trans and non-binary staff during structural changes could	The vast majority of staff will work in the same location and with the same teams as they do currently. Any line management changes will be managed in the same way as currently happens. Creating psychological safety will continue to be a priority and will be in the draft People Plan for the WOS. Access to and membership of staff networks in their place of work will continue. The vast majority of staff will work in the same location and with the same teams as they do currently. Full care and support will be provided to all staff

		expose the Trusts to significant reputational risks, given the heightened public and political sensitivity around trans rights.	and we work alongside staff networks.
• Marriage and civil partnership – marriage can include a union between a man and a woman and a marriage between a same-sex couple.	No	• **Indirect impact through changes to benefits and entitlements:** While marriage and civil partnership protections under the Equality Act 2010 focus primarily on protection from direct discrimination, organisational changes that affect employment benefits could have an indirect impact. For example, if access to partner-related benefits (e.g., spousal pension rights, special leave entitlements, compassionate leave policies) changes over time within the SubCo, this could disproportionately affect married or civil partnered employees. • **Risk of divergence in family-friendly policies:** If SubCo policies evolve separately from NHS Trust policies over time, there is a risk that benefits related to marriage, civil partnership, and family life (e.g., shared parental leave, bereavement leave) may not remain aligned. Staff currently relying on these provisions might feel their family status is less supported. • **Cultural implications:** Working within a distinctly separate organisation, even if wholly owned by the NHS Trusts, could lead to a perceived weakening of institutional commitments to equality in family life, particularly if SubCo branding, policies, or communications do not mirror NHS EDIB values. • **Potential intersectional impacts:** Staff who are in same-sex marriages or civil partnerships could experience compounded anxiety if LGBTQIA+ inclusion is not made visibly consistent across the SubCo structure, particularly if combined with relocation or changes in line management. • **Childcare logistics:**	All terms and conditions will remain the same. All terms and conditions will remain the same. The WOS will be fully committed to belonging and inclusion and will develop its own strategies and People Plan to support this work. Working closely with staff networks will continue to help inform and guide people plans and strategies.

		Staff with childcare responsibilities (including those currently pregnant or returning from maternity leave) often have finely balanced arrangements involving nursery schedules, school pickups, car sharing, and local family support. Any changes in work location, increased travel distances, or multi-site working requirements could significantly disrupt these arrangements, leading to increased stress, higher childcare costs, and potential barriers to fulfilling work duties. • **Increased travel time and costs:** Employees with family responsibilities may be disproportionately affected if commuting becomes longer, less predictable, or more expensive — particularly if they are already balancing demanding personal schedules. • **Reduced flexibility for emergencies:** Being based further away from home or working across different Trust sites could limit the ability of staff to respond flexibly to family emergencies (e.g., collecting a sick child), potentially disadvantaging those with caregiving roles. • **Gendered impact:** Given that caregiving responsibilities still disproportionately fall to women, this type of change could particularly disadvantage female staff, indirectly impacting gender equality and retention.	The vast majority of staff will work in the same location and with the same teams as they do currently. All terms and conditions will remain the same and in line with AfC terms.
• Pregnancy and maternity – pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after	No	**Uncertainty regarding maternity provisions and entitlements:** Staff who are currently pregnant, on maternity leave, or considering future parental leave might experience uncertainty or concern about the continuity and equivalence of maternity-related provisions within the new SubCo framework. Potential ambiguity around future policy alignment or administrative responsibility for maternity	All terms and conditions and access to SMP and OMP will remain the same. Line managers will continue to support pregnant staff.

the birth and is linked to parental leave in the context of employment. In the non-work context, protection against maternity discrimination is for 26 weeks (about 6 months) after giving birth, and this includes treating a woman or birthing person unfavorably because they are breastfeeding.		entitlements could create anxiety or confusion. · **Impact on flexible working arrangements:** Employees with caregiving responsibilities, particularly those returning from maternity leave or currently pregnant, often rely heavily on flexible working arrangements to balance professional and personal commitments. Any potential structural or procedural changes related to working hours, work patterns, or flexibility arrangements within the SubCo could disproportionately impact this group. · **Accessibility of workplace facilities:** Employees who are pregnant or breastfeeding depend on the consistent availability and suitability of facilities such as quiet rooms, lactation spaces, rest areas, and easily accessible amenities. Changes to facilities management or relocation to other sites could unintentionally disrupt established support and accommodation arrangements. · **Increased commuting or multi-site working challenges:** Potential relocation of workplaces or increased requirements to work across multiple locations could present significant practical challenges for employees who are pregnant or recently returned from maternity leave. Such staff often have established childcare arrangements, family routines or logistical setups which could become disrupted by changes in commuting demands or work locations. · **Potential impacts on career progression and job security perceptions:** Pregnant employees or those returning from maternity leave might perceive increased vulnerability or reduced job security due to organisational restructuring. Any ambiguity or change in job roles, line management structures, or perceived career opportunities within the SubCo	The vast majority of staff will work in the same location and with the same teams as they do currently. All terms and conditions will remain the same and in line with AfC terms. As above As above All staff will be supported in their career development and the WOS will provide better career progression opportunities by virtue of its size an focus of activities.

		may heighten feelings of insecurity or marginalisation among this group. · **Psychological impact and workplace stress:** The period of pregnancy and maternity leave is often associated with heightened emotional vulnerability. Additional stress caused by organisational uncertainty or concerns regarding future employment stability, maternity entitlements, or working arrangements could negatively impact employee mental health and wellbeing. · **Interruption of established support networks:** Employees on maternity leave or returning from it may depend on specific NHS organisational support networks or informal peer relationships. Restructuring processes could disrupt these networks, impacting their perceived social and emotional support upon return.	As above Access to the existing staff networks in their place f work will continue.
• Race – refers to the protected characteristic of Race. It refers to a group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins.	No	- **Disproportionate representation:** Employees from Black, Asian, and minority ethnic backgrounds are often statistically overrepresented within Estates and Facilities Management roles across NHS Trusts. Consequently, structural changes such as moving these services into a SubCo could disproportionately affect ethnic minority staff, creating a perception or experience of increased vulnerability or marginalisation. It will be important to ensure all implementation-related communications are available in accessible formats, including plain English and translated materials where necessary, to support staff for whom English is a second language. · **Career progression and developmental opportunities:** Organisational restructuring may	The WOS will be fully committed to belonging and inclusion and will develop its own strategies and People Plan to support this work. Access to interpreting service and support for those for whom English is a second language will continue. Working closely with staff networks will continue to help inform and guide people plans and strategies. Continued access to staff networks in their place of work

		unintentionally affect established pathways for career progression, mentoring, training, and development, potentially impacting ethnic minority employees who already face documented systemic barriers in accessing equitable career advancement opportunities within large organisations.	As above
		· **Potential disruption of existing staff networks and support structures:** Employees from ethnically diverse backgrounds may currently rely on established NHS ethnic minority networks, peer groups, or informal support arrangements. Transitioning into a SubCo environment may disrupt access to, or visibility of, these existing support mechanisms, potentially reducing employees' sense of inclusion, voice, and organisational belonging.	As above
		· **Differential workplace cultures across sites:** Given the SubCo spans multiple NHS Trust locations, staff from diverse ethnic backgrounds could face varying degrees of inclusion or awareness of cultural sensitivities at different sites. Such inconsistencies may inadvertently create less inclusive working environments for ethnic minority staff at certain locations, leading to feelings of exclusion or isolation.	As above
		· **Perceptions of institutional inclusion:** Transition to a SubCo may unintentionally signal to some employees a perceived reduction in organisational commitment to racial equality and inclusion. Even if policies remain unchanged, the symbolic shift from an NHS Trust structure into a SubCo could potentially be experienced as a less inclusive organisational environment by staff from ethnic minority backgrounds.	As above
		· **Impact of relocation or multi-site working on community ties:** Changes in workplace locations or requirements for staff to move frequently between Trust sites could	The vast majority of staff will remain in their current place of work

		disproportionately impact ethnic minority employees who may have stronger community ties or specific logistical arrangements, including car-sharing, childcare arrangements, or cultural support networks. · **Indirect discrimination risks in policy or procedural divergences:** The introduction of potentially separate HR and operational frameworks within the SubCo could unintentionally result in procedural or policy variations affecting recruitment, selection, training, and performance management. Such variations could disproportionately impact ethnic minority employees if equity and inclusion standards are not consistently maintained.	As above
• Religion and belief – religion has the meaning usually given to it but belief includes religious and philosophical beliefs including lack of belief (such as Atheism). A belief should affect your life choices or the way you live for it to be included in the definition.	No	**Impact on religious observance and facilities:** Employees may currently have access to specific facilities enabling religious observance, such as prayer rooms, quiet spaces, and areas designated for religious activities. Organisational restructuring, changes in estate management, or relocation to different work sites could impact the consistent availability and quality of these facilities, potentially disadvantaging staff who depend on them for regular religious practice. · **Dietary and cultural requirements:** Staff who observe religious dietary practices may experience uncertainty about whether existing catering arrangements will be maintained in the SubCo structure, particularly if there is a change in catering providers, facilities management practices, or physical location. Variations in the provision of appropriate food options could impact staff wellbeing, inclusivity, and morale. · **Working hours and religious commitments:** Changes in shift patterns, working hours, or flexible working arrangements within the SubCo may disproportionately affect employees	The vast majority of staff will remain in their current place of work As above Terms and conditions will remain the same and agreed flexible working arrangements will

		whose religious observance requires attendance at specific times or events. Staff could experience difficulty in balancing professional duties with religious commitments if flexible arrangements become more restricted or differ across various Trust locations.	remain in place and only altered with agreement as is currently the case.
		· **Cultural sensitivity and workplace inclusivity:** Transitioning to a new SubCo structure may inadvertently impact organisational culture regarding religious sensitivity and inclusion. Any shift in managerial responsibility or organisational identity could lead to variations in the understanding, respect, and support of religious diversity across different teams or locations.	The WOS will be fully committed to belonging and inclusion and will develop its own strategies and People Plan to support this work. Access to interpreting service and support for those for whom English is a second language will continue.
		· **Impact of relocation and multi-site working:** Employees who rely on established community networks or local religious communities near their current workplace may experience increased challenges if their working location changes or if their roles become multi-site. This could create logistical difficulties in maintaining religious observance, participation in community events, or sustaining support networks tied to religious identity.	Working closely with staff networks will continue to help inform and guide people plans and strategies. Continued access to staff networks in their place of work.
		· **Perceived changes in organisational commitment:** The creation of a separate SubCo could inadvertently signal to some employees a perceived weakening of organisational commitment to religious inclusion and diversity. Even if policies remain unchanged, subtle shifts in organisational culture or visible support for diverse religious practices may affect employee perceptions and sense of inclusion.	As above
		· **Indirect impact on religious holidays and leave:** If leave entitlements or policies around special leave for religious observance differ or become inconsistent within the new SubCo structure, staff observing specific religious holidays could be disproportionately impacted.	As above

• Sex – a man or a woman.	No	**Impact on flexible working arrangements:** Female employees, who statistically continue to carry disproportionate caregiving responsibilities, could experience heightened impacts if structural changes within the SubCo result in variations to flexible working patterns, shift scheduling, or arrangements for remote work. Potential increases in commuting distance or multi-site working could disrupt finely balanced family logistics, disproportionately affecting women and potentially impacting their ability to remain engaged or maintain current work arrangements. · **Perceptions around job security and career progression:** The restructuring process could inadvertently create a perception of reduced job security or altered career prospects, particularly for female employees in traditionally lower-paid or part-time roles within Estates, Facilities Management, or Procurement. Any uncertainty around future policy alignment, development opportunities, or promotion criteria could disproportionately impact female employees. · **Changes in workplace culture and organisational identity:** Structural transitions into a SubCo may unintentionally affect established workplace cultures regarding gender equity. Potentially altered communication, leadership structures, or organisational identities might impact how inclusive and supportive the workplace feels, particularly for female staff, who may already experience different workplace dynamics and opportunities. · **Consistency in gender equality policies and initiatives:** Female employees may experience uncertainty or concern about whether established NHS gender equality initiatives, gender-specific leadership training programmes, or support networks will remain equally	The vast majority of staff will remain in their current place of work The WOS will be fully committed to belonging and inclusion and will develop its own strategies and People Plan to support this work. Access to interpreting service and support for those for whom English is a second language will continue. The WOS will work closely with staff networks will continue to help inform and guide people plans and strategies. Continued access to staff networks in their place of work. As above

		accessible or applicable within the new SubCo. Any lack of clarity around continuity of these provisions could disproportionately disadvantage women. · **Potential disparity in employment terms and conditions over time:** Although initial contractual protections may be offered through TUPE, female employees could perceive potential future divergence in terms and conditions—such as maternity provisions, family leave policies, or special leave entitlements—as disproportionately impactful. Even subtle changes in conditions or entitlements could significantly affect their employment experiences and wellbeing. · **Impact on pay and reward structures:** Historically, organisational restructuring processes carry an inherent risk of inadvertently affecting pay equity, potentially impacting female staff disproportionately, particularly in roles already subject to structural pay gaps or discrepancies. Ambiguity around future pay reviews or incremental progression mechanisms within the SubCo could exacerbate perceptions or realities of gender-based pay inequalities. · **Work-life balance and emotional wellbeing:** Organisational restructuring could heighten stress or anxiety for female staff balancing complex work and caregiving responsibilities, particularly if changes to workplace location or working arrangements affect existing family routines, childcare arrangements, or community support networks.	All terms and conditions will remain the same and will remain aligned to the AfC terms The WOS will undertake a Gender Pay gap reporting and this will be presented to Board. All staff will be supported in their career development and the WOS will provide better career progression opportunities by virtue of its size and focus of activities. The WOS will work closely with staff networks will continue to help inform and guide people plans and strategies.

• Sexual orientation – whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes.	No	• **TUPE:** Staff who identify as lesbian, gay, bisexual, pansexual or otherwise within the LGBTQIA+ spectrum and who have disclosed their orientation in their current teams may face renewed emotional stress if organisational restructuring leads to new management structures, different work locations, or new peer groups. This can create anxiety about needing to re-establish their identity in unfamiliar environments and uncertainty about levels of acceptance. • **Disruption of psychological safety:** Being "out" at work often depends on the trust and psychological safety built within a known team. A change in employer, even within a wholly-owned NHS SubCo, may disrupt this dynamic and cause staff to reconsider how open they feel they can be about their sexual orientation. • **Concerns over policy consistency and organisational culture:** Staff may worry whether existing LGBTQIA+ supportive policies (such as dignity at work, harassment protections, inclusive language guidance) will be consistently applied within the SubCo, or whether their visibility and protection might diminish outside the direct Trust environment. • **Reduced access to LGBTQIA+ staff networks and initiatives:** If SubCo staff are not automatically and equally included in existing NHS staff networks (e.g., LGBTQIA+ Networks, Pride events, mentoring schemes), they may experience feelings of exclusion and alienation. Maintaining full, active inclusion is crucial. • **Variability across locations:**	The WOS will be fully committed to belonging and inclusion and will develop its own strategies and People Plan to support this work. The WOS will work closely with staff networks will continue to help inform and guide people plans and strategies. Continued access to staff networks in their place of work As above As above As above

		Given the cross-Trust nature of the SubCo, it is possible that staff will work across different geographical sites, where workplace cultures and levels of LGBTQIA+ awareness or support may vary. Without strong, consistent standards, LGBTQIA+ employees may encounter more challenging environments at certain locations. • **Cumulative impacts on wellbeing and retention:** The combined pressures of uncertainty, potential re-outing, and concerns over inclusion could lead to increased stress, reduced engagement, and in some cases, higher turnover among LGBTQIA+ staff.	The vast majority of staff will remain in their current place of work As above.
7. If you have identified potential discrimination, are the exceptions valid, legal and/or justified?	N/A	N/A	
8. If the answers to any of the above questions is 'yes' then:	**Yes**	**Rationale**	
Demonstrate that such a disadvantage or advantage can be justified or is valid.	N/A	N/A	
Adjust the policy to remove disadvantage identified or better promote equality.	N/A	N/A	

KLOE questions for Subsidiary transactions

"Guidance for assuring and supporting complex change – subsidiaries guidance for trusts forming or changing a subsidiary."

KLOE questions are a starting point and will develop from the actual business case.

DRAFT REPLIES. REVIEWERS, please:

- **Is the question answered, yes/no/partly?**
- **If no/partly, how can the question be fully answered?**
- **What evidence, or action needs adding to strengthen the response?**
- **Any major showstoppers or wrong assumptions?**

Strategic rationale

1. *Does the transaction make sense strategically and is it likely to deliver material benefits to the population?*

See strategic case.

The material benefits are identified and quantified in the case based around:

Benefit	Cashable	Non-Cashable	Societal	Enabling
1. **Dedicated Company Structure**				
a. Board Time on EFM/P moves from minimum at FT to main focus of SubCo. b. Customers can enforce terms, separate accounts not "lost" in wider Trust. c. HSE etc. would hold SubCo responsible for the "managed service" provided.				Y Y Y
2. **Dedicated Board leadership, greater client focus**				
a. Execs/NEDs have EFM/P professional qualifications. b. Greater assurance, less reactive compliance to regulators. c. KPIs agreed with Trusts, with expected improvements. d. Customer & patient benefits e.g. wayfinding; single system to report issues etc.		 Y Y Y	 Y Y Y	Y
3. **Freedom to operate and innovate**				
a. Procurements, capital deployments, staffing decisions. b. Able to move resource where needed, shape supply chains etc. c. Take on new services and customers, invest to save, e.g. use of AI and asset tracking tech.		Y Y Y	 Y	Y Y

	4. **Commercial Drive**				
	a. Reduce contractor spend by growing team. b. GP practices unable to get quotes, let alone works done; Care homes, vol sec. c. NHP 10+ year opportunity, on client and supplier side d. At scale purchasing, systems etc. for better service. e. Rationalise catering offer in NHS, then offer to care homes, schools etc.	Y Y Y Y Y	Y Y Y	Y Y Y	
	5. **Dedicated workforce**				
	a. AFC+ to reflect competitive market, RRPs, profit share etc. b. Faster vacancy approvals, consistency checking within SubCo only. c. Strong evidence (Prof West) + improvement methodology (Patient First). d. Scale allows more entry level & development roles, reduce turnover. e. Use of task allocation systems, saving time. f. Recruitment in communities, offer volunteer and work experience.	Y	Y Y Y Y Y	Y Y Y	Y Y Y Y
	6. **Asset Management**				
	a. "Up" time made contractual, so beds, theatres more available. b. Use of community hospitals improved, for rad, endo, clinics etc. c. High transactional cost if separated. d. £750m investment in estate, if not maintained well, will cost more long term. e. Develop expertise, links to utilisation of estates. f. Better fill rate of accommodation; regular rent reviews etc. g. Expertise developed, legal & fees reduced, rents and rates improved.	Y Y	Y Y Y Y Y Y Y	Y Y	
	7. **Value for money duty**				
	a. Current costs will benchmark higher, and duty to address this. b. Outsource (private or subco) instantly lower cost as tax efficient. c. NHP descoped schemes, VAT reclaim means the investment can go ahead. d. If VAT not charged on med kit, buildings, +20% spend power etc.	Y Y Y	Y		Y
	8. **Shared procurement service**				

a. Current pay bill reshaped, new career structure. b. Single purchasing, strategic supply chain management etc. c. Combine spend and standardise - maintenance, contractors etc. d. Invest in cutting edge IoMT tracking, reduce stock holdings. e. Drive 10% social value impact e.g. Blackpool case study on boost to local economy.	 Y Y Y	Y Y	 Y Y	
9. **Services Management**				
a. Changes to estate (insulation, PV etc.) and servicing BMS controls. b. Detailed programme by site for NZC. c. Change service model and aims, to BNG and rangers/volunteers. d. Multiple services, sites, times & systems for "customer services". e. Develop best practice, use of tech, cleaning robots, rotas etc.	Y	Y Y Y	Y Y Y	 Y
10. **Strategic Focus**				
a. Better governance to drive high impact improvements (&avoid fines). b. NHS land across Dorset, potential for 2,000 homes. c. Enable strategic service changes, e.g. move services, tech enabled change to clinical models, patient edu classes.		 Y Y	Y Y Y	Y

Detailed review

2. *What challenges faced by the trust, the Integrated Care System (ICS) and the wider NHS is the subsidiary transaction seeking to address?*

The Dorset ICS is a well-developed system serving 850,000 population, with one of the eldest populations in the UK. Population growth is leading to intense pressure on both NHS and local authorities. A record of ambitious goals and delivery includes a major reconfiguration of services by 2027. This has led to New Hospital Programme capital investment into all 3 Dorset Trusts, including mental health services.

The financial pressures on Dorset have increased in recent years, leading to a worsening financial rating, indicating a need for major change. 2024/25 saw delivery of a 5% provider cost improvement, and 5% increased productivity. For 2025/26 at least an 8% cost improvement is needed.

The proposal for combining critical services like estates FM procurement is under discussion, as a way of achieving direct benefits to staff and taxpayers, at speed. This is one of the financial recovery schemes being worked up across Dorset, that can improve cost and quality.

The importance of closer working and collaboration across services will help us to improve patient experience. The Dorset ICS strategy gives many examples of this, including with the “five

pillars" for Dorset to become the healthiest place to live in the UK. Examples of service collaboration include rheumatology and orthodontics under CANDo. As estates, FM and procurement become a single provider so this supports better joined up support services as an enabler for clinical services and patients served.

3. *Has there been a detailed options appraisal of the alternatives for addressing these challenges and is there a clear case for change and rationale for selecting the subsidiary transaction?*

Yes, see business case option appraisal. Preferred option agreed by all three Boards in April 2025.

All options, except Do Nothing, meet the case for change. The ranking is that the subsidiary best meets this because of the benefits being most achievable and transparent (See management case). The option to expand an existing Dorset subsidiary is excluded, as it would require the same governance and approval as setting up a new subsidiary, and therefore brings no benefits, and considerable extra complexity.

4. *Have all short-listed options been subject to the same level of scrutiny across non-financial and financial criteria and have key criteria used for the options appraisal been applied consistently across all the options considered?*

See Options Appraisal section of business case. This uses criteria and a thorough process. This has been developed from a decision-making process that has successfully been defended at judicial review.

5. *Does the options appraisal consider the long-term environment and any potential changes (e.g. ICS co-operation and integration)?*

Long term it is assumed that Dorset will remain a system in the South West, and the Dorset Trust will continue to work ever closer. Dorset Healthcare (DHC) and Dorset County Hospital (DCH) have a single Chair and CEO, and increasingly singular structures. University Hospitals Dorset (UHD) was formed out of the merger of Poole and Bournemouth & Christchurch hospitals.

The One Dorset Provider Collaborative is a forum to further develop collaboration, and integration, for clinical and support services. Shared back-office services have been identified, such as Procurement, and Staff Bank, but progress has not been as fast, for reasons explained in the business case. The Subsidiary company (SubCo) options best addresses the barriers, and fits within the local environment and strategic direction.

6. *Has appropriate market research been undertaken into the risks and opportunities for goods and services to be provided by the subsidiary?*

Yes, this has occurred through the Capita review for procurement, and also in considering the "managed service" and the "become a customer of another subsidiary" options. The risks and opportunities are then feed into scoring against criteria for the options appraisal.

Benchmarking has also been undertaken using the Model Hospital (MH) and other data sources, such as ERIC (Estates Return Information Collection). This is used to assess scale of opportunities for services in scope, sense checked with local knowledge.

In addition, interviews with existing SubCos have been undertaken, and lessons learnt applied. The most important being retaining Agenda for Change.

7. *Does this rationale set out why it is the best option for patients, the Trust and the ICS?*

The rationale is including the strategic chapter (drivers 1-5), and the best option emerges via the options appraisal scoring.

8. *Has there been a reasonable level of transparency about plans, e.g. public articulation of options considered and engagement with key stakeholders?*

Yes, the plans are now in the public domain, and there is a process of further staff and stakeholder engagement planned.

The timeline is summarised as below, for all three Trusts:

- Dorset provider trust executives discuss, via the Provider Collaborative.
- Draft paper taken to relevant Board committees (Part 2).
- Engagement with NHSE transactions team, and SW NHSE.
- Engagement with legal and financial advisors to shape proposal.
- Decision at Trust Management Boards of exec and clinical leadership, decision to proceed and develop business case.
- Outline Business Case, then Full Business Case approved at Trust Boards.
- Pre meet with staff side (union chairs) and regional union offices.
- VAT staff forums.
- Presentation.
- Letter to all staff shared.
- Publish briefing and FAQs.
- Local MPs are also being contacted and briefed.
- A briefing may be given to a local authority Health Scrutiny panel.
- Council of Governors receive Full Business Case (at Part 2).
- Staff Q&A sessions have been run from April and into May. Several hundred staff have attended.
- A weekly meeting with unions has been offered.
- Governors (inc. staff reps), and leaders in affected teams would be engaged, explaining the rationale, and asking for comments, alternative suggestions and what FAQs are required.

9. *Has the trust board considered the wider public acceptability and national communications risk of the proposal?*

The wider public acceptability and communications include the following key messages:

- There are many subsidiaries in the NHS, including one in Dorset already, so this is not novel.
- Whilst there has been some controversy with earlier SubCos there is a clear Board commitment to maintaining NHS staff terms and conditions, pensions etc. The proposal instead is to support greater NHS recruitment and retention, by offering better career development and support, including more local employment and apprenticeships.
- Ownership will remain 100% NHS. This provides further certainty of employment, and de-risks issues of staff retention.
- The simple message is the services remain wholly owned by the NHS, under NHS control. The wholly owned subsidiary arrangement is to allow a level playing field with non-NHS options, such as outsourcing services.

10. *Does the proposed subsidiary transaction align with ICS plans for back-office consolidation and transformation?*

Yes absolutely. The ODPC has a priority programme around shared services, for which procurement is first area of focus, then EFM services creating the SubCo is a major enabler to achieving this.

The barriers to overcome and the enablers for the change are assessed in the business case, and as part of the options appraisal. The transaction being a subsidiary is recommended, based upon it has the best alignment with the ICS and provider collaborative plans.

11. *How is the trust board assured that the subsidiary board has the capability, capacity and experience to deliver the strategic objectives of the transaction?*

The management chapter sets out the governance and proposed structure, and this is being developed through the implementation planning. A full project team is in place. The establishment of a Shadow Board is in hand. The assurance process will include developing and testing this, to provide an objective conclusion.

UHD has experience of merging, and the DCH/DHC team and UHD have also both got experience of delivering large capital programmes, through dedicated management teams. This involves assessing and assuring around capability, capacity, and experience. In addition, the Boards of the Trusts have extensive non-executive experience, with many working in group structures in both private and public sector organisations.

DCH has been running a small sub-co and so has experience and lessons learned. There is extensive exec and NED involvement and experience of running companies and group structures, including in commercial ventures e.g. property and private healthcare.

12. *Does the business case set out how the proposals will enable a fundamental transformation in trust operations? (For clarity, simply moving assets into a subsidiary does not.)*

The procurement business case draws heavily upon the independent assessment by Capita, of the potential for a single approach to procurement within Dorset. This would be transformational in redesigning the teams, structures and processes to deliver greater value and quality.

For estates there are multiple areas of transformation proposed, to include developing a single workforce plan for recruitment and retention, developing specialist expertise to cover at scale, and provide greater service resilience without reliance on costly and uncommitted contractors.

The sustainability "green" agenda is heavily focused in procurement and estates, and so working at scale allows greater progress, such as in reducing single use items, cutting plastic, waste and costs. Likewise, energy management can cut cost and carbon.

With major capital expenditure on buildings occurring the "soft landings" agenda requires a skilling up to ensure the benefits are achieved, and maintenance contracts managed well, and lifetime costs optimised. With £750m investment in estates this is a major asset management challenge that PFIs and similar set ups are designed to address. Without dedicated, professional and transparent focus, especially via the PropCo part of the proposal, there is a risk in a do-nothing scenario. Scaling up to the challenge requires a fundamental transformation in the scale and expertise of the estates function in Dorset.

Other aspects are set out in the benefit case, and these will be part of the business plan developed by the OpCo. These will be mainly phased to be achieved in the first three years. There will be a balance with ensuring "business as usual" is maintained, especially in year one for EFM, given the scale and complexity of other changes in Dorset, including the largest service reconfiguration in a generation. Therefore, the plans are ambitious and transformational, but balanced by realism and robust phasing.

<u>Delivery</u>

Capability and capacity

13. *Does the trust board have the appropriate capability and capacity to minimise implementation risks?*

The UHD Board (and successor members) have the experience of managing the successful merger in October 2020, which was whilst also managing covid. The DCH board have experience of managing an existing subsidiary (established for pharmacy). All Trusts have experience of implementing change programmes and multi-organisational working is common practice.

The capacity to manage the set up and operation of a subsidiary is via a Shadow Board, acting as Programme Board. This is a task and finish group with NED oversight.

The One Dorset Provider collaborative has dedicated staffing, who are supporting the governance of the transaction and implementation. The actual establishment and running of the subsidiary has a dedicated project management team which includes two dedicated senior HR professionals. Use of Dorset system project software and methodology is well established,

including for the major capital programmes. This would ensure efficient and effective programme management reporting.

In addition, legal and financial expertise has been procured. They have experience of setting up c30 subsidiaries in the NHS.

14. *How is the trust board assured that the subsidiary board has the appropriate capability and capacity to minimise implementation risks?*

The make-up of the subsidiary board is likely to be:

- Managing Director
- Finance Director
- Procurement Director
- Estates and Facilities Director
- Major Programmes Director

Plus, there could be non-executive directors. These would be two per Foundation Trust (six in total) plus two independent NEDs, plus a Chair.

Whilst a Board of fourteen is large, this will be a £100m turnover, 1,300 staff organisation, serving three Trusts and other companies over time. A larger Board with broader skills and experience is therefore deemed appropriate.

The PropCos would have a simpler Board, reflecting the single Trust consolidation and focus on the assets and management service contracting. Five Board members, with two FT execs and two FT NEDs and an independent NED.

15. *What is the trust's current NHS Oversight Framework segment and does this have any implications for its ability to execute and implement the transaction successfully?*

Dorset ICS has agreed a break-even plan for 2025/26. There remains considerable risk in the plan, including having to achieve 8% cost improvements. Delivery of the SubCo proposal is a core part of the success of the plan, hence the Boards focus and support for an "at pace" implementation.

16. *How is the trust board assured that the subsidiary will have the organisational capacity and capability to deliver the business plan, taking into account the nature and scope of services to be provided by the subsidiary?*

There will be an initial period of establishing the subsidiary, during which a "business as normal" approach will continue for delivery of key services, such as supply of service materials, estates works and capital projects. This should not vary the current operational capacity required for these services.

Effort will be especially focused on the procurement tea and on the contract management and tendering of goods and services. To maximise the chances of success of the single approach and FM, Capita have helped identify benefits, and can be mobilised to help in the implementation stage.

The operational estates and FM functions will continue to operate on a site basis for day-to-day activities, as the most efficient and effective way for the majority of responsibilities. Over time the maintenance contracts, and specialist roles (such as Authorised Persons, AP) can be combined to achieve a greater standardisation and resilience. Likewise moving to a single reporting framework will also help provide a greater transparency on performance. The due diligence and benchmarking will also set out areas of priority to deliver service improvements, efficiencies, and workforce developments.

The use of ISO 9001 Quality Management System may also be used, as it provides transparency against the national standards and legal requirements of an estates Team. This was first implemented in Bournemouth and rolled out to Poole over the first-year post-merger, allowing a levelling up of quality and assurance, and evidence base regarding investment decisions.

Taken together the business plan for the first three years should be achievable in delivering the benefits identified and ensuring delivery of these key services.

17. *As part of this, how is the trust board assured that the subsidiary will be able to attract and retain staff with the appropriate skills and experience to deliver the service requirements, both immediately and over the life of the business plan?*

Staffing is a critical area of focus as the workforce development is core to these services succeeding, whether they are retained as now, or enter the wholly owned subsidiary. The risk of staff becoming unsettled by change, should be mitigated firstly by guaranteeing the current NHS Terms, Conditions and Pension remains the same, retaining the parent Trust as ultimate owner, and mitigating any sense of risk for individual member of staff. The task will then be to offer better than the status quo in terms of satisfaction at work, being a responsive employer, and where appropriate offering RRP. This will be developed with the staff themselves, and staff representatives (Unions, governors, staff networks) as well as intelligence gathered from local workforce data such as rates of pay and conditions. Developing entry level job (such as apprenticeships), and career ladders will also be crucial. This is much easier to facilitate when working at scale.

As major capital build contracts come to an end there will be some local workforce opportunities to recruit contractors who may want to maintain the estate they help build. There is also the opportunity to block book training and apprenticeship courses. These often don't run as the minimum number of students isn't met. Taking the role of an anchor institution, the NHS in Dorset, possibly with local authority and supply chain partners, can then forward plan running entire courses to ensure a steady supply of skilled labour. Whilst there will inevitably be drop out and students going into the private sector, this will be a net increase in skilled labour in the locality, which will help address a major shortfall holding back the local economy.

18. *Have similar arrangements to the subsidiary transaction proposal been implemented elsewhere and, if so, have any lessons learned from these arrangements been considered in developing the proposal?*

Lessons from within Dorset:

DCH already has a bespoke subsidiary providing pharmacy services. This has clear roles, responsibilities and governance. UHD has a range of managed contracts in place for services with a supplier (Pathology equipment and supplies, pharmacy, home care deliveries). Other services that have moved from in-house to supplier based include accountants payable, payroll and internal audit. Over time these services have moved to become Dorset wide provision, demonstrating experience of aligning across Trusts within the collaborative.

The change in governance with the merger to create UHD, as a major transaction, and the move to a single leadership team for DHC/DCH also represent examples of adapting organisation forms, in controlled and risk identification and mitigation.

Lessons learnt include:

-detailed research of mergers, with a focus on "safe and legal" to prioritise they systems, processes, assurance, and people management, and what can wait for after the transition. The assurance process used for merger, and developed further for the reconfiguration process, which has had external validation from Assure Ltd, and the Infrastructure and Projects Authority (IPA)

- having sufficient ring-fenced capacity and capability dedicated to the task, alongside organisation wide commitment to making this happen. Board sign up and gateway process, with a dedicated project management team will mitigate this risk. A retained legal and finance team will also ensure expertise and learning from similar transaction is also achieved. Capita is to be retained to focus on the procurement benefits delivery.

- avoiding the process dragging on, as this creates risks in itself, about uncertainty, planning blight and loss of momentum. A realistic timetable agreed with regulators is key mitigation.

Lessons from discussions with other SubCos:

As well as the ones above, which were commonly cited, the other lessons included:

- Keeping to A4C etc. to avoid a two-tier workforce.
- Union opposition and recruitment drives can become confrontational, so early engagement and professional approach is required.
- The need to set up the SubCo with sufficient freedom to act to be able to deliver.
- The relationships, at all levels, need constant work to maintain focus on best value for patients and the NHS pound.

These learnings are influencing the set-up of the SubCos.

Planning

19. *How is the trust board assured that there is a robust and comprehensive plan for implementation of the transaction, including detailed plans for the first 100 days post transaction and plans for the realisation of benefits over the longer term?*

The plan is being developed as part of the business case implementation. This will use Capita, and the legal and finance subject matter experts as well as the in-house expertise. The Boards have experience of scrutinising large, complex business cases from concept to delivery, for example the New Hospital Programme (NHP).

100-day post transaction plan was used in the UHD merger, with the expert leaders still working in the Trust. This team are now working on the assurance around service moves, having moved and transformed stoke, cardiac, pathology, haematology, maternity, catering and other services in the past 18 months. The organisational learning on managing change is well embedded.

Using NHS Impact methodology, to manage the process of continual improvement, with frontline ownership, is critical. At UHD the approach is called "patient first" using ThedaCare and Virginia Mason Institute learning, which in term draws from the Toyota Production system of process improvements, similar improvement methodology is used at DHC/DCH. Developing a common approach across Dorset, will be helped by the subsidiary adapting such a methodology, of a continuously learning system.

Benefits realisation is critical, and the ICS has an open book culture, with benefits tracking system. This includes risk assessment and ratings, mitigations, and escalation processes. This has proven successful in ensuring a strong improvement in performance, quality, and targeted cost improvement schemes.

20. *Has the trust board considered the financial, operational and clinical implications of contract termination and developed appropriately detailed exit plans to address these, including ensuring appropriate legal protection for the staff and for any early termination of the contract?*

If the subsidiary has its contracts terminated, by one or all Trusts, it will either carry on serving remaining Trusts, or be effectively "wound up." The legal and finance advisors will be tasked with drafting the appropriate contracts to manage this eventuality. This will become a pre-agreed part of any contract. Any costs, risks or commitments would be shared pro-rata on the same basis that any investment, ownership and liabilities are shared.

The contract will be drafted for all three Trusts, to avoid multiple sets of advisors costing the NHS. All the costs and liabilities will ultimately remain within the NHS. Where the subsidiary enters into a contract with a third party, and relies upon the group consolidated structure, for example as a guarantor, this will need to be agreed with the Trusts' CFOs, in writing in advance. If the Subsidiary is wound up, the Trust will remain as guarantor.

If the subsidiary is wound down, then the Trusts would receive back the staff most appropriate to where their work is focused, based on the overall position of staff per Trust, as set up. The option for one Trust to host on behalf of the others would also be an option, but this is considered less likely as if the subsidiary is being would down, it's unlikely any Trust would want to host. Staff recruited directly to the subsidiary would be on the same A4C so re-absorption into an FT should be manageable. The reality is that without the subsidiary the services will still be needed, and therefor in most circumstances, the Trusts would be working hard to retain staff. Therefore, the risk is less about redundancy costs, and more about avoiding vacant posts and losing talent.

21. *As part of this has the trust considered and mitigated the risk of exit, e.g. through dissolution of the subsidiary?*

Scenario planning for the exit of the subsidiary will be part of the preparation and contract setting phase of work to assess risk and impact. As stated in question 20, much of this is about retaining staff. Other issues like novation of contracts, and distribution of assets and liabilities would be as per the formula agreed in setting up the subsidiary contract.

Where a contractor to the subsidiary is exiting, putting the subsidiary at risk of a service delivery failure to the Trust(s), then business continuity plans will be required, as they are currently for the trusts. This is not expected to be any higher risk than the Trust currently face.

Where one Trust wishes to exit, this may affect the viability for the remaining Trust(s). However, with the two Trust leadership teams, representing similar sized estates and procurement functions there should still be critical mass, and in effect the revert position is as per option of (single trust subsidiary). Therefore, this should be manageable level of risk. Legal advice will be taken to ensure appropriate articles of association and other partnering documents to ensure processes are in place to manage these potential scenarios.

22. *Will the trust continue to meet all the regulatory and legal requirements following implementation of the subsidiary transaction?*

Yes, the model assumes an LLP structure to maximise the "pass through" of responsibilities and minimises the duplication of regulations and legal requirements. The exact nature of these will be assessed as part of the preparation planning. Learning from other SubCos will also be covered as part of the set-up check lists for being "safe and legal".

23. *As part of this does the trust have a process for managing any confidential patient data shared with the subsidiary?*

As the employees of an NHS owned company, they will be subject to the Trust policies and procedures, these include Information Governance, and duties of confidentiality.

The digital systems and support will be provided via a contract with the parent Trusts, and will have the current levels of protection, firewalls, and support. Over the next 2-3 years a single Electronic Health Record (EHR) will further support convergence of clinical and information systems.

As part of the due diligence the current state of procurement and estate digital (and analogue) systems will be reviewed, including data confidentiality. These will assess whether data systems are critical path to combine or can continue to operate "as is". If change is required it will be decided if this is pre, or post transaction. Any costs of change will be included in the business case.

24. *Will the subsidiary be able to obtain the necessary registrations and insurances, leases or licences required to deliver the goods and services set out in the business case?*

This will be an area of set up action plan and due diligence once the legal and finance support is procured and starts work. The default assumption is registrations, insurances, leases and licences will be amended to include the subsidiary. This will be more complex with the three Trust model for the subsidiary requiring the PropCo and OpCo model. DCH have already

secured insurance on DCH sub-co and so have experience of the process. There will be a strict management plan, including key go/no-go criteria. The move towards a Dorset NHS "passport" so staff can rotate between Trusts with less friction e.g. only one set of mandatory training will be required. Thus, costs of registrations, insurances and licences are an area to highlight in the workplan but is considered surmountable. They will also be included in the finance model.

Risks

25. *Has the trust board conducted appropriate enquiry about the organisational and management capacity and capability, financial position and track record of any partners involved in the proposed subsidiary, with consideration of the nature and scope of services to be provided by the subsidiary and the potential risks to clinical, financial, and operational sustainability?*

The partners involved are all NHS Foundation Trusts, within the same ICS. They have a long track record of working together, including through the Provider Collaborative. There are only two exec teams involved, further reducing the risks, and enabling good working relationships. Both management teams have experience of transactions, and leading large-scale change (such as mergers, service reconfigurations, and staff consultations).

The financial position of each Trust is shared transparently, and all work towards the same "bottom line" as the ICS control total is a key regulatory measure. The operational and financial benefits of this transaction will be part of the system recovery plan, and therefore be supported by the ICS.

The nature and scope of the services (Procurement, FM and Estates) are critical to the functioning of clinical services, by ensuring safe and functional premises, medical equipment, goods and services in support of clinical care, and for support services. The risks of disruption during the period of change are mitigated by having a phased approach to consolidating and realising the benefits, as set out the Management Chapter of the business case. Day One activities are designed to be as small a change as possible as viewed from clinical and front-line staff. The focus is safe and legal from Day One. The benefits then come from targeting improvement opportunities in a systematic way (see benefits case).

Overall, the implementation of the SubCo proposal leads to improved financial sustainability, which in turn helps operational and clinical sustainability.

26. *Is the trust board able to identify and quantify transaction risks appropriately?*

The trusts Boards have a track record of taking advice, and identifying and quantifying risk, in major transactions such as merger, as well as major investment decisions (e.g. £70m to £263m estate investments). The Boards also have a track record of working together on major decisions, such as EHR procurement, and for the New Hospital Programme cases.

The programme Board will oversee risk registers, and identification, quantification and mitigation process. This will inform the Board self-certification, and then the final go / no go decision.

27. Is its approach to due diligence robust and comprehensive?

Due diligence will be undertaken for the estates, FM and procurement functions. Independent subject matter experts will be used. For procurement this is Capita.

For estates a common specification and brief of the yearly estates backlog assessment, called the six-facet survey, is being prepared to be undertaken as an ICS wide exercise, to deliver comparable results and costings. There is already published data for ERIC, Premises Assurance Model (PAM) and model hospital benchmarking that already allows a significant level of due diligence.

As part of the leadership team preparations at both exec and service level, a series of organisational development activities would also be undertaken, to better understand each other, ways of working, personality profiles, and what's important to keep and what are priorities for change. This "soft side" of due diligence is critical. It will build upon the "One Dorset" ethos, and examples of success. There are already high levels of collaboration within the capital development teams, as evidenced by the successful New Hospital Programme approvals and implementation.

28. Is there evidence for a clear understanding of the baseline for operational performance, governance, risk and financial position, and that key risks have been recorded?

The due diligence stage will assess the baseline position. This is a critical stage as the levels of starting points vary between trusts, and within them. Not all trusts record the same information, or if they do there can often be variation is recording methodology, and thresholds/tolerances. There is also differential investment, both annually, and historically. Accepting these differences, and a transition towards common reporting, and over time levelling up performance is something the Boards are briefed on and is referenced in the FBC.

Estates backlog is one of the largest baseline issues, with a multi-billion backlog across the NHS. The use of a six-facet survey, planned for 2025, across the NHS estate will allow a similar methodology and more accurate comparison. The speed of addressing any priority works will be largely dependent upon the level of capital investment, which may vary by Trust.

The financial budget, work levels and experience will also vary especially within operational estates. Again, the transparent acceptance of difference will allow a baseline to be established and change over time will be a mix of operational improvement and investment levels.

29. Has the trust board effectively mitigated key risks and established effective processes for the continued oversight and/or management of these risks post transaction?

Risk registers will be used, with reporting to all Trust's governance processes. This will identify key risk and mitigations, and residual (target) risk levels. These will be established before the transaction, and then maintained, post transaction. Regular alignment with the Trusts will be ensured by the approach of open information sharing, attendance at Trust and OpCo meetings by staff of each organisation.

30. *How is the trust board assured that transition risks have been considered and mitigated, including any risks around the impact of new systems and processes and any cultural changes impacting on staff transferring from the trust to the subsidiary?*

Staff changes will be carefully managed. All the Trusts have experience of this, including via mergers, and service changes. The use of organisational development professionals will be used. The development of OpCo brand, uniforms and other signs and symbols of the new organisation will be carefully used.

New systems and processes will develop, prioritised around the risks and benefit case. The Use of the ISO 9001 process provides a written, teachable and auditable standard of work. Over time other "One Dorset" ways of working will also be developed, including a single mandatory training "passport." To begin with the lowest risk approach is to "lift and shift" system and processes, per Trust, and to keep staff working at those Trust sites. Integration can then be managed over time, in a logical and prioritised way.

31. *How is the trust board assured that the risks around the impact of any changes or differences to staff terms and conditions and/or pension arrangements as a result of staff transferring from the trust or a third party to the subsidiary have been considered?*

See Qs above. Same terms and conditions, and pension arrangements. No third-party transfers envisaged. New employees will be taken on with standard NHS T&Cs. Therefore, this risk is virtually eliminated. Minor changes will be any variation in Trust policies. Over time these will converge.

32. *Has the trust board undertaken an equality impact assessment to assess the impact of these changes or differences?*

As there is no change to T&Cs, pensions etc the equality impact is negligible on staff with protected characteristics. Non-financial issues like location of work and line management may need consultation, but the bulk of staff are expected to continue working where they are now. If a restructure is expected, e.g. procurement, then consultation is needed and further EIAs will be undertaken.

33. *Has the trust board effectively mitigated any risks identified as a result of these changes or differences?*

As per Q29-Q32 the changes are actively risk managed. The EIA is considered small and following a consultation, if required, then changes would be implemented in line with Trust policies. As one of the objectives of the subsidiary will be to attract, retain and grow staff, then being a good employer will be the best mitigation to the risk of loss or disengagement of staff. This will include equality, diversity and inclusion practices being as good or better than the parent Trusts.

34. Does the business case outline a robust and comprehensive workforce strategy for the subsidiary?

This will be developed, and draw heavily from the Dorset ICS workforce strategy, and the Trusts own workforce plans. The Dorset trusts start with overall good staff survey results and have comprehensive workforce strategies. However, staff vacancies especially within estates and procurement, and salaries being lower than many private sector comparators in estates roles, project roles and procurement, mean addressing pay and conditions will be a critical success factor. This may mean use of recruitment and retention premiums (RRPs), in line with Trust policies. The funding for these would need to come from improved efficiency, and lower use of contractors.

Having a dedicated HR function will also help hugely in deploying the workforce strategy.

Workforce

35. *Has the trust engaged staff in decisions that affect them and the services they provide as set out in the NHS Constitution?*

As per Q8, the involvement and engagement of staff has started Trust Boards and One Dorset Provider Collaborative will keep an overview. This will need to assess and support the recommendations.

The other options considered to be more disruptive to staff (e.g. a managed service or becoming a customer could see some staff transferring employer). This does not meet the Boards criteria. As these are not shortlisted, it would create unnecessary and avoidable anxiety to consult on these lower scoring, less likely options.

When the time to formally TUPE consult arrives, this will be to engage, listen to comments and ideas, and explain the rationale for the proposal (based upon the drivers). This information will be used to develop the personal letter and engagement opportunities. The results will be shared with each Board.

36. *Has the trust followed staff and trade union engagement good practice guidance at all stages of the transaction?*

All the Trusts involved have recent relevant experience as all are going through various stage of management of change consultations. For DCH/DHC this involves services coming together under single executives. For UHD this occurred post-merger and is now underway for service moves happening in 2025/26. Awareness and co-ordination of these other consultations will also be undertaken as part of the transaction planning.

A review of good practice and current status against each item has been undertaken and is available on request.

37. *Has the trust appropriately considered the labour market for each category of staff, including in light of the trust's role as a major employer in a locality (if relevant)?*

Yes, this has been considered, and is one of the benefits over the status quo. A SubCo would be able to better meet the employment needs of the services and be more agile in responding to local labour market conditions. This is set out in the FBC. It includes practical examples such as

operating at scale, allowing more career structures, from entry level and apprenticeship posts, through to being able to support more senior specialist roles.

As EFMP services have many specialist roles, often with commercial alternatives e.g. procurement, construction, retail. A further specific benefit will be in being able to have dedicated HR expertise that is attuned to these labour markets, combined with a shorter decision-making chain of command, that allows greater responsiveness. A specific example is in setting Recruitment and Retention Premiums (RRPs) which is currently a slow and fragmented process, with different rates paid by different Trusts for the same hard to recruit roles. This would be resolved with the SubCo taking a single, streamlined approach.

38. *Did it consider pension provision, continuity of service, equality impact and all other relevant factors?*

Yes, these have been considered. As covered above the pension, terms and conditions and equality impact will be minimised though these then Board commitments, for dynamic keeping up to date. All three FTs will offer and protect continuity of employment. For newly employed staff by the subsidiary, all this will also apply.

39. *Does the business case outline plans to comply with any consultation requirements, including staff consultations?*

Yes, the business case plans comply with the Trust policies and TUPE legislation, which are agreed with staff side unions. As well as being legally compliant they are also aligned with the NHS constitution, and good practice. The consultation requirement will be for staff protection. As referenced above all the Trusts have recent, relevant experience of successful consultations with staff.

Governance

40. *Has the trust considered how governance works within the group to ensure that the various dependence, interdependence and independence requirements of the relationship between parent trust and the subsidiary will be met?*

The Board of the subsidiary will be established in line with Q14. This will ensure that there is representation from each trust, in proportion to the formula agreed, to ensure a degree of dependence and transparency to the parent trust(s).

The Directors of the subsidiary are bit expected to be on Trust board. This will ensure independence of the subsidiary to make the best decisions and be accountable, without any favouritism to any parent Trust.

The interdependence of the subsidiary will be through a variety of mechanisms. These include:

- Service level agreements (SLAs) to contractually deliver services to the parent Trusts, and other customers in return for an agreed level of funding.
- Key performance indicators (KPIs)

- Performance against a budget plan, for costs and income, with agreed tolerance levels
- Cashable, non-cashable and cost avoidance benefits plan
- Investment criteria for capital and revenue business cases
- Gain share formula to pre-agree share of benefits (and risks)

The above will also have a basis in a robust professional set of relationships, able to both support and challenge on all sides, based on evidence, and professional judgement, and from the basis of shared NHS values, with the patient, community and taxpayer at the centre of decision making.

41. *For example, is it clear how the board of the subsidiary will be able to meet its fiduciary duty under the Companies Act and how any conflicts of interest between the boards of the parent trust and the subsidiary will be managed for individual directors who sit on both?*

Fiduciary duties required under the proposed LLP structure will be explored, once the professional advice is engaged. UHD has experience of several commercial LLPs (including property and private patients) and DCH operates a subsidiary for pharmacy services.

A conflicts of interest policy will be developed. This will include the scenario with use of a total approach. All the parent Trust boards already have a conflicts of interest policy, upon which the subsidiary will draw upon to ensure appropriate governance is in place.

Individual directors sitting on the parent board of one (or more Trust) will be in a minority to ensure the subsidiary retains operational independence and is not dominated by any single organisation.

The set up, constitution, and contracts between the parent Trusts and the subsidiary will have a disputes clause, in line with good practice. This includes mechanisms for mediation and arbitration to manage disputes where required. These will include the role of directors on differing Boards.

42. *Does the business case outline robust and comprehensive governance systems and processes in both the trust and the subsidiary that work together to provide the trust board with suitable clinical, financial, and operational oversight of the subsidiary?*

The implementation plan for the business case will develop the governance structure. This will draw upon learning and best practice from the larger subsidiaries with similar services. This then informs the legal drafting of contracts and constitutions of the companies. These will include reverse matters such that on key issues, the FT Boards can invoke these. The existing governance of the Trusts and ICS will be used to ensure the subsidiary remains embedded in the system, but with clear accountability for delivering its plan, outcomes, and benefits.

The subsidiary board will meet at least 10 times a year to monitor progress against the annual plan, risks and mitigations, budget, and contract performance.

The clinical, operational, and financial KPIs will be developed, but will start with the measures the existing services already report on. For procurement this will include KPIs such as payment standards, and social value. For estates this will include Premises Assurance Model, Model Hospital metrics and PLACE standards. Both services will support the Trust in achieving other

metrics and improvements, such as Getting it Right First time (GIRFT) and productivity and quality measures.

In addition to these robust oversight systems and processes each FT will have two appointed NEDs onto the OpCo Board to provide additional oversight.

43. *Specifically, will these systems and processes ensure that the trust board is aware on a timely basis of overall performance and significant risks (and their mitigation) in the subsidiary?*

Yes, this will be both by written reporting, and by the FT directors' presence on the Board of the SubCos. In addition, the Trust will employ a relationship manager, acting as intelligent client, who only sits on the Trust (client) side.

Variance outside of tolerance from the annual plan and budget will be identified at the regular Board meeting and in the contract reporting, both OpCo to PropCo, and PropCo to individual Trust. Daily management and "hot" issues will be picked through the direct service delivery, which is used to dealing with issues in the "here and now."

For risks, the same risk register process will be used, thus maintaining the risk and quality reporting systems into each Trust, with any adaptation for the small differences in reporting formats at Trust level. This includes near misses and learning incidents. There will be clear oversight at both tactical, thematic, and strategic levels.

44. *As part of this, does the business case outline how the relationship with the subsidiary will be managed on a day-to-day basis, e.g. a dedicated relationship manager in both the trust and the subsidiary?*

Each Trust will identify a relationship manager dedicated to ensuring oversight of the delivery against plan and benefits realisation as part of the managed service. This will be to the PropCo, for the total managed service of buildings, equipment, and service. As the services are subcontracted to the OpCo, so in turn the PropCo manages the contract and has an "intelligent client" function itself. This is likely to be a dedicated team working across the three PropCos. It is expected the subsidiary will operate in a very open way, with direct relationships to the relevant director and their service team (Procurement, FM, Operational Estates, Major Estates developments). The overall relationship to the OpCo will be with the managing director and the finance director.

Potential other customers (GPs, other capital projects outside of Dorset etc) may require a dedicated client manager time, but this would only be once these services are established and the post was justified.

The operational estates and FM teams will have the greatest day-today engagement with the Trust staff and services. On day one this is expected to vary little from the current relationships. However, over time the use of modern technology, and task allocation, the focus on fixing root cause issues and improved maintenance. This should lead to a different, more proactive culture with a greater planned and preventative approach, and less reactive, and so the relationship is expected to mature.

45. *How is the trust board assured that there are appropriate governance systems and processes in the subsidiary to provide the subsidiary board with suitable clinical, financial and operational oversight of detailed performance as well as risks and their mitigation?*

As well as establishing governance and oversight, the Internal audit programme of the host Trusts will cover the subsidiary. Dorset has a single tendered IA function and so this would be easy to instruct on behalf of the Provider collaborative, to provide this assurance on performance and risks.

Clinical input into procurements and estates design will continue as now. There is a clear and robust process for estates developments and projects, built from best practice and dozens of projects. This has been codified using the ISO 9001 process. This provides auditable standards, for both estates maintenance and major projects. This is already considerably in advance of most NHS estates departments and would be developed further as the main source of quantified governance. For procurement developing the way the Target Operating Model works, as set out in the procurement case will provide a more robust oversight of this significant part of SubCo business.

Operational SLAs with KPIs would also be developed. This will highlight performance, variances and recovery programmes. It will also inform funding decisions including capital and revenue, and where backlog reduction plans should be focused.

Estates

46. *For estate proposals, do these demonstrate how the subsidiary supports the provision of services and improvement to the estate?*

See Q45. In addition, the 6 facet survey will provide a baseline of the state of estates, with estimated cost to bring to Category B (no backlog, but not new). The progress to which capital is deployed will be for the Trust Boards to allocate through the annual and five yearly capital plans. These plans are part of the Dorset ICS infrastructure strategy.

Having a single backlog reduction and new capital developments plan for the county will allow a single prioritisation process, the allocation of the scarce project management specialists, and coordinated tendering to ensure best market response. Currently there is a risk of local and regional capacity having “feast and famine” with no co-ordination of NHS works packages.

Additionally having the scale allows the development of more in house staffing and specialist expertise. It will also allow cohorts of apprenticeships to be recruited and trained, both for NHS work and within supply chains. As the benefits case sets out other benefits these are not listed here in full, but include the ability to provide more in-house, at better value.

47. *Are detailed plans in place for the treatment and protection of assets once they are no longer owned by the parent trust?*

The PropCos will hold estate assets upon transfer, either via a lease or a “right to occupy” would be issued. The latter would be more likely for smaller, disparate properties used by the community trust DHC. The three PropCo model allows consolidation at Trust level and avoids

the complexity of moving assets between Trusts. The detailed plans for this will be completed once the NHSE assessment has completed, as this will entail legal costs, via an instruction to Hill Dickinson LLP, who have been procured on this basis, and have undertaken this exercise for many Trusts and SubCos.

Quality

48. *Is the transaction likely to deliver material benefits to patients and the population, and be executed without compromising patient safety?*

Material benefits to patients from better quality and better maintained estates. This will be measurable through PLACE audits, which identify the patient experience including of FM and estates. It will also be measurable through health and safety incidents, error reporting and the ISO 9001 estates scorecard for compliance against standards. These standards come from the Health Building Notes, regulation and legislation.

Population benefits come through improved employment and careers as anchor institution, such as greater number of apprenticeships.

Environmental benefits from reduce energy costs and carbon, and less single use plastic and waste.

Further patient safety benefits come through procurement. Examples include standardisation of equipment and use of human factors in product selection. This "designs out "user errors. Improved procurement and stock maintenance, can lead to reduced downtime, allowing clinical staff to be more productive, and not having to chase and check equipment or stock availability.

49. *Have senior trust clinicians been appropriately involved in the decision- making process for the subsidiary transaction?*

As per Q8 senior clinicians have been part of the decision making at Trust Management Group meetings, where the senior doctors, nurses and allied health professionals are represented. Clinicians working closely with the services will be involved, e.g. the Product Engagement Groups (PEGs) which provide a clinical voice into procurement decisions.

50. *Have they raised any concerns in relation to the subsidiary transaction and, if so, have these been addressed?*

No issues have been identified so far, from senior Trust clinicians, but if they are then the TMG action log will be used to track follow up actions. If, later on, during engagements and consultations other concerns are raised then tracking and responding to these is part of the formal process. In addition, there are freedom to speak up guardians, (FTSU) in all the trusts that provide an independent voice to raise issues directly with executives, or non-executives, as they see fit.

The benefits of the preferred option have generated senior clinician interest, especially the improved EFMP services and contribution to value for money.

51. *Is it clear how the trust board will be made aware on a timely basis of quality risks and incidents in the subsidiary, and how these are followed up and mitigated*?

The quality governance, including health and safety reporting, will use the trust systems. Therefore, they will be as timely as now, and use the same follow up processes and mitigation plan formats as new. Dorset is looking at moving to a single instance of the error and near miss reporting system. Until then there will need to be some double reporting if the issue is Dorset wide. Otherwise, if the quality incident occurred on one site, it would be reported using that site system. There are already numerous examples of staff from one trust working in another (e.g. DHC mental health staff working in acute hospitals of UHD and DCH, or clinical teams working on a network basis, e.g. oncology, vascular etc) and the quality reporting is timely, with reporting and follow up and reporting systems. More work will be done as part of the preparation plans then 100-day plan.

52. Does the proposal involve the delivery of any services with potential to have a material operational impact on the delivery of clinical services?

Procurement involves purchasing and supplying medical equipment, contracted services and supplies from gloves to medical gases. Estates maintains wards, operating theatres, and support areas, as well as the critical infrastructure of the sites (electrical, water, fire safety, ventilation etc) as well as the maintenance of medical and electrical devices. Facilities provide housekeeping, catering, portering and security. All these services have a direct impact on clinical services.

53. If so, have clinical risks been considered and appropriate mitigations developed?

The approach is minimising front line change, and focus on the greatest opportunities identified, as per the FBC.

To minimise impact and risk, especially in year one, the EFM services will "lift and shift" the existing teams and line management. The OpCo will then have teams dedicated to each Trust as they are now. Procurement is the exception where the Target Operating Model, sets out a new structure. Over time EFM services may then combine where it makes sense e.g. specialist or senior roles. For the cleaner, cook, porter and estates trade professionals, the changes should be minimal, allowing them to focus on doing the best job possible. Any significant changes later would be via the management of change policy.

The benefits in the case are often "unseen" and planned, such as standardisation of equipment and supplies, which can happen over time, in a phased way, minimising risk to clinical services.

The proposal should reduce operational and clinical risks, but reducing downtime due to unavailability of estate, or equipment or supplies. By developing KPIs around these areas this will highlight patterns of risk and progress in improving these.

Finance

54. *Do the financial benefits of the transaction outweigh the costs over the medium term, without material short-term deterioration?*

Short term costs (set up and transition) plus any mitigations in change, are recovered within the first few months of operations. Multi-year benefits are then accessed. This is set out in the Economic and Finance chapters.

55. *Does the business plan demonstrate financial viability for both the trust and the subsidiary over the forecast period?*

Yes. By operating the LLP model, this reduces the risk of imbalance on either the subsidiary or Trusts side. Accounts will be fully consolidated based upon the ratio and pro rata share of costs, risks, and rewards formula. To demonstrate this in more detail the finance model is available for scrutiny.

56. *Has market testing been undertaken and does this demonstrate that the proposed subsidiary arrangements achieve value for money for the taxpayer?*

The market analysis and options appraisal exercise confirm the subsidiary arrangement (preferred way forward in Dorset) are the best balance of benefits, costs and have greatest chance of success. The Board's key principes of retaining ownership, and staff pay, T&Cs, means a market testing procurement was not appropriate. Therefore, the best value option is the Preferred Way Forward and is superior to do nothing or move to managed services.

57. *Has the trust board conducted an appropriate level of financial, clinical, market and any other relevant due diligence relating to the proposed subsidiary, including appropriate financial due diligence covering the financial position and track record of any partner in the proposed subsidiary?*

See Q 16, 23, 24 and 28

58. *Are there arrangements to ensure that the subsidiary will have access to adequate cash, particularly for the first few months of its operation?*

As an LLP the cash holdings of the parent company are especially important. The Trusts within Dorset have reserves of over £150m. Therefore, cash flow is not considered a major risk.

59. *Have the financial implications of contract termination (including any early termination) been estimated and have any associated financial risks been identified and mitigated?*

See Q29 that sets out the proposal in event of early termination. The workforce implications are limited due to the proposal retaining pay and T&Cs being the same as the owning Trust.

60. *Is there a clear commercial strategy for the transaction that is not dependent on any taxation benefits?*

The 10 benefits only have 1 related to tax, and this is based on achieving a level playing field with other SubCos, and managed service providers. The preferred option will help deliver a robust commercial strategy, for procurement plus the development and maintenance of estates. Tax issues are mainly considered in a best case "upside" scenario. Overall, there is a strong case, regardless of tax treatment.

61. *Is the trust board assured that the subsidiary transaction should be undertaken regardless of any possible taxation benefits identified?*

The Board's assessment of the totality, including risks, used the 5-case model. Benefits include cashable, non-cashable (cost avoidance) and societal benefits, as well as enablers. As made clear in Q60.

The benefits, regardless of tax, are still compelling to progress. The only tax benefits in the base case would be historic, one-off recovery using the tax rules of 2025/26. Future tax benefits and costs are in the upside / downside case, so the Board's assessment is based on the majority being non-tax related.

62. *Are the operational savings from the creation of a subsidiary largely nontaxation?*

Yes, the procurement benefits, as identified by Capita, are through better procurement practices leading to operational, cashable savings. The estates and FM benefits include economies of scale, reduced contractor costs, better recruitment and retention, and lower energy and waste costs, all collectively are larger than the tax savings in the base case, as set out in the financial model.

63. *Has the trust received appropriate professional advice on the taxation implications and treatment of the transaction?*

Yes. Professional advisors have been instructed, Hill Dickinson LLP for legal and governance, and Colbeck Brighton for finance and tax. Together they have supported or reviewed over 30 NHS SubCos. This is in addition to the usual tax advice each FT currently has, from EY and BB.

64. *Have key assumptions in the business plan been agreed with stakeholders?*

The business plan has been agreed between the three Trusts. Key assumptions include:

- on workforce (same terms and conditions, pensions etc.)
- on structure (LLP and maximum transparency of costs)
- on cross charging (minimise charges, and transaction costs)
- on assets (transfer to PropCos)
- on financial planning, (inflation, pay and non-pay costs etc. in line with NHS Dorset financial modelling), any VAT changes flow to the incurring Trust.
- On CDEL, fully consolidated, to parent trust and Dorset "bottom line"

Other assumptions will be developed through the business plan process and agreed with partners and commissioners where appropriate.

65. *Specifically, where the trust receives funding from DHSC (including Public Dividend Capital, PDC), have the assumptions around the impact on future funding been agreed with DHSC?*

The SubCo itself will not change the values of PDC and other funding. This can be checked with DHSC, following NHSE transaction team engagement. The assumption is as the accounts are fully consolidated at FT level, so there will be little or no difference at ICS level. Where any change to VAT improves the "buying power" of the allocated CDEL this will be applied as part of Trust capital plans, using the governance, and VFM checks and within the overall ICS capital plan priorities.

66. *Do the financial projections make reasonable assumptions regarding the impact on savings of any transfers of assets, liabilities, or staff to the subsidiary?*

The bulk of savings identified are through procurement and better operation of estates. Transfer of assets, liabilities, and staff in themselves are not significant savings. The financial model provides more detail, including assumptions.

67. *Are the economic risks to the model fully understood, particularly in relation to the availability of PDC and funding for workforce pressures?*

PDC availability is assumed in the base case as being at the same level as for the Dorset ICS medium term financial plan. This includes the New Hospitals Programme multi-year funding. Therefore, the risk is the same level as the counterfactual (of not having a subsidiary).

Funding for workforce will also be subject to the same RDEL constraints the ICS faces. Thus, to address any workforce pressures this will have to come from the savings identified in the services themselves. This is the same situation as now, regardless of the SubCo being set up or not. This is set out in the business case. If some or all the upside scenario is achieved, then these can be re-invested back in the services for greater benefits or returned to the parent Trusts.

68. *Is the trust board assured that the finance teams in both the trust and the subsidiary have appropriate skills, experience, and capacity to manage the execution and implementation of the subsidiary transaction?*

The Trust finance teams are well established, with experience and skills of managing a £1bn+ set of providers, contractors, and financial flows. UHD finance team have experience of many well-established partnerships including a successful private patients joint venture LLP. All three Trusts have experience of reorganisation of services, and transfer of services between Trusts. Where a shortfall in skills or capacity is identified then additional resource can be brought in, via the legal and financial advisors procured to support the transaction. As part of the project costs the subsidiary will also have a finance manager, (on secondment) to ensure the LLP can operate effectively.

With the project finance workstream and action plan, preparation for the finance systems and teams is being developed, and this will include assessing how much is provided with a "reverse SLA" to existing finance teams, and how much via in-house SubCo staff. There will be a go / no go checklist before final decisions that will assess readiness, and finance will be a core part of that.

69. *Are there clear arrangements for any cross charging and invoicing between the trust and the subsidiary?*

These will be further developed as part of the preparation. They will be based upon a "at cost, net neutral" position, that is any cross charging will not be to make a profit for the parent trust or subsidiary. This is to ensure there is no advantage (or disadvantage) to the subsidiary compared to Trust or external services. The transaction costs will also be minimised wherever possible to avoid creating non-value add costs and distraction from delivering the benefits set out in the business case.

A "unitary charge" will be considered to provide the simplest, low-cost way of ensuring the subsidiary is able to access group services, such as HR, Digital, finance, quality and governance, communications, facilities, and other services. A simple SLA will be established to ensure the current level of corporate support services continue to be provided to the subsidiary. Where there is any growth in "corporate services" within the subsidiary, (such as HR or finance) then this will be a cost borne by the LLP and included in the business case.

70. *Is it agreed how the subsidiary will be charged for the cost of occupying trust-owned premises (if applicable), including how such charges will be calculated?*

It is assumed there will be a lease or right to occupy agreement, that will be "at cost" or peppercorn rates. This will be net neutral to the group financial position and established to minimize any transaction costs.

71. *Are there detailed plans in relation to any assets to be transferred and any that will be leased?*

There will be assets transferred to the PropCo and the LLP is consolidated to the parent Trust. The right to occupy used to access the community estates, and infrastructure where it is disproportionately complex to lease, such as community trust level property.

72. *Does the business case outline plans for the ongoing management and investment in any assets transferred to the subsidiary?*

The PropCo function will maintain estates and will commission new buildings and refurbishment as the lead organisation. To begin with, these will follow the current 2025/26 plans for each Trust's capital programme. Over time the PropCo / OpCo will develop a Dorset wide programme that offers best value, suitable prioritisation and economies of scale and coordination. This will be developed over year one of new arrangements, and so is not covered in detail in the FBC. Learning from good practice, existing SubCos, managed service providers

and similar asset management contracts will be used to make whole life cost decisions, and so maintain assets in the most cost-effective ways.

73. *Has the trust resolved any issues relating to the proposed subsidiary and its treatment for accounting purposes, and received appropriate professional advice?*

The PropCo and OpCo arrangement is the agreed way forward based upon professional advice and discussion with the lead accountant for DHSC on issues of consolidation. This ensures local consolidation of accounts is maintained. As further work is undertaken in the set-up phase, so professional advice from Colbeck Brighton will be used, drawing upon their extensive experience of SubCos.

74. *As part of this, has the trust confirmed the treatment of the subsidiary for accounting purposes, the impact on its NHS accounting and reporting responsibilities, and the implications of any consolidation or non-consolidation into the group position?*

The Trusts have confirmed with their advisors and via discussion with the DHSC lead accountant, that the proposal works in achieving local consolidation of accounting and reporting at FT group level.

75. *Has the trust considered whether the scheme will have any impact on Capital Departmental Expenditure Limits (CDEL) and Resource Departmental Expenditure Limits (RDEL), taking into account the agreed accounting treatment if applicable, and confirmed the CDEL and RDEL treatment assumed in the business case with all key stakeholders (including DHSC if applicable)?*

No, see Q63, and 73-74. There should be no impact either way on CDEL or RDEL, as the position is consolidation of the accounts to the parent Trust. Other related issues are covered in the earlier answers.

Further questions or clarifications may be added.

Ends.

Risk or Issue	Risk Code	Name	Risk Description, Causes & Consequences	Initial Score	Current Score	Target Score	Risk Owner	Mitigation/Last Updated	State	Next Review Date	Risk Health
Risk	Implementation	Union opposed to decision on Shared services	Unions opposed to the principle of NHS subsiduaries. Fears for longterm risk to pay, pensions and remaining NHS owned, despite clear commitment by Boards. Impact: negative view on Subco which may result in disengagement from others. Worst case scenario, protests begin which will derail the project.		15	15	10 HR workstream	Mitigations: communication of overall benefits, and protection to pay, pensions, 100% NHS ownership etc. Pre-meets with unions before engagement, and then in April/May. Update: triple lock for extra protection; pension advice nationally os reassuring; 25 years contract; Walk through of full business case and key benefits e.g. ability to bring more work in house to public sector. More meetings with unions planned. Correspondence with Head of Health at Unison, with specific reference to key concerns.	Active	29-Jun-25	Up To Date
Risk	implementation	Wider stakeholder interest	Wider stakeholders (i.e. MPs, Councillors, staff not in scope), raising concerns, similar to those raised by unions. Impact: negative view of proposal, may result in disengagement and/or increased resources needed to address negative publicity and/or incorrect information re: pay, jobs, pensions, ownership).		15	15	6 Comms team	Mitigations: communications including the key benefits of Subco, protection for staff and public ownership, etc Increase communications and briefings to wider audience. Hold June Boards in public to review full business case. Update: disucssions with MPs, planned or happening; Meeting with BCP councillors; dedicated comms professional time allocated.	Active	29-Jun-25	Up To Date
Risk	Implementation	Resource availability	Resource availability. Project team/key staff with particular expertise may have other commitments and can only provide a limited amount of time on the project. Finance for set up flagged, and then preparations for TUPE transfer. Impact: lack of resources may result in slippage on timelines, or quality of work affecting progress through each stage, and ultimatley the timeline.		12	9	6 Finance workstream	mitigation: external legal and finance resource procured. Secondment/bank staff used to strengthem workstreams; agreement by exec teams of the level of importance of the project; resource plan and timelines agreed. Update: work underway to identify governace team support; June Board recommendations to include add 1 month to target start date at, set up legal entity to allow preparatory work and stagger this over several months ; finance work underway to specify ledger and other day one finance actions;	Active	29-Jun-25	Up To Date
Risk	Implementation	Anticipated benefits not achieved or take longer than expected to be delivered.	Anticipated benefits not achieved or take longer than expected to be delivered. Risk bsuiness as usual delivery may crowd out cash out savings. Impact: lower financial and quality of service provided, than anticiated.		12	12	6 Finance workstream	Mitigation: ensure there is a robust benefits realisation plan. Use of Capita to focus help on largest cashable savings, around procurement at Dorset level. Update: Capita approved and mobilising; robust methodology for cost improvement, to take long list of details benefits, and track through to budget adjustements; tax opinion recieved and confirms low risk approach being taken.	Active	29-Jun-25	Up To Date
Risk	Implementation	Incomplete or inaccurate data on “as is” services being migrated, and overall preparedness for transfer of services.	Incomplete or inaccurate data on “as is” services being migrated causes difficulties with the transition or inaccurate representation of the benefits achieved. Lack of preparation for transfer on "safe and legal" basis, where lift and shift the case for the majority of services, and then planning benefits delivery and set up in Nov-March 2026 period. Impact: Errors or omissions in any of the data provided could delay delivery of the benefits associated with transformation. Lack of preparedness may result in hiher cost, lower quality and/or staff morale being affected.		12	12	6 EFM, HR and Finance workstreams	Mitigation: Review / confirmation of critical data to be completed during mobilisation of the transformation programme, to reduce the likelihood of errors or omissions, and enable early interventions to be put in place if required. Workstream leads repsonsible for their areas. Ensure good 'baseline' as part of the due diligence process. Any KPIs to be based on robust data sources. Ensuring the correct people with subject matter expertise are part of the project team and data collection. Update: review of specs/KPIs are progressing with the EFM workstream. Budgets mitigation - lift and shift services is the basis wiht budget transfers and run rates to be agreed before Sept. Reasonable endeavours approach with "safe and legal" transfer being the priority.	Active	29-Jun-25	Up To Date

Risk	Implementation	NHSE assurance process delays programme	Impact: delayed project completion (or request to pause/abort project). Change in guidance or policy from the Feb 24 guidance	9	9	6	Working Group	Mitigation - engagement with NHSE national and regional team; feedback on draft proposals; close following of the guidance issued on comply or explain basis. Update - Programme recommended extension of one month to allow extra time	Active	29-Jun-25	Up To Date
Risk	Implementation	Unable to recruit into Subco leadership/Board of sufficient calibre to manage organisation	Unable to recruit into Subco leadership/Board of sufficient calibre to manage organisation. Impact: The set up of organisation may be delayed if key roles are not filled by capable staff. Risk of impacting employee morale and job satisfaction through the recruitment process.	8	8	4	HR workstream	Create JDs and undertake market assessment of similar roles. Non executive roles will be filled by Trusts and are on track. Confidence in being able to recruit into the independent non-exec roles. Update: TUPE to identify what if any postholders are eligible; initial disucssion with search agencies to understand the market beyond NHS for these roles. Use of interims if required.	Active	29-May-25	Up To Date
Risk	Implementation	Disagreement about what is in/out of scope for Subco causing added complexity or delay to the project	Disagreement about what is in/out of scope for Subco. Impact: Added complexity or delay to the project and slows down FT Board approval process.	6	6	4	Governace workstream	Early alignment from partners on initial scope has taken place. Update: Main disucssions to complete in June aroudn corporate service support models, and some specific areas in EFMP services.	Active	29-May-25	Up To Date
Risk	Implementation	Reluctance of FTs to "let go" of activities	Reluctance of FTs to "let go" of activities causes duplication of teams/costs and causes friction between Subco and shareholders. Impact: can reduce relisation of some benefits e.g. commerical focus	6	6	4	Working group , then Shadow Board	Agree scope at outset, and actively communicate to reinforce project deliverables through Comms plan. Ensure concerns are actively raised and addressed as project proceeds. Agree the business plan for implementation. Update: recruitment of shadow Board; to then undertake group learning from other subcos; process for medium term and annual business plans.	Active	29-May-25	Up To Date
Risk	implementation	NHSBSA team do not approve open direct order for NHS pensions to be protected	NHS pensions not providing confirmation that NHS pensions will be protected. Impact: may create more anxiety for staff moving into subco.	6	6	4	HR workstream	HR/Comms workstream working to get formal words to ensure pension is locked in upfront prior to going live. Update: national wording provides clear certainty; priject team looking if any further assurance possible eg letter of comfort. Once legal entity set up	Active	29-May-25	Up To Date
Risk	implementation	Complexity or issues arise in detailing estates and assets transferring	Impact: May cause delay, or extra costs, if porcess larger than estimated in project plan.	6	6	4	EFM workstream	Due diligence process and development of documentation and engagement in professional advice ongoing - reduce impact in cost and go live . Agreed approach for DHC so looking at right to access. Leases for UHD and DCH. Update: detailed worked planned for July and August.	Active	29-May-25	Up To Date
Risk	Implementation	Challenges in bringing trusts together for discussions and managing legacy issues.	Challenges in bringing trusts together for discussions and managing legacy issues. Impact: If lack of buy-in from stakeholders could undermine/slow project, delaying implementation or reducing benefits	6	6	4	Working group, then Shadown Board	Mitigation: Strong/clear stakeholder engagement plan which is actively pursued with areas of concern highlighted early and addressed actively. Update: June Board to establish Shadow Board and ensure clarity that the Trust boards are to self-certify and sign off final 'go live'. Board to Board sessions have taken place and future sessions are planned to ensure communication between Trust Boards.	Active	29-May-25	Up To Date

Risk	Implementation	Staff uncertainty and reluctance to move into subco	Staffing issues – staff not wanting to move to Subco. Impact: Staff may resign or become disengaged with work resulting in lack of performance. Effect and uncertainty of change on employee morale – risk of disengagement with the transformation delivery. Impact: Lower morale can result in disengagement, reduced productivity, and potential resistance to change, hindering the transformation success and increasing staff attrition.	6	6	4	HR workstream	Mitigation: Ensure clear communication and engagement with staff early on. Communicate the benefits to staff and provide reassurance in terms of job security. Well designed TUPE consultation, making clear no change to pay, conditions, pensions, line management and place of work for virtually all staff (exception being Procurement, and most senior staff on or reporting to Board). Update: TUPE prep underway. Briefings for line managers being planned.	Active	29-May-25	Up To Date
Risk	Implementation	Clarity on legal responsibilities between Subco and Trusts and group structure	Clarity is required on legal responsibilities between subco , Trusts and Group structure Impact: Process friction, potential for multiple teams to be doing the same work (inefficient) or for gaps in the process where each thinks the other is doing something (potential breakdown in quality standards etc).	4	4	4	Governace workstream	Think through the separation of entities as part of process design; ensure specific roles (eg for quality sign-off) are in the “correct” entity. Update: Governance structure and responsibilities are being reviewed at Programme Board level for agreement. Legal advice and learning from others being used.	Active	29-May-25	Up To Date

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

Dorset Shared Services (SubCo) headline FAQs

29 May 2025

After listening to feedback from hundreds of staff, these are the seven most commonly-asked questions about the subco proposal.

1. Will my current pay and benefits stay the same as they are now?

Yes. Pay, terms and conditions will stay exactly aligned to our NHS and Agenda for Change terms and conditions, plus continuous service and wider benefits such as salary sacrifice schemes. This will be for current and new staff. TUPE protections (in place to protect employees' rights) apply. These protections are not time-limited, but it is true they could be varied in future. So, following engagement and listening to staff the NHS Boards will be asked to support three extra layers (the 'triple lock') of protection for pay, terms and conditions plus 100% NHS ownership:

1. Trust board members will be part of our subco governance arrangements, meaning each Trust can ensure these commitments are honoured.
2. When we set up the new arrangements, the legal documentation will set out that nothing can be changed without the approval of all three boards.
3. The contracts with the three Trusts will make it legally binding that we continue to comply with NHS terms and conditions for staff in the new arrangements.

In addition, the three trusts will extend the contract for providing these services from 10 to 25 years to provide an even longer period of certainty.

2. Will I still be part of the NHS pension scheme?

Yes. Updated from our first set of FAQS, guidance from the NHS Pensions Agency confirms this:

Staff who are compulsorily transferred from an NHS organisation to a Wholly Owned Subsidiary retain their employment terms and conditions, in accordance with TUPE regulations ***and access to the NHS Pension Scheme, in accordance with His Majesty's Treasury's (HMT's) New Fair Deal guidance.***

In practice, as soon as we go live we will apply for an NHS Pensions Agency Direction Order. This confirms access to the NHS pension for all those who have one

now. New staff would also be able to join. The triple lock proposed would also include NHS pensions.

3. Will I still work for the NHS?

Our subco arrangements would guarantee 100% NHS ownership, with a triple lock so it stays that way. While staff would not be employed by an NHS trust, everything they do will continue to be as important in the provision of safe, effective care for NHS patients as it is now. Our subco model will continue to be funded by the NHS, offering NHS pay, terms and conditions, and staff will work just as closely as they do now with teams in the trusts. Uniforms, identity badges, signs on buildings and transport will all make it clear that we serve NHS patients and uphold NHS standards and values.

The main change is that colleagues will be employed by an NHS-owned subsidiary company.

4. Why are we now talking about a subsidiary company model?

The three Dorset NHS Trusts are in a very difficult financial place, like many trusts around the country, and we need to find large savings of around 8% of our budgets. If we don't achieve this, we could lose control over what we do and how we do it, with external people coming in to make those decisions for us.

The pressure is on us to respond, and we have been looking at a whole range of ways to be more cost-effective, while still protecting jobs and services.

After exploring various options, we believe that setting up a shared service subsidiary company model for Estates, Facilities Management and Procurement offers a positive solution, compared to outsourcing or cutting our workforce. The details are set out in our business case, which will be published in June. We will continue to provide further briefings going into the details.

5. What exactly is the Dorset Shared Services subco proposal?

In April the Boards of the three Dorset NHS trusts approved the preferred option to create a subsidiary company solution to provide estates, facilities management and procurement (EFMP) services for all three Dorset trusts.

EFMP teams will continue to do their vital work for patients and our local population, working on our sites, with colleagues and patients, just as they do now.

We believe that bringing the three services together, with a specialist leadership team and a subco board, would enable us to develop and improve services for everyone. The new arrangements will be able to use combined buying power to drive up to an estimated £58m of savings from goods and services we buy, over the first five years. Operating at a greater scale will allow more specialist roles, bringing outsourced services back in house, and taking a more commercial approach – with all the benefits going back into Dorset's NHS trusts.

Each of the trusts has built up individual expertise in different areas – bringing all that together creates an exciting opportunity to share knowledge and best practice. It can build a much stronger structure for careers, training and development support than we have now in three separate trusts.

There will also be potential to grow and supply new customers beyond the three trusts, such as primary care (GPs).

Being 100% owned by Dorset County Hospital, Dorset HealthCare and University Hospitals Dorset will mean no outsourcing, and no private involvement or shareholders. We're aiming to keep adapting, changing and doing the best thing for our trusts, our staff and our patients.

There are already 60+ subcos in the NHS, providing accountable services to NHS trusts and patients. The case for subcos is so strong NHS England now requires all trusts to set up a company, if they haven't already.

6. What's the process and timetable?

There are several stages before a final decision to proceed. The current stage is informal engagement, which has already informed revisions to the business case that will go to the public board meetings in June. This is why suggestions like the triple lock and 25-year contract term will be improvements on the original draft of the case.

We are working through the details, and listening and talking to staff, stakeholders and unions. There are legal requirements to go through, including formal consultations and the process and procedures for transferring staff under TUPE. Specialist advisors are guiding us through the process, and we'll be assessed by NHS England before we start formal consultations under TUPE.

There will then be a decision on go-live following the formal consultations. We expect that to be taken by the Trust Boards around September, to approve go-live in October or a later date if necessary for a safe and smooth transfer.

7. Where can I find out more?

You can read more detailed FAQs on the intranet. There will also be a range of staff engagement meetings and materials, and regular newsletters, to keep you updated and to share views.

You can ask questions online at https://app.sli.do/event/9t6WeNxU2frq85tD4FemuN which you can access on a personal or work computer or phone. You can also feed back on the proposal through the trade unions, staff governors, freedom to speak up guardians, staff network leads, as well as line managers and trust executives. We will be listening to feedback from all sources.

April 2025 briefing for staff in Estates, Facilities Management & Procurement (EFMP).

These briefing notes and Frequently Asked Questions will be updated as we brief staff and representatives and respond to their additional questions. If you do not find the answer to your question, please raise it with your line managers.

This briefing is for staff in Dorset County Hospital, Dorset Healthcare and University Hospitals Dorset NHS Foundation Trusts. It includes information about the process and what comes next.

The proposal:

To bring together Estates, Facilities and Procurement services, across Dorset. This is to provide a better service, safeguard jobs and deliver savings that are required across the NHS. The services would sit within an operating company (called “OpCo” for short). This is 100% owned between the three Trusts, to retain these important services within the local NHS family.

Key messages for staff:

1. NHS Agenda for Change Terms and Conditions (pay, increments, leave etc) will be protected for all employees (existing and new) of the OpCo.
2. Both transferring and new staff will be able to access NHS pensions in the same way that they do now. (This requires NHS Pensions Agency Direction Order, which has been granted to all other staff in similar situations).
3. There is no plan for any redundancies, as we are doing this to help us recruit and retain staff.
4. The OpCo will continue to recognise unions, as well as giving full access to staff wellbeing, speak up guardians and staff networks.
5. This transfer of EFMP services comes under the TUPE Regulations, which will offer those staff affected the Regulations employment protections.

The role of Unions:

As is the practice of all three Trusts, we will inform and consult with our recognised Trade Unions – with Regional as well as Staff-sides representatives and with staff affected. This briefing is not part of the formal TUPE information or consultation but an informal way to bring all EFMP staff up to speed.

In this briefing we will cover:

- The transfer of EFMP services – the mechanics of the decision making.
- The impact of the transfer of EFMP services on the employment of affected staff.
- The benefits of the transfer to staff, patients and the Dorset population
- Why it is not sustainable for the Trusts to carry on operating EFMP services as they do now.
- How to find out if you come within the definition of affected staff
- Keeping staff representatives informally and formally informed and consulted
- Keeping staff informed throughout – before and after the transfer.

The transfer and the mechanics of the decision making:

The Boards of the three Trusts have agreed the principle of a shared EFMP service, held within a subsidiary company (an Operating Company, “OpCo”). This will be subject to further working up the proposal and getting assurance ahead of a go/no-go decision to go live. Assurance includes review by NHS England, setting up all the systems and processes, and feedback from this engagement process.

The three Trusts will also set up their own wholly owned property company (a “PropCo”) per Trust. This is to be the guardian of the property, equipment and to ensure the EFMP service meets the requirements of each Trust.

There are around 1,300 people across all EFMP services in all three Trusts, so this is a major change, affecting many people. The transfer would be covered by the TUPE Regulations. Retaining staff, recruiting to fill vacancies, and providing an exciting future where career development is better supported are just some of the reasons why this change is supported by the Boards.

The timeline is estimated, as getting the assurance and all mechanics in place to go live can be subject to change. At this stage the aim is to go live halfway through the financial year, that is beginning of October. Updates will be provided as the work is progressed.

The benefits of the transfer for staff, patients and the Dorset population:

Beyond protecting pay and conditions for current and future staff, and keeping services within the NHS family, there are other benefits and protections the OpCo brings:

- Minimising change. All staff - those transferring and new - will continue to do their vital work for patients, our local population and to support our colleagues. We will still put patients first. Most EFMP services will continue to be on site, with patients, as it is now.
- The scale of our combined workforces gives the OpCo greater operational resilience and allow specialisation where this is helpful, like in procurement.
- By being focused on the EFMP staff groups, this allows better, more tailored staff development and support. Doing this at scale, also enables the OpCo to offer better career pathways and opportunities for career development and progression.
- For example, the OpCo will be able to review vacancies, assess the local jobs market, and develop an attraction and recruitment package that increases candidate interest at both entry level, and more experienced staff.
- This would make working for the OpCo a more attractive option and would help in retaining and recruiting high calibre staff who share our NHS values. Better retention and filling vacancies promptly helps all services.
- Having the OpCo, allows the new organisation’s leadership to focus on the specialist nature of the EFMP services and workforce.
- The company structure will allow quicker decisions to be made by specialists in EFMP services.
- The structure puts the NHS on a level playing field with outsourcing options. This allows better value for money for Dorset’s NHS Trusts, and makes us more comparable in cost with Trusts that have outsourced.
- There is potential to grow the company in ways Trust run services couldn’t, such supplying new customers (such as GP practices) and bringing work back into the NHS that is currently contracted out.
- Any profits made on new work stays within the NHS, with no private shareholders taking anything out.

- There are 60+ such companies in the NHS already, who are using this model effectively to provide accountable services to NHS Trusts and patients. The number is expected to grow rapidly this year. By the three Trusts applying this model jointly across Dorset we are getting the benefits of more integrated services and operating at scale.

Why is it not sustainable for the Trusts to carry on operating EFMP services as they do now:

The financial situation the NHS faces is now stark. Dorset is having to make at least an 8% cost improvement to break even. Future years are looking even tighter as the national, and international situation leaves virtually no room for extra health spending. This means carrying on as we are, is not an option. There are considerable savings especially in buying and standardising goods and services. Doing that once in Dorset, we can be far quicker and better with a single service.

In addition, the proposal puts these services on a level playing field with private competitors, as the tax rules are then the same. This means the risk of outsourcing is reduced, as the two main arguments for outsourcing (tax and scale) are removed.

How to find out if you come within the definition of affected staff:

In general terms staff in the Estates, Facilities Management and Procurement functions for the Trusts are affected by the transfer and will be covered by TUPE. A few areas still need some discussion, and final exact services and named individuals will be identified over April and May prior to launching the formal consultation process. This briefing is aimed at the widest group to allow staff to be aware, and to comment, ahead of any formal process.

Keeping staff representatives informally and formally informed and consulted:

We have started talking with Regional and Staff-Side representatives, and we will honour our organisational change policies and respect our duties under TUPE to inform and consult representatives and affected staff. This requires both informal and formal communication.

The Chief People Officers, their Deputies have set up a regular series of meetings, and the staff side representatives will be involved in the planning and content of events and the formal information and consultation stages under TUPE.

Keeping staff informed throughout – before and after the transfer.

The plan (to be discussed with staff side and management colleagues) is to use a variety of channels for communicating with EFMP staff. For example,

- Face to face sessions with Estates, Facilities and Procurement managers and staff – such as drop-in sessions to get EFMP staff up to speed.
- Face to Face sessions with CEOs and Executives, to have a two-way discussion to inform the Boards of all three Trusts.
- Briefing notes and slide decks used in these Drop-in sessions which will be available on the intranet for all, including those not able to attend in person. We will also make them available through your line managers in hard copy format.
- FAQs. There are a lot of questions we think most staff will want answered so this is a long document. This will be on the intranet, and we will circulate hard copies. You can also request hard copies via your line managers. We will find out what are the most useful and commonly asked questions and will also issue a short version FAQs.
- Regular meetings with your Regional and Staff-side representatives.

- There is a Dorset Shared Services Programme that will take forward the planning and implementation. The HR & Comms workstream plan to work closely with staff & staff side reps.
- Setting up an email address for any staff to ask questions in confidence. If appropriate these can be added to the FAQs anonymously, protecting individual confidentiality.
- We will write to all impacted staff at the start of the formal consultation process with a formal consultation document that will set out additional details, the timeline, the Equality Impact Assessment (EIA) and the TUPE process. All staff and Trade Unions will be invited to formally feedback their views which will help inform and refine the proposal as we work towards implementing it.

See below for Frequently Asked Questions.

Dorset Shared Services Proposal: Estates, Facilities Management & Procurement
Frequently Asked Questions

These briefing notes and Frequently Asked Questions will be updated as we brief staff and representatives and respond to their additional questions. If you do not find the answer to your question, please raise it with your line managers.

Within the NHS in Dorset, the idea of creating a single Estates, Facilities Management & Procurement service is being considered. Staff affected by this transfer will have many questions about their employment and the proposal.
This document aims to help staff by initially setting out some of the most frequently asked questions. This document will be developed further as more questions are asked.
We propose setting up a central email to enable staff to send their feedback or questions.

1. Background

Q1.1 What is being considered?

The key proposal being considered by the Boards of the three NHS Trusts in Dorset is to create a shared Dorset-wide service for NHS Estates, Facilities Management and Procurement (EFMP).

This is to improve services, provide better employment and career opportunities, and offer better value for money.

The preferred way to achieve this ambition is for the three Trusts jointly to create a wholly owned subsidiary, known as the Operating Company (the “OpCo”). This will employ the vast bulk of the staff in those three services.

Q1.2 What is a wholly owned subsidiary company?

Wholly owned subsidiary means it is 100% owned by parent NHS Trusts, that is DCH, DHC and UHD. There is no private or other owners.

In this case, where there are three Trusts involved, the ownership of the OpCo is shared between each Trust, with 100% NHS ownership a key principle each Trust Board will ensure.

In addition there will be one wholly owned subsidiary company per Trust that leases and is responsible for the property and equipment that each Trust owns. These are referred to as the

property company (PropCo). There will be three, one per Trust, so the assets of the Trust remain with the Trust.

The vast bulk of staff affected by the transfer of these EFMP services will be transferred to the Operating Company (OpCo).

The OpCo and PropCo are all subsidiary companies, so are collectively referred to as SubCos.

Q1.3 Why is a wholly owned subsidiary company being considered?
This approach will allow operational services to work in a more efficient and effective way, creating more resilient and cost-effective services.

It allows the new organisation to focus on the specialist nature of the Estates and Facilities Management and Procurement Services (EFMP) and its workforce.

The company structure will allow quicker decisions to be made by specialists in EFMP services.

There are tax advantages for this structure, putting the NHS on a level playing field with outsourcing options. This reduces the likelihood of outsourcing and keeps alignment of the services with the NHS.

There is potential to grow the company, supplying new customers and keeping the profits within the NHS.

There are 60+ such companies in the NHS already, and this number is expected to grow rapidly this year. This is because it is a national expectation for every Trust to have, or work with a wholly owned subsidiary.

Q1.4 Why is this being considered now?
Guidance came out last year from NHS England which provides a framework for setting up subsidiary companies. This has been reinforced by the transition CEO for NHS England, Sir James Mackey. It is now expected almost all Trusts will set up a company, if they haven't already.

The One Dorset provider collaborative also identified shared corporate services as an area where NHS Trusts in Dorset could potentially provide better services by collaborating.

The financial situation the NHS faces is now stark. Dorset is being highlighted for its lack of financial health. Budgets need reducing by 7% this year. This means carrying on as we are, is not an option. There are considerable savings especially in buying and standardising goods and services. Doing that once in Dorset, we can be far quicker and better with a single service.

There are still several months of discussion before any change occurs, with final Board decisions still to be made.

Q1.5 When could this happen?
The timing is subject to change but at a high level:

When	What
April to October	Details are worked through, staff engagement and communications will run through this period. Legal

	requirements will be worked through including the process and procedures for transferring staff under Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE).
April to October	Specialist advisors will guide the Trusts through the process ready for a final decision to go live by the Trust Boards. This includes assessment by NHS England.

If the three Trust Boards give final approval targeted for September, this could mean the companies 'go live' and staff transfer in on a target date of 1st October. This could be sooner or later, depending on how the work unfolds.

Q1.6 Could it still go ahead if not all Trusts give a final approval?
The subsidiary approach could still proceed without one or two of the Trusts agreeing to proceed and the model adjusted to reflect the other(s) joining at a later date or not at all. This would reduce some of the benefits, but is an option.

There are numerous examples of NHS wholly owned subsidiaries being successfully operated by Foundation Trusts. A key objective here is to achieve those, plus greater benefits through creating a wider offer across the Trusts in Dorset.

Q1.7 Is this privatisation? Are we being outsourced?
No, the companies (OpCo and three PropCos) will remain 100% NHS owned.

Q1.8 What are the services that could be in scope?
The following services are in scope, along with the associated staff.

- Estates
    - Maintenance, inc grounds staff
    - Estate management
    - Helpdesk and reception
    - Estates Health & Safety, Fire
    - Waste Management
- Facilities
    - Housekeepers
    - Linen
    - Portering
    - Security
    - Catering
    - Transport
- Procurement / Supplies
    - Procurement
    - Materials management
- Sustainability
- Electronic and Biomedical Engineering
- Capital Estates and development

A more detailed list will be available as the work progresses. Every individual affected will receive a personal contact to confirm if they are in scope.

If you are uncertain if you are in scope, please contact your line manager who will be able to escalate your question to the appropriate Senior EFMP manager.

Q1.9 There are staff and structural changes planned for the immediate future, should these be placed on hold?

In the case of Procurement, the expectation is that staff and structural changes proposed for the immediate future would continue. Informal discussions will continue and with staff side colleagues we will start the formal information and consultation in line with Trusts' organisational change policies and the TUPE Regulations.

In other areas, as we continue to change ways of working to adapt to changes in each of the Trusts, any structural changes planned for the immediate future will continue in line with staff-side involvement and application of the Trust's organisational change policy and TUPE regulations.

2. The Reasons for Change

Q2.1 What are the benefits to patients?
We already know that our staff do a fantastic job and this is why the Trusts are keen to keep these services within the NHS family, as they are so core to the quality of patient care.

As well as making the money go further, key performance indicators (KPIs) will be used to ensure service to patients is maintained or improved. These include patient satisfaction, and safety, such as cleanliness, and safe medical device usage.

Q2.2 What are the benefits for staff?
By being focused on the EFMP staff groups, this allows the OpCo to provide better, more tailored, staff development and support.

One example will be to review vacancies, assess the local jobs market, and develop an attraction and recruitment package that increases candidate interest at both entry level, and more experienced staff.

The ability to ensure consistency in roles is another area that the OpCo will able to address and there are likely to be other benefits for staff, but these will need to be prioritised as to what are most attractive, viable and affordable to deliver. The engagement process will help identify these.

Q2.3 What are the benefits to taxpayers?
Taxpayers and the wider public are paying more for the NHS than ever but still see a service struggling to provide services within budget.

By working across Dorset this brings economies of scale whilst also still being local enough to be responsive. By being 100% NHS owned it also keeps the money within the NHS in Dorset.

Q2.4 Has this happened elsewhere?

There are many subsidiary companies across the NHS already, probably 60+.

There is one already for Dorset County Hospital providing the outpatient dispensing service (at UHD this is provided by Boots).

The national guidance on setting up subsidiaries was issued in February 2024, and this is being followed, and includes learning from other SubCos.

Q2.5 Will other services also become shared across Dorset?
Other services could, in future, be added to the operating company, however these would be subject to a business case setting out the risks and benefits, staff engagement and the assurance around legal and financial rules. These will only be considered after there is a period of successful operation and settling in of the subsidiary company.

Q2.6 Is there a risk that the tax rules around VAT could change?
VAT is just one of the benefits of the proposed shared services, and while there is a risk that changes to the VAT regime may occur in the future the non-VAT related benefits continue to make a considerably compelling case for collaboration of these services across Dorset.

3. My Employment

Q3.1 Is the plan to reduce NHS terms and conditions (T&Cs)?
No, it's the opposite, this is about maintaining the current terms and conditions. The three Trust Boards have agreed the following principles that must be followed. These are:

- Must follow agenda for change pay, terms & conditions and cost of living, for existing and new staff.
- NHS pension for existing & new staff,
- Trade union recognition
- The company must remain wholly owned by the NHS.

As the Trusts are making this a longterm commitment there are several ways to secure this for the future. Firstly the Trusts are the owners and will have legal rights and Board membership. There can also be contractual terms set before the SubCo starts, that say the employment needs to follow Agenda for Change. These are all in addition to the TUPE protections in law.

Q3.2 Will I still be employed by the NHS when I transfer to the Subsidiary company?
The direct employer is the company. The subsidiary company is owned by the NHS. This is a change. As an employee of a company that is wholly owned by the NHS Trusts in Dorset, you will still be providing services to the NHS, funded by the NHS and a critical part of the NHS family.

This includes using the NHS email, badge, uniform, and most importantly NHS values. Therefore, you will still be very much part of the NHS family. This is similar to the way that GP practices are part of the NHS family, but not counted in the number of NHS employees. As covered above the Agenda for Change pay, terms and conditions etc will remain as now and be updated in the same way as happens currently.

Q3.2 Will my Terms and Conditions of employment change?

No, current employees are covered by the Transfer of Undertaking (Protection of Employment) Regulations 2006 (known as TUPE). These are in place to protect employment rights of employees when their employment is transferred from one employer to another.

More information on TUPE can be found at TUPE transfers | Acas

Under TUPE staff that transfer into the company will transfer on their existing terms and conditions of employment. Your continuous employment will also be honoured by the new company as a part of the regulations.

Detailed advice will be secured to ensure any continuous service is recognised by the NHS in Dorset (ie if you voluntarily move jobs again, back to any of the Dorset Trust). Outside of Dorset it will become discretionary as to whether Trusts recognise the continuous service. This will be raised at a national level, as this affects all staff employed by subcos.

Q3.3 Will I still be able to access the NHS Pension scheme?

Yes, we expect that to be the case, based on all other subsidiaries. There is a special status called a Direction Order that the Trusts in Dorset can apply to NHS Pensions for. An approved application will mean that both transferring staff and any future staff of the company will be able to access NHS pensions in the same way that they do now.

The application can only be made on the first day the subsidiary company is operational. Therefore, it can only be made after 'go live'. The Pensions Agency has confirmed they will advise the subsidiary company of their decision on the outcome of the Direction Order within 14 days of the Order being made. All the existing subsidiaries that have applied have been approved. There is no reason to believe that it will not be granted for Dorset.

Q3.4 Will I still be able to access NHS benefits, salary sacrifice, Blue Light card etc?

Yes, staff will still have an NHS e-mail, a badge with the NHS logo which can then be used to access blue light and other NHS discounts. Salary sacrifice will be set up with the same provider.

Q3.7 Will Trust HR Policies change?

For Trust staff transferring into the company any HR policies from their original Trust that are deemed to be contractual will transfer with them, as these are part of your terms and conditions.

Work will be undertaken to establish which trust HR policies are contractual. These are likely to be policies such as disciplinary, absence and performance. For other policies, we will consider with staff side representative the options for a single version, for example, this may be from either one Trust, or a blended version.

Q3.8 Can I choose not to transfer?

There will be a formal process of staff engagement and communications through which staff may object to being transferred to the new subsidiary company. However, refusal to transfer to the new subsidiary company would be considered as a resignation and your employment would end the day before the formal transfer date.

There is no entitlement to any financial compensation as this is not redundancy situation. The intention of setting up the shared services is to improve employment and the service, and every effort will be made to not lose any staff.

Q3.9 Will there be an option for existing staff to be re-deployed?
There will not be an option for existing staff to be re-deployed as an alternative to transferring under TUPE into the company.

Q3.10 Will I continue to be paid in the same way and on the same date each month?
Staff will continue to be paid at the same intervals, e,g, if you are paid monthly now, you will continue to be paid on a monthly basis. Pay date has not yet been determined but staff will be informed if there are any changes to the pay date, prior to transfer, but it is not anticipated to change.

Pay will continue to follow AfC and therefore will mirror national increments.

Q3.11 I receive a Trust contribution towards a training course, will this continue?
Yes. If staff have an existing agreement in place to support training fees and release this will continue in the company for the time frame it was originally agreed. Any planned training would also continue, it is important to keep training and developing.

Q3.12 I have a flexible working arrangement in place, will this continue?
For Estate and Facilities Management colleagues, the answer is yes. If you currently have an agreed flexible working arrangement in place this will continue in line with the original agreement made.

In the case of Procurement staff, we recognise there are different practices across the trusts. Whilst there is no plan to move a member of staff's base, they would be required to travel to different parts of Dorset and there may be a need for staff to be in the office at particular times even if they are not required to do so now. This might impact arrangements for working remotely versus being in the office. In any event, staff and their representatives will be informed and consulted about this organisational change in line with Trust policy and TUPE.

Q3.13 What terms and conditions will apply for new starters of the company?
The subsidiary company will offer Agenda for Change terms and conditions of employment for new starters, with the agreed adopted HR policies that will either be one Trust's, or a blend of the three Trusts.

Q3.14 Will I still receive the same rates for unsocial hour's payments and overtime?
Yes. Unsocial hours and overtime rates are part of your terms and coployment and will transfer with you under TUPE to the subsidiary company.

Q3.15 Will I still receive the same annual leave entitlement?
Yes. Annual leave entitlement is part of your NHS terms and conditions of employment and will transfer with you under TUPE to the subsidiary company.

Q3.16 Will this effect sick pay?
Sick pay entitlement is part of your NHS terms and conditions of employment and will transfer with you under TUPE to the subsidiary company

Q3.17 If I voluntarily apply for a new role in the company, will my NHS terms and conditions of employment continue to be protected?
If you choose to apply for another role within the company, your terms and conditions will reflect those of the company but these will still be Agenda for Change, but there may be some

small differences with the contractual policies depending on which ones the company adopts, i.e. this may be from either one Trust, or a blended version. We will consider with staff side representative the options for a single version.

If an application is through the TUPE led change process, then your original T&C's will remain the same.

Q3.18 Will the subsidiary company recognise the unions and will representatives be allowed to attend staff side meetings with NHS staff or will a new staff side need to be formed?
The company will take over any collective agreements made on behalf of the employees and in force immediately before the transfer. The company will then work with staff side to agree a subsidiary company recognition agreement and anticipate that the current partnership working with our Staff Side colleagues will continue.

Q3.19 Will this effect on call pay, call out pay and expenses?
For Trust employees who have a contractual obligation to participate in on call the current Trust on call agreement (including associated payments) will transfer with staff under TUPE into the company.

Once established and operating, engaging staff and staff side representatives, the OpCo will consider if the current, varied on call arrangements, should stay or need to be changed in future. This would be via a formal consultation process. For new company employees it is possible there may be a different on call payment scheme, however, this has not yet been determined.

Q3.20 Will we be restructured and have to re-apply for our jobs?
With the exception of Procurement, there are no plans for any major restructuring which will necessitate people having to apply for their jobs in connection with the transfer of services into the subsidiary company. For the vast majority of staff it will be about continuing their jobs as now. At this stage only Procurement has had had detailed work done on options. For most staff there will be no noticeable, or significant changes as the job will continue much as now.

The intention is to 'lift and shift' services, and minimise change in year one. If at some point in the future, if service requirements change and where there is a requirement to re-structure this would follow the usual consultation process with staff.

In Procurement, for Specialist roles, a new structure is being developed. This is based on a target operating model (TOM). This uses the larger scale of the company to offer more senior, specialist roles, and thus a better career structure. This 'TOM' approach could be used more widely to engage, consult and the move over time to better management and specialist staffing structures covering Dorset.

Q3.21 I am on a fixed term contract, will I transfer?
If your fixed term contract end date ends after the date of the transfer, you will transfer under TUPE into the subsidiary company and continue with your fixed term contract until the agreed end date.

Q3.22 Will we still follow mandatory training etc?
There will still be a requirement for mandatory training within the company to enable the company to meet its statutory duties. However, it is likely that some training currently deemed

mandatory by the Trust will not be mandatory within the subsidiary company and therefore, there will be key changes in this area and the number of modules is likely to reduce.

Q3.23 Will there still be long service awards?
Long service awards are not a contractual entitlement, and each Trust varies in what they do. The subsidiary company will review whether it wishes to implement a long service awards scheme for its staff, alongside reviewing other staff recognition and reward schemes. The working assumption is to 'level up' to the best of the three Trusts' current offer.

Q3.24 Will car parking fees remain the same for subsidiary company and NHS staff?
Yes, these will continue to be set by each Trust.

Q3.25 Will the ID badge still show the NHS logo?
Yes. The ID badge will state "Company Name "and this will include the NHS logo.

Q3.26 If I request to reduce my hours after the transfer, will I then transfer onto the new company T&Cs?
No, you would remain on your existing T&C's that you transferred on.

4. My Role

Q4.1 Will my role change?
Apart from Procurement, for most staff there will be no noticeable, or significant changes as the job will continue much as now. Porters, Housekeepers, Catering, Procurement and Materials Management Staff, Estates and other operational staff will need to continue to do the vital work you're doing now, on the same sites as now.

This proposal is to secure jobs, fill more vacancies, and expand the workforce by bringing more work in-house. The ambition is to increase the apprenticeships and training to future proof the workforce remaining local and part of the NHS family.

For Specialist roles, in procurement, a new structure is being developed. This is based on a target operating model (TOM). This uses the larger scale of the company to offer more senior, specialist roles, and thus a better career structure. This 'TOM' approach could be used more widely to engage, consult and the move over time to better management and specialist staffing structures covering Dorset.

Q4.2 I'm a manager, will my role change?
Apart from Procurement, the first year this will be largely about transferring and ensuring a safe, effective service. This means a 'lift and shift' with the subsidiary retaining services and structures as they are now. The very top will change with a Board for the company.

Over time, and through consultation, the objective will be to bring the teams together as one organisation and this will mean there is likely to be some changes in the future, mainly around management and specialist roles.

Any proposed changes will only be only after settling in services after the setup and will be discussed with opportunity to input ideas before decisions are made and consultation commences. Changes would be discussed with Staff side representatives and there would be a formal consultation process. There is no plan for any redundancies.

In Procurement, for Specialist roles, a new structure is being developed. This is based on a target operating model (TOM). This uses the larger scale of the company to offer more senior, specialist roles, and thus a better career structure. This 'TOM' approach could be used more widely to engage, consult and the move over time to better management and specialist staffing structures covering Dorset.

No redundancies are planned or expected, as the approach is to retain and grow the talent within existing, plus new staff.

Q4.3 Will I have to move sites?
In the case of Procurement, whilst there is no plan to move a member of staff's base, they would be required to travel to different parts of Dorset and there may be a need for staff to be in the office at particular times even if they are not required to do so now. This might impact arrangements for working remotely versus being in the office. In any event, staff and their representatives will be informed and consulted about this organisational change in line with Trust policy and TUPE.

For Estates and Facilities Management colleagues, most staff will need to stay where the work is, which is by patients and other NHS staff, in current locations. UHD is reconfiguring services this year, so any changes are already planned and being consulted on, separate to this proposal.

Management and specialist roles will be expected to move sites more often, as they are now.

Q4.4 Will my line manager remain the same when I transfer?
With the exception of Procurement, the management structure below Board level is not expected to change and therefore, for the majority of staff, your line manager will remain the same when you transfer into the new company.

For Procurement staff, your line manager may change, this may not happen immediately, but it depends on how quickly we transform (based on the TOM), and how soon staff transfer to the Subco. Subject to full information and consultation with recognised staff representatives and affected staff, in line with Trusts' organisational policies; changes could be made prior to staff being TUPE transferred in.

Q4.5 Will I be issued with a new uniform and ID badge?
If you currently wear a Trust uniform for your role then you should continue to wear this. New staff and replacements of uniforms will be issued in whatever form the company agree. Staff will be involved in deciding about any new uniforms. All company staff will be issued with new ID badges. These will continue to give access as now.

5. Working through the Change

Q5.1 Will there be a formal consultation with Trade Union involvement?
Yes, there will be formal consultation, with full union involvement. If the decision is made to set up the company, then it will recognise Trade Unions, in the same way the Trusts do now.

Q5.2 There is so much change already in Dorset, should this be delayed?

There is undoubtedly a lot of change in Dorset's NHS. The next 12 months sees huge service changes across Bournemouth and Poole hospitals as they reconfigure. Dorset Healthcare and Dorset County Hospital see their federated model develop, as well as the building works for mental health services and at DCH for the new ED and critical care.

However, Dorset also faces very significant funding issues. The proposal saves money and thus helps the wider NHS in Dorset – for this reason delaying is not an option.

Q5.3 How will each Trust ensure resource is available to ensure the change happens well and the benefits are realised?

We recognise that specific expertise and resource will be required to establish the new structure and ensure a safe and smooth transition. The business case, and decision to work up the implementation has now been approved by all organisations' boards and this includes transitional funding to support this, funded from the savings expected in year.

Q5.4 Are there redundancies planned?
There are no redundancies planned, this is about protecting jobs and growing the workforce, especially by bringing work in-house.

Q5.5 Can I input comments, ideas and influence the process?
Yes, we want to hear from you. There are likely to be more questions, so we plan to provide a central contact email, for you to use or ask your line manager to register questions, so a written answer can be given, and shared more widely.

You may also have ideas, and views about what could be improved for patients and staff. Please share these as well.

There will also be a range of staff engagement meetings and materials, and regular bulletin updates, to keep you updated and to share views.

Feedback can also be given via range of independent or separate process, such as trade unions, staff governors, freedom to speak up guardians, staff network leads as well as line managers and Trust executives. We will be listening to feedback from all sources.

Q5.6 How can I find out more?
The plan is to ensure staff affected by the transfer and staff side representatives are kept regularly and fully informed, consulted with and engaged in the process of change. We want to understand from all concerned what is the best way of doing this – so that you hear what you feel you need to, when and how suits you best. We will do our best to make sure we take on board what you and your staff side representatives tell us work for you. There will also be wider communications to ensure that all staff are aware of the changes.

Q5.7 What is the company name?
The company name has not yet been agreed and staff suggestions are very welcome.

Q5.8 Will job descriptions be reviewed?
With the exception of Procurement and the OpCo Board, reviewing job descriptions in connection with the transfer is not planned.

If at some point in the future job descriptions require review due to service changes or where discrepancies are identified between similar roles, it would follow the agreed process of discussion with the job holder/s.

For Procurement there will be new job descriptions for all roles in the new structure, in which Heads of Procurement have been actively involved in designing. All Procurement staff were issued a copy of the new structure and were invited to a briefing in March where this was explained and they were able to ask questions. This was an informal session and not part of the formal information and consultation required under TUPE and the Trusts' organisational change policies which we will honour and comply with.

Q5.9 Who will be delivering support services to the new company?
For services like HR, digital, payroll etc this will need to be decided over the next few months. This will follow reviewing what services are needed, who will deliver them and then contracts for those service provision will need to be developed and agreed; including KPI's.

6. Setting up the Company

Q6.1 Who will the Board members of the subsidiary company be?
The Board members of the subsidiary company have not been appointed.

Initially there will need to be a shadow Board, to help in the set up stage along with project support including HR, comms, finance and other staff. External expertise will also be used, especially in the procurement area, to help speed up delivery of the savings.

Q6.2 Up to what level will the senior manager team be included in the transfer?
The senior management teams responsible for services transferring will be included in the transfer.

Q6.3 Will the new company own the buildings and equipment currently used?
Each Trust will set up its own property company (PropCo) and it is these three, individually owned, property companies that will lease the buildings and equipment. The vast bulk of staff will transfer to the operating company (OpCo), which is jointly owned by the three Trusts.

Q6.4 Who will own the companies and where will any profits go?
Each property company will be wholly owned by each Trust (DCH, DHC, UHD). The operating company will be a shared ownership. Any profits will be reinvested in the company to fund service developments and/or go back into the Trusts. This will be after paying any taxes or other costs due. Any profits will remain within the NHS.

Q6.5 What investment will be made in the business in terms of systems, equipment, staffing, training, etc?
Initially there will not be many changes, but as the business develops and makes a surplus, it is anticipated that the company would look to invest some of this in improvement in services and staff. This can include profits made on supplying services to other customers. This will be part of the annual business plan.

Q6.6 Is it possible the subsidiary company could be bought out by another company?
This is highly unlikely as the Trusts are committed to keeping the subsidiary 100% NHS owned. Thus whilst is technically possible under company law for the subsidiary company to

be sold, this requires the Trust to want to sell, which is against the commitment each Board has made.

It is also against the interest of the Trusts to sell, as 100% of the benefits of the shared service are kept in Dorset. To sell would be to lose those.

If it was sold the benefits of the NHS Trust would be significantly diminished. This loss of control and benefits is why each Trust board is committed to keeping the company's wholly NHS owned. See also Q6.15

Q6.7 Will we get shares in the subsidiary company?
No. The NHS Trusts are the only shareholders of the subsidiary company.

Q6.8 If the subsidiary company fails, will employees then be transferred back into NHS structure?
The set-up proposed is likely to be very beneficial, and each service is already well run. So, there is no expectation of failure. However, in the unlikely event that this occurs it would be for the parent company, i.e. each Trust, to decide whether the service transfers back into the NHS structure, or how to improve the subsidiary's performance.

Q6.9 How will the subsidiary company be paid for its services?
The company will be paid by the Trusts it supplies services to. This will be via a Contract. The contract will include key performance Indicators and standards, as well as the amount of funding.

Q6.10 Could there be penalties for the company for example if compliance checks are not 100% completed within the year?
Within the Service Specifications and Contract with the Trusts there will be a range of key performance indicators (KPI's). The company will need to comply with or explain variations. Penalties and improvement targets have yet to be discussed and agreed, and this will be done as part of the set up process. However, as the Trusts own and consolidate the accounts at group level, and the aim is high quality, affordable services, this means penalties and fines are all unlikely to achieve that aim.

Q6.11 Will there be scope for career progression in the company if the business proves successful?
Yes, if the company develops its services and expands there could be new roles available within the company which may offer career development opportunities for staff.

Q6.12 Will the company involve the current staff to do small projects within the Trust that are usually sourced out to contractors i.e. kitchen re-fits, ward and room refurbishments?
It is a part of company strategy to reduce costs where possible, whilst maintaining quality, which may include bringing minor work schemes in house. However, the company needs to ensure that these are good quality and cost effective.

GP practices and other specialist providers struggle to find contractors, so this may be another area of growth.

Q6.13 Will every work task be costed and timed?

There will be a unitary charge for total services provided, rather than piecemeal charges for individual tasks. Any contract variations will be picked up through annual contract setting.

Q6.14 Will any departments be contracted out to outside contractors?
No, this is not anticipated, and in fact the reverse is more likely. That is currently contracted out services are brought in house. The company is being set up with the aim to develop and grow its business. This will include looking at contractor spend and if it is more cost effective to provide using the larger scale and specialisation that the shared services provide.

Q6.15 In 10-15 years' time could you put the company out to tendering?
This is considered highly unlikely given that the Company will have a minimum 10-year contract with each Trust. Any private sector provider will no longer have a tax advantage, plus they would be likely to be more expensive as profits would go to their shareholders. So retaining the company within the NHS is much more sensible

Q6.16 Is there potential for new roles to be created within the company?
Yes, a key aim is to develop the company over time to expand the services delivered and create new opportunities for the workforce.

Q6.17 Will the company continue to buy services in e.g. the use of external contractors?
There are and always will be some specialist areas where it is essential to buy in external expertise. The company is keen to minimise this wherever possible, to provide local jobs and careers, to keep any profit within the NHS, and to ensure a joined-up service to the customer, the Trust and its patients.

Q6.18 Is the subsidiary company a PLC?
No. The subsidiary company will be a limited company.

Q6.19 How will the estates backlog of work be addressed and funded?
We would continue to manage and fund this in the same way we do now, including formulating our individual backlog needs; and then prioritising these with each Trust's Capital Planning processes. The opportunity to access Government funding will also be available as now. Through the OpCo we would also be able to explore opportunities to access additional funding, and the ability to combine similar works to give better value for money.

Q6.20 Will roles be centred around Trusts or across all?
With the exception of Procurement, to begin with, there will be little visible change. But over time, the ambition will be to bring the teams together to function as one.

In Procurement, things are likely to move faster, because as a function they started discussing a new Trust Operating Model with Procurement colleagues earlier, so they will have some expectations about changes to come.

Q6.21 Will the charge that each Trust will pay to the subsidiary company be sufficient to meet the KPI's?
Each Trust will define the level of service it requires, and the associated charge will be based on that service level. The financial envelope is intended to be sufficient to deliver the agreed-upon services and meet the corresponding KPIs.

Q6.22 H&S is a complex, diverse and highly legislated discipline, how will all the aspects be considered and regulatory and statute obligations met within the subsidiary company?
This is an area that will be explored in more detail. Using the expertise in house, and learning from other subcos that have been operating for 10 years+

Q6.23 Moving to a subsidiary company will require all staff to have a more commercial mindset, systems and processes to be more agile, efficient, standardised and reliable, all of which will take time. How will this be achieved?
Over a period of time, as teams embed and start to work closer together there will be a need to encourage value-for-money thinking, accountability, and responsiveness. Training managers in commercial awareness, service costing, and client-focused delivery will also help. Ultimately, the subsidiary will be a partner to the NHS, focused on more efficient and effective working.

Q6.24 Is there an opportunity to take onboard NHSE Estates property?
This is currently considered unlikely as NHSE Estates are unlikely to sell, and there are very few such properties in Dorset.

Q6.25 What level of autonomy will the subsidiary company have?
The level of autonomy the subsidiary company will have is still under discussion. While there are clear advantages to allowing the subsidiary to make some operational decisions independently, it will also be necessary to agree on which types of decisions should be reserved to the Trusts. This will be reflected in the governance documentation for the subsidiaries.

Q6.26 Who and how will the KPI's be managed?
KPIs will be managed and scrutinised by the intelligent client function which will sit within the Trusts (or the PropCo) and will ensure service delivery is at the required levels under the agreements with the subsidiary (OpCo).

Q6.27 Will any unitary charge include investment?
The Unitary charge will include what has been agreed between the respective parties for operational service delivery. This will be agreed annually at contract setting and ideas for investments will be considered. Agreed capital project purchases and lifecycle equipment purchases will be agreed through an annual capital plan.

Q6.28 Will the subsidiary company be expected to make a profit each year? And if so, what will happen to it?
The detailed financial modelling is still being worked through. However, it can be confirmed that any profits arising from the subsidiary structure will remain within the Dorset NHS system.

Q6.29 Will each Trust have their own KPI's? Or will they be across all three?
Each Trust will have the flexibility to define their own desired service standards. Many of these will be similar and over time may converge. As each Trust has a different starting position and differing systems, these service standards will take some time to develop. The level of funding available and the service standards required will determine the associated charges. This will be recorded and set out in the agreement between the subsidiary and the Trust.

Q6.30 How and who will set the strategy?

The level of autonomy the operational subsidiary company has around setting the strategy is still under discussion. We would anticipate that the operational subsidiary will provide a draft strategy document which would be subject to comment from and the approval of the three Trusts as shareholders. The agreed position will be reflected in the governance documentation for the subsidiaries.

Q6.31 How will CDEL be allocated and utilised under the new arrangements?
Capital Departmental Expenditure Limit, (more commonly known as CDEL) is the limit on capital spending that government departments are allowed to incur in a given financial year. Capital pays for buildings and equipment. It is not anticipated that there will be any change to how CDEL is allocated. Each individual Trust will continue to make decisions about how it's CDEL allocation is best deployed, working in collaboration across Dorset.

By sharing the capital developments and procurement services across Dorset means delivery is in a more efficient and effective way. This means the proposal can achieve better value for money from the CDEL budgets available.

7. Additional Questions raised by Procurement staff

7.1 The Procurement TOM requires significant engagement by clinical staff in order to achieve the savings anticipated in the procurement business case, which is something procurement have struggled with in the past. How will you improve clinical engagement?
Good engagement with our clinical colleagues is recognised as important and that we can improve. We will do this with clinical colleagues so that there is a shared understanding of what we are trying to achieve and how we need to work together to do that.

7.2 For personal reasons I can't travel between sites, what happens if I'm expected to?
Your situation will be considered in the light of your contract of employment, and the relevant organisational policy. As is the case now, it might be that your circumstances can be addressed under the flexible working policy arrangements. Account would also be taken of whether this is a temporary or permanent restriction on your travelling.

7.3 It was titled NHS Dorset procurement service – what is the ICB's involvement?
This refers to the Dorset provider Trusts only, the ICB are not part of this collaboration

7.4 Where will the subsidiary base be?
The subsidiary will work from all the sites that the current services operate from. For procurement specifically any changes of office locations is still to be determined. See other questions regarding travel.

7.5 Our pay scales are different across each organisation, is it likely our pay may reduce?
For Procurement staff, where structural changes are proposed, new roles will be assessed based on job descriptions. Whilst jobs that appear similar may currently have different grades, all three Trusts use the NHS job evaluation scheme and the new roles will be fairly assessed, matched, and evaluated consistently with the scheme rules and principles. Any inconsistencies will be addressed during the consultation in discussion with staff representatives and individual staff members.

7.6 If my base changes, do I get time for travel?
The organisational change policy for your employer at the time of the change will apply and this can be discussed as part of the consultation process.

7.7 Will we have new contracts?
If you transfer under TUPE, your current terms and conditions of employment automatically transfer from your current employing Trust to the OpCo, your new employer. You do not need to do anything to make that happen.

7.8 What happens if my procurement role doesn't have an obvious slot in the proposed structure?
There are no reduction in staff numbers planned, but some roles will be different and require a selection process. It is not anticipated there will be any redundancies. Your Trust organisational change policy will apply to ensure that you are fairly considered for slotting in opportunities and where that is not possible, suitable alternative employment is sought for you.

7.9 When will the Procurement Director be appointed, as that seems key to driving this forward?
We plan to start a recruitment process as soon as we have received Board approval from all three Trusts.

Ends

Formal Consultations with staff and staff representatives about creating a WOS shared service

1. Introduction

The Trusts tabled on May 1st, a draft approach for discussion with Trade Unions about how we would informally and formally inform, engage and consult with Trade Unions, (see slides at end).

This paper sets out the approach to formal consultations. It should be treated as a draft which we plan to discuss with trade union representatives.

2. Formal Consultations

As shared with the Trade Unions on 1st and 8th May, our aims with formal consultation are:

- Formal consultations will not start until the Trust Boards have self-certified, using the NHS England framework, that they have satisfied themselves with regards to the process for establishing 100% NHS owned subsidiaries.
- The Trusts will adhere to their organisational policies, adopting the best practice for staff where there are differences. The policies were shared with trade unions attending the WOS meeting on 1st May.
- The Trusts will comply with the requirements to inform and consult with staff and staff representatives under TUPE.
- The Trusts would want to work closely with the trade unions during this phase, perhaps:
    - through the weekly meetings set up with unions re: Dorset Shared Services and
    - With their participation in the planning alongside the HR&Comms Workstream team, and
    - via Staff Partnership Forums.

The Trusts would also follow ACAS guidance for employers: those transferring services and staff (the Transferor employer) and those to whom the services and staff are being transferred into (the Transferee employer, the Subco).

3. Planning for formal consultations:

The plan for formal consultations, in line with policy, will treat the creation of a WOS company to provide shared EFMP services as a major change. It will make the case for

change and put in place consultations with staff representatives and individuals; both explained in more detail below:

3.1 Make the case for change

The case for change will cover the matters set out below, will be documented and issued to all staff affected by the WOS company shared services model. It will be shared with staff side representatives, about one working week before issuing, to allow for comments. The case will cover:

- An overview of how services will be provided, or roles will be changed under the revised arrangements, and what isn't changing (eg pay, terms, pensions);
- The reasons for making the change;
- The extent of the change, including the number of staff likely to be affected;
- The process / project plan for managing the change and approximate timescales.
- New structures confirmed, if applicable, together with any new or revised job descriptions and person specifications, where applicable.
- The consultation document will be accompanied by an Equality Impact Assessment (EIA). This document will provide the basis for the initial discussions with trade unions and staff, but as part of the Trust's commitment to meaningful consultation, it is recognised that the plans may subsequently need to be amended to take account of the outcome of the consultation.

3.2 Consultation arrangements

The Trust recognises that open and effective communication and consultation is key to successful organisational change. This consultation will take place with both staff side partners and individual members of affected staff, starting after the Boards self-certification and Board decision. The Board is currently planned for June 2025.

In line with policies, most organisational change consultations will usually be for a period of 30 days. The Trusts recognise that a longer period of consultation might be appropriate if the change is complex and / or meaningful consultation cannot be achieved within 30 days. As per the Trusts' normal practice, the aim would be to agree with staff side, where possible, the duration of consultations.

He current target is for the consultation to occur over July and August. Starting before the school holidays is preferrable to avoid any extended periods of leave. However it is not expected many individuals will be on leave for the whole period, but if thye are then special arrangements will be made (along with staff on maternity, longterm sick leave or secondments).

Where the proposed organisational change involves all three Dorset Trusts, all affected Trusts will work collaboratively to meet the requirement for consultation and communication with all staff side partners and individual members of affected staff and ensure that this is as open and effective as possible.

The Trusts will discuss the proposals with its recognised staff side partners through the appropriate Committees – for example Staff Partnership Forums (SPF) in addition to the WOS meetings referenced in the Engagement paper.

The proposed creation of a WOS is to protect jobs, and so does not involve any plans to make staff redundant. It is anticipated that staff in EFM services will transfer "As Is" to the Subco – what is being referred to as an organisational 'Lift and Shift' of structures and roles. This might involve some changes in reporting lines, most likely only at the senior levels and this will be explained in the consultation document.

The main exception is in the case of Procurement Services, as explained to Procurement staff since March 2025 and through the FAQs of 22nd April. Here a "Target Operating Model" is being considered for Procurement. This will involve changes to ways of working and jobs, but it is anticipated that all existing staff will either continue in their existing roles or be redeployed to roles offering suitable alternative employment within Procurement. No redundancies are expected or being planned, and the new structure is designed to enable more senior, specialist roles and a better career structure.

Consultation will be carried out with a view to seeking to reach agreement with the staff side partners, particularly in relation to where changes do occur. All three Trusts have policies to address the fair and consistent handling of change and these will be applied, if required to ensure fairness and consistency across all three trusts.

Normal practice is to achieve this in consultation with individuals and trade union representatives.

3.3 Consultation with individual Staff

The Trusts recognise that not all staff are members of a union. In addition to consulting with relevant staff side partners, the Trust will also ensure that those individuals in posts potentially affected by the change (regardless of the nature of the change) are fully consulted at the earliest opportunity.

The Trust recognises that organisational change can be difficult for staff and will endeavour to ensure that any changes are implemented as sensitively and openly as possible. This will include:

- Involving, as far as possible, the affected staff in the initial shaping and design of the new way of providing the service;

- Meeting with the affected staff during the consultation period (in small groups and/or individually) to advise them of the change and provide them with the opportunity to give their views and alternative suggestions in relation to the proposals;
- Ensuring that staff are communicated and consulted with at all stages of the process through a variety of mechanisms, team meetings and briefings, newsletters and briefing notes. Staff may choose to be accompanied by a trade union representative or a workplace colleague at any stage of the change process. Special arrangements may need to be made to ensure that staff who are on leave (including maternity and sick leave), or on secondment, are adequately communicated and consulted with throughout the process.

3.4 Employee Support

The Trusts are committed to doing all they can to support staff during organisational change. The vast bulk of staff will not be required to apply for a job, as the lift and shift affects nearly everyone, with the exceptions of the Procurement Team and some senior roles, mentioned above. Organisational change policies will be applied which may include:

- Offering advice in completing job application forms or producing a Curriculum Vitae (CV) and interview skills (for the small number of staff that may be required to apply)
- Reasonable paid time off, to prepare for and attend interviews, etc;
- Managers and members of the HR team being available throughout the change process, so that staff can discuss any concerns or confusion they may have about the options available to them;
- Staff Side representatives being available throughout the change process to provide advice and support to both staff and the Trust, including helping to seek resolution in a timely and constructive way and to accompany or represent an employee at any formal meeting;
- Providing access to an Occupational Health service;
- Providing access to a confidential counselling service, so that staff can discuss their personal concerns with an independent counsellor.

4. Planning to meet the obligations of Transferor and Transferee employers under TUPE

As mentioned above ACAS guidance has been used to inform the HR&C workstream project plan on the obligations and actions of the Trusts and Subco.

Both the Trusts and the Subco as employers will inform the representatives of affected employees in writing about the details of the transfer.

The Subco will inform the Trusts of any 'measures' that are likely to affect employees transferring in. The Trusts will pass this information on to trade union representatives of affected employees.

The information from the Trusts and Subco will be given to the appropriate representatives in writing (either by being delivered to them, or sent by post to an address they have provided or (in the case of representatives of a trade union) to the union's head or main office – as applicable):

- Confirmation that the transfer is happening, when it is expected to happen and why
- The number of agency workers employed, the departments they are working in and the type of work they are doing, if agency workers are used
- Any measures the Subco is expecting which may affect staff transferring in – for example, salary payment dates
- The legal, economic and social implications

The Subco will inform the Trusts and the Trusts will consult with the recognised trade union about expected measures proposed by the Subco.

5. After the consultation

During the course of formal consultations, management will provide responses to the questions, concerns and issues raised by staff and trade union representatives. At the end of the formal consultation period any outstanding matters will be considered by management along with feedback collated during the course of consultations.

In line with Trust policies, management will respond formally in writing to staff and trade union representatives. This formal response (the consultation outcomes paper) will set out the outcome of the consultation period, including amendments to the proposal for change, based on what staff and their representatives have said. Where representations have not been accepted the rationale will be explained. The consultation outcome paper will also set out a high level implementation.

The consultation outcomes paper will be considered by the programme team, steering group and the Shadow Board (as receiving organisation). It will also be considered by each Trust as both the shareholders of the new organisations, and as current employer – before it is submitted to staff and trade unions.

Any adjustments to the proposal recommended in the final consultations outcomes paper, together with a high level implementation plan will then be taken to the Trust Boards for approval, (target date September). This could include (but not would be limited to) change in scope, timescales or remedies to address any material issues.

Ends.

Dorset Shared Services for Estates, Facilities Management and Procurement

Three phases of staff engagement
Draft for discussion and feedback

Slides prepared for meeting of 1st May 2025 with Staff Side representatives

The three phases of staff engagement

1. Pre-Formal Consultations: already started, likely to continue to end of June 2025
2. Formal Consultations: would not start until the Trust Boards have all received assurance from the NHSE Panel and approve self -certifying the OpCo can be set up. This is anticipated to be completed by end of June. Formal Consultations therefore, would not start before July 2025.
3. Post Formal Consultations: would follow formal consultations. The aim would be to build for staff transferring as rich an understanding of what working in the OpCo would be like for them personally.

We would hope to work jointly with you on engagement with staff in all three phases happens

Phase 1: Pre-Formal Staff Consultations

- We are in that period now and have been engaging with our staff to explain what the organisational changes in the business case are and the rationale for those changes.
- So far that has been communicated through the PowerPoint presentation and FAQs.
- Going forward we will prepare materials and schedule events (like CEO Teams Meetings, and Drop-In sessions with Senior EFMP managers) to enable us to communicate the rationale for the OpCo: the strategic, financial, commercial and economic reasons that make the OpCo the best option and also explains why we cannot stay as we are.
- During this period we would expect to complete the NHSE assurance process and self -certification by the three Dorset Trust Boards, including developing a robust staff engagement plan that provides assurance that we have engaged and have plans to engage with staff and their representatives through all three phases and beyond the TUPE transfer into the OpCo
- The timeline currently is anticipated to be: we hear from the NHSE Panel by mid -June; and subject to that, the Trust Boards meet to approve self -certification by the end of June.

Phase 2: Formal consultations

- We will adhere to Trusts' organisational policies, adopting the best practice where there are differences.
- We will comply with the requirements to inform and consult with staff and staff representatives.
- We would want to work closely with during this phase, perhaps:
  - through these weekly meetings; and
  - With your participation the HR&Comms Workstream team.

Phase 3: Post-formal consultations

- Depending on the Trust Boards' final decisions, expected in September, we would want to continue joint working on planning events and developing content.
- The aim would be to build for staff transferring as rich an understanding of what working in the OpCo would be like for them personally, involving them in:
  - Building their knowledge of and relationship with the Shadow Board
  - Being involved in the development of the OpCo vision, mission, values and alignment with NHS values.
  - Building their understanding of OpCo business goals, aims and plans
- Some of this would be achieved through the OpCo Corporate Induction and the local induction programmes.

Shadow Board Profiles

Chris Hearn

Joint Chief Financial Officer – Dorset HealthCare University NHS Foundation Trust

Chris was appointed Joint Chief Financial Officer of Dorset Healthcare and Dorset County Hospital NHS Foundation Trust (DCH) on 1 February 2024.

Chris joined DCH in October 2022 from DHC, where he was Director of Operational Finance. During his time in the NHS, Chris has worked in a number of senior finance roles within acute, mental health and community Trusts, and prior to this has experience across a variety of technical and commercial finance roles within a large FMCG organisation.

Chris is a Fellow of the Institute of Chartered Accountants in England and Wales (ICAEW), having qualified with PwC London where he was involved in the audit of a number of FTSE 100 companies.

Dawn Dawson

Joint Chief Nursing Officer – Dorset HealthCare University NHS Foundation Trust

Dawn is a nurse with an extensive clinical background having worked in acute, community and the mental health sector; most recently she has held a number of senior positions in an integrated mental health and community trust.

Dawn has a broad academic background, which includes psychology, law, and post-compulsory education. Her focus on high quality patient care combined with workforce development led to Dawn working strategically across an STP footprint successfully heading up a national test site for the Nurse Associate Programme.

She is also Interim Deputy Chief Executive since July 2024.

David Underwood

David Underwood

Non-Executive Director – Dorset County Hospital

Dave is an experienced and respected senior leader having worked first at the Civil Aviation Authority as an Air Traffic Control Scientist and Research Manager before joining the Met Office, in 1998, to lead their Civil Aviation Business. Over 20 years with the Met Office Dave undertook a range of senior executive roles including Group Head of Public Sector Business, Deputy Director of Technology and Information Systems and latterly Deputy Director of High Performance Computing.

In addition to his executive roles Dave has more than 15 years non-executive leadership experience gained in the fields of Environmental Business, Further Education (serving on the Board of Exeter College) and Healthcare (having served in Non-Executive roles with the Royal Devon & Exeter NHS Foundation Trust (2018-2021), Dorset County Hospital NHS FT (Since 2020) and Dorset Healthcare University NHS FT (Since 2024).

Dave is passionate about delivering effective leadership of Change & Transformation and promoting the benefits of careers in science, technology, engineering, mathematics and medicine.

Stuart Parsons

Non-Executive Director – Dorset County Hospital NHS Foundation Trust

Stuart is a fellow of the Association of Chartered Certified Accountants, having qualified whilst working at Eldridge, Pope Brewery in the centre of Dorchester. He has more than 30 years of experience in commercial finance and has held senior positions in a number of sectors including telecoms, logistics, equipment rental, asset management and engineering services. Before retirement he held the position of Group Commercial and Finance Director for Briggs Equipment UK Limited based in Staffordshire. His roles have included international businesses across Northern Europe and Russia. His experience demonstrates a strong collaborative approach, whilst improving governance and control, along with the critical challenge to improve performance and efficiency. He has a keen love of sport and music and is returning to Dorset after moving to the Midlands more than 23 years ago.

Pete Papworth

Chief Finance Officer – University Hospitals Dorset NHS Foundation Trust

Pete was appointed director of finance for the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust in 2017 and was subsequently appointed director of finance for Poole Hospital NHS Foundation Trust in 2019 in a joint role across both organisations. He led the financial aspects of the merger of the two organisations and was appointed as the first chief finance officer for University Hospitals Dorset NHS Foundation Trust on 1 October 2020. Pete is a chartered accountant with experience working across all aspects of the public sector locally, since joining the Audit Commission's graduate scheme in 2003.

Tracie Langley

Non-Executive Director - University Hospitals Dorset NHS Foundation Trust

Tracie Langley has had a distinguished career as a senior strategic executive across both public and private sectors. She is a qualified accountant and has held a number of director roles across a variety of organisations and industries, most latterly as Chief Operating Officer and Finance Director of Cornwall Council.

Tracie has a deep understanding of how the public sector functions and how to overcome the challenge of the provision of quality services in a financially constrained environment. She has an ability to connect and grow strong collaborative relationships between health and social care organisations to best support the patient's needs.

Tracie lives in Dorset with her husband and is committed to ensuring that Dorset offers the best healthcare in the country.

Richard Renaut

Chief Strategy & Transformation Officer - University Hospitals Dorset NHS Foundation Trust

Richard lives in Dorset and grew up here, and is a passionate supporter of the NHS, having worked in it since 1997. He has experience of working in primary, secondary and tertiary care settings.

He has been CSTO for UHD since it's creation in 2020. The portfolio includes capital and estates. Richard has been the lead executive for the £500m reconfiguration programme, to create the emergency hospital at Bournemouth, and England's largest planned care hospital at Poole.

Prior to UHD Richard was a Board member at the Royal Bournemouth and Christchurch Hospitals, since 2006. This included 7 years as Chief Operating Officer. He was also the lead exec for the merger process.

DRAFT: version 28 May 2025

Dorset Shared Services - Terms of Reference for the Shadow Board v1

Section	Content
1. Introduction	The Shadow Board will come into place to facilitate and oversee the formation and set up of the joint subsidiary ("OpCo") between University Hospitals Dorset NHS Foundation Trust; Dorset Healthcare University NHS Foundation Trust, and Dorset County Hospital NHS Foundation Trust (the "**Trusts**")with a planned go-live in October 2025, in line with the approved Full Business Case. The Shadow Board will act as a precursor and oversee the creation of the body corporate for OpCo including, but not limited to, the formation of its board of directors (the "**Board**") . Following the go-live of OpCo, the Shadow Board will be dissolved (the Go Live Date).
2. Purpose	To oversee the development of the shared services including the formation of OpCo from set-up to the Go-Live Date, ensuring the successful implementation of the shared services, providing strategic direction, oversight, and governance to achieve the objectives outlined in the Full Business Case, and to ensure the successful set-up of the Board. Throughout this time the Shadow Board shall make recommendations to the Trust boards to assist in the wider project decision making.
3. Membership	There shall ultimately be 14 Shadow Board members, consisting of representatives from each of the three Trusts and individuals appointed to prospective roles within OpCo, including: • Chair; • Six stakeholder non-executive directors (comprised of 2 from each Trust, one being an executive, and one being a non-executive director within the relevant Trust); • Two independent non-executive directors; • Five executive directors (including one managing director; one financial director; one director of procurement; one director of major capital, and one director of estates and facilities management). Further detail including specific post-holders [as at the date of these Terms of Reference] is included at Annex A. Members of the Board will be appointed to roles when they are confirmed and therefore the numbers of and membership of the Shadow Board will be subject to change as appointments are made to fill the membership roles set out above. For the avoidance of doubt, upon any individual

Section	Content
	ceasing to hold their relevant post referenced above, their membership of the Shadow Board shall automatically terminate.
4. Roles and Responsibilities	The Shadow Board members will have the following roles and responsibilities: - **Programme Management**: Provide strategic oversight of programme management for OpCo. - **Strategic Oversight**: Provide strategic direction and ensure alignment with the business case. - **Governance**: Establish governance frameworks and ensure compliance with relevant regulations. - **Resource Allocation**: Oversee the allocation of resources to ensure efficient utilisation. - **Risk Management**: Identify and mitigate risks associated with the collaboration.[proposed shared services (rather than risks of collaboration)?] - **Performance Monitoring**: Monitor progress and performance against key milestones and objectives. - Consider the above from the perspective and in the best interests of OpCo prior to its formation in order to make recommendations and provide direction to the Trust boards to assist in decision making.
5. Meetings and attendance	The Shadow Board will meet fortnightly, with additional meetings as required. Meetings will be chaired by the Chair or a designated deputy. Agendas will be circulated in advance of meetings and minutes shall be circulated promptly following meetings. The quorum for a meeting shall be 50% of the membership at the relevant time, including at least one of the stakeholder non-executive director representatives from each of the Trusts. [Board members cannot be represented at meetings by a nominated representative [except in the case of [insert member(s)]]]. tbc Meetings of the Shadow Board will not be held in public. This decision shall [may] be reviewed on the formal constitution of the Board. Corporate governance representatives from each of the Trusts will be invited to attend all Shadow Board meetings. The Shadow Board may also, at its option, invite additional Trust representatives or external advisors to meetings as required for the business to be discussed or where considered appropriate engage with new advisers to provide an independent opinion to the Board.

Section	Content
6. Decision-Making	Any decision to make recommendations to or provide assurance to the Trust boards will be made by consensus and agreement at the Shadow Board. Board recommendations, including whether Board members agree or disagree can be made via email, provided that these decisions are clearly recorded and can then be ratified at the following Board meeting.] The Board shall have the ability to consult its external advisors as required in discharging its duties and request the attendance of individuals and authorities from outside of the Trusts with relevant experience and expertise if required.
7. Reporting	Workstreams have been formed in order to feed into the Shadow Board. As at the date of these Terms of Reference, the seven workstreams are: 1. Estates and facilities; 2. Procurement; 3. Finance; 4. Digital; 5. Governance and legal; 6. Workforce; and 7. Communications. The Shadow Board will provide reporting to be made available to the respective Trust boards on a [monthly tbc] basis, providing updates on progress, challenges, recommendations and key decisions. The Shadow Board shall also report to the Trust boards where it has not been able to reach an agreement on any matter and considers that the matter should be escalated.
8. Confidentiality	All discussions and documents related to the Board will be treated as confidential, with information shared only with authorised personnel.
9. Review and Amendments	The terms of reference will be reviewed and amended as necessary to reflect changes in the collaboration or external environment.
10. Dissolution	The Shadow Board will be dissolved following the successful go-live of the OpCo and Board, with responsibilities transitioning to the new governance structure.

Annex A

Organisation	Role in Shadow Board	Post Holder
Dorset Health Care University NHS Foundation Trust		
Dorset Health Care University NHS Foundation Trust		
Dorset County Hospital NHS Foundation Trust		
Dorset County Hospital NHS Foundation Trust		
University Hospitals Dorset NHS Foundation Trust		
University Hospitals Dorset NHS Foundation Trust		
	Managing Director	
	Director of Estates and Facilities	
	Director of Capital projects	
	Director of Procurement	
	Director of Finance	
	Corporate Governance	
	Minute-taker/programme support	

Pre- Formal Consultation Engagement and Information Sharing Report:

Dorset Shared Services - Wholly Owned Subsidiary

1. Introduction

This report is to summarise the engagement with staff and unions regarding the Dorset NHS shared services proposal. This was held over April and May 2025.

The Board is asked to note the work that has been undertaken, and the key themes that have emerged. Engagement is an important part of the work of NHS FTs, as it helps shape and strengthen the decisions that Boards will make.

Working with staff and stakeholders the key themes emerging have been used to shape and strengthen the proposal, as well as the communications around this. As a direct result of this engagement work the Full Business Case has been updated, and several important changes have been proposed:

- The triple lock of pay, terms and conditions.
- Triple lock on keeping public ownership.
- Clarity that NHS pensions will be available for all staff.
- Lengthen the contract, to provide certainty for next 25 years

As the most important message heard has been staff wanting greater assurance about pay, terms and conditions and pensions, and remaining part of the NHS, these changes are proposed for the Dorset NHS FT Boards to consider.

The report below sets out the process, and themes. Many executive Directors were present at the staff listening events, and will be able to add first-hand experience of the sessions.

As the Board considers the updated Full Business Case, in public, this report provides the evidence that the Board can use to aid the self-certification and assurance, ahead of deciding whether to progress to the next stage, of formal staff consultation.

2. Pre-formal consultation engagement and information sharing

The audiences for this phase of pre-formal engagements events are:

1. Relevant Staff in the Estates, Facilities Management and Procurement services that would be affected by the proposed transfer of these services to a WOS.
2. All staff, in all three Dorset Trusts
3. Trade union representatives at Staff-Side and Full-Time Officer levels.

Engagement has been through a combination of:

1. Existing CEO briefing sessions and newsletters.
2. Q&A sessions for relevant staff, with senior managers and Executives
3. The setup of a series of meetings with Trade union representatives and senior managers from across all three Trusts and responsible for setting up the WOS and workforce matters.
4. Existing Staff Partnership Forum meetings.
5. Many ad hoc discussions with staff

These engagement events are described in more detail below. They have been planned and implemented having regard to the NHSE guidance and the Trusts' policies and practices.

The key information shared is included in the FBC annexes.:

- The future of our shared services in Dorset slide deck – appendix 1
- Joint letter from CEOs – appendix 2
- Correspondence with Unison - appendix 3
- Staff briefing and FAQs are included in the FBC annexes

2.1 Timing of engagement

By early April all three Dorset NHS FT Boards had selected a preferred way forward option.

On a point of process, there has been challenge from Unison that earlier engagement, prior to the engagement described in this report, should have happened.

The rationale to undertake engagement when there was a preferred option, is important to explain. Engagement happening earlier, would have been on options that had not been scored, and with no preferred option agreed. If views had been sought with all options "on the table" this would have included privatising services, or transferring to another Subsidiary owned by a Trust outside of Dorset. These had to be on the options list, to consider, for it to be a meaningful options assessment. This would have caused considerable staff uncertainty, far greater than we have seen through this engagement. This would have led to significant drop in morale and weeks of turmoil, ahead of the Board then considering these and ruling these out.

This would have been a very negative experience and entirely avoidable. So by taking the route the Dorset Boards did, it still allowed the meaningful engagement that has occurred, (as listing of the other options are mentioned). However it meant the focus of the engagement was on the strongest options, and so allows more focused discussions.

As a result whilst some of the engagement feedback has been that the process should have been earlier, there is a clear rationale why this would not have been constructive.

2.2 CEO engagement with all staff in all three Dorset Trusts

A written joint statement from the CEOs of the three Dorset Trust was issued on 10th April. This went through a combination of postings on the three Trusts' intranets, distribution of hard copies by line managers to relevant staff and posting copies on the staff notice boards.

On 11th April, using his regular newsletter, the Joint CEO of DCH and DHC also addressed the subject (see attached). This approach enabled maximum coverage using established channels of communication with CEOs and recognising the way relevant affected staff preferred to receive information.

The two page joint statement explains the proposal to create a subsidiary company and the rationale for change: the need for improved financial performance, efficiency, value for money and service quality and delivery. It also sets out the benefits for patients, staff and the Trusts.

It states which services and staff would be affected (staff working in estates, facilities management and procurement services). It explains the principles the Trust Boards committed to in approving the proposal to set up the WOS:

- Anyone working for the sub-co will have the same NHS terms and conditions as they do now.
- Their NHS pension will be protected.
- The OpCo will be fully NHS owned. (So this is not "privatisation" as it remains publicly owned).

The CEOs recognised that some staff would have concerns and gave advance notice of the engagement sessions that would be run by managers for relevant, affected staff. They also recognised that colleagues would have lots of ideas and suggestions and encouraged them to share them.

2.3 Engagement sessions with relevant, affected staff

The Drop- in sessions were held between 22nd April and 4th May. Relevant, affected staff in EFMP services were invited by their managers to attend a session that suited them in terms of location and timing. There were about 56 sessions planned across this period, in different locations and to cover different shift patterns. Trade union representatives were invited to join and members of the Dorset Shared Services HR workstream attended as many as they could to hear the feedback from staff and trade union representatives.

The sessions were a combination of meeting in a physical venue, face-to-face with staff and online meetings. The physical venues, where possible also set up an online link, extending the number of staff who were able to attend and join in the session.

The larger face to face and / or online meetings were led by senior managers in EFMP services, often with Executive Directors. Where staff were based in multiple sites and not able to attend at one of the physical venues, the use of existing team meetings were used. This was more the case for some Dorset Healthcare staff working across a large number of sites in community services.

The number of drop-in sessions held per Trust were 26 for DHC staff (due to number of locations), 20 for UHD staff and 10 sessions for DCH respectively (2 were joint procurement).

- DCH had some combined sessions with the Estates and Facilities management teams and separate sessions for Procurement teams
- Distinct sessions were held for DHC teams in estates, facilities management, and procurement respectively.
- At UHD, several sessions were primarily divided into professional/service groups, e.g. Facilities but they were open to all and had mixed groups.

Attendance at each session were between 2 to 138 staff. Most sessions had been held by the 1st week of May, with an average completion rate of 70% across the Trusts. In UHD, the subsequent meetings were opened to all teams in order to promote flexibility and engagement, taking into account the sites and staff schedules.

Line managers were also asked to use their normal agreed channels of communication to inform and engage with staff who were not at work and might miss the chance to attend the sessions, e.g. because of maternity leave or sickness absence.

2.4 Content of the engagement sessions

The sessions, used a slide deck presentation (attached), to share information on:

- The context and rational for setting up the subsidiary: options and why going on as we are is not a viable, and why setting up a subsidiary company providing shared EFMP services across Dorset Trusts is the strongest option
- Key principles agreed by Dorset's FT Boards of protecting NHS terms and conditions and pensions, not choosing outsourcing or privatisation, reiterating the messages from the CEOs' joint statement of 10th April.
- Identifying the services within EFMP that potentially were in scope and the WTE number of staff by Trust who were potentially affected.
- Indicative timeline and process including Trust Boards self-certifying, formal TUPE consultation, set up of the shadow board and organisation and potential go live date.

- The proposed plan for engaging with staff informally, as well as formally
- Where staff could get support

These went alongside the comprehensive written FAQs that have been made available to all staff on all three Trusts' intranets. Because we know some EFMP staff are not always able to access their emails or the intranet, FAQs have been made available in hard copy and on the staff notice and through their line managers.

Also to note there were 4 earlier listening sessions with UHD FM staff, the week following the joint letter from CEOs. These ran on a listening basis, to provide a rapid forum to collate staff views. They were then followed by sessions that used the standard slide set as part of the 46 events listed above.

4. Feedback: key themes

The top three questions, by theme were:

1. Certainty on pay, terms and conditions. In particular how to strengthen the legal protections beyond TUPE.
2. Assurance on NHS pension access.
3. The links and attachment with being part of the NHS, publicly owned and public service ethos.

There were of course many other questions, which are picked up in the extensive FAQs. The number of FAQs is now over 90. The revised FAQs have a "most frequent" summary at the beginning to help guide to the most common questions.

These other question themes included:

- Ensuring longterm sustainability of the OpCo, and avoiding selling off at a later stage.
- The exact scope of services and posts in scope.
- The process, timelines and decision points.
- The level of union engagement.
- The level of information shared, and whether there was sufficient, or if it was too much (e.g. the number of FAQs were too many).

Over the earlier Q&A sessions a lot of time was spent clarifying some of the misconceptions, e.g. this is privatisation, job losses etc. This was understandable given the media were carrying stories about job losses at NHS England, NHS Dorset and in University Hospitals Southampton. Once the actual Dorset shared services proposal had been corrected, the later sessions tended to focus more on the longterm assurances, listed above.

The Unison position of outright opposition to subsidiaries was made clear early on. RCN and Unite have also indicated their support for this position, although they are expected to have less members affected by this. Some of the Q&As included discussions as to the principles of what constitutes the NHS, what the correct levels of public funding should be, and similar topics outside the remit of the engagement.

5. Engagement with Trade Union Representatives

Engagement with Trade union representatives has been through existing channels and relationships, and expanded to include regional reps and more regular meetings.

There has also been a correspondence with the national Health of Health at Unison. The letters are attached, (with Unison's permission). These provide a good summary of the main Union objections, on both substance and process, and the Trust's joint response.

A series of meetings between the three Trusts and Unions have been specifically set up to share information and engage about the proposal for a shared service model. The dates of these are below. They have been held with trade unions staff side Chairs and Full Time Officers.

The timeline of union meetings is:

6th March 2025. Meeting with Unison Steward who is also Chair of Staff Partnership Forum "to talk through options we're exploring around estates, FM and procurement services, that protect their future, the staff, and do more NHS-NHS work." 1.5 hours, but informal so not minuted.

19th March 2025. UHD Staff Partnership Forum. Presentation of the slide deck (slightly earlier version of the one attached).

24th March - internal staff side meeting on 24 March at DCH with our DCPO and key staff side colleague (UNISON). No minutes.

28th March 2025. Meeting with Unions, local and regional officers to discuss the informal engagement. Not minuted.

10th April. Joint letter from CEOs to staff.

17th April – weekly Union meetings start. Then:

24th April, 1st May, 8th May

Then mutually agreed pause for remainder of May.

14th May UHD Staff Partnership Forum meeting where RR presented and CFO and CEO also attended and answered questions on shared services proposal.

3rd June. Walk through of business case, with Unison's lead for business case reviews. Others are invited.

5th June meeting is resumption of weekly meetings.

Also April/May – 46 staff sessions. Whilst not formal meetings with unions, union representatives were welcome to attend and often did.

DHC/DCH additional meetings:

The SubCo was discussed in one of the regular meetings between DCPO and Staff Side Chair in late March.

Discussed at the full Trade Union Partnership Forum on 8 May. Minuted.

Discussed at the full Trade Union Partnership meeting on 9 May. Minuted.

In addition, Unison full time officer has been allowed full access to areas of the Trust were affected staff work (being mindful of patient confidentiality, and safety).

Union organised protests have also been held outside RBH, DCH and Poole Hospital. These received media coverage. These were joined by Trust staff on break times, and non-Trust supporters.

Unions have also encouraged residents to write to their MPs, who have in turn written to the Trusts. Written briefings and/or letters have been supplied to MPs.

5. Lessons learnt and planning for the next stage

The engagement stage has been significant, and it is likely staff in scope will be aware of the proposal, and where to get extra information.

The earlier part of the engagement has been criticised for not being co-ordinated enough, with some staff finding out ahead of other staff, which naturally creates tensions. It is proposed any future communications and engagement is led by the Shadow Board, and the project team, to ensure it is done once, and co-ordinated in a single place.

A second criticism has been the Business Case not being in the public domain. This is not a requirement, but the publishing of the June Board papers, and the meetings being in public are to address this.

A third area, of not engaging earlier, is addressed at the start of this report, at 2.1. On reflection this was still the best time to run the engagement, to minimize staff uncertainty, but this is something where views with the unions differ.

In terms of good practice the depth of the FAQs, the number of engagement sessions, and the executive team attendance at so many events should be noted.

Looking forward, for the next five months ahead of a target go live in November, it is recommended:

- For the Shadow Board and project team to be the single point of co-ordination for engagement work
- To have a full time communications professional dedicated to supporting this work
- To have a tracking process for stakeholder written communication, ensuring timely replies
- For TUPE preparations to be undertaken with due care, mindful of the feedback around co-ordination of timing of publishing information.

6. Recommendations

Having considered this report, the Board will be asked to self-certifying against the 42 areas listed in the NHSE guidance. This includes staff and union engagement. If further evidence or additional engagement work is requested by the Board, then this can occur in June. If the work extends beyond this, then the TUPE consultation can be moved back from their July start.

The ongoing work on communications and engagement should be stepped up, for the next phase (June-November). This includes applying the lessons learnt, as per section 5.

Work with unions, MPs and other stakeholders should continue. This will include sharing all the public Board papers and offering to walk through these and answer questions.

In summary the Board is asked to

- Self certify the engagement work having occurred, or request more assurance
- Step up engagement work as per section 5
- Continue to link with unions, MPs and other stakeholders

Our Dorset
Provider Collaborative

NHS

The future of our shared services in Dorset

Presentation for Drop-In sessions for staff
Dorset County Hospital, Dorset HealthCare and University Hospitals Dorset

Setting the scene

Why do we need to change?

- NHS funding is going to be tighter than we have ever known
- Dorset is an NHS system in financial deficit – efficiency requirement of c.11%.
- If we don't live within our means, we will lose autonomy to make our own decisions.
- Nationally: NHSE is being abolished, with 50% staff savings mandated.
- Number of ICBs will be reduced with 50% reductions in programme and running costs mandated.
- National benchmarking evidences savings opportunities in all organisations in Dorset, with particular opportunities in procurement, estates and facilities.

Key principles

The three foundation trust boards have been explicit that the following will be protected as the key principles that have to be part of any proposal:

Agenda for Change, NHS Terms and conditions, NHS pensions, plus union recognition protected for all staff (new and existing), now & future.

Any subsidiary remains wholly owned, 100% NHS.

Assets remain within Trust control.

The decision to set up a subsidiary company will follow an assessment process. This process is starting now, and will include staff feedback, costs and expert advice.

Proposed solution

What are the options?

- Do nothing
  - Not a real option given the financial situation

- Hosted by one Trust
  - Staff transfer into one Trust who provide services back to the other Trusts. Some of the benefits would be realised, but there is potential for inequity of service delivery and not all the benefits of effective working would be attainable.

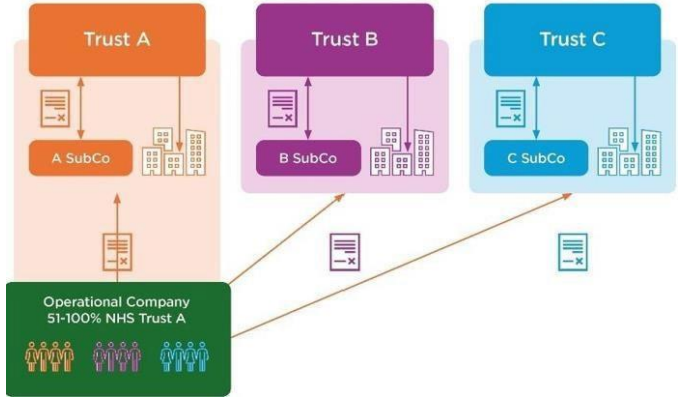
- Outsourced
  - Services being provided by an external organisation did not fit with the values of the Trusts in Dorset and their key priority of protecting staff and roles.

The proposed model

The preferred option is to set up Wholly Owned Subsidiary Companies (SubCo's).

- Each Trust would set up its own SubCo for the property and equipment that it owns (Propco)

- In addition, there would also be a jointly owned Operating Company (OpCo), which is where the staff would be placed.



The proposed scope

The initial scope is expected to include:

- Procurement.
- Materials Management.
- Operational Estates.
- Fire Safety, Estates Health and Safety.
- Sustainability staff, including energy and waste management.
- Grounds staff.
- Property Management, including residences.
- Capital / Estates development.
- Medical Engineering.
- Travel Team, including Car Park Management.
- Catering
- House keeping
- Portering

	WTE approx
DHC	330
DCH	222
UHD	703

What are the benefits to staff?

- Valued colleagues to stay within the NHS family, keeping their NHS terms and conditions and their NHS pension. Best way to prevent privatisation and outsourcing.
- Greater opportunities for career development and progression across Dorset.
- Dedicated, skilled workforce, with expert leadership, training and development.
- Increased autonomy to innovate and improve services.
- Improved attraction, recruitment and retention of staff due to the above

What are the other benefits?

- Dedicated company structure for transparency and accountability.
- Dedicated leadership – 100% focus on delivering these services.
- Ability to grow, through securing new customers (primary care, local authority, etc).
- Improving value for money – securing tax efficiencies.
- Shared services, learning from current expertise.
- Single procurement service driving out unwarranted variation (improving safety).

Indicative timeline

Start engagement with stakeholders and staff	April
Trust Boards consider Full Business Case for approval	April
NHS E assurance (Regional and Transactions team)	By June
Formal Consultation likely to commence	From June
Preparations and on going consultation under TUPE	From June
Starts operating in shadow form, with target start date for new organisation, subject to approval to proceed at previous steps.	Target by October

Staff engagement – the proposed plan

The plan (to be discussed with staff side and management colleagues) is to use a variety of channels and these will include:

- Face-to-face sessions with EFMP managers and staff – such as drop-in sessions.
- Face-to-face sessions with CEOs and executive colleagues, to have a two-way discussion.
- Dedicated pages on each Trusts intranet for FAQ's and up to date information – managers can print off the latest versions for staff circulation of hard copies
- Regular meetings with your regional and staff-side representatives.
- The HR and Communications workstream to work closely with staff and staff side reps.
- Dedicated email address for any staff to ask questions in confidence.

All staff and Trade Unions will be invited to formally feedback their views which will help inform and refine the proposal as we work towards implementing it.

Further Information

A briefing document including Frequently Asked Questions has been shared with all staff and is available of Trust intranets using the following links:

Dorset County Hospital

https://dchftnhs.sharepoint.com/sites/SubsidiaryCompany

Dorset HealthCare

https://doris.dhc.nhs.uk/news-and-events/local-nhs-sub-co-proposals

University Hospitals Dorset

https://intranet.uhd.nhs.uk/index.php/communications/latest-news/4484-the-future-of-our-shared-services-in-dorset

Support

We appreciate that any change can bring a level of uncertainty. Please talk openly to your line manager if you have any concerns.

We will shortly have an email address that questions can be posted to.

Further support is available through our Employee Assistance Programme's:

Dorset HealthCare
https://doris.dhc.nhs.uk/hr/health-wellbeing

Dorset County Hospital
https://dchftnhs.sharepoint.com/sites/OrganisationalDevelopment/SitePages/Health-and-Wellbeing.aspx

University Hospitals Dorset
https://intranet.uhd.nhs.uk/index.php/thrive-wellbeing

Questions

10 April 2025

Dear colleague

Creating a subsidiary company (sub-co) to support staff across Dorset

We are writing to update you on proposals to set up an NHS owned company that will provide some of the services we currently deliver in the three NHS trusts across Dorset (University Hospitals Dorset, Dorset HealthCare and Dorset County Hospital). We have an opportunity to work more closely with our Dorset partners to help improve the care we can provide to our patients and to make the best use of our resources together.

Nationally every NHS trust has been asked to look at setting up a wholly owned subsidiary company to help improve efficiency. The benefits would include: sharing skills to improve the service over more than one trust, improving career opportunities and pathways and offering better value for money through working together at scale. The context is the huge financial challenge faced by the NHS and the need to adopt different ways of working to be able to provide services that are affordable.

In Dorset we have been working together across our three trusts to develop an approach that would provide some services for all of us, and our three trust boards have now all agreed to develop a full business case for this.

The new arrangements being planned mean that some functions such as estates, facilities management and procurement services would be provided for the three trusts by teams based in the new company. The company will be wholly-owned by the trusts so remains in the NHS family – it is not the same as privatisation or outsourcing.

The proposal to be consulted on would be for colleagues to transfer into the company and retain their NHS terms and conditions and their NHS pension. Staff working in these services are highly valued colleagues and absolutely central to the provision of safe, effective patient care. We know that working for the NHS is really important to you and that is what we want to retain via this model. We want to assure you that even though the set-up will be a little different, you will still be part of the NHS family, supporting our staff and our patients.

We know there will be many views about this change and absolutely appreciate some colleagues will be worried about what this will mean for them. We are still creating the plan that describes what will happen and when, and that includes opportunities to talk with colleagues informally in the next few weeks. There are several examples where this has been done successfully elsewhere in the country and has made a real difference for colleagues and we will be learning from these.

We are working closely and openly with our staffside representatives so that they can also support you through the changes to come and there will need to be a full consultation process on this proposal.

Managers will be running a number of drop-in sessions with teams involved in this proposal to speak directly to you, and we will contact you from **next week** with information about when these will be taking place. We are also working closely with our unions and staffside representatives and our teams are finalising a set of FAQs to help explain more. These will

also be shared as soon as possible as we need to ensure they are as accurate and informative as possible, and agreed with staffside and across all the organistaions.

We also want to make it clear at this stage that:

- Anyone working for the sub-co will have the same NHS terms and conditions as they do now
- Their NHS pension will be protected
- The sub-co will be fully NHS owned. This is not “privatisation by the back door” as is often rumoured - it is the opposite. It helps us to protect our NHS family within an NHS organisation
- We are working closely with our regional officers and staffside reps of all three Dorset trusts as we develop our plans together

We also know that colleagues will have lots of ideas and suggestions which will help us develop a company that provides really excellent services and is a great place to work.

We have an opportunity here to strengthen our NHS partnerships across Dorset, to offer better career opportunities across our county, and to use our resources in the best possible way within our NHS family. Please do take a look at the documents as they are shared, share your ideas and ask any questions you may have. We want to work together with you to explore this option for the future of our NHS in Dorset as we continue to work more closely together across the three trusts, to deliver improved care for our patients.

We will have a number of engagement events in all three trusts, involving managers and executives so you can come and ask questions and give your ideas and views. This will take place from later in April onwards and we will let you know the dates as they are agreed. In the meantime, if you do have questions or concerns please raise them in your teams or speak with your line manager.

Thank you for all you do in your roles to make a difference for patients and colleagues.

Best wishes,

Matthew and Siobhan

Matthew Bryant, Chief Executive, Dorset County Hospital and Dorset HealthCare

Siobhan Harrington, Chief Executive, University Hospitals Dorset

University Hospitals Dorset
NHS Foundation Trust

10 April 2025

Dear colleague

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Nationally every NHS trust has been asked to look at setting up a wholly owned subsidiary company to help improve efficiency. The benefits would include: sharing skills to improve the service over more than one trust, improving career opportunities and pathways and offering better value for money through working together at scale. The context is the huge financial challenge faced by the NHS and the need to adopt different ways of working to be able to provide services that are affordable.

In Dorset we have been working together across our three trusts to develop an approach that would provide some services for all of us, and our three trust boards have now all agreed to develop a full business case for this.

The new arrangements being planned mean that some functions such as estates, facilities management and procurement services would be provided for the three trusts by teams based in the new company. The company will be wholly-owned by the trusts so remains in the NHS family – it is not the same as privatisation or outsourcing.

The proposal to be consulted on would be for colleagues to transfer into the company and retain their NHS terms and conditions and their NHS pension. Staff working in these services are highly valued colleagues and absolutely central to the provision of safe, effective patient care. We know that working for the NHS is really important to you and that is what we want to retain via this model. We want to assure you that even though the set-up will be a little different, you will still be part of the NHS family, supporting our staff and our patients.

We know there will be many views about this change and absolutely appreciate some colleagues will be worried about what this will mean for them. We are still creating the plan that describes what will happen and when, and that includes opportunities to talk with colleagues informally over the next few weeks. There are several examples where this has been done successfully elsewhere in the country and has made a real difference for colleagues and we will be learning from these.

We are working closely and openly with our staffside representatives so that they can also support you through the changes to come and there will need to be a full consultation process on this proposal.

Managers will be running a number of drop-in sessions with teams involved in this proposal to speak directly to you, and we will contact you from **next week** with information about when these will be taking place. We are also working closely with our unions and staffside representatives and our teams are finalising a set of FAQs to help explain more. These will also be shared as soon as possible as we need to ensure they are as accurate and informative as possible, and agreed with staffside and across all the organisations.

We also want to make it clear at this stage that:

- Anyone working for the sub-co will have the same NHS terms and conditions as they do now
- Their NHS pension will be protected
- The sub-co will be fully NHS owned. This is not “privatisation by the back door” as is often rumoured - it is the opposite. It helps us to protect our NHS family within an NHS organisation
- We are working closely with our regional officers and staffside reps of all three Dorset trusts as we develop our plans together

We also know that colleagues will have lots of ideas and suggestions which will help us develop a company that provides really excellent services and is a great place to work.

We have an opportunity here to strengthen our NHS partnerships across Dorset, to offer better career opportunities across our county, and to use our resources in the best possible way within our NHS family. Please do take a look at the documents as they are shared, share your ideas and ask any questions you may have. We want to work together with you to explore this option for the future of our NHS in Dorset as we continue to work more closely together across the three trusts, to deliver improved care for our patients.

We will have a number of engagement events in all three trusts, involving managers and executives so you can come and ask questions and give your ideas and views. This will take place from later in April onwards and we will let you know the dates as they are agreed. In the meantime, if you do have questions or concerns please raise them in your teams or speak with your line manager.

Thank you for all you do in your roles to make a difference for patients and colleagues.

Best wishes,

Siobhan and Matthew

Siobhan Harrington, Chief Executive for University Hospitals Dorset
Matthew Bryant, Chief Executive for Dorset County Hospital and Dorset HealthCare

Appendix 3. Correspondence with Unison

UNISON
the public service union

UNISON Centre
130 Euston Road
London NW1 2AY

Tel: 0800 0 857 857
Fax: 020 7121 5101
Text tel: 0800 0 967 968

unison.org.uk

To trust Chief Executives:

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

Responses: headofhealth@unison.co.uk

6 May 2025

Dear Dorset NHS leaders

Wholly owned subsidiary plans in Dorset

Following UNISON's letter of 20 March to all trust chief executives, you will be aware of the union's position of outright opposition to trust proposals to create wholly owned subsidiary companies. UNISON considers this a form of outsourcing that is designed to move staff away from direct employment by NHS trusts, and which is effectively a form of tax avoidance that falls foul of Treasury rules.

The union notes that, after repeated calls for it to be circulated, a business case for the proposals in Dorset was sent to staff side representatives on 29 April 2025, along with a PowerPoint presentation entitled "The future of our shared services in Dorset". Given that there appears to be an attempt to rush these proposals through, it is unfortunate that it has taken so long to share important information with staff and their union representatives.

UNISON will continue to take part in any meetings about these proposals as a way of receiving information, to continue to register our opposition to the plans, and to continue to call for the plans to at least be paused to ensure compliance with NHS England guidance.

However, for the union to engage fully, our expert panel will need around 2 weeks to carry out an analysis of the plans received so far, and we also require the rest of the documentation that has previously been requested if we are to get the full picture about what is being proposed in Dorset. This includes the Strategic Outline Case and Outline Business Case (as well as the Full Business Case); the relevant minutes of any committee, board, or governors' meetings where the proposals were discussed; evidence that the business case documents comply with HM Treasury (Green Book) guidance and have been assured against the Better Business Case requirements; the minutes of any meetings with staff representatives where issues around subco formation were

discussed before any long list of options was drawn up or any preferred option was determined; the minutes of any meetings with the ICB/ICP on the proposals and any correspondence with the ICB/ICP on the business case; and the communications with NHS England (including its regional teams) about any proposals to form a subsidiary company or companies. Once we have received this documentation, it is possible that further requests will emerge based on the information contained therein.

As you may be aware, UNISON is currently involved in a dispute with Newcastle upon Tyne Hospitals FT on their plans to outsource staff to a subco. But at Newcastle the trust has at least provided all of the above information to UNISON to enable the union to provide a full evaluation of the plans.

UNISON has recently taken part in a meeting with NHS England to raise the union's concerns about the process followed at Newcastle trust and we would expect to proceed down a similar route at Dorset. It would be particularly useful to know therefore who at NHS England has been informed about the Dorset plans, if indeed anyone has been.

Aside from the failure to share information with trade unions when requested, the most obvious failing of the Dorset project so far is that no attempt was made to engage staff at the options appraisal stage of the process. Staff engagement is a requirement under the NHS Constitution and is clearly articulated in the most recent NHS England guidance (and accompanying workforce engagement guidance) from February 2024. This stipulates that engagement with staff representatives should take place at a much earlier stage and *before* permission is given from NHS England to begin formal consultation with staff about any decision to form a subsidiary company.

As it stands, there is not even any attempt to claim that staff or unions were engaged at the options appraisal stage; the decision to form the subsidiary companies and transfer staff is effectively a fait accompli. The presentation referred to above lays out three blunt options on slide 6, before providing news of the proposed model (wholly owned subsidiary companies) on slide 7.

I look forward to hearing from you about these worrying developments. But if the trusts continue to press on with decisions without the full engagement of staff and in direct contradiction of NHS England's established guidance, then UNISON will have no choice but to consider an industrial response, which we know is not something that anyone wants.

Yours sincerely

Helga Pile
Head of Health, UNISON

University Hospitals Dorset NHS Foundation Trust

Dorset HealthCare University NHS Foundation Trust

Dorset County Hospital NHS Foundation Trust

20 May 2025

Helga Pile
Head of Health
Unison

Dear Helga,

Thank you for your letter of 6th May. We welcome the opportunity for discussion and dialogue and value the voice of Staff Side bodies. Whilst we will do our best to address the issues raised via correspondence, we would also hope to meet and discuss these with you, we feel a face-to-face meeting is important.

To that point we have a potential half day on 3rd June to go through the business case with local, regional and national colleagues and answer questions.

If there are questions on the business case that you would like to ask immediately, or after your two-week review, we would of course be willing to address these.

In responding to your letter, we group the issues raised into the matters of the proposal's substance and matters of process.

Firstly, to address issues of substance. We hear and respect Unison's outright opposition to wholly owned subsidiaries. Based on your letter, Unison's literature and dialogue with local and regional representatives, our understanding of your opposition is based on the following key points of substance:

1. Reduction in pay, terms and conditions, and pensions.
2. Back door privatisation i.e. loss of public ownership.
3. Risk to jobs (total number of paid employees).
4. Cutting standards and quality of services.
5. Risks of increased corruption.
6. This is a form of tax avoidance.
7. This is a move away from direct employment.

Whilst our preference would always be to have a face to face discussion we have tried to respond to these points of substance as far as possible below:

1. Reduction in pay, terms and conditions, and pensions. The Trusts are clear and consistent: Agenda for Change terms and conditions, including pay and leave policies will be protected. This will include a commitment to cost of living increases and a firm and unequivocal commitment to NHS Pensions. This will be dynamic i.e. will be updated to stay in line with national agreements. As part of the engagement staff have asked if greater assurance than TUPE legal protection can be given. We are developing a legally binding "triple lock" and would welcome the chance to discuss this with you, and have your involvement in shaping this, as it may be applicable more widely.

2. Back door privatisation i.e. loss of public ownership. This is not a loss of public ownership – the services are 100% publicly owned and this is a core part of the proposal. As two individuals we are proud to be within the public sector and it is a core part of our values, and keeping these services 100% publicly owned, and colleagues within the NHS family is a central part of the proposal. Indeed, one of the benefits you may have read is that we hope over time to bring more work and jobs back into being part of our services.

   Our own belief is this would be an even stronger defence of public ownership than the status quo, where outsourcing could be constantly on the options list.

3. Risk to jobs (total number of paid employees). The proposal keeps all the staff employed. Despite Dorset NHS having to make 8% cost improvement this year to break even, there will be no redundancies in Estates, Facilities or Procurement related to this proposal. As you are aware redundancies are widespread elsewhere in the NHS, and we have very challenging headcount reductions to meet, through turnover and reduced agency. Our plans to break even this year are hugely supported by the procurement savings and ensuring we are on a level playing field with other providers of these services. These two benefits are included in the business case, whereas there are no cost out plans for reduced headcount or pay. Indeed future savings are identified by bringing services back in house, by allowing an expansion of head count, something very difficult with the status quo, given the restrictions on recruitment Trusts are currently facing.

4. Cutting standards and quality of services. One of the benefits of the shared services would be a standardised set of performance metrics across our three Trusts. These quality and safety measures will be part of formal contract review, and so more robust than now. By achieving the scale, this brings better transparency, resilience and economies of scale. Therefore, this means quality is both more visible, and can be improved further.

5. A risk of increased corruption. High standards of corporate governance will be maintained, not least because the subsidiary is part of the group structure of the NHS Foundation Trusts. Therefore, the same level of audit, policies and procedures will apply. Unison literature says you have experience of greater corruption from subsidiaries. This is a serious charge, and we would advocate that any information should be shared with the relevant authorities, including counter fraud services. If there are learning points and protections beyond what the Trusts already do, this would be welcomed, so we can include in our deliberations.

6. This is a form of tax avoidance. If the Boards were to outsource to private providers the private companies would legitimately, and as a matter of routine, reclaim the VAT. The Treasury would accept this as totally normal practice. This has been the case for many years. It may change in future, but the business case has a majority of other benefits, separate from this. However, whilst this longstanding tax regime remains the Trusts are not currently on a level playing field with external providers.

   As Trusts we have a legal duty to ensure we live within our budget. Benchmarking is often used to ensure the costs of Trusts are compared. Currently Trusts with outsourced or subsidiary delivered services will be millions of pounds lower costs than our Dorset services. In reviewing options, to stay within our allocated budget we need to get onto this level playing field with other Trusts, but we want to do this in a way that avoids outsourcing and keeps services and colleagues as part of the NHS and within the public sector. This is why we are now engaging on a preferred option, ahead of a Board decision.

7. A move away from direct employment. When Trusts, then Foundation Trusts were established, there was a concern in some quarters this meant an end of direct NHS employment, and a loss of public sector ethos. We have both worked for the NHS for over 25 years each, in Trusts and have not seen this risk and remain passionate about the NHS. Having a wholly NHS owned subsidiary, with the same staff, on the same pay and conditions, as part of the group model is, in our minds, a way of providing a better service to all our Dorset residents. The only viable alternative to outsource would be a far less attractive route to go down.

The second set of concerns you have raised are to do with process. Our summary of these is as follows:

8. The stage at which engagement with unions happened.
9. Whether this is a done deal.
10. The number of documents shared.
11. If anyone at NHS England has been involved and if so who.
12. Whether guidance has been followed, especially on engagement ***before*** formal consultation.

Just before responding to these points in detail, we would like to apologise if it feels that staff side colleagues have not been involved sufficiently early in the process. We believe strongly in the partnership with staff side and colleagues. There were several meetings with your local representatives ahead of the wider staff engagement, but we accept we don't always get this right at every stage but offer a genuine commitment to want to work together in partnership. Going forward we would like to seek to shape a process together, even if we are approaching this from different standpoints.

In the meantime, our reflections and responses are:

8 The stage at which engagement with unions happened. As above – we apologise if it feels as though engagement was not begun early enough. The reason the first phase of business case development was not undertaken in public, is due to the process requiring a long list of options to be considered. This had to include outsourcing, as it is an option some Trusts have taken. Once we had assessed options and found a "preferred way forward" that met the criteria, this was the point at which we started engaging yourselves and others.

We recognise we have different views on the preferred way forward but want to work with you to make sure that we are hearing all concerns from colleagues, and if we proceed with the proposal, that the relationship with staff side is at the heart of the new organisation.

9. Whether this is a done deal. We have several stages still to progress through. At each stage the Boards will consider all the information gathered, and the best course of action. As explained above there is a preferred way forward, we are looking at, but this is not a final decision. We welcome comments on the business case and will also get an assessment from NHSE which will also inform the Boards' decision.

10. The number of documents shared. We have shared the full business case, and we hope this is helpful. We are due to meet and discuss this and hope this will be helpful in terms of supporting staff side members and other colleagues with their questions and concerns.

    Our reasons for not sharing earlier versions of the business case are that these have been superseded by the Full Case that you have. We will share the appendices, except where they are commercial in confidence (e.g. where they refer to procurement issues).

    Regarding minutes and correspondence with Dorset ICS, NHSE etc we do not publish these, but for the most part any discussions were informal and not minuted. This is normal practice, as we have not entered any formal process that requires documentation with these bodies. From the end of April, we have asked NHSE to assess our business case, and we will ask the Transaction Team if they are willing to put the feedback into a written form, the summary of which will inform the Board's deliberations in public.

    Your last set of information requests is for minutes of Board meetings. We do not share minutes of the part 2 Board meetings, especially when we are then publishing the documents. The next set of our Board meetings, deciding the next stage, will be held in public. Members of the public can attend and can submit questions in advance. We will share the dates with our local union representatives.

11. If anyone at NHS England has been involved and if so who. As part of the process, we have requested NHSE to review the business case, in line with the guidance. This will provide independent expert assessment. The Boards remain the legally responsible bodies for decision making.

    We have also asked for a contact with the national team. They have provided their email england.subsidiaries.incomegeneration@nhs.net. We have alerted them you may wish to request a meeting.

12. If the guidance has been followed, especially on engagement *before* formal consultation. The guidance, especially for engaging ahead of formal consultation is being followed, as this is the stage we are in now. The decision to proceed to formal consultation has not yet been made.

In conclusion we are keen to have future discussion with you and your colleagues, and particularly to hear local concerns about the proposal. Our sharing of the business case and offer for a half day workshop provide evidence of our commitment to this.

In summary we believe in protecting pay, conditions and jobs, NHS ownership, quality, and safety, as well as recognising our duty to live within the resources allocated to us within the

NHS. All of these underpin the preferred way forward. We recognise the concerns of colleagues locally, many of whom are your members, and we want to work with you and colleagues to seek to address these as far as possible.

Thank you for writing to us.

Yours sincerely,

Siobhan Harrington
Chief Executive
University Hospitals Dorset

Matthew Bryant
Chief Executive
Dorset County Hospital & Dorset HealthCare NHS Foundation Trust

Annex 18 Go / No Go checklist

SUBCO - ESSENTIAL/HIGHLY DESIRABLE GO LIVE CRITERIA

RAG STATUS
The action has been fully complete
The action is on track for completion date
Minor deviation from plan, this is being managed effectively and it is expected that the action will be delivered with only minor impact to timeline
Action significantly off track and requires additional support / resources for delivery/escalation
Action not yet started & not off track

No.	ESSENTIAL OR HIGHLY DESIRABLE	CRITERIA	RAG STATUS
		WORKSTEAM 1. GOVERNANCE AND LEGAL (Lead Sarah Macklin)	
1.1	**Essential**	Agree go/no go list for Day 1 safe and legal, and the process (this spreadsheet)	complete
1.2	**Essential**	Agree subsidiary Boards membership and receive approval from the Trust Boards	on track
1.3	**Essential**	Obtain NHSE approval to proceed (with process in place to resolve outstanding matters)	on track
1.4	**Essential**	Agree renumeration for OpCo and PropCo Boards	Action not yet started & not off track
1.5	**Essential**	OpCo Agree list of legal documents incl. Articles of Association, shareholder agreements, leases, specifications, contracts, reverse SLAs etc.	on track
1.6	**Essential**	PropCos Agree list of legal documents incl. Articles of Association, shareholder agreements, leases, specifications, contracts, reverse SLAs etc.	on track
1.7	**Essential**	**June - Trust Boards approval to self certify and progress to TUPE formal consultation**	on track
1.8	**Essential**	Agree schedule of reverse Service Level Agreements for services by provided by Trusts to the company (HR, Digital, Finance, Comms, IG for example)	Action not yet started & not off track
1.9	**Essential**	Approve intelligent client role and have resource in place for Day 1	on track
1.1 0	**Essential**	Agree OpCo/PropCo reporting structure and meetings	Action not yet started & not off track
1.11	**Essential**	Register OpCo company with Companies House	Action not yet started & not off track
1.12	**Essential**	Agree reserved matters and changes to schemes of delegation retained by Trust Boards	on track
1.13	**Essential**	1st Shadow Board in place & meeting schedule agreed	Action not yet started & not off track
1.14	**Essential**	Start recruitment of OpCo independent NEDs (agree process)	Action not yet started & not off track
1.15	**Essential**	Interview and select OpCo Executives who have not been identifed through TUPE process	Action not yet started & not off track
1.16	**Highly Desirable**	Agree corporate governance support for opco/prop co Boards	Action not yet started & not off track
1.17	**Essential**	Opco Executives in place	Action not yet started & not off track
1.18	**Essential**	Execute all legal documents	Action not yet started & not off track
1.19	**Essential**	**September - Final approval to proceed from Trust Boards, and go live**	Action not yet started & not off track
1.2 0	**Essential**	**October - First OpCo Board meeting**	Action not yet started & not off track
1.21	**Highly Desirable**	Confirm process for Closing the Project, transition to Business as Usual, capturing the benefits and completing/sharing Lessons Learnt report	Action not yet started & not off track
		WORKSTREAM 2. FINANCE (Lead Andrew Monahan)	
2.1	**Essential**	Finance SLA options agreement	on track
2.2	**Essential**	Company Set Up Arrangements (bank account, HMRC gateway, register with government gateway, agree year end date, agree length of first reporting period, confirm name of auditors)	on track
2.3	**Essential**	Financial Model (agree pricing methodology, confirm preferred debt/equity split, agree funding model, monitoring of expenses incurred in relation to set up and ongoing, Trust income streams)	on track
2.4	**Essential**	Identify and procure general ledger and other systems	on track
2.5	**Essential**	Map integration of feeder systems to the ledger	Action not yet started & not off track
2.6	**Essential**	Review coding structure and reporting hierarchies	Action not yet started & not off track
2.7	**Essential**	Confirm SFIs	Action not yet started & not off track
2.8	**Essential**	Review existing finance and consolidation systems and ensure fit for purpose	Action not yet started & not off track
2.9	**Essential**	Agreement of baselines (receive baseline 24/25 budget and forecast, compare actual costs to budget, review and finalise pay and non-pay budgets to transfer)	Action not yet started & not off track
2.1 0	**Essential**	Completion of Stamp Duty Land Tax documentation	Action not yet started & not off track
2.11	**Essential**	Agree Finance Lease/Operating Lease arrangements with auditors	Action not yet started & not off track
2.12	**Essential**	VAT implementation (notification letter to HMRC, schedule of capital schemes costs, tax advice note, land registry numbers and site plans for all transferring property)	Action not yet started & not off track
2.13	**Essential**	Finance SLA in place	on track
2.14	**Essential**	Asset transfer (catergorised assets, non-capital furniture and fittings, full valuation, non building assets, capital and non capital assets	Action not yet started & not off track
		WORKSTREAM 3. WORKFORCE (Lead Louella Johnson)	
3.1	Essential	Finalised affected staff list	on track
3.2	Essential	Engagement plan agreed for 3 phase consultation period	on track
3.3	Essential	HR service provision options paper agreed	on track
3.4	Essential	Due diligence prior to TUPE consultations	on track
3.5	Essential	Confirm employee liability information	Action not yet started & not off track
3.6	Essential	TUPE Consultations complete	Action not yet started & not off track
3.7	Essential	Outcome of TUPE consultations reported	Action not yet started & not off track
3.8	Essential	SLAs and contracts agreed	Action not yet started & not off track
3.9	Essential	Establishment of SLAs, processes, people and systems	Action not yet started & not off track
3.1 0	Essential	Set up of HR systems	Action not yet started & not off track
3.11	Essential	In-house OpCo HR team established	Action not yet started & not off track

		WORKSTREAM 4. ESTATES AND FACILITIES (Lead David McLaughlin)	
4.1	**Essential**	Agree in/out of scope services	on track
4.2	**Essential**	All service specification complete	on track
4.3	**Essential**	Collate all site plans	on track
4.4	**Essential**	Centralise all legal documentation (e.g. Titles, leases, licences etc.) and obtain new documentation where required.	Action not yet started & not off track
4.5	**Essential**	Ensure DVLA notified of transfer of vehicles	Action not yet started & not off track
4.6	**Essential**	Appoint any critical day 1 posts	Action not yet started & not off track
4.7	**Essential**	Complete QA of Service Pricing (Calculation of Monthly Payment)	Action not yet started & not off track
4.8	**Essential**	Agree E & F policies & procedures for Subsidiary e.g. asbestos policy	Action not yet started & not off track
4.9	**Essential**	Review implications of revision on Trust Policy and Procedures	Action not yet started & not off track
4.1 0	**Essential**	Ensuring access control for all staff is maintained	Action not yet started & not off track
4.11	**Essential**	Environmental agency licences	Action not yet started & not off track
4.12	**Essential**	EHO (Catering) Health Executive, Local area Fire Brigades, Council, etc - statutory notifications	on track
4.13	**Essential**	Uniforms - Option Appraisal	on track
4.14	**Essential**	Transfer of leases and/or owned vehicles	Action not yet started & not off track
4.15	**Essential**	Transfer of all live contracts to new entity	Action not yet started & not off track
4.16	**Essential**	Any notifications required for NHP	Action not yet started & not off track
4.17	**Essential**	Process for transfer - EFM staff leased vehicles primarily, salary sacrifice, etc.	Action not yet started & not off track
4.18	**Essential**	EFM Safety Management Plans	Action not yet started & not off track
4.19	**Essential**	Safety Groups AE's, Authorised Persons and Competent Persons	Action not yet started & not off track
4.2 0	**Essential**	Agree processes for managing Capital schemes	Action not yet started & not off track
4.21	**Essential**	Final agreed and signed off EFM SLAs and KPI's	Action not yet started & not off track
		WORKSTREAM 6. COMMUNICATIONS (Lead Sally Northeast)	
6.1	**essential**	Agreed OpCo/PropCos naming process	on track
6.2	**essential**	Comms service provision for OpCo paper approved	on track
6.3	**essential**	Prepare and share external communications throughout the programme	on track
6.4	**essential**	Tracker system for stakeholder communications upto and past go live	on track
6.5	**essential**	Continuously support the HR/OD workstream with staff communications	on track
6.7	**essential**	OpCo/PropCos name approved	Action not yet started & not off track
6.8	**essential**	Intranet set up	Action not yet started & not off track
6.9	Highly Desirable	Website set up	Action not yet started & not off track
		WORKSTREAM 7. DIGITAL (Lead Sam Critchell)	
7.3	Essential	Approval of Data Protection Impact Assessment from the Trusts IG leads	Action not yet started & not off track
7.4	Essential	Review user accounts within the new organisation - set up new accounts where required	Action not yet started & not off track
7.5	Essential	Migrate emails where required	Action not yet started & not off track
7.6	Essential	Migrate user credentials or federate access	Action not yet started & not off track
7.7	Essential	Review and apply appropriate access permissions to systems, applications, and shared drives	Action not yet started & not off track
7.8	Essential	Review Multi-Factor Authentication	Action not yet started & not off track
7.9	Essential	Review exisiting devices and ensure alignment	Action not yet started & not off track
7.1 0	Essential	Ensure access to core systems	Action not yet started & not off track
7.11	Essential	Update user support models and IT Service Desk contact points	Action not yet started & not off track
7.12	Essential	Ensure the knowledge base and self-service IT portals are updated.	Action not yet started & not off track
7.13	Essential	Final and signed off SLA	Action not yet started & not off track

		RAG	**Overall total**
		Fully Completed	**1**
		On track	**25**
		Minor Deviation	**0**
		Off track	**0**
		Action not yet started & not off track	**37**
		TOTAL	**63**

Naming the Dorset Shared Services SubCo

Guidelines, principles and process for choosing the name

1. Introduction

Our NHS trusts in Dorset are working together to improve the care we provide to our patients and to make the best use of our resources. After exploring various options, we believe that setting up a shared service subsidiary company model for Estates, Facilities Management and Procurement (EFMP), with a specialist leadership team and a subco board, would enable us to develop and improve services for everyone.

EFMP teams will continue to do their vital work for patients and our local population, working on our sites, with colleagues and patients, just as they do now. The new arrangements will be able to use combined buying power to drive savings from goods and services we buy. Operating at a greater scale will allow more specialist roles, bringing outsourced services back in house, and taking a more commercial approach – with all the benefits going back into Dorset's NHS trusts.

There are still several stages before a final decision to proceed. After the current informal engagement stage, there are legal requirements to go through, including formal consultations and the process and procedures for transferring staff under TUPE. We will also be assessed by NHS England before we start formal consultations under TUPE. There will then be a decision on go-live following the formal consultations.

However, we need to start the process to decide on the name for the new subco arrangements now, as well as starting to consider our branding principles. We cannot leave the decision until after go-live.

2. Getting it right - some things to consider

Naming the subco is an important step as we move towards greater service integration and transformation. The name will be important to the patients and public we serve and to EFMP staff, colleagues across the three trusts, other stakeholders and the wider NHS.

To get this naming process right we need to consider the following questions:

- How might we distinguish the functions of the company?
- Would having a concise name help or hinder staff/public understanding of the activities within the company?
- How do we ensure that any name is future proof, allowing the three trusts to maintain flexibility around future services?
- Should the name have a geographical reference?

3. Naming principles

We propose that, in considering the name and branding for the new arrangements, we align with national NHS guidance, namely:

- clear, logical and descriptive so as not to conflict or confuse with the names of neighbouring NHS organisations
- clear when written out in full, and/or when used as an acronym

- follows the trusts' corporate guidelines i.e., avoidance of abbreviations or symbols such as '&'
- avoids a name that will be impractical and cumbersome
- will stand the test of time
- preserves the existing overall positive regard for our services.

4. NHS service branding guidelines

In considering the name we need to consider how we would reflect the strong connection with the NHS, and therefore how we would be impacted by the NHS brand guidelines. The NHS service branding guidelines do not specifically mention wholly owned subsidiary companies. However, the guidance on service branding sets out that:

> All NHS services should be clearly branded NHS, regardless of who the provider is, so that it's clear to the patient that it is an NHS funded service which meets NHS quality standards. Our research also showed that if an NHS service is being delivered by a third party provider, patients and the public want to know who the provider is – it needs to be open and transparent.

The NHS service logo is made up as follows:

- The NHS logo
- The name of the service, which appears in black text underneath the NHS logo. It must follow NHS naming principles to ensure that it makes sense to patients and helps them identify where the service is being delivered.

An NHS service logo can/should be used by:

- NHS organisations who are delivering services outside their geographical area, where their name could confuse patients and the public
- a partnership of providers commissioned by the NHS to deliver NHS services
- third party providers delivering NHS services
- NHS organisations who are delivering a commercial service that is either internal/staff facing or business-to-business.

5. Other NHS-owned subcos

Research into the names of other wholly-owned subsidiary companies (Appendix 1) has revealed two approaches:

- A name which includes the name of the trust(s) it is owned by, such as 'North Tees and Hartlepool Solutions' (North Tees and Hartlepool NHS FT) or 'Barnsley Facilities Services' (Barnsley Hospital FT)
- A name which does not make it immediately clear that the company is associated with a trust, such as 'Synchronicity Care' (a wholly owned subsidiary of County Durham and Darlington NHS FT) or 'Quality Trusted Solutions' (wholly owned by Central and North West London NHS FT)

Many of the subcos include in their name the type of services they provide. However, not all the subcos on the list provide Estates, Facilities Management and Procurement. The ones that do cover all three include:

- Atlas BFW Management Ltd (Blackpool Teaching Hospitals FT)
- Barnsley Facilities Services (Barnsley Hospital FT)
- CHoICE (South Tyneside and Sunderland NHS FT)

- Integrated Facilities Management Bolton Ltd (Bolton FT)
- SWFT Clinical Services (South Warwickshire University NHS FT)

None of the subcos on the list use 'NHS' in their name. However, three on the list include the NHS logo as part of their logo.

Some of the subcos have stand-alone websites, while others demonstrate a strong link to the NHS by having content as part of their owner trust's website.

6. Previous engagement on a name

In March 2025, senior EFMP managers came together for an initial engagement event about the proposal to create the subsidiary company arrangements. The managers were invited to put forward suggestions and comments on the topic of company name, branding and uniform.

Name suggestions included:

- Coastal Health Shared Services
- Combined Dorset Estates Facilities (CDEF) Group
- Health Care Support
- Wessex Regional

Comments included appeals to 'Retain NHS sense, clear local identity', 'not just health support services – show expertise' and 'Let the staff decide'.

While the topic of naming the company has not been specifically covered in the engagement sessions with all affected colleagues across the three trusts, it is clear that a strong and visible connection with the NHS is extremely important to these teams. This will be an essential element in creating the organisational culture within the new arrangements and should therefore be considered as a central plank in creating the new name, brand and identity. We can also consider a strapline giving more information as part of the brand.

7. Recommended naming process

We propose a process which gives the opportunity for engagement with key stakeholders, although the timescales may limit the scope of this in the initial phases. However, the naming is not the end of this work and there will be opportunities as the arrangements develop for colleagues to influence the brand values and the way the company presents itself.

- Engage with programme board members and EFMP senior managers across the three trusts to invite name suggestions.
- Shortlisting panel review: consider initial suggestions of new names in line with guidelines and criteria. Agree three suggested names to go forward for vote.
- Run a voting process with as wide a group of stakeholders as possible (NB timing and stage of the programme may mean this will be limited).
- Shortlisting panel agrees recommendation to the programme board.
- Programme board agrees preferred option and recommends it for approval at all three trust Boards.
- Further work continues to develop brand values and visual identity, involving colleagues in shaping this.

Appendix A

Trust(s)	SubCo name
Airedale FT	AGH Solutions Ltd
Barnsley Hospital FT	Barnsley Facilities Services
Birmingham Women and Children's FT	BWC Management Services Limited
Birmingham and Solihull Mental Health FT	Summerhill Supplies Limited
Blackpool Teaching Hospitals FT	Atlas BFW Management Ltd
Bolton FT	Integrated Facilities Management Bolton Ltd
Calderdale and Huddersfield FT	Calderdale and Huddersfield Solutions Ltd
Central and North West London FT	Quality Trusted Solutions LLP
County Durham and Darlington FT	Synchronicity Care Ltd
City Hospitals Sunderland FT	City Hospitals Independent Commercial Enterprises Ltd
East Kent Hospitals University FT	2gether Support Solutions
Gateshead Health FT	QE Facilities Ltd
Gloucestershire Hospitals FT (2017)	Gloucestershire Managed Services Ltd
Guy's and St Thomas' FT	Lexica Health and Life Sciences Consultancy Ltd (previously Essentia Trading Ltd)
Hampshire Hospitals FT	Hampshire Hospitals Contract Services Limited
Harrogate District FT	Healthcare Facilities Management Ltd
King's College Hospital FT	KCH Interventional Facilities Management LLP
Northumbria Healthcare FT	Northumbria Healthcare Facilities Management Ltd
Northumberland, Tyne and Wear FT	NTW Solutions Ltd
North Tees and Hartlepool NHS FT	North Tees and Hartlepool Solutions LLP
Royal Free FT	RFL Property Services
Salisbury FT	Salisbury Trading Limited
South Central Ambulance Service FT	South Central Fleet Services Ltd
South Warwickshire University NHS FT	SWFT Clinical Services
The Clatterbridge Cancer Centre FT	Clatterbridge PropCare Services Ltd
University Hospitals Birmingham FT	UHB Facilities Ltd
University Hospital Southampton FT	UHS Estates Limited
Yeovil District Hospital FT	Simply Serve Ltd
York Teaching Hospitals FT	York Teaching Hospitals Facilities Management LLP

1. Introduction

In setting up wholly owned subsidiary (WOS) all three Trusts have made a firm commitment that pay, terms and conditions will remain the same and aligned to the NHS and Agenda for Change terms and conditions, including continuous service and wider benefits such as salary sacrifice schemes. Ensuring all staff working within the WOS whether transferred under Tupe or newly recruited, have access to the NHS Pension scheme has been a key concern raised by staff and trade unions during engagement. Being able to provide as much assurance as possible on this matter to staff is essential and this paper sets out the current situation, process, risks and recommendations for the Board's consideration.

2. Application for an Open Direction Order

2.1 To access the NHS Pension scheme organisations need to apply for either a Closed or Open Direction order. We wish to apply for an Open Direction Order which will allow for all existing and new staff in the WOS to continue their membership or join the NHS Pension Scheme.

2.2 The pension administrator, NHS Business Services Authority, have provided the following information;

> Staff who are compulsorily transferred from an NHS organisation to a Wholly Owned Subsidiary (WOS), retain their employment terms and conditions, in accordance with TUPE regulations and access to the NHS Pension Scheme, in accordance with HMT's New Fair Deal guidance.
>
> For new staff (starting after the SubCo has gone live): Ministers from the Department of Health and Social Care have reached a decision to accept applications for new starter access to the NHS Pension Scheme from Trust WOSs. The Department of Health and Social Care is satisfied that allowing new starters in trust subsidiary companies into the scheme is consistent with wider scheme access policy, provided that such companies can prove that they are wholly owned by an NHS organisation.

2.3 A telephone discussion was held with a representative from the Pensions Agency's Scheme Access team 30 May regarding pension arrangements for the WOS and conformed the following:

- The Pensions Agency representative will be our dedicated liaison for future queries and clarifications. This is extremely helpful to have one point of contact.
- The agency is currently handling approximately 200 direction order applications, many involving small staff numbers but requiring significant administrative effort.
- A critical requirement for a direction order to be approved is that the shareholders of the WOS much be named as the Trust, not an individual, and must remain so.
- Direction order applications cannot be submitted until the new company is formally established.
- Approval of direction orders by the Department of Health and Social Care (DHSC) typically takes several months.

- Where WOS are set up and staff transferred prior to the Direction Order being accepted, interim arrangements were outlined for deducting and paying contributions to the NHS Pensions Agency so scheme membership could continue.
- A 'letter of comfort' from DHSC can be requested, but it involves substantial work and is unlikely to be received before SubCo goes live.
- Staff must continue performing NHS-related work for the direction order to remain valid. If the company expands into commercial activities and NHS work drops below 50%, the direction order is likely to be made void.
- The Pensions Agency has limited experience handling direction orders affecting a large number of staff, as is the case with the proposed WOS (circa 1600 staff in the proposal).
- Historically, direction orders are rarely rejected as DHSC aims to retain as many staff as possible in the NHS pension scheme.
- Since staff will be transferred from three Trusts, and no new Employer's Agent (EA) Code will be available at go-live, three separate direction order applications may be required, one for each Trust.

3. Risks and considerations

3.1 While not guaranteed, the structure of WOS and the nature of the work make the approval of the direction order highly likely, however, this cannot be fully guaranteed until the application is agreed.

3.2 Applying for a letter of comfort should be weighed against the time and resources required versus the benefits it provides.

3.3 It is not yet decided who will deliver the people services to the WOS and both the letter of comfort application and the Direction Order process will require significant effort from pension teams and will necessitate interim arrangements to ensure continuity of pension contributions.

3.4 There are other reasons why it would be helpful to set up the WOS in advance of formal consultation and final Board approval. This needs to be weighed up against a perception of progressing an option ahead of final go/no go decision.

4. **Recommendations**

4.1 From all the information we have received to date, it is highly likely that an Open Direction Order application for the WOS will be successful, however, it is recommended that we apply for a 'letter of comfort' now as this will provide more assurance to staff and trade unions. We can do this now, whilst making preparations for the WOS to be formally set up as a legal entity, and to be prepared for the Direction Order.

HILL DICKINSON

DORSET SHARED SERVICES: PROCUREMENT, ESTATES & FACILITIES

PROPOSED LOCK IN FOR NHS TERMS AND CONDITIONS UNDER THE GOVERNANCE OF THE SUBSIDIARY - 26 MAY 2025

Outline corporate and contractual protections for the retention of NHS terms and conditions within the proposed subsidiary model

1. Introduction

We have been asked to summarise the protections which are to be set out in the governance and contractual arrangements for the new subsidiary structure for the Dorset Shared Services in relation to how (i) the employment status under Agenda for Change and NHS Pensions of the transferring staff into OpCo will be protected and also (ii) how the potential sale of OpCo shares to a third party would be restricted.

2. Governance of OpCo

a) Board Control:

- The proposed model of governance is for the three Trusts to retain strong membership and influence over decisions in the OpCo board of directors.
- The parent trust shareholders can also remove other directors by exercising their shareholder rights so can continue to exercise influence in the board alongside the provisions of the Shareholder Agreement and Articles of Association set out below

b) Articles of Association:

- The draft Articles will be provided for approval by the Trust Boards before the PropCo and OpCo subsidiaries go live. The Articles are a public document and form a company's constitution under *section 17 of the Companies Act 2006*.
- They bind the company and its members as if they were a contract.
- For OpCo we suggest that they include additional key terms, specifically provision:
    - to restrict changes being made to staff terms and conditions; and
    - to prevent the sale of any OpCo shares

    without the approval of the three Trust boards to underpin the provisions of the Shareholders Agreement.
- The Trusts as shareholders would be required to approve any changes to the Articles of Association.

c) Shareholders Agreement (OpCo):

- Governance arrangements must ensure accountability whilst not hindering operational activity. An agreement across the Trust shareholders is required to regulate, amongst other matters how the OpCo subsidiary is to be governed. This will be a key document as it will capture how the Trusts as

shareholders will exercise control over the OpCo subsidiary. Whereas the Articles of Association are a public document the Shareholders Agreement would not be (subject to FOIA requirements) and could therefore include more of the practical details of the arrangements.

- The Shareholders' Agreement (private contract) between the shareholders and OpCo will then include *reserved matters* being actions that the OpCo subsidiary cannot take without the parent trust's consent. While not binding on third parties, the Shareholders' Agreement *will* be enforceable between the Trust parties and OpCo.

- The agreed list of reserved matters (matters which cannot be enacted by OpCo without all parent trusts consent) will prevent OpCo from changing and not mirroring NHS Agenda for Change terms and conditions of employment without all three Trust Boards' approval. This will apply to both transferred and new staff and will include applying the annual national cost of living pay increases.

- It will also include a provision that requires the three Trust Boards' consent for any sale or transfer of the shares in OpCo. Any such proposal would also be likely to require the approval of NHS England, as well as the Trust Board and Governors. In addition, selling all or part of the shares in OpCo would be likely to change its procurement status, meaning it would potentially not be advantageous for any non-NHS third party.

- There will also be an obligation on OpCo to offer NHS Pensions to those who are eligible on the same basis as NHS employees.

3. Contractual provisions (Operated Healthcare Facility Agreement (OHFA))

a) OHFA / Contractual Agreements:

The service agreements between the Trusts and OpCo/PropCo can outline that the required terms and conditions of employment by the subsidiary should be in line with Agenda for Change unless otherwise agreed with the Trusts (as per the Shareholder Agreement).

b) OHFA / Restrictions on changes of provider:

The OHFA will include provisions that prevent PropCo/OpCo from transferring or subcontracting services to a new provider without the prior written consent of the relevant Trust.

c) OHFA / Reporting Mechanisms:

The contract management arrangements in the contract between OpCo and the Trusts (with the PropCo's) will include reporting mechanisms that will require OpCo to report to the Trusts on any proposed changes to staff terms and conditions or any potential sale of assets/contracts related to the contract and (as stated above) any proposed changes of this type would need to go to the Trust Boards for approval.

Once the OpCo commences trading, the hosting Trust's Audit Committee and the Intelligent Client function of the Trusts can provide assurance that the governance arrangements are being applied in accordance with the governing documents.

FURTHER QUERIES

If you require any further information or have additional queries please contact Robert McGough.

DORSET SHARED SERVICES:
Decisions reserved to the Trust Boards (v1.3 30 May 2025)

The following shows the main matters reserved for the OpCo subsidiary board and those matters requiring shareholder (Dorset NHS Foundation Trusts) approval (the list is not exhaustive).

- Where the approval required is "TRUSTS TO APPROVE" this will require the consent of the three trusts to make the decision.
- The Trusts may decide to delegate some of these reserved matters to individuals, committees or joint committees across the Trusts if they determine it is appropriate and retain the other key decisions for Trust Board decisions.
- If there is any disagreement between the Trusts as to the matter which they are required to approve then this will be referred to the Dispute Resolution Process under the Shareholders Agreement for OpCo which will require them to work through a number of stages to attempt to resolve any issues and reach consensus.
- It should be noted that some of the reserved matters will be covered under the contract management of the OHFA by the Trusts as well as under the Articles of Incorporation and Shareholders Agreement for OpCo.

Matters for OpCo Board	Trusts Shareholder approval required?
1. Strategy and Management	
1.1 Responsibility for the overall leadership of the Company and setting the Company's values and standards	OpCo
1.2 Approval of the Company's strategic aims and objectives.	TRUSTS TO APPROVE
1.3 Approvals of the annual operating budget and capital	TRUSTS TO APPROVE
1.4 Material changes to annual operating expenditure budget.	TRUSTS TO APPROVE (where planned limit exceeded)
1.5 Material changes to annual capital expenditure budget.	TRUSTS TO APPROVE (where planned limit exceeded)
1.6 Oversight of the subsidiary's operations ensuring: • competent and prudent management; • sound planning; • maintenance of sound management and internal control systems; • adequate accounting and other records; and • compliance with statutory and regulatory obligations.	OpCo
1.7 Review of performance in the light of the subsidiary's strategic aims, objectives, business plans and budgets and ensuring that any necessary corrective action is taken.	OpCo
1.8 Extension of the subsidiary's activities into new business or geographic areas which has not been approved under the Annual Business Plan.	TRUSTS TO APPROVE
1.9 Any decision to cease to operate all or any material part of the subsidiary's business.	TRUSTS TO APPROVE
1.10 The right or ability of OpCo to (or consider any proposal to) sell shares in OpCo or transfer ownership of all or any part of the OpCo business to a third party. .	TRUSTS TO APPROVE
2. Structure and capital	

2.1 Changes relating to the subsidiary's capital structure.	TRUSTS TO APPROVE (with OpCo)
2.3 Changes to the subsidiary's Board management and control structure.	TRUSTS TO APPROVE (with OpCo)
3. Financial reporting and controls	
3.1 Approval of the annual report and accounts.	TRUSTS TO APPROVE
3.2 Approval of the dividend policy.	TRUSTS TO APPROVE
3.3 Recommendation of the dividend.	OpCo
3.4 Approval of any significant changes in accounting policies or practices	TRUSTS TO APPROVE (with OpCo)
3.5 Approval of treasury policies.	TRUSTS TO APPROVE (with OpCo)
3.6 Approval of material unbudgeted capital expenditure (in excess of Business Plan limits).	TRUSTS TO APPROVE (where exceeds agreed limit)
3.7 Approval of material unbudgeted operating expenditures (in excess of Business Plan limits).	TRUSTS TO APPROVE (with OpCo) where exceeds agreed limit
4. Internal controls	
4.1 Ensuring maintenance of a sound system of internal control and risk management including: • Approving the subsidiary's risk appetite statements; Receiving reports on, and reviewing the effectiveness of, the subsidiary's risk and control processes to support its strategy and objectives; • Approving procedures for the detection of fraud and the prevention of bribery; • Undertaking an annual assessment of these processes; and • Approving an appropriate statement for inclusion in the annual report.	Assurance via Annual Assurance Report and refer OpCo to main shareholders Trust Audit Committees
5. Contracts	
5.1 Approval of procurement strategy for award of new contract by subsidiary where contract value (over the life of the contract) expected to be in excess of £5m.	TRUSTS TO APPROVE
5.2 Any contract award decisions from OpCo (for above any agreed threshold value) where: 1. Procurement strategy approval was not correctly obtained in advance of procurement activity, and/or; 2. Following the procurement activity, the proposed Contract value is [20]% more than was estimated in the approved procurement strategy, and/or: 3. The Contract Award is within scope of the Cabinet Office spend controls, and/or; 4. The procurement route taken to award the contract is materially different to that proposed in the approved procurement strategy.	TRUSTS TO APPROVE
5.3 Disposal of land or rights over land to a third party.	TRUSTS TO APPROVE

5.4 Disposal of obsolete or surplus items of plant, vehicles or equipment where the consideration is expected to be in excess of £1m.	TRUSTS TO APPROVE
5.5 Purchase of land/buildings, including leases of material value (over £250K pa).	TRUSTS TO APPROVE
6. Board membership	
6.1 Ensuring adequate succession planning for the board and senior management to maintain an appropriate balance of skills and experience within OpCo and on the OpCo Board.	OpCo
6.2 Appointment, removal or replacement of executives to maintain appropriate balance of skills and experience within the OpCo and on its Board.	BOTH Trust and OpCo
6.2 Appointment, removal or replacement of executive directors of the OpCo.	BOTH Trust and OpCo
6.3 Appointment, removal or replacement of OpCo Board Chair.	BOTH Trust and OpCo
6.4 Appointment, removal or replacement of any independent directors of the OpCo.	OpCo
6.5 Appointment of members of Board Committees (including appointment of the Committee Chair).	OpCo
7. Remuneration	
7.2 Approving remuneration policy applicable to executive directors of the subsidiary and senior management (including the subsidiary's forward-looking policy on remuneration).	TRUSTS TO APPROVE
7.3 Approving the implementation of the Remuneration Policy including approving the total pay received by each director during the year,	TRUSTS TO APPROVE
7.4 Determining the remuneration of the non-executive directors, subject to the articles of association and shareholder approval as appropriate.	TRUSTS TO APPROVE
8. Delegation of authority	
8.1 Agreeing the division of responsibilities between the Chairman, the Chief Executive Officer and other executive directors.	OpCo
8.2 Establishing board committees and approving their terms of reference, and approving material changes.	OpCo
9. Corporate governance matters	
9.1 Undertaking a formal and rigorous annual review of its own performance, its governance framework and individual directors, and the division of responsibilities.	OpCo
9.2 Determining the independence of non-executive directors in light of their character, judgment and relationships.	OpCo
9.3 Reviewing the OpCo's overall corporate governance arrangements.	OpCo
9.4 Authorising conflicts of interest where permitted by the OpCo's articles of association.	OpCo
9.5 Approval of the appointment of the auditors for the OpCo.	TRUSTS TO APPROVE
9.6 Prosecution, commencement, defence or settlement of litigation, or an alternative dispute resolution mechanism involving claims above £1m or being otherwise material to the interests of the OpCo.	TRUSTS TO APPROVE subject to agreed limit
9.7 Approval of the overall levels of insurance for the OpCo and the group up including directors' & officers' liability insurance.	BOTH TRUSTS and OpCo TO APPROVE

9.9 Approval of draft and final business plan.	BOTH Trust and OpCo
9.10 Approval of changes to the Articles of Association	TRUSTS TO APPROVE
10. Policies	
10.1 Approval of material policies, including: • Code of Conduct; • Bribery prevention policy; and • Whistleblowing and reporting concerns policy.	OpCo
10.2 Approval of the OpCo's Health and Safety Policy.	BOTH Trust and OpCo
11. Employee Protections	
11.1 Any proposed change to the terms and conditions of any employees of OpCo (including new and transferring staff) that would move them off Agenda for Change terms and conditions. **Note that any such proposal will be subject to the Trusts unanimous approval** as a part of triple lock against change.	TRUSTS TO APPROVE
11.2 Any proposed change to limit or remove access to NHS pensions for employees of OpCo. (including new and transferring staff) that would move them off Agenda for Change terms and conditions). Any such attempt would be referred to the Trusts as a part of triple lock against change.	TRUSTS TO APPROVE

4 Appendix 2 NHSE Board Certification for Subsidiary Transaction guidance - Dorset Shared Services proposal 28 May 2025				
	In relation to	**Guidance description**	**Response & references**	**Future work for next phase of programme**
1	Strategic	Considered a detailed options appraisal before deciding that the proposed subsidiary transaction aligns with and supports the delivery of the ICS's integrated care strategy and five-year joint forward plan, is at least financially neutral for the ICS, delivers benefits for patients, the trust and the ICS, and is the best vehicle to deliver these benefits.	Options Appraisal section and Annex with scoring and process	
2	Strategic	Considered how the commercial rationale for the proposed subsidiary aligns with ICS plans for back-office consolidation and transformation.	Very strong alignment, as proposal is ICS wide.	
3	Strategic	Provided a reasonable level of transparency about plans, e.g. public articulation of options considered and other engagement with key stakeholders.	Annex report on engagement. Have engaged 100s of staff, shared communications on options, had Union and media publicity. June Boards will be in public, including published business case and annexes. So considerably beyond the expectation in the guidance.	
4	Strategic	Considered the wider public acceptability and national communications risk of the proposal.	Retaining pay, terms, pension and 100% public ownership, and no job losses as a result of the transfer is positive and acceptable. Going beyond TUPE protection with "triple lock" on these points of principle is far stronger than the status quo. Main risk is Unions have made clear their public opposition to subsidiaries in principle, and this is a national campaigning and recruiting objective for them. Secondary risk is miscommunication around taxation. Mitigation is a communication plan and key messaging: 10 benefits of the change, triple lock goes beyond TUPE, level playing field for tax.	Continued communications work
5	Financial	Ensured that a clear case for change exists and the commercial rationale for the proposal does not include the subsidiary enabling a taxation treatment different from current trust arrangements.	See 2.7 Strategic rationale and 10 benefits Case for change is strong, based on 10 benefits, (cashable and non-cashable). Level playing field on tax treatment is just one benefit, and bulk excluded from base case upon which the decision is made.	
6	Financial	Ensured that the majority of savings result from cash-releasing operational improvements (not tax-related benefits).	See financial Model Annex. Main cash releasing savings are from procurement, as scale and standardisation. This is larger than the base case tax recovery, in the ten year model. Long list of other benefits identified (see financial model), but not yet moved to cash-out. This is because our robust methodology is to develop these further and then agree budget adjustments with budget holders. As the budget holders for the shared services are not yet in post, the prudent approach is to show estimated savings under non-cashable part of the spreadsheet. This will then become the year one cashable savings of the OpCo, in addition to the procurement.	Develop year one (26/7) cost improvement plans from current list of opportunities.
7	Financial	Conducted an appropriate level of financial, clinical, market and any other relevant due diligence relating to the proposed subsidiary, including appropriate financial due diligence covering the financial position and track record of any partner in the proposed subsidiary	The three partners are the three Dorset NHS FTs, all of whom are in Dorset ICS. Financial - have for many years operated an open book, "one system-one bottom line" approach. All other key data is public domain e.g. ERIC, PAM, PLACE. Already sharing capital plans and New Hospital Programme work. Joint work on a 6 facet survey of estates backlog being jointly commissioned, to enable a standard methodology for this. Clinical data and strategies already shared, again using common data systems. Market data for NHS work implicit in in the above data sharing.	

	In relation to	Guidance description	Response & references	Future work for next phase of programme
8	Financial	Conducted an options appraisal of alternative approaches (including consideration of the counterfactual position) and an appropriate level of market testing that demonstrates the proposed subsidiary arrangements accord with best practice guidance and achieve reasonable value for money for the taxpayer.	See Options appraisal section and Annex with scoring and process. Includes counter factorial of option 1, carry on as now (e.g. procurement savings averaging 0.88%, vs up to 5% through scale, specialisation and standardisation approach in the preferred option). Best practice process followed, including full response to KLOE questions (see FBC annex). Clear demonstration of VFM *and* deliverability for taxpayer, over other options.	
9	Financial	Considered the implications of the proposal for the NHS Oversight Framework (or any subsequent NHS England frameworks) segmentation of both the parent trust and the subsidiary where applicable, taking full account of reasonable downside sensitivities.	Main impact for Oversight Framework is financial recovery of parent Trusts. Absent progress of the preferred option, serious risk of not achieving the 25/26 cost out programme, of c8% per provider.	
10	Financial	Taken into account the implications for access to capital and revenue funding from DHSC as well as commissioner funding in developing the financial plan for the subsidiary, and agreed key assumptions in the business plan with relevant stakeholders, including DHSC where appropriate	The case assumes no change in access to capital and revenue funding from DHSC. Instead the case is based upon better deployment of those resources, through the focused, transparent and commercial drive a subsidiary approach can bring to Estates, Facilities Management and Procurement (EFMP). Operated at ICS scale then brings economies and resilience. See "Letter of Support" from Dorset ICS See 5.2 for treatment of capital	
11	Financial	Taken into account the independence of the subsidiary in relation to the delivery plans for the parent trust's own efficiency and cost savings targets.	This is taken into account, as the budget held within the proposed subco will be their responsibility to deliver, whilst achieving KPIs, service specs and outputs as per annual business plans negotiated with Trusts. Draft service specs in development, and budget envelope on transfer will be current budgets. See management case	If given agreement to proceed more detailed business plan, specifications and outputs will be agreed for 26/7. (Current part year remaining will be about completing this years plans, and a safe and legal transfer).
12	Financial	Ensured that relevant commercial risks are understood and mitigated, including risks to the trust from the subsidiary's credit arrangements and the relationship between any existing guarantee arrangements and funding arrangements for the subsidiary.	The credit arrangements will be entirely within the group structures of the Trusts, with assets held within the PropCo, (one per Trust). There are no PFIs or other loans or guarantees affecting either the Trusts or the proposed subsidiaries.	
13	Financial	Ensured that any transactions between the trust and the subsidiary do not pose a risk to existing credit arrangements, such as loan agreements with DHSC.	See above, no risks posed.	
14	Financial	Ensured that the risks associated with any transactions between the trust and the subsidiary are understood: for example, those associated with any asset transfers, including the impact of any existing guarantee arrangements on such transactions.	The lease agreement for assets is single Trust to the PropCo within the Trust group structure. This is a well established approach. There are no guarantee arrangements and so no effect/risk to these.	Lease advise and legal documentation July-August
15	Financial	Received appropriate external advice, and opinions where appropriate, from independent professional advisers with relevant experience and qualifications, including tax advice where the subsidiary enables a taxation treatment different from that of the current trust arrangements*.	Following a procurement exercise the Trusts have appointed experienced external advisors: Hill Dickinson LLP (Legal and governance) and Colbeck Brighton (finance and tax). Between them they have supported 30+ NHS subsidiaries and dealt with HMRC reviews. Please note the tax advice referenced in the responses below.	

	In relation to	Guidance description	Response & references	Future work for next phase of programme
16	Financial	Resolved any issues relating to the proposed subsidiary and its treatment for accounting purposes, and received appropriate professional advice. As part of this, the trust has confirmed the treatment of the subsidiary for accounting purposes, the impact on its NHS accounting and reporting responsibilities, and the implications of any consolidation or non-consolidation into the group position.	Discussion with DHSC lead accountant that the proposed set up is locally consolidated. Each PropCo will be 100% owned by its parent Trust, this means that the PropCo will be consolidated into the parent. The OpCo will be 51% owned by Dorset Healthcare FT, the other two will own 24.5%. This means that OpCo will be consolidated into the accounts of Dorset Healthcare with 51% ownership and the other two Trusts will show investments in OpCo in their accounts. There is no known impact on consolidated accounting.	
17	Financial	Considered whether the scheme will have any impact on Capital Departmental Expenditure Limits (CDEL) and Resource Departmental Expenditure Limits (RDEL), taking into account the agreed accounting treatment if applicable, and confirmed the CDEL and RDEL treatment assumed in the business case with all key stakeholders (including DHSC if appropriate).	It is not expected that the scheme will have any impact on CDEL or RDEL limits. The treatment assumed in the business is appropriate and prudent.	
18	Financial	Trusts to obtain appropriate taxation advice where proposals with a clear commercial rationale result in a taxation treatment different from existing trust arrangements.	See financial model. The Trusts have engaged professionally qualified and experienced tax experts to review the proposed structure as set out in the business case. As per 15, taxation advice procured and initial review indicates some recovery of historic tax via Capital and Goods Scheme and this is included in the base case, as highly unlikely to see retrospective tax changes. Any future tax recovery (VAT) is in upside case, as this is on estimated future expenditure, and future tax rules can change. Payment of Corporation Tax included within the financial model. The tax opinion report has been produced by the tax experts and they have concluded that the proposed structure is compliant with current tax legislation and, provided the establishment of the structure follows the guidance provide by our legal, financial and tax advisors, it is their opinion that the structure is low risk from a tax perspective.	
19	Delivery	Conducted appropriate enquiry about the probity of any partners involved in the proposed subsidiary that considers the nature of the services provided and the likely reputational risk.	Partner are all well established Foundation Trusts, and services provided currently. Therefore, on comply or explain basis, no probity checks required, as explanation is these are well established, well regarded NHS organisations.	
20	Delivery	Conducted appropriate enquiry about the organisational and management capacity and capability of any partners involved in the proposed subsidiary; this considers the nature and scope of services to be provided by the subsidiary and the potential risks to clinical, financial and operational sustainability.	See 19 above. See Shadow OpCo Board Profiles In addition the specific services moving into the subsidiary will transfer existing management capabilities, who are successfully running the services currently. For the 3 PropCos the Boards will be made up of NHS FT Directors +1 independent to be recruited to.	Work to recruit the permanent OpCo exec directors won't start until FT Boards agree this, following approval of this self-cert. The independent NEDs recruitment will start after the final go live decision.
21	Delivery	Conducted an appropriate assessment of the nature of services to be provided by the subsidiary and any implications for reputational risk arising from this.	EFMP services provided by all 3 Trusts currently. Combining these into an ICS wide service has many benefits, and resilience and scale will reduce reputational risks of the services themselves. The main reputational risk is Union opposition to the principle of wholly NHS owned subsidiaries. This risk is being managed via engagement - see sections 3&4 above.	

	In relation to	Guidance description	Response & references	Future work for next phase of programme
22	Delivery	Sought legal advice on the transaction, including on transfer of staff and TUPE arrangements, to confirm the transaction can legally proceed.	The Trusts have sought and obtained legal advice on the transaction from Hill Dickinson LLP as set out in the response to query 15 above, and on aspects of the TUPE arrangements, e.g. triple lock for protection of NHS terms and conditions. The Trusts have had advice on their powers and the governance of their arrangements and will also review their position under the proposed revised guidance on subsidiaries which is anticipated from NHS England to ensure that the process and set up of the subsidiary model should proceed.In terms of experience of TUPE, UHD also has extensive experience of staff consultations on change, including 1000s of staff moving site as part of the reconfiguration. For this consultation, the main change is transfer to the Operating Company. There are no changes to site of work, pay, and the vast majority of staff the line management will remain the same. The procurement teams are the only exception, as they have a new Target Operating Model (TOM) to create a larger team, with more senior, specialist roles.	TUPE consultation will not progress until Board self certification, as ready to proceed.
23	Delivery	Engaged staff in decisions that affect them and the services they provide as pledged in the NHS Constitution, and has plans to comply with any consultation requirements, including staff consultations.	See engagement documentation annex. April and May 2025 has seen extensive engagement with staff, via hundreds attending Q&A sessions, plus written materials e.g. FAQs. The formal consultation with staff will not occur until the Boards Self Certify to progress. There has also been extensive Union opposition to the principle of the Subsidiaries, in the form of a protest outside each site, flyers, and media coverage. See letter & reply to Head of Health at Unison. The first engagement stage has identified several updates to the business case as a result of staff feedback e.g. protections greater than TUPE, and retaining NHS public ownership - response "triple lock"; more certainty about retaining public ownership move form 10 to 25 year contract.	TUPE consultation will not progress until Board self certification, as ready to proceed.
24	Delivery	Undertaken comprehensive staff engagement on the commercial rationale (including options considered) and consequences for staff.	See 23 above. In addition the staffing briefing slides include other options, and commercial / benefits rationale. Consequences for staff (protected pay, pensions, jobs) and opportunities of scale (more career opportunities, level up recruitment premiums, better potential for entry level roles and apprenticeships). See benefits section, workforce.	
25	Delivery	Appropriately considered the labour market for each category of staff, pension provision and continuity of service implications for staff before determining the approach to terms and conditions, taking into account (where relevant) the trust's role as a major employer in a locality.	By retaining pay, T&Cs, pension etc implications for staff are the same as now. There is then the benefits of working for a larger service in EFMP, bringing economies of scale, workforce support (see 24 above). The main risk would be in managing the transition in set up, and retaining staff during change. This will need managing through communications and line management support.	
26	Delivery	Ensured that the trust has regarded staff engagement good practice guidance at all stages of the transaction, including reference to terms and conditions and pensions provision.	See staff engagement report (annex). Reference to pay, T&C and pension to relevant as no proposal to change these.	
27	Delivery	Undertaken an equality impact assessment of the proposals.	See EIA annex of FBC	

	In relation to	Guidance description	Response & references	Future work for next phase of programme
28	Delivery	Established the organisational and management capacity and skills to deliver the planned benefits of the proposed subsidiary, including where relevant the delivery of services at scale. In particular, the trust should assure itself that the subsidiary will be able to attract and retain staff with the appropriate skills and experience to deliver the service requirements, and that staff will become more engaged and committed over the life of the business plan.	See 20 above. In addition having dedicated HR resource, working across Dorset allows better jobs market intelligence. The EFMP services have many more non-NHS alternatives employers locally, compared to wider Trust workforce, and so more aligned recruitment and retention, careers, standardisation of RRP, will all helping fill vacancies. See 2.7 Benefits, workforce and financial model (treating these currently as non-cashable benefits).	
29	Delivery	Considered the financial, operational and clinical implications of contract termination and developed detailed exit plans to address these, including where appropriate to ensure appropriate legal protection for staff and the continued availability of estate. As part of this, the trust has considered and mitigated the risks of exit, e.g. through dissolution of the subsidiary.	The legal documentation required for set up, and the 3 Property subsidiaries (PropCo) and Operating Company (OpCo) model has been identified and will be finalised in detail over June-Sept. This will include exit plans and clear contractual termination provisions under the Operated Healthcare Facility Agreements (OHFA) for the delivery of services to the Trusts from PropCo and exit arrangements for Trusts under the Shareholders Agreement for OpCo and Articles of Association for the companies. Assets will remain within Trust consolidation under PropCo. The most likely exit for services would be splitting the services back to the Trust who receives the services. Exit arrangements will be covered both in the OHFA (contractual implications of service changes and exit) and the OpCo Shareholders Agreement in terms of how it may impact the wider collaboration between the Trusts. The option to "sell" any aspect of the model to a private provider would be excluded by the documentation (reflected in the triple lock principles) on retaining public ownership. Appropriate clauses in the legal documents will also not impede the FTs changing their form e.g. group model or merger in the future.	
30	Delivery	For estate proposals, demonstrated that the subsidiary supports the provision of services and improvement to the estate.	See Benefits 2.7 and especially 6 "Asset management." Other benefits also applicable e.g. for estate services improvements (benefits 1-5, 9). Plus strategic focus on estates master planning and developing estate e.g. key worker housing. Benefit 7 (VFM) also has the upside case, for up to 20% more spending power on capital, if VAT is fully recoverable, allowing a larger capital programme within the same CEDL funding envelope.	
31	Delivery	Made provision for the transfer of all relevant assets and liabilities.	Yes, the Trusts have made provision for this. As is common in this model, the premises are either leased or licensed (as appropriate) to the PropCo rather than an outright sale. The PropCo will also acquire the assets necessary for service delivery under an Asset Transfer Agreement with the Trust. Operational liabilities directly associated with the transferred services (e.g. maintenance contracts, supplier agreements etc) are novated or assigned to the subsidiary. Staff liabilities are transferred under TUPE (Transfer of Undertakings (Protection of Employment)) regulations, to OpCo ensuring continuity of employment terms and protections for affected staff.	Leases to be set up with Hill Dickinson support (July-Sept)

	In relation to	Guidance description	Response & references	Future work for next phase of programme
32	Delivery	For estate proposals, ensured that detailed arrangements are in place for the protection of assets with a level of control that ensures sufficient oversight including, where appropriate, the requirement for parent organisation approval for capital investment and disposals.	The capital plan will for each Trust, will be part of the ICS wide capital plan, agreed each year, and through a medium term capital plan. This will be still be set by each Trust with PropCo and OpCo providing support and advice along the capital plan pathway from 'wish list' to 'costed plan' Under the contractual arrangement the PropCo will be charged with delivering the capital plan. The day-to-day delivery of the plan will be contracted to OpCo. The capital assets that PropCo is charged with managing under the contractual relationship are buildings and equipment. In relation to buildings PropCo will have no ability to dispose of these assets as they will be leased from the parent Trust. The ability of PropCo to sublet, novate or underlease the properties will be strictly governed through a landlord/tenant relationship which will restrict PropCo's ability to use the buildings for any other purpose than that allowed by the Trusts. In relation to capital equipment, PropCo will hold title as it will need to be able to call on the supplier should it need to and the supplier will need to be contractually bound to PropCo. However, as the Trusts will contribute to these assets by way of an upfront premium (bullet payment), for affordability reasons, the contractual documentation will restrict their ability to dispose of them without the authorisation of the Trust.	
33	Delivery	Ensured that the subsidiary will be able to obtain the necessary registrations and insurances, leases or licences required to deliver the goods and services set out in the business case.	The legal advisors checklist will ensure the necessary registrations, insurances, leases and licences are in place, prior to the go/no go decision. The initial preparedness work has highlighted no areas that would stop progress.	Leases, registrations etc to be set up with Hill Dickinson support (July-Sept)
34	Delivery	Taken into account the good practice advice in NHS England's transaction guidance or commented by exception where this is not the case.	The good practice guidance has been taken into account throughout the transaction planning. The main areas of where interpretations vary between the Unison and the Trusts is whether the engagement phase (May-June) should be on all options, or the Boards' preference to engage on the "preferred way forward" (PWF) which protects jobs, pay, pensions and NHS ownership. Unison's position is that the guidance was not followed as options appraisal engagement should be on all options. The Trusts position is that engaging on outsourcing, or transfer to an out of area NHS subsidiary, would cause several months of uncertainty and anxiety for staff, and are options that score poorly in the appraisal. The other options are referenced in Trust briefings, so the Trusts view in the guidance has been followed, and focus on the PWF is appropriate and sensitive to staff.	
35	Delivery	Ensured that regulatory requirements are understood and complied with, including the potential requirement for the subsidiary to hold an NHS controlled provider's licence.	It is not envisaged that any of the subsidiaries will provide patient services, require a CQC licence, or provide commissioner requested services. None of the subsidiaries will be required to hold a NHS controlled provider licence. The provision of the Operated Healthcare Facilities Service will be under the OHFA contract, which will require the facilities to be maintained in accordance with legal and regulatory standards and the facilities will be inspected in the normal way as part of the Trust CQC requirements.	
36	Delivery	Confirmed that all decisions are consistent with HM Treasury's Managing public money	To ensure consistency with HM Treasury's "Managing Public Money" guidance, the Trusts have focussed on (i) legal compliance in the structure and approach – including by following the NHSE Guidance for Trusts considering setting up or dissolving a subsidiary, (ii) looking to demonstrate value for money in the Full Business Case and throughout the process, and (iii) establishing strong governance and financial controls within the PropCo/OpCo structure.	
37	Delivery	For a parent trust that is an NHS trust, complied with paragraph 20(2) of Schedule 4 of the NHS Act 2006, and specifically ensured that the subsidiary proposal has consent pursuant to the Directions issued by the Secretary of State.	The parent Trusts are all Foundation Trusts, and so this requirement is not relevant.	

	In relation to	Guidance description	Response & references	Future work for next phase of programme
38	Delivery	Considered how governance works within the group to ensure that the various dependence, interdependence and independence requirements of the relationship between parent trust and the subsidiary will be met. For example, obtained assurance that the board of the subsidiary will be able to meet its fiduciary duty under the Companies Act and that any conflicts of interest between the boards of the parent trust and the subsidiary can be managed for individual directors who sit on both.	This has been an area of focused legal advice which the Trusts have considered, especially given the ICS wide / 3 Trusts, shared service approach. It should be noted that there is already a group governance approach operating across two of the Trusts with a shared CEO, Chair and a majority of shared Board Directors. Advice has been provided on the model and the requirements of the relationship between the parent Trusts and the subsidiaries. The Governance and Legal Workstream is developing reserved matters which are retained by the Trusts in OpCo as well as the Shareholders Agreement across the three Trusts with the Articles of Association. There has been advice given and discussions on the proposed board structure for the OpCo and the PropCo's with some Trust appointments as well as external. A plan has been developed for the shadow board to be formed to prepare for go live and feed into the process. The potential for conflicts of interest in the model has been acknowledged and will be mitigated through clear processes in the documentation which for example allow for reserved matters to be referred back to the Trusts and for transparent management of individual as well as organisational conflict points which may arise in OpCo. The governance and legal set up in the model will also include scenario planning for any potential risks around the fiduciary duties for Board members on more than one Board. Whilst the group structure and aligned objectives of the NHS in Dorset will mean the risks are low and resolvable, planning for scenarios, and legal structures to support these, as well as training for directors to understand their fiduciary duties under the Companies Act as part of the legal set up, being undertaken June-September.	
39	Delivery	Ensured that the systems and processes in both the parent trust and the subsidiary interact to assure the parent trust board that it has suitable clinical, financial and operational oversight of the subsidiary. Specifically, these should ensure that the parent trust board is aware on a timely basis of overall clinical, financial and operational performance and significant risks in the subsidiary and can monitor development and implementation of mitigations to address any significant risks. As part of this, the parent trust board is assured that the subsidiary board has sufficient capability and capacity to provide effective organisational leadership, and that systems and processes are in place to provide the board with suitable clinical, financial and operational oversight.	See management chapter. The EFMP services are currently managed within the three Trusts, with clinical, financial and operational oversight held internally. The preferred option starts with safe and legal transfer as is, with service specifications and KPIs reflecting current performance. Then for year one (2026/7) the annual business plan would reflect new risks and benefits being managed. Budgets, risks registers and performance data would continue to be see by all parties. There will be FT oversight by direct shareholder representation on the OpCO and PropCo Boards, at least monthly formal contract meetings OpCo-PropCO to FT, and daily contact (as now) on operational issues and service delivery. Assurance on capability and capacity will be via the Shadow Board for pre-go live, and then as actual OpCo Board, with 6 FT shareholder Directors, 5 OpCo execs, and 3 independent NEDs including chair. The management leads for services would move with their teams, ensuring continuity and capacity. The systems and processes would remain specific to the Trust being served, and over time would become standardised to a single one Dorset approach. This speed of this would be aligned to the scale of benefits and risks of change.	
40	Delivery	Ensured that the trust can continue to comply with all legal requirements following completion of the subsidiary transaction.	See management chapter. The Trust will follow a clear process to ensure the safe, legal, and compliant establishment of the subsidiary model which will be in line with NHS England's guidance on complex change and subsidiary formation (29 February 2024). Actions to support this compliance include: The Business' Case development, regulatory notification and approval process with NHS England, risk assessment and mitigation in the programme board, stakeholder engagement - with staff, unions, governors, and other stakeholders to ensure transparency, governance and oversight of the subsidiary structures, legal advice obtained to ensure compliance with company law, NHS regulations, and procurement rules, financial due diligence, development of a detailed implementation plan, including timelines and resource allocation. Ongoing assurance will be provided through regular reporting to the Trust Boards. A "safe and legal" transfer to the new model is the guiding principle for the Trusts , with the service and system changes to follow once the Board and leadership team are in place.	

	In relation to	Guidance description	Response & references	Future work for next phase of programme
41	Quality	Involved senior clinicians in the decision-making process and confirmed they have no material clinical concerns about proceeding with the proposed subsidiary, including consideration of the subsequent configuration of clinical services.	Engagement via the Trust Management Groups with most senior clinical staff. Also Boards include Chief Medical and Chief Nursing officers. No clinical concerns, and positive support for the improvements a shared service will bring to Dorset. There are no changes to configuration of clinical services as a result of this proposal.	
42	Quality	Ensured that sufficient funding is available to maintain assets to the required healthcare standards.	The funding available to maintain assets will be the same as no change to CDEL. However a positive upside case is that there will be greater sending power is the reclaimable VAT on CEDL spend is then available.	

Quality Committee in Common Assurance Report
for the meeting held on Tuesday 27 May 2025

Chair	Claire Lehman, NED
Executive Lead	Dawn Dawson, Joint Chief Nursing Officer Lucy Knight, Chief Medical Officer (DHC) Rachel Wharton, Chief Medical Officer (DCH)
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

Joint:

- This was the first meeting of the new Quality Committee in Common. A transition report detailing the work to develop the committee and ensure all matters were appropriately transitioned to the new committee was received. Annual effectiveness reports for the former trust-specific committees were also received.
- Review of the Board Assurance Framework and Corporate Risk Register, as detailed below. In particular, consideration was given to increasing the score for SR1.
- Learning from Deaths reports for each trust presented and discussed. To be discussed at Board as well.
- Safe staffing mid-point review, with assurance provided around the processes in place for both organisations. For DCH an issue was raised that a previously approved uplift in headroom had not materialised.

DCH:

- An unannounced CQC inspection of maternity took place last week.
- Update provided on the ophthalmology service lost to follow up – detail provided below.

DHC:

- Receipt of the CMHT and Intensive and Assertive Community Mental Health Service Review – System Level Joint Action Plan (DHC), noting the strong starting position for the trust.

Key issues / matters discussed at the meeting

The Committee received, discussed and noted the following reports:

Chief Nursing and Chief Medical Officer Update (DCH/DHC) providing updates on hot topics within the trusts, and national and regulatory matters. Of note:

- The decommissioning framework has been requested from the ICB

- 'Nurse' is now a protected title; only registrants may call themselves nurse

Dorset HealthCare

- Kimmeridge Court was under enhanced surveillance due to staffing and complexity of patients.
- The forensic provider collaborative had raised concerns about Twynham Ward; the trust had responded, and confirmation was received today that the collaborative was satisfied with the response.
- Three recent CQC visits; two positive reports received to date, the third was awaited.
- 29 applications for international medical graduate recruitment programme, with a view to reducing agency use in psychiatry workforce

Dorset County Hospital

- An unannounced CQC inspection of maternity took place last week.
- Ophthalmology update:
    - Lost to follow up: 5,000 potential patients had been identified within 2024/25. Of those, the records of 4,056 have been reviewed with 42 lost to follow up. These had been clinically reviewed, and appointments had been booked for 7 of those, with the remainder added to the follow up waiting list.
    - Overdue follow up: 3,000 letters had been sent out to patients. 119 calls and 30 emails had been received back from patients. Of those 5 patients had been sent for clinical review. All other patients were on the waiting list or had told the trust they had gone elsewhere.
    - At present, there was nothing to suggest any harm had come to patients, although work remained ongoing and would continue to be fed back to committee.

Committee Transition Report and Annual Reports (Joint)

- A great deal of work had gone in to creating the Quality Committee in Common including planning meetings, development of a joint workplan and terms of reference. This includes increased NED membership as learning from other committees.
- Each trust's Quality Committee had discharged their duties for 2024/25.
- Positive feedback had been received, with similar themes for each trust re improvement/development.

Board Assurance Framework (DCH/DHC) noting an overdue action for each trust but with clear reasons and mitigations in place.
Consideration given to increasing the risk score for SR1. The impact of closure of the maternity unit at Yeovil District Hospital to be considered and reflected in the DCH Board Assurance Framework, whilst not being blurred with the Corporate Risk Register.

Corporate Risk Register (DCH/DHC)

Dorset County Hospital

- The impact of the closure of the maternity unit at Yeovil District Hospital was noted and may have increased certain risk scores since the publication of papers.

Dorset HealthCare

- 18 risks overdue for review – this is an area that needs additional focus to ensure is up to date
- Discussion about the risks relating to school nursing service and the CAMHS HIE.

Quality Report (DCH/DHC)

Dorset County Hospital

- Positive infection, prevention and control position
- Levelling out of hospital acquired PUs and reduction in prevalence
- Friends and Family Test continues to be a challenge, with a focus on improving response rates in ED. No update on the NHS Dorset solution
- Good outcomes for key quality metrics. Consideration to be given to how those are maintained as things get leaner
- Improvement in compliance with section 132 rights

Dorset HealthCare

- Low numbers of self-harm and restrictive practice in under 18 patients
- Norovirus cases across a number of units, with 34 patients affected
- Areas of focus: call back time in integrated urgent care, falls, infection prevention and control, and pressure ulcers

Update – Trust Response to NHSE Letter re Maintaining focus and oversight of quality of care in pressurised services (DCH)

- Audits undertaken in relation to the seven-day standards of care and CQC fundamentals. Outcomes detailed in the paper and actions to be picked up with the necessary services.

Regulatory Compliance Internal Assurance Report (DHC)

- Outlining key activities of the trust relating to CQC fundamental standards and CQC visits. Since writing the report 3 further CQC visits had been undertaken.

Quality Account (DCH/DHC)

- The reports for each trust were set out in the prescribed format, had been presented to each Council of Governors. The reports would be shared with partner organisations for comment and then presented to Boards for approval.

Duty of Candour Plan (DHC)

- Report produced due to a recognised dip in duty of candour reporting. A review of records is being undertaken to improve compliance in

future. To date have seen evidence of duty of candour but not necessarily recorded in the way necessary to capture as data. Outputs to be reported to committee in July.

Learning from Deaths Report Q4 (DCH/DHC)

Dorset County Hospital

- SHMI within expected limits. Coding still challenging and remains on risk register. No other metrics suggest the mortality rate is a concern.

Dorset HealthCare

- A slow increase in overall deaths between April 2023 and March 2025. Data to be reviewed in more depth in a workshop next week.
- Increase in expected deaths of patients on the memory assessment service waiting list. Data to be reviewed in the above workshop, and question about whether this cohort should be included in the trust's death statistics

Maternity Reports (DCH)

- Receipt of the below reports
  - Maternity and Neonatal Quality and Safety Reports
  - PMRT Report
  - Multiprofessional Training Report
  - Maternity Insight Visit Action Plan
- Discussions around the increase of work due to the closure of maternity service at Yeovil District Hospital. The escalation policy would be reviewed in respect of this, and options for secondment for Yeovil staff into the trust was noted.

Safe Staffing Mid-point review (DCH/DHC)

- Assurance provided that there are robust processes in place for both organisations, using evidence-based tools. Midpoint reviews of staffing across all areas, good oversight and knowledge and meeting requirements re processes. For DCH an issue was raised that a previously approved uplift in headroom had not materialised.

CMHT and Intensive and Assertive Community Mental Health Service Review – System Level Joint Action Plan (DHC)

- The trust was starting from a strong position and was working with system partners on this plan. Some actions related to the work of system partners and were not owned by the trust.

Quality Governance Groups Assurance Reports (DCH/DHC)

Decisions made at the meeting

- Approval of the minor amendments to the committee terms of reference
- Approval of the committee workplan
- Approval of the Quality Account for DCH and DHC
- Approval of the safe staffing mid-point review

Issues / actions referred to other committees / groups	• Nil

Quoracy and Attendance						
	27 May 2025	29 Jul 2025	23 Sep 2025	25 Nov 2025	27 Jan 2026	24 Mar 2026
Quorate?	Y					
Claire Lehman	Y					
Suresh Ariaratnam	Y					
Dawn Dawson	Y					
Lucy Knight	Y					
Eiri Jones	Y					
Stuart Parsons	Y					
Rachel Small	A					
Anita Thomas	Y					
Rachel Wharton	A					

Report to	Board of Directors, Part 1	
Date of Meeting	10th June 2025	
Report Title	Maternity and Neonatal Quality and Safety Report (May 2025 report with April data)	
Prepared By	Jo Hartley Director of the Midwifery and Neonatal Service	
Approved by Accountable Executive	Dawn Dawson, CNO	
Previously Considered By	Quality Committee in Common 17/05/2025 Quality Governance Group 13/05/2025	
Action Required	**Approval**	No
	Assurance	Yes
	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 the Trust	
Statutory & Regulatory	Elements in this report relate directly to Maternity Incentive Scheme alongside other national and local KPIs	
Equality, Diversity & Inclusion	Not specifically	
Co-production & Partnership	Nil	

Executive Summary

This report sets out the quality and safety activity covering the month of April 2025 (some dates may vary as specified). This is to provide assurance of maternity and neonatal quality, safety and effectiveness with evidence of quality improvements to the Executive and Non-Executive Team.

Smoking at birth achieved KPI but carbon monoxide monitoring still slightly below KPI.

Datix for staffing and for delayed induction of labour continue to dominate

Two datix submitted concerning a consultant not being available on his phone over an extremely challenging weekend.

Significant improvement in Avoiding Term Admissions Into Neonatal units (ATAIN) data. Also, ATAIN data reviewed and the criteria corrected

Two third degree tears

The Risk Register has been updated

1.1881: Neonatal staffing now high risk at 20. No change to a heavy reliance on agency staff

2.876: Maternity staffing now high risk at 20 significantly challenged with vacancies of 6.37wte midwives due to maternity leave and LTS (approaching 10% of the band 5&6 workforce). 2.29wte midwives due

to start maternity leave soon with no-one returning from maternity leave until the Autumn. The next roster has <10 shifts fully staffed out of a total of approx. 90 (early, late and night)

3.2044: Maternity & neonatal digital service now high risk at 20. The lead for maternity digital service on LTS. Currently no specialist digital maternity service which is impacting BAU, MIS safety action relating to MSDS, trouble shooting, change requests and LMNS workstreams. Risk increased to reflect change

Four complaints received. The themes are:

- Endeavour not to cancel appointments
- The importance of carrying out all health checks with due care and diligence, ensuring nothing is missed
- Careful debriefing of patients after a procedure, in this case a caesarean section when there was an incident with the surgeon

Workforce data - sickness average last 12 months

- Midwives – 6.26%
- Maternity Support Workers – 10.37%
- Special Care Baby Unit – 8.99%
- Midwifery shifts not fully staffed 9.67%
- MSW shifts not fully staffed 29%

Training figures overall positive with robust plans in place to ensure compliance in areas of <90%

Joint Quad and Safety Champion Meeting took place in March

The Insight Action Plan - actions completed:

- Online safety champion meetings arranged alongside face to face meetings
- Ante Natal Clinic capacity improved with the additional 10th consultant. Significantly less women attending Ante Natal Day Assessment Unit (ANDAU) due to no clinic appointments
- ANDAU midwife training as a prescriber
- Second theatre business case and options appraisal completed and now with Division
- Escalation policy being reviewed alongside LMNS escalation policy
- Enhanced Continuity of Carer provision for pregnancy and after birth commenced in Weymouth & Portland
- Seven-day bereavement care Standard Operating Procedure completed
- Community review has commenced. ToR agreed and preliminary meetings occurred. However, Long Term Sickness (LTS) within the senior midwifery team will require this review does not proceed if backfill is not funded and agreed

Recommendation

Members are requested to:

- **Receive the report for assurance.**

NHS
Dorset County Hospital
NHS Foundation Trust

Maternity & Neonatal Quality and Safety report

May 2025

Submitted by Jo Hartley, Director of Midwifery & Neonatal Services

Executive sponsor: Dawn Dawson CNO

Executive Summary

This report sets out the quality and safety activity covering the month of April 2025 (some dates may vary as specified). This is to provide assurance of maternity and neonatal quality, safety and effectiveness with evidence of quality improvements to the Executive and Non-Executive Team.

- Smoking at birth achieved KPI but carbon monoxide monitoring still slightly below KPI.
- Datix for staffing and for delayed induction of labour continue to dominate
- Staffing challenges continue to feature in neonatal datix submissions
- Two datix submitted concerning a consultant not being available on his phone over an extremely challenging weekend. The CS met with the consultant. He explained his mobile signal had become very patchy (now resolved). Discussion and response attached as an email to the datix.
- Significant improvement in Avoiding Term Admissions Into Neonatal Units (ATAIN) data. Also, ATAIN data reviewed, and the criteria corrected
- Two third degree tears

The Risk Register has been updated:

1. 1881: **Neonatal staffing now high risk at 20** No change to a heavy reliance on agency staff
2. 876: **Maternity staffing now high risk at 20** significantly challenged with vacancies of 6.37wte midwives due to maternity leave and LTS (approaching 10% of the band 5&6 workforce). 2.29wte midwives due to start maternity leave soon with no-one returning from maternity leave until the Autumn. The next roster has <10 shifts fully staffed out of a total of approx. 90 (early, late and night)
3. 2044: **Maternity & neonatal digital service now high risk at 20.** The lead for maternity digital service on LTS. Currently no specialist digital maternity service which is impacting BAU, MIS safety action relating to MSDS, trouble shooting, change requests and LMNS workstreams. Risk increased to reflect change.

Complaints:
Four complaints received. The themes are:

1. Endeavour not to cancel appointments
2. The importance of carrying out all health checks with due care and diligence, ensuring nothing is missed
3. Careful debriefing of patients after a procedure, in this case a caesarean when there was an incident with the surgeon

Workforce data
Sickness average last 12 months:

- Midwives – 6.26%
- Maternity Support Workers – 10.37%
- Special Care Baby Unit – 8.99%
- Midwifery shifts not fully staffed 9.67%
- MSW shifts not fully staffed 29%

- Training figures overall positive with robust plans in place to ensure compliance in areas of <90%
- Joint Quad and Safety Champion Meeting in March

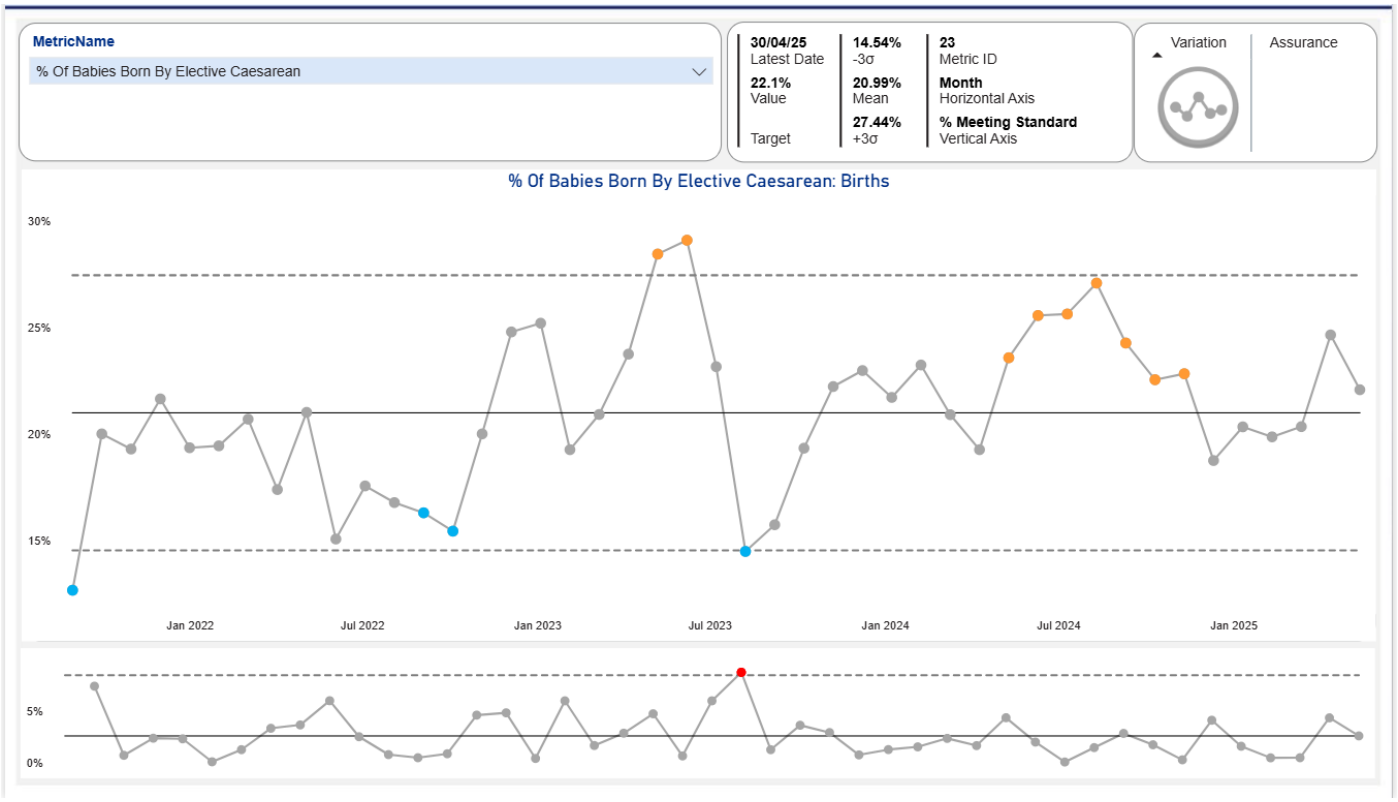
The Insight Action Plan - actions completed:

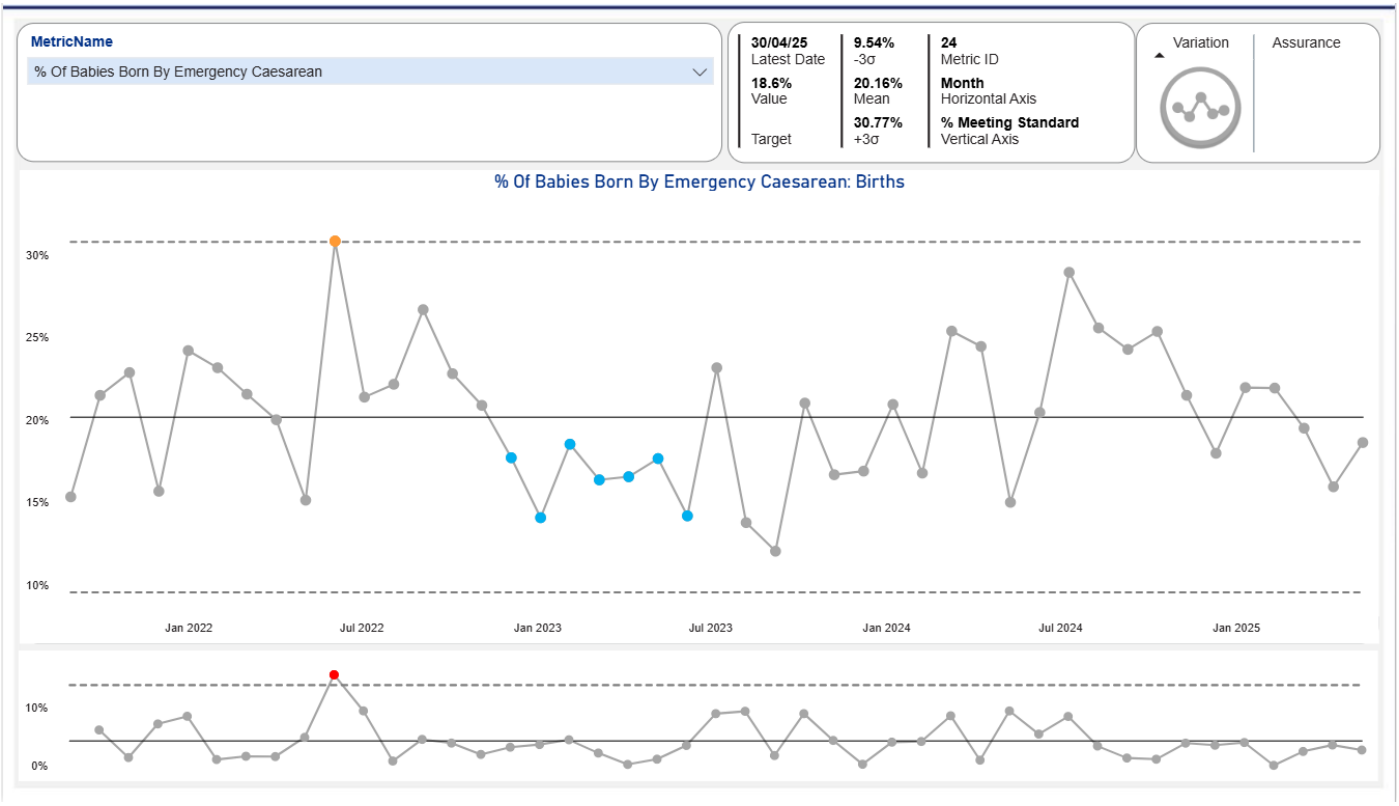
1. Online safety champion meetings arranged alongside face to face meetings

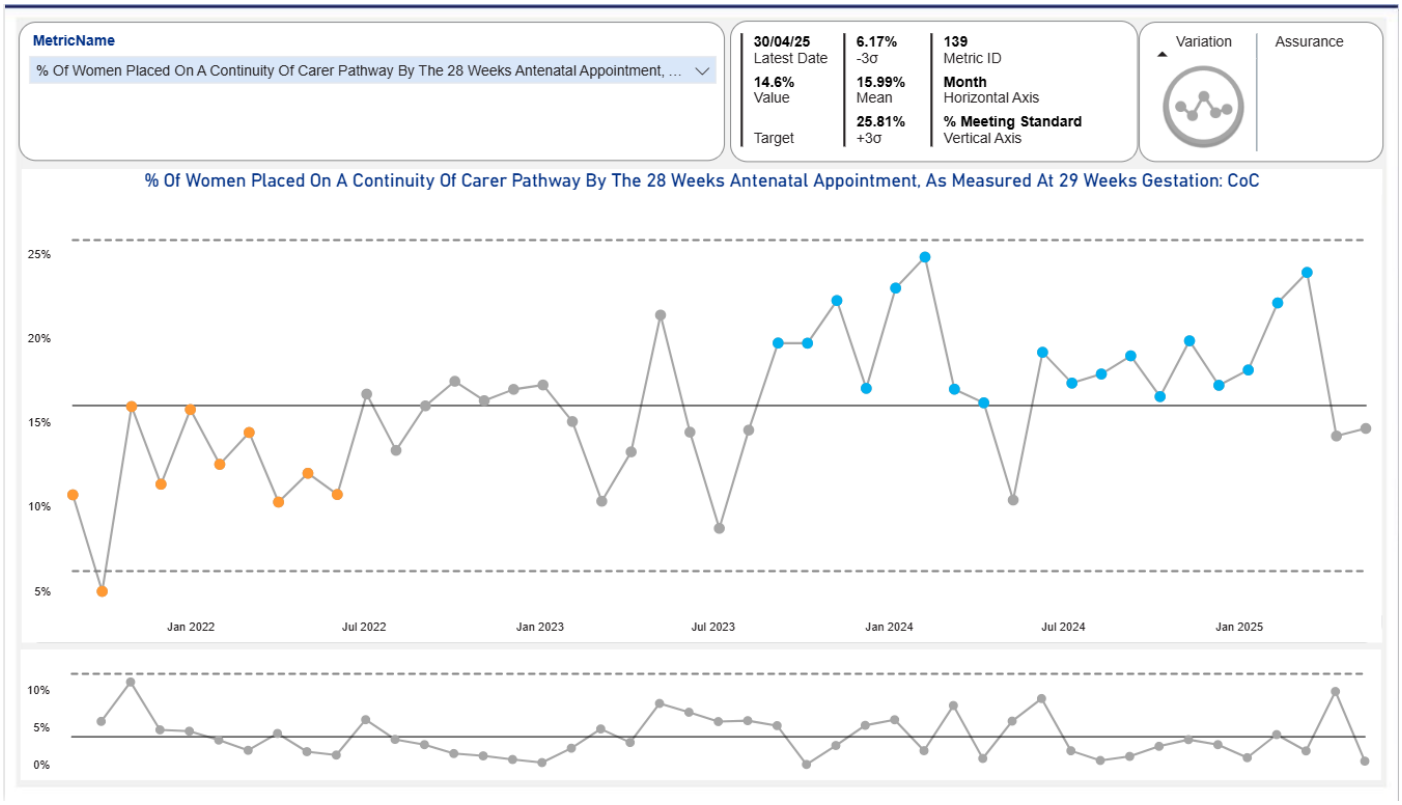
2. Ante Natal Clinic capacity improved with the additional 10th consultant. Significantly less women attending Ante Natal Day Assessment Unit (ANDAU) due to no clinic appointments
3. ANDAU midwife training as a prescriber
4. Second theatre business case and options appraisal completed and now with Division
5. Escalation policy being reviewed alongside LMNS escalation policy
6. Enhanced Coc provision for pregnancy and after birth commenced in Weymouth & Portland
7. Seven-day bereavement care Standard Operating Procedure completed
8. Community review has commenced. ToR agreed and preliminary meetings occurred. However, Long Term Sickness within the senior midwifery team will require this review does not proceed if backfill is not funded and agreed

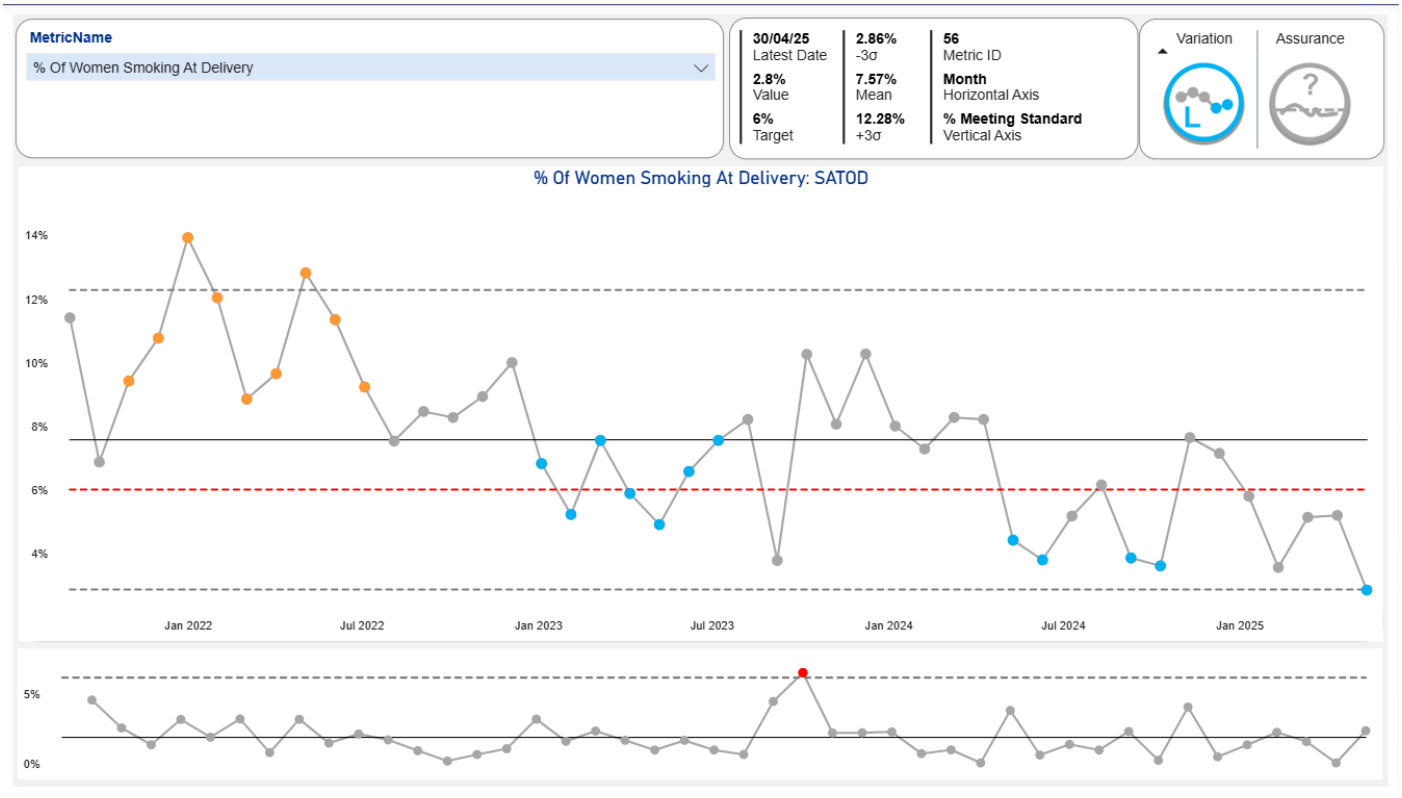
Exception report for SPC charts (NTI – no target identified)

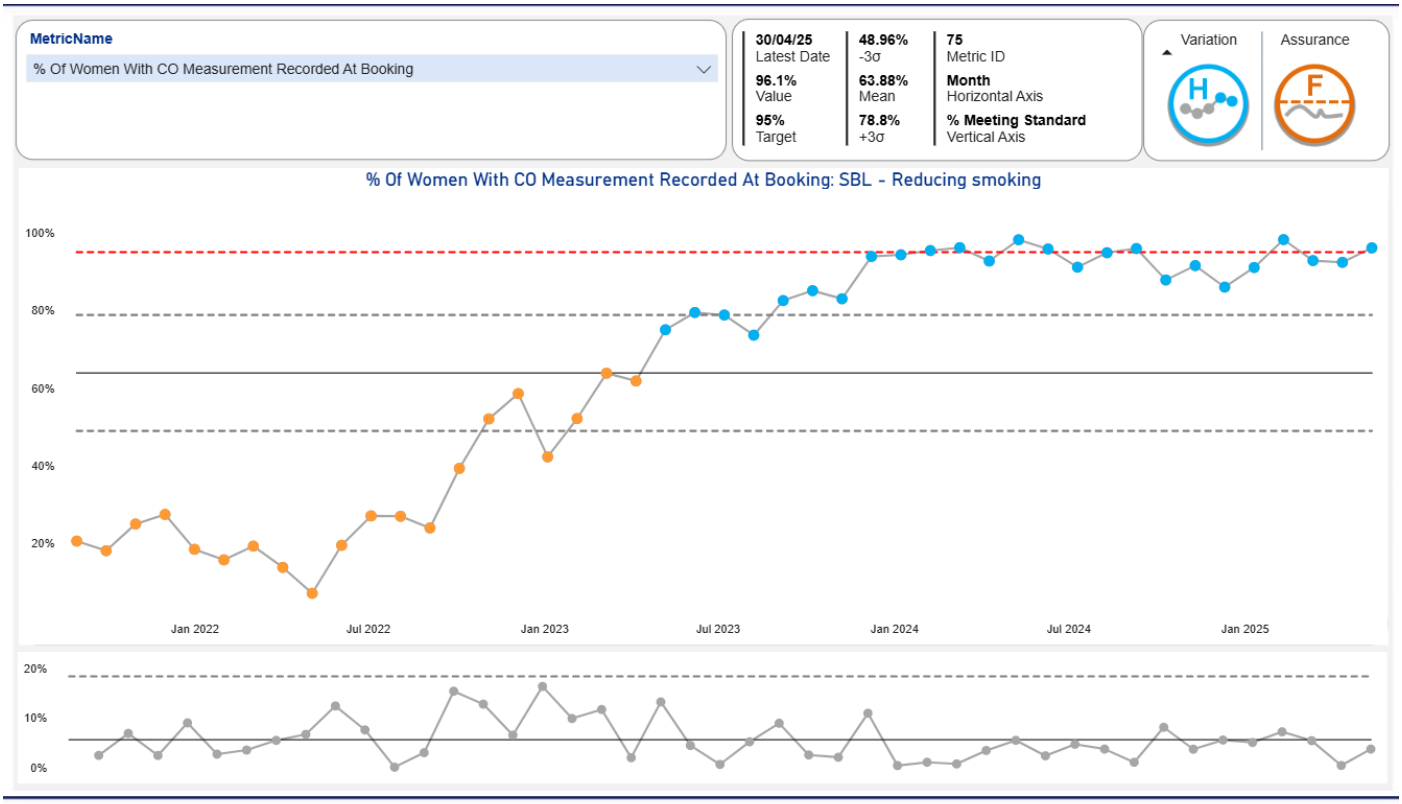
Metric	Target	Current position and mitigation/actions
% babies born by elective caesarean	NTI	22.1%
% babies born by emergency caesarean	NTI	18.6%
% women on a continuity of care pathway by 28 weeks	NTI	14.6%
% women smoking at time of delivery	6%	2.8%
% CO recorded at booking	95%	96.1%
% CO record at 36 weeks	95%	87.2%
Number of stillbirths		nil
Number of neonatal deaths		nil
% babies >37 weeks admitted to SCBU	5%	3%
Rates per 1000 of PPH >1500mls (current 3 months)	30	33.1
Rates per 1000 of 3rd/4th degree tears (current 3 months)	25	17.5
% live births <37 weeks gestation	6%	6.3%
Hypoxic Ischemic Encephalopathy incidents		Nil
Percentage of babies with 1st feed maternal	NTI	81.6%
Percentage of babies with fetal growth restriction <3rd centile, born after 37 weeks and 6 days	nil	nil

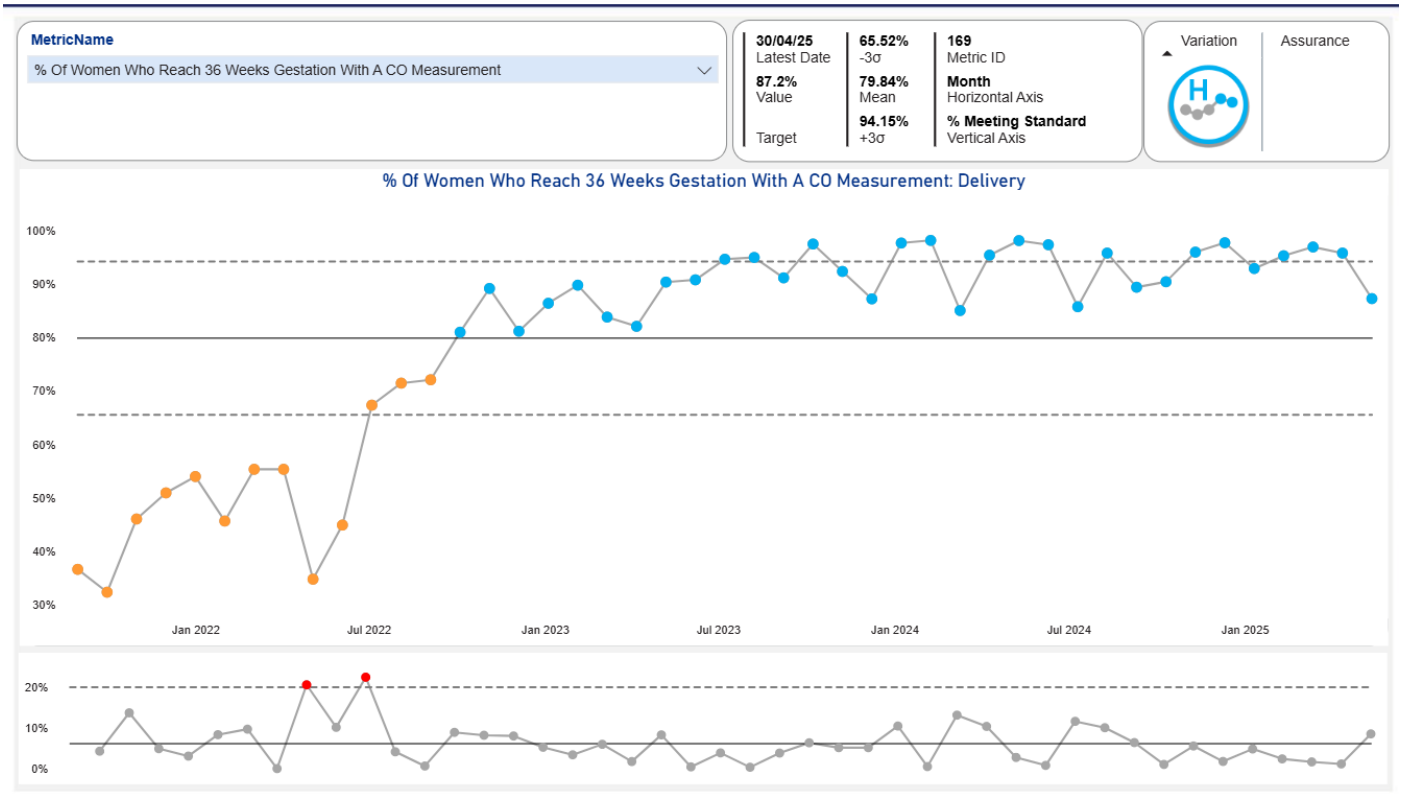


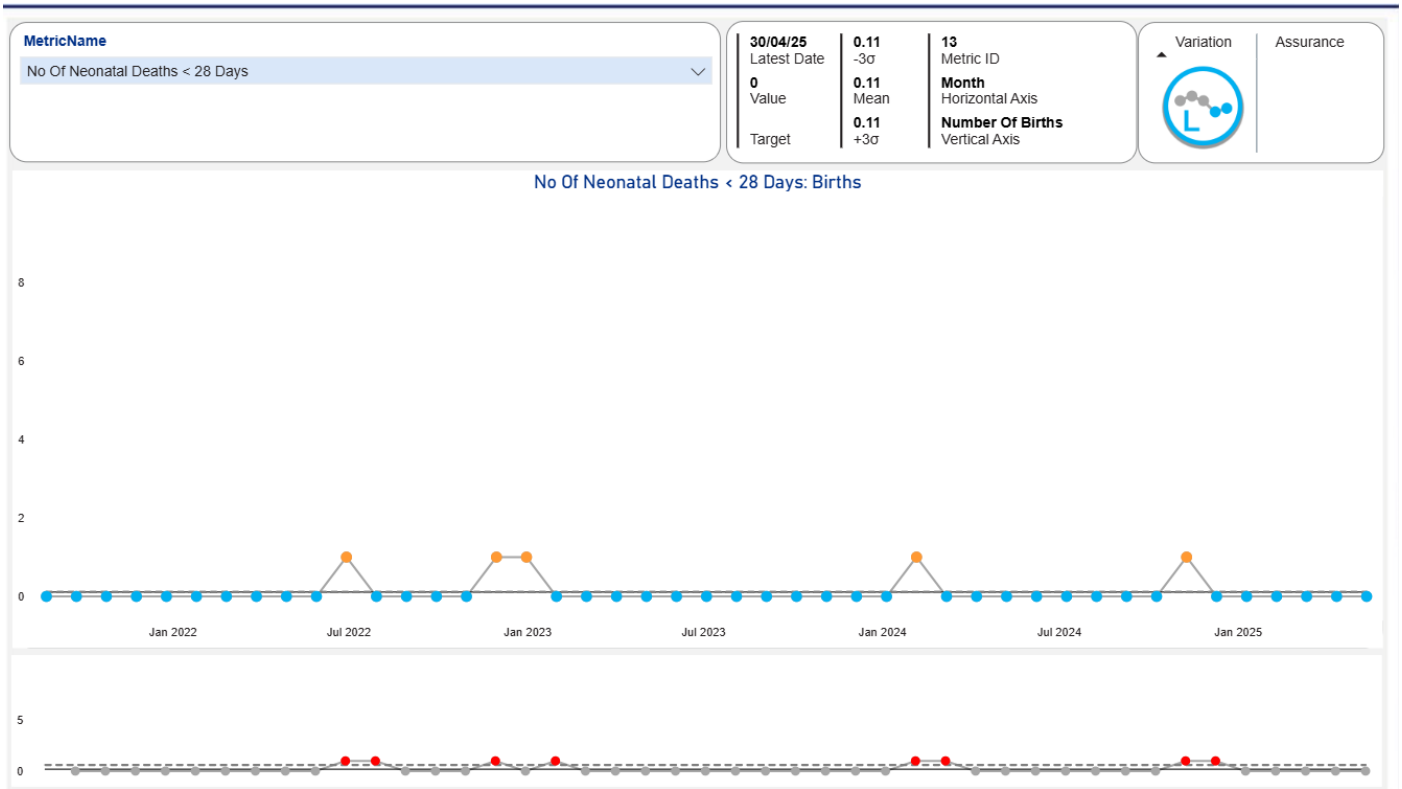


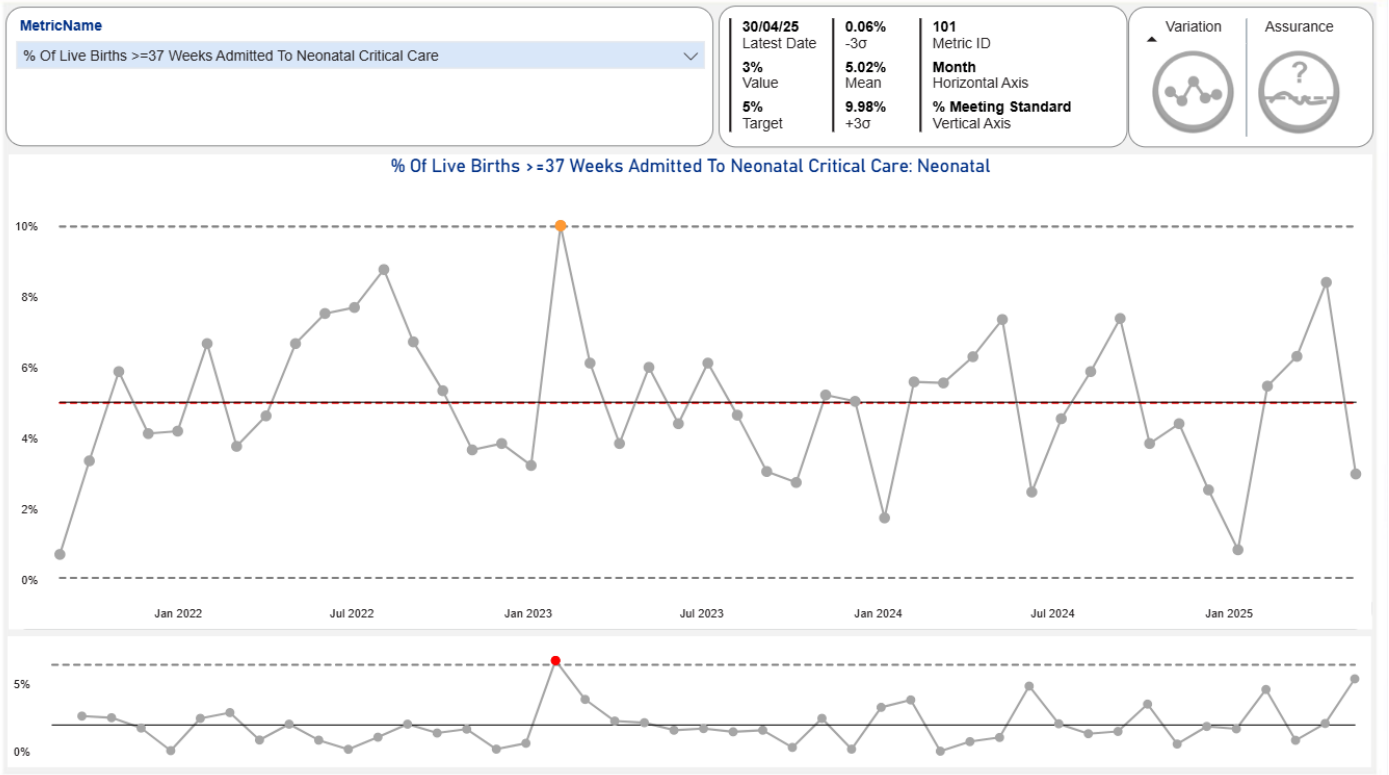


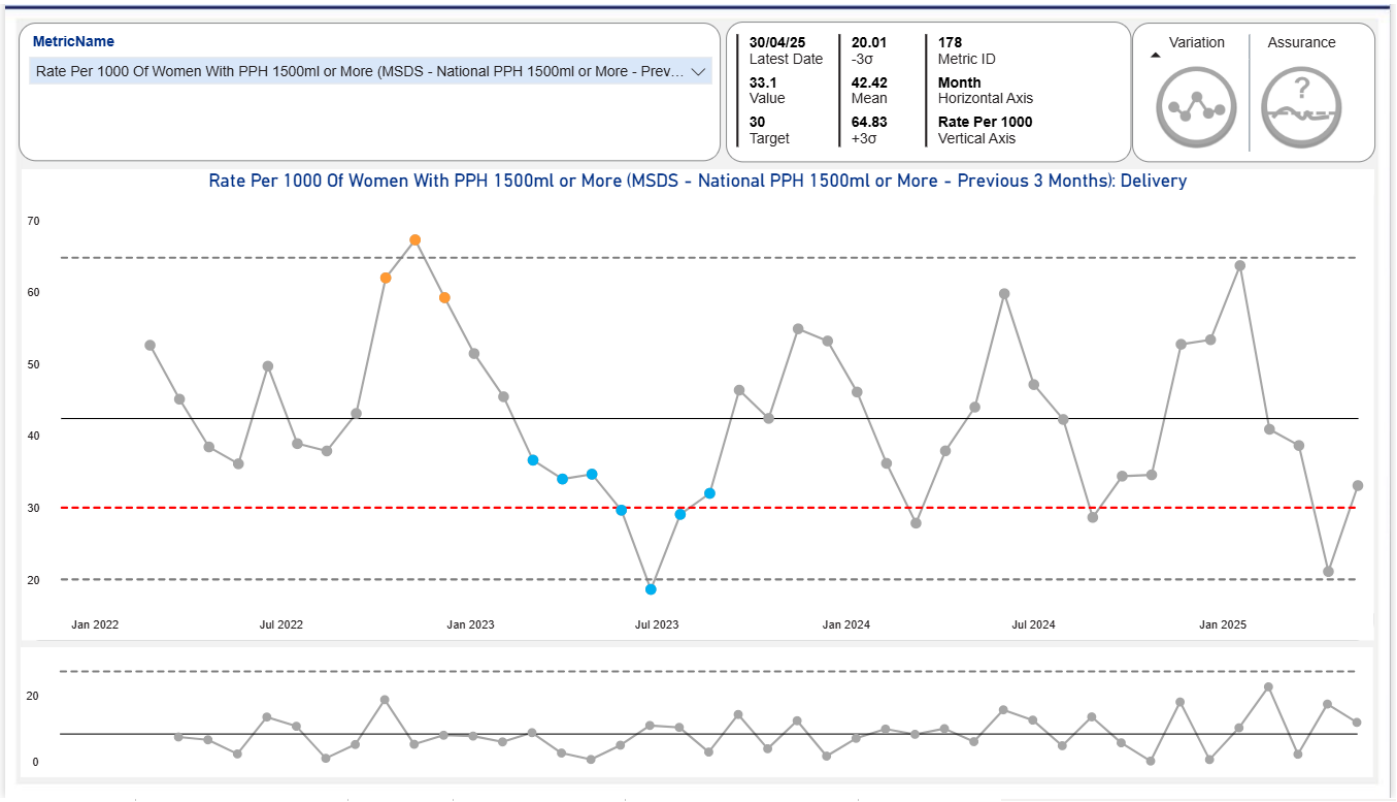


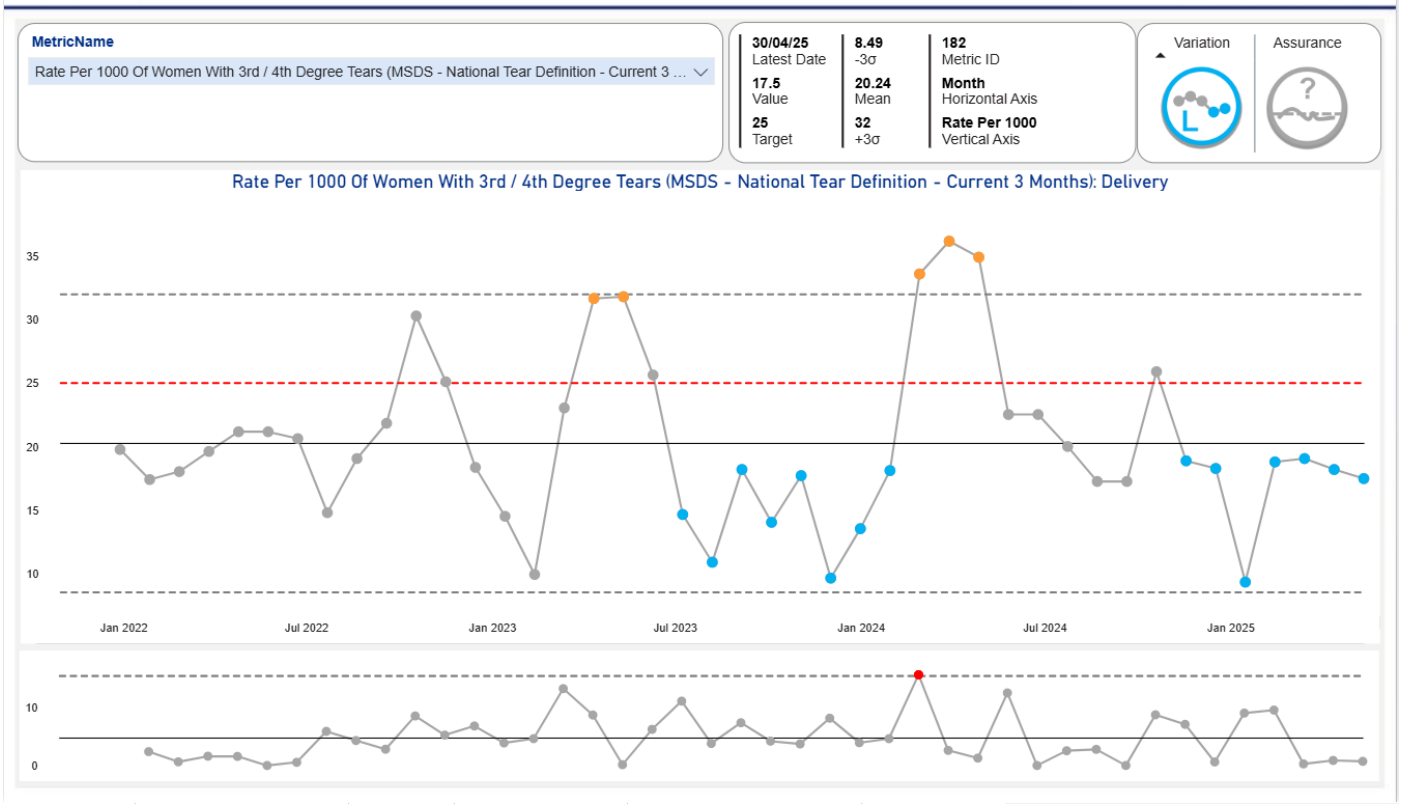


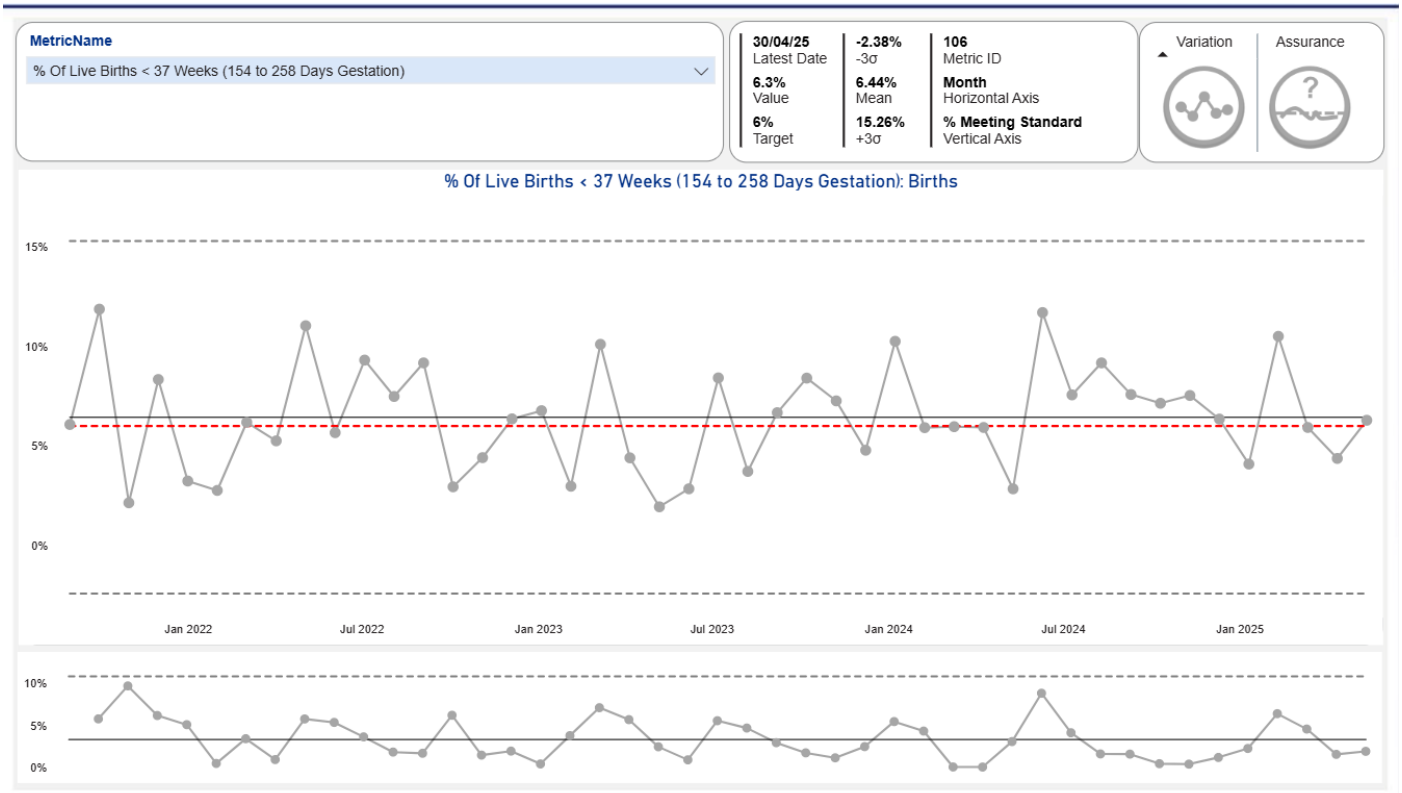


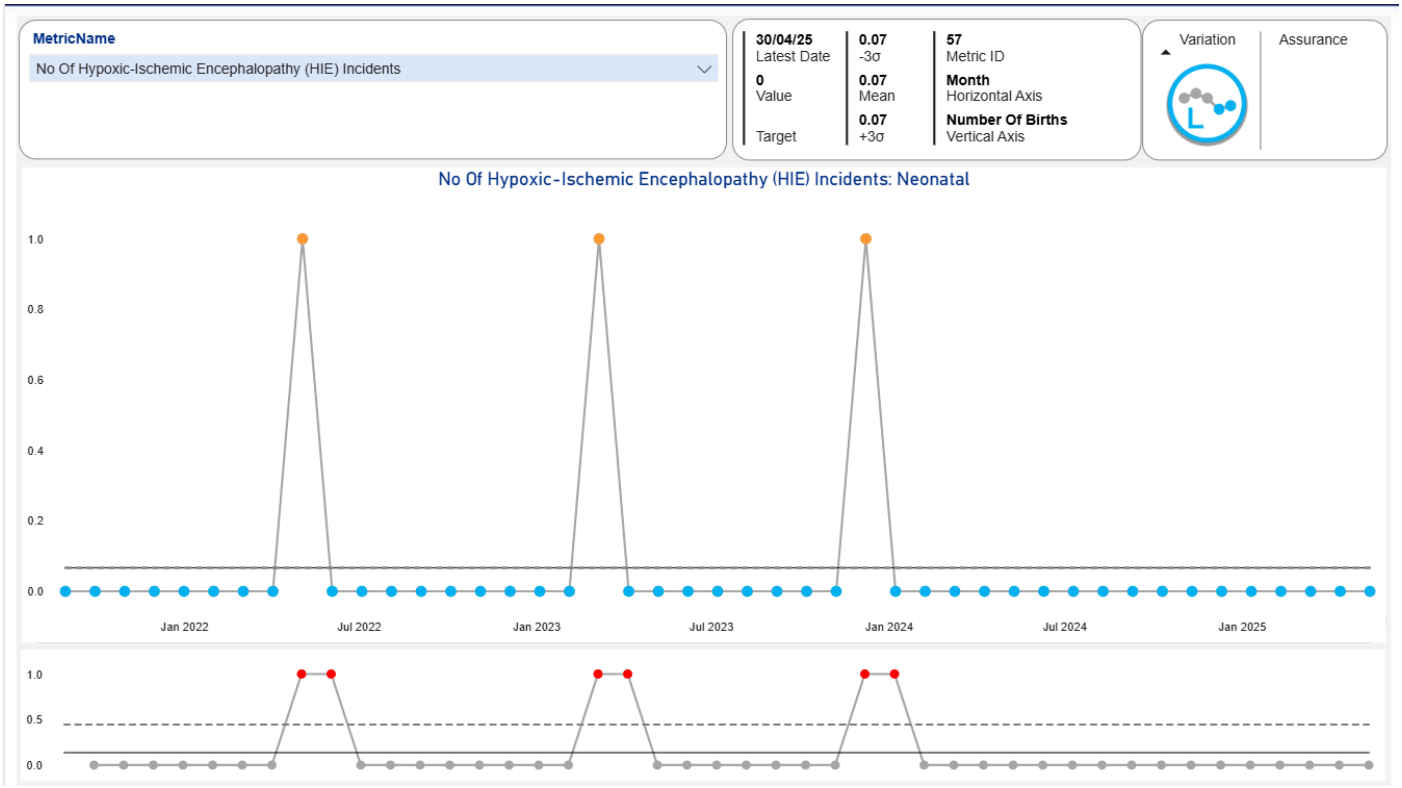


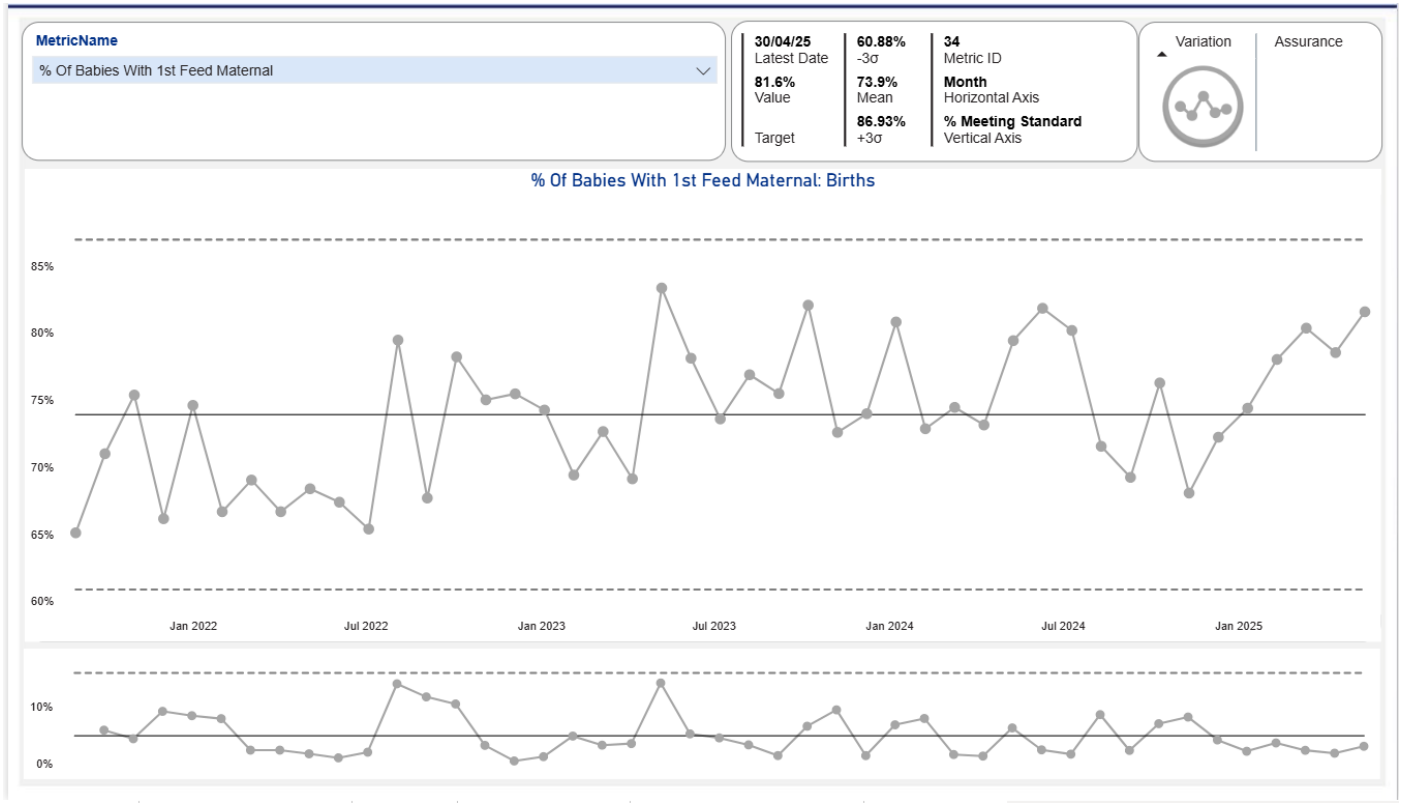












Total Number of Incidents submitted for April 2025

maternity & neonatal
61

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

Red flag	Descriptor	Incidents for April
RF1	Escalation to divert of maternity services & poor staffing numbers, including medical staffing and SCBU	5 for maternity, 2 for SCBU
RF2	Missed medication	1
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	8
RF7	Delay in continuing the process of induction of labour	
RF8	Unable to provide 1 to 1 care in labour	0
RF9	Unable to facilitate homebirth	1 – due to midwives already in attendance at a homebirth

RF10	Delay of time critical activity	0

In-utero transfers – UHD is default level 2 NICU for DCH pregnancy <32 weeks	
28+2 gestation	Vaginal bleeding. Transferred to UHD

harm	incident	Action
Moderate harm or more	nil	

required for labour ward Manager oncall informed The consultant returned call over 1 hour later from initial attempt at contact asked to come in - not keen to do so discussion between consultant and spr who further asked for their attendance	the weekend in question. He had now resolved this. He apologised and agreed, he should have informed the coordinator and the manager on call of this problem as soon as it came to his attention. He explained he did not know who the manager oncall was for that weekend (the scheduling is on display in three places but will now be circulated to all consultants). He explained he tried to let the coordinator know by phoning the desk phone. He was not aware the coordinator had a mobile (number now circulated to all relevent team members)
DCH104617 as submitted by the manager on call: The obstetric rgiostrar in theatre ask me to contact consultant as the unit was in OPEL 4. Multiple attempts to contact the consultant by phone and text. Eventually contacted. During this time there was significant concerns with two women on labour ward.	

3rd & 4th degree tears April

Ethnicity	BMI	Grade of tear	Mode of birth	Hands on	OASI	Position of woman	Baby's weight	Blood loss	Referral made
White British	34	3a	spontaneous	yes	yes	Semi prone	3368g	300mls	yes
White British	30	3b	Spontaneous, shoulder dystocia	Unable to determine	Unable to determine	Semi prone	4082g	1084mls	yes

Risk Register

ID	Title	Risk Statement	Open	Risk	responsibility

2139	Risk to the maternity advice line provided by UHD for all of Dorset	the maternity advice line provides a dedicated maternity triage service for all pregnant women in Dorset. A request has now been submitted by UHD that DCH pay a proportion of running costs – approx. £80k per annum. UHD may serve notice on the service if an agreement is not made. Without UHD providing this dedicated service, DCH would have to provide a 24/7 service for DCH women **Update** No progress with this. Awaiting a decision from UHD about withdrawal of the service and from DCH about funding	07/04/2025, Jo Hartley, DoMN Services, quarterly review	12	Division
1980	EPAC restricted service	**Update** Currently EPAC remains open for most Mondays-Fridays. However, this comes at a cost pressure to maternity as a midwife has been reallocated to EPAC and vacant shifts are being covered by bank staff Business case has been submitted and awaiting amendments **Update** No change	20/09/2024, Jo Hartley, DoMN Services, quarterly review	Moderate 9	Division
2031	Maternity Reception Cover	**Update** Cover for Reception has improved significantly with very few shifts vacant. Once fully recruited following a recent resignation, reception will be covered 0800-2000, 7 days a week	19/12/2024, Jo Hartley, DoMN Services, quarterly review	Low 6	Care Group.
1881	Neonatal Nursing	**Update** Risk raised due to daily challenges to fill vacant shifts. Following a discussion at Safety Champions outlining the daily challenges to staff SCBU, there was agreement to recruit 1wte band 6 nurse plus block booking for 2/52 with agency to cover recent vacancies exacerbated by LTS for a fulltime nurse and an HCA. **Update** No change	01/05/2024 Débora Pascoal-Horta, Neonatal Matron, monthly review	High 20	Corporate

1825	3 x neonatal ventilator SLE 5000 out of service	Current ventilators available in SCBU (X3) reached end of life and the period of maintained support has now passed. **Update** Different options being trialled. Funding identified to replace the first ventilator	26/02/2024, Debora Pascoal-Horta, neonatal matron, monthly review	Moderate 8	Division
2044	Risk to sustainability of Maternity & Neonatal Digital Service	Currently the maternity digital team is 1 wte midwife only. The admin support has left due to her secondment ending. The band 6 is on secondment (essential role within the Trust Digital Team) Education lead midwife for digital on maternity leave with no replacement identified. **Update** Lead for maternity digital service on LTS Currently no specialist digital maternity service which is impacting BAU. MIS safety action relating to MSDS, trouble shooting, change requests and LMNS workstreams. Risk increased to reflect change	14/01/2025, Jo Hartley, DOMN, monthly	20	Corporate
1689	Opening a second theatre in an emergency &the elective pathway	All incidents where a second theatre is required are reviewed by the Safety Team and where relevant through M&M or other specialist groups. Discussions starting about establishing a pathway for elective theatre work - planned caesareans. **Update** This workstream continues, led by the Intrapartum matron. Business case recently completed for a dedicated second theatre for elective provision	29/06/2023 managed by Jo Hartley DoM, quarterly review	moderate 9	division
1742 & 1759	Additional obstetric consultant capacity required to meet national KPIs	Unable to provide nationally mandated level of care to some high-risk groups of women. Also unable to provide a consultant evening (8pm) face to face handover. **Update** 10th consultant has started and there is now a morning and evening f2f ward round. Risk can be closed	013/10/2023, closed	Low 4 closed	Division
876	Maternity Staffing	**Update** maternity staffing significantly challenged with vacancies of 6.37wte midwives due to maternity leave and LTS (approaching 10% of the band 5&6 workforce). Recruitment unsuccessful for fixed term so currently reallocating midwives from community (potential impact on safety and quality of services in community), specialist services	21/09/2021 Managed by Jo Hartley, Director of Midwifery, monthly reviews	High 20	Division

		(impacting on national KPIs) and manager on-call required on the ward (impacting on major workstreams as well as appraisals etc). Also staff working significant amounts of overtime and on-call. A further 2.29wte midwives due to start maternity leave soon with no-one returning from maternity leave until the Autumn. The next roster has <10 shifts fully staffed out of a total of approx. 90 (early, late and night)			

Complaints for maternity and SCBU

Total informal and formal

Month	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
total	3	2	1	1	1	1	1	3	2	2	2	4

Themes
Endeavour not to cancel appointments
The importance of carrying out all health checks with due care and diligence, ensuring nothing is missed
Careful debriefing of patients after a procedure, in this case a caesarean when there was an incident with the surgeon

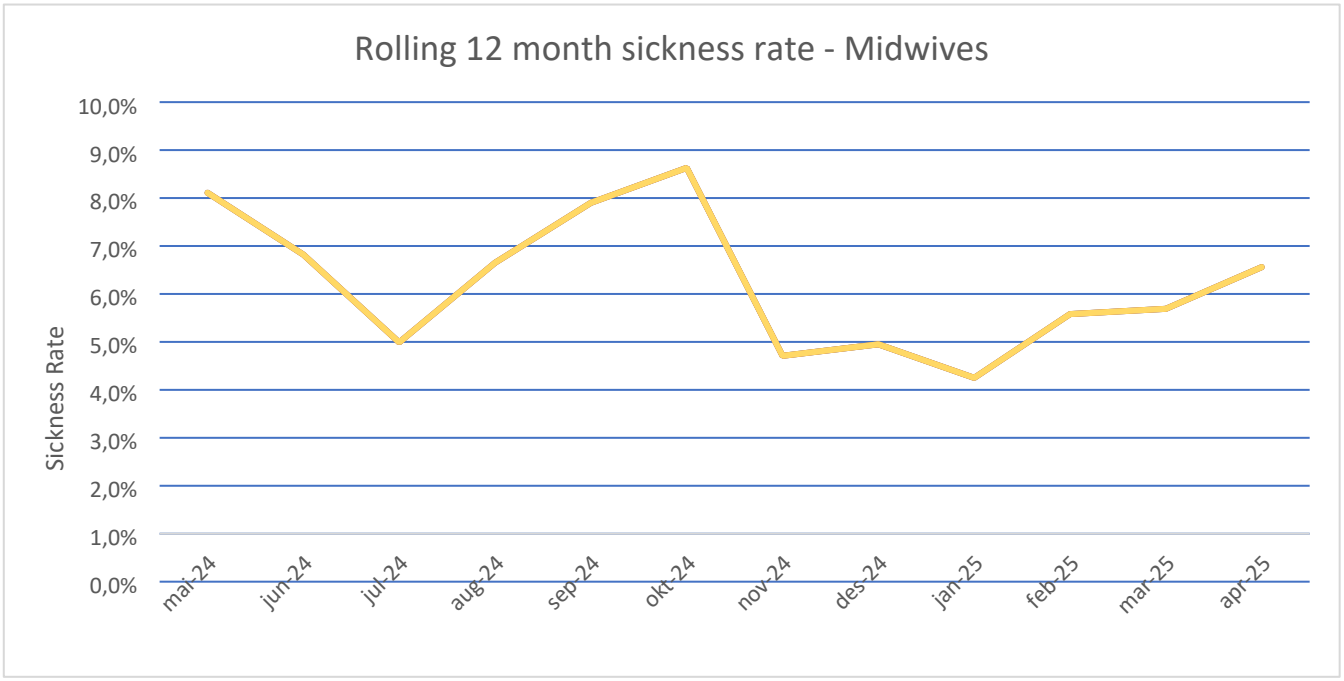
Neonatal transfer out data for April

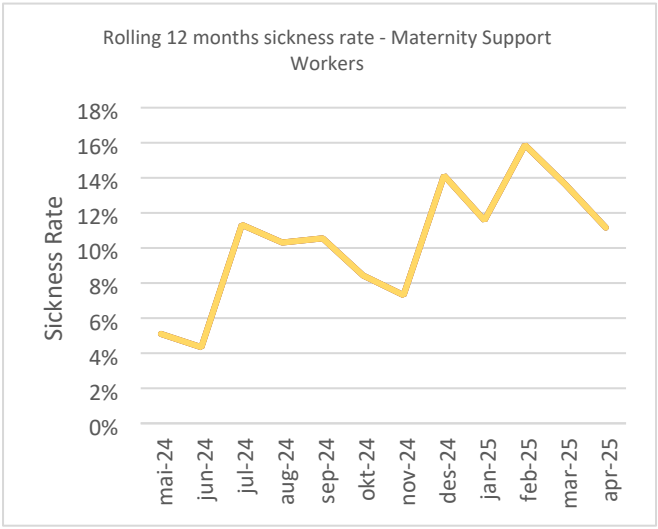
Gestation	Weight	Reason	Transferred to
nil	nil	nil	

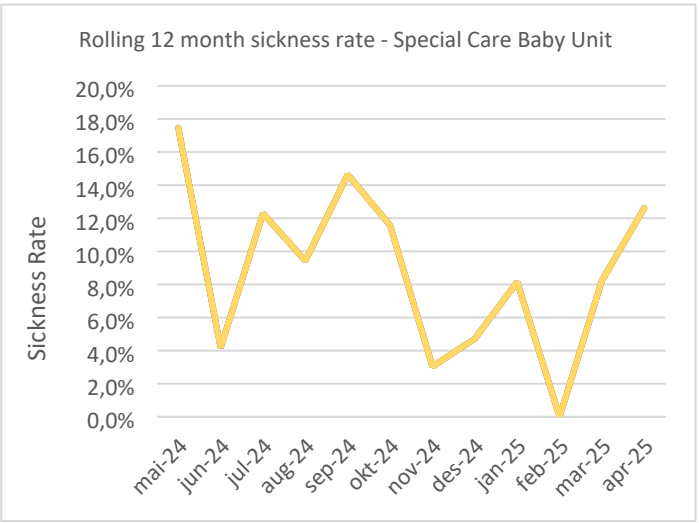
Neonatal exceptions (babies that should have been transferred out of SCBU)

nil		

Workforce data - April



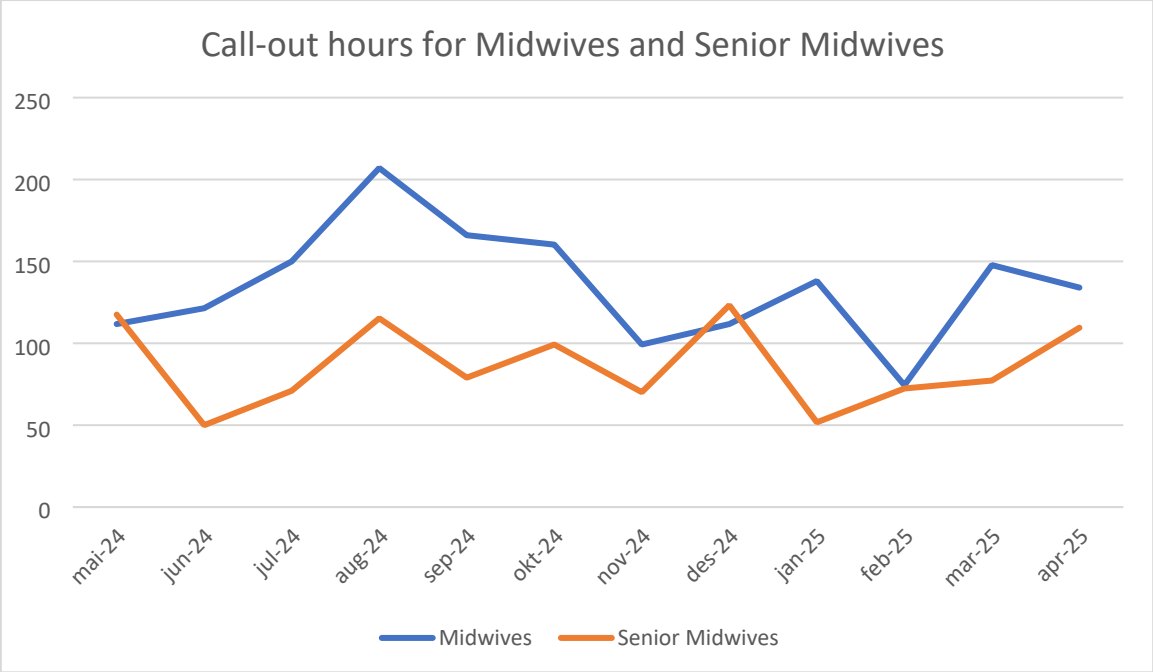




Overall sickness rates from 1st April 2024 – 31st March 2025
Midwives – 6.26%
Maternity Support Workers – 10.37%
Special Care Bay Unit – 8.99%

April Call-Out Hours

Midwife call-out for the unit – **134 hours.**
Senior Midwives call-out – **109.5 hours**



Bank and Excess hours

	Maternity Unit/ DAU	MSW's / DAU	SCBU Registered	SCBU Band 3
Bank	86.5 hrs / 99.5 hrs	118 hrs/28.25 hrs	462 hrs	62 hrs
Excess/Overtime	449.25 hrs	53 hrs	185 hrs	

Shifts not covered by substantive or bank staff

Maternity Unit – based on 6 midwives per shift		**Special Care Baby Unit**	
Day Shift	9.67%	Band 5/6	3 shifts not covered
Night Shift	9.67%	Band 2	3 shift not covered
Total	**9.67%**		
Maternity Support Workers			
Day Shift	29%		
Night Shift	30.6%		
Total	**29.5%**		

Babyloss for April

Baby loss statistics for April			
Intrauterine death	Medical termination	Neonatal death	Late neonatal death
Not available – will report next month			

Training Figures for April

Key	
≥90% compliance	
<90% compliance	

Training	Role	Compliance (percentage)	Non-compliance (number)	Narrative
Safety Action 6 Saving Babies Lives care Bundle Version 3.0				
SA6 Saving Babies Lives V3 (SBLv3) Study Day	Consultants	90%	1	BAU
	Registrars	89%	1	BAU – only 100% compliance meets threshold.
	Drs on SHO rota	71%	2	1 booked for next month, I new staff member pending booking, only 100% compliance meets threshold.
	Midwives	97%	4	BAU
SA6 SBLv3 Element 1.8	Midwives and MSWs giving AN care	93%	12	BAU
SA6 SBLv3 Element 1.9	VBA all staff (midwives, obstetricians and MSWs)	92%	25	BAU
SA6 SBLv3 Element 2.11	Practical SFH assessment	96%	6	BAU
Safety Action 8				
Fetal Monitoring and Surveillance in the AN and Intrapartum period	8.1 90% of all Obstetric Consultants	90%	1	As per Trust induction policy.
	8.2 90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2025)	100%	0	BAU
	8.3 For rotational medical staff	N/A	N/A	For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm

	commencing on or after 01/07/25			that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?
	8.4 90% of midwives	96%	5	BAU
Practical Obstetric Emergency Procedure Training (PROMPT)	8.5 90% of obstetric consultants	90%	1	BAU. Staff member may be in date, pending confirmation from previous Trust, booked to attend June 2025.
	8.6 90% of all other doctors contributing to obstetric rota	100%	0	Commencing with the organisation prior to 1 July 2025, interpreted as Doctors on the obs registrar rota.
	8.7 rotational obstetric staff (*Drs on obs SHO rota)*	86%	1	Interpreted as Doctors on Obstetric SHO rota. BAU – due to size of cohort only 100% compliance meets threshold.
	8.8 90% midwives	98%	2	BAU
	8.9 90% of MSWs	92%	3	BAU
	8.10 90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors	92%	1	BAU
	8.11 of all other obstetric anaesthetic doctors commencing prior to 01/07/25	84%	4	Including any anaesthetists in training, SAS and LED doctors who contribute to the obstetric anaesthetic on-call rota. This requirement is supported by the RCoA and OAA.
	8.12 rotational anaesthetic staff commencing work on or after 01/07/25	N/A		

Neonatal Basic Life support (NBLS) Yearly	8.15 90% of paediatric consultants	91%	1	BAU
	8.16 90% of neonatal junior doctors commencing prior to 01/07/25	100%	0	90% of neonatal junior doctors (commencing with the organisation prior to 1 July 2025) who attend any births *Includes Paediatric registrars and doctors on Paediatric SHO rota.*
	8.17 rotational medical staff commencing work on or after 01/07/25	N/A	0	
	8.18 90% of neonatal nurses	94%	1	90% of neonatal nurses (Band 5 and above who attend any births)
	8.19 90& of MSWs and HCAs	57%	3	90% of maternity support workers, health care assistants and nursery nurses *dependant on their roles within the service - for local policy to determine. *3 HCA on SCBU out of date.*
	8.20 90% of ANNP	100%	0	BAU
	8.21 90% of midwives	92%	9	BAU
RCUK Neonatal Life Support (NLS) Certificati on 4 Yearly	8.22			In addition to the above neonatal resuscitation training requirements, a minimum of 90% of neonatal and paediatric medical staff who attend neonatal resuscitations unsupervised must have a valid Resuscitation Council (RCUK) Neonatal Life Support (NLS) certification or local assessment equivalent in line with BAPM basic capability guidance.
	The staff cohorts within 8.22 are separated out below to allow for accurate monitoring within the differing management streams.			
	Paediatric Consultants	100%	0	BAU
	Paediatric Registrars	100%	0	BAU
	Neonatal Nurses	100%	0	BAU
	Senior midwives and	100%	0	BAU

	homebirth midwives			

Report to	Board of Directors, Part 1	
Date of Meeting	10 June 2025	
Report Title	Learning from Deaths Q4 2024/25	
Prepared By	Dr Adam Nicholls	
Approved by Accountable Executive	Dr Rachel Wharton, Chief Medical Officer	
Previously Considered By	Quality Governance Group Quality Committee in Common 27/05/2025	
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	Please complete all boxes in this section. If there is no implication, please state 'no implication'.	
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	Please complete all boxes in this section. If there is no implication, please state 'no implication'.	

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 for the rolling year January to December 2024 is 1.05. This is within the expected range. SHMI data is showing a stable trend at DCH.
- Coding remains a significant risk for our SHMI. There has been a recent decrease in depth of coding but this now appears stable and not further reducing.
- Division A have introduced a new process for SJR completion which is seeing rates of completion increase

Recommendation

Members are requested to:

- Receive the report for **assurance** and **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 4 2024/25 Report

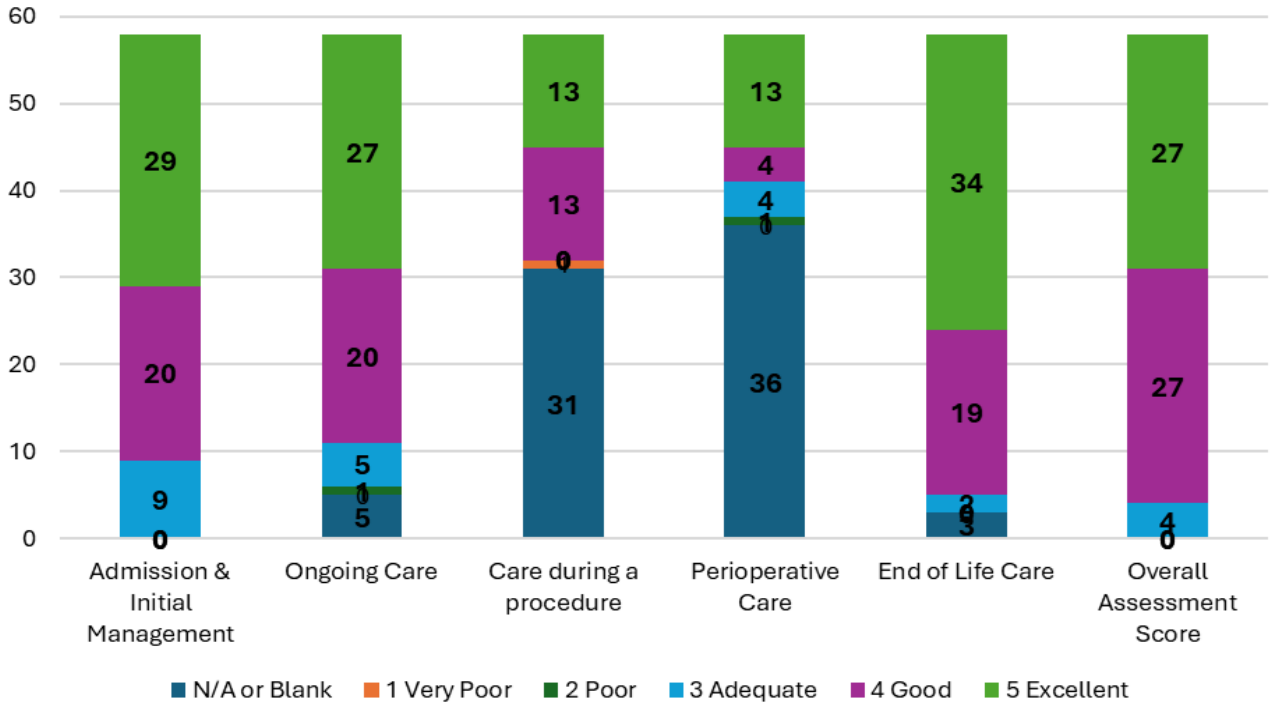
Structured Judgement Review Results:
The Family Services & Surgery Division had 59 deaths in quarter 4, of which 50 that require SJR's to be completed. Within quarter 4 57 SJR's have been completed from this quarter and previous months.

Outstanding SJR's:
The Division have completed a number of SJR's from previous quarters. The backlog of outstanding SJR's (over 2 months) for the Division as at 30/04/25 is 21:

January	February	March
7	6	8

Feedback from SJR's Completed in Quarter 4:

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	3	27	44	1	0
1 Very Poor	0	0	0	0	0	0
2 Poor	1	2	1	0	1	2
3 Adequate	6	5	5	1	5	6
4 Good	22	22	17	6	26	24
5 Excellent	28	25	7	6	24	25



Overall Quality of Patient Record:

Blank	Score 1 Very poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
0	0	3	3	35	16

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

Avoidability of Death Judgement Score:

Score 1 Definitely avoidable	Score 2 Strong evidence of avoidability	Score 3 Probably avoidable (more than 50:50)	Score 4 Possibly avoidable but not very likely (less than 50:50)	Score 5 Slight evidence of avoidability	Score 6 Definitely not avoidable
0	0	0	0	7	51

Action Required:

Following completion of the 57 SJR's, 10 were highlighted as requiring actions.

Further learning via:

- 7 were for formal documented feedback to Department or clinical team – this is completed at the time of the SJR completion.
- 1 was for formal documented feedback to Department or clinical team and SJR required – both completed.

Other actions:

- 1 was for review and discussion at Specialty M&M/Clinical Governance meetings – completed.
- 1 was for education re escalation of a deteriorating patient.

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

Emerging themes from Divisional Learning:

1. Missing medications from admission documentation
2. Quality of admission documentation
3. Early signal of delay in NG insertion and then repeated attempts following failure of insertion (this has been shared via the divisional mortality newsletter).

1.2 Division of Urgent & Integrated Care – Quarter 4 Report 2024 / 25

In quarter 4 there were 188 deaths, 39 SJR's were requested from these deaths, and 0 SJR's were completed during this period (completed SJR's not necessarily from this quarter). Division A have started a new process for completing SJRs which saw completion rates increase to 13 in April. Providing this is maintained this will meet the quarterly requirements. Further changes are planned including the allocation of SJRs to all consultants within the division to ensure that the backlog is reduced. This will be monitored to ensure that this progress continues.

	Q4			Q1			Q2			Q3			Q4		
	Jan -24	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan – 25	Feb	Mar
Deaths	41	49	41	48	59	65	53	52	45	75	105	82	62	61	66
Deaths requiring SJR'S from Month	14	11	14	9	14	12	15	8	15	6	22	26	7	7	3
*Completed SJR'S	12	20	12	6	4	0	1	10	9	1	9	2	0	0	0

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

Outstanding SJRs for the Division as at 31/03/2025 is 79 including outstanding nosocomial reviews:

September	October	November	December	Jan	Feb	Mar
26	10	12	14	7	7	3

Phase score from 13 completed SJR's in April 2025:

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	1	12	11	3	0
1 Very Poor	0	0	0	0	0	0
2 Poor	0	1	0	0	0	0
3 Adequate	1	0	0	0	0	1
4 Good	7	6	0	1	3	3
5 Excellent	4	5	1	1	7	9

Overall Quality of Patient Record:

Blank	Score 1 Very poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
3	0	0	0	10	0

- Clear and concise throughout
- Good, clear plans and documentation
- Records completed. All documentation good. However, the notes are not filed.
- Clumped together and not filed however information was documented when found amongst the bundle.

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	12

Action Required:

Following completion of the 5 SJR's, 0 required further action as they were all scored as 'definitely not avoidable'.

SJR Key themes from Areas of Good Practice:

- Good involvement of patient and/or family,
- Thorough assessment,
- Good documentation,
- Prompt Consultant review,
- Second opinions sought where appropriate

SJR Key theme of Areas for Improvement:

- Greater focus on advanced care planning would improve patient care
- Some improvements needed in documentation – in particular timing of records
- Flow out of the emergency department means that some patients have a poor experience of care for example waiting for a long time in the department, or deteriorating in the department.
- Earlier Consultant review

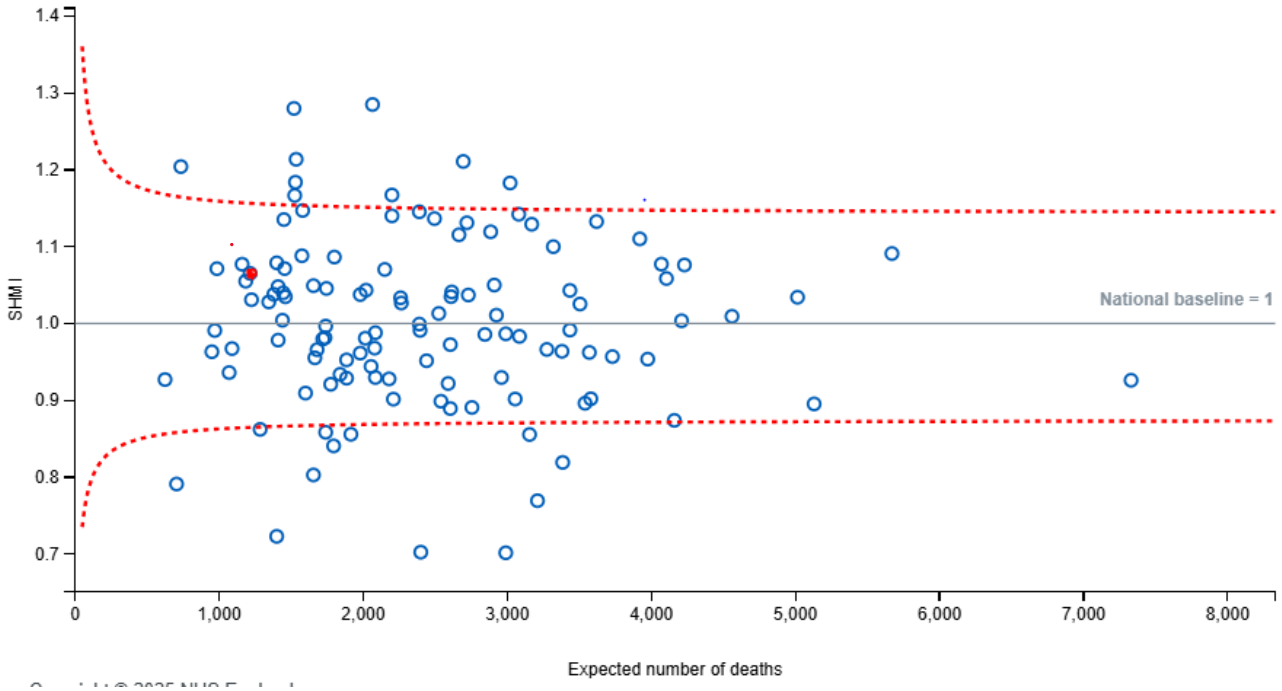
2.0 NATIONAL MORTALITY METRICS AND CODING

2.1 Summary Hospital-level Mortality Indicator (SHMI)

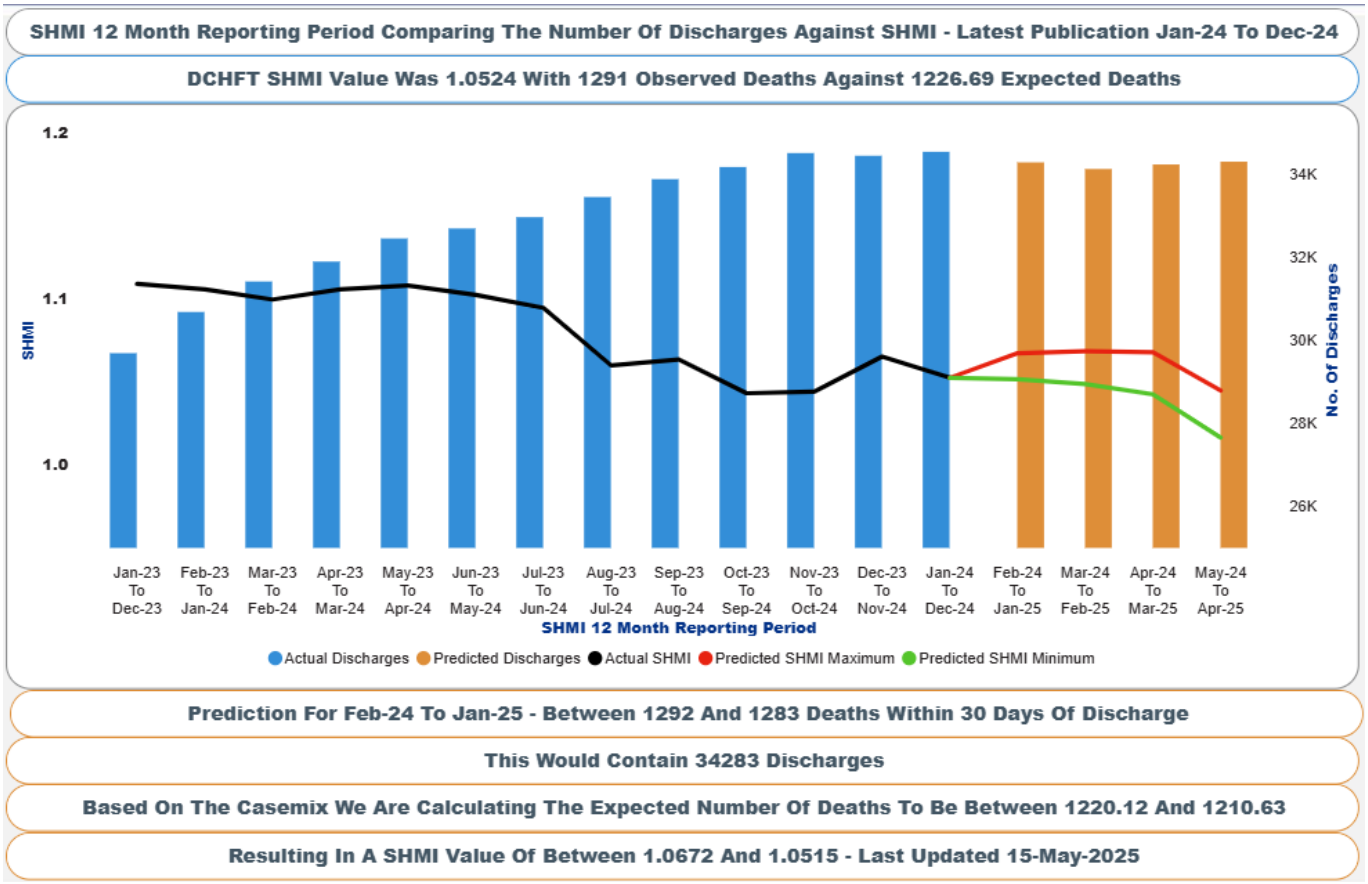
SHMI is published by NHS Digital for a 12-month rolling period, and 5 months in arrears. It takes into account all diagnostic groups, in-hospital deaths, and deaths occurring within 30 days of discharge. It is calculated by comparing the number of observed (actual) deaths in a rolling 12-month period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

The latest SHMI publication for funnel plots from NHS England is for the period January 2024-December 2024 (published 8th May 2025). The trust's SHMI value is 1.05 which is as expected.

DCH =red dot



SHMI data is reported with a 5 month data lag. Our business intelligence team have produced a dashboard which predicts our SHMI aiming to give assurance and the chance to act early if we see a predicted rise in SHMI.



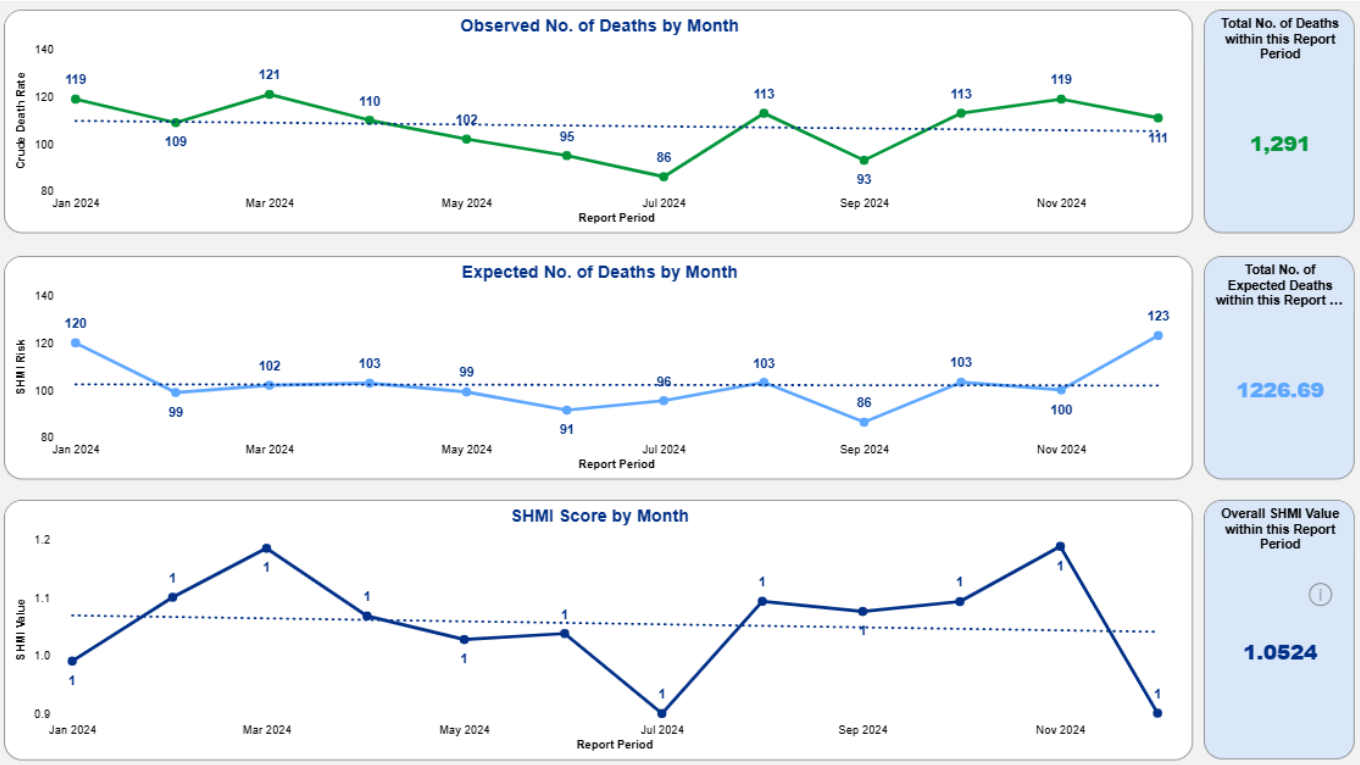
2.2 Depth of coding: NHS Digital states "*As well as information on the main condition the patient is in hospital for (the primary diagnosis), the SHMI data contain up to 19 secondary diagnosis codes for other conditions the patient is suffering from. This information is used to calculate the expected 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 previously stabilised at around 6.0 – in line with the national average for non-elective admissions. Our depth of coding remains reduced at 5.7 for non-elective admissions. This remains below the national average of 6.3. This is not impacting our SHMI at present, but needs to be closely monitored. Concerns remain over lack of resource for coding. DCHFT mean depth of coding for elective admissions remains further below the England Average at 5.2 (compared to 6.2), which is a small reduction on quarter 3 (5.3).

DCH % of provider spells with a primary diagnosis which is a symptom or sign is 16 (England average 14.8). This is similar to Q2. This reflects the quality of documentation enabling accurate coding.

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.



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.

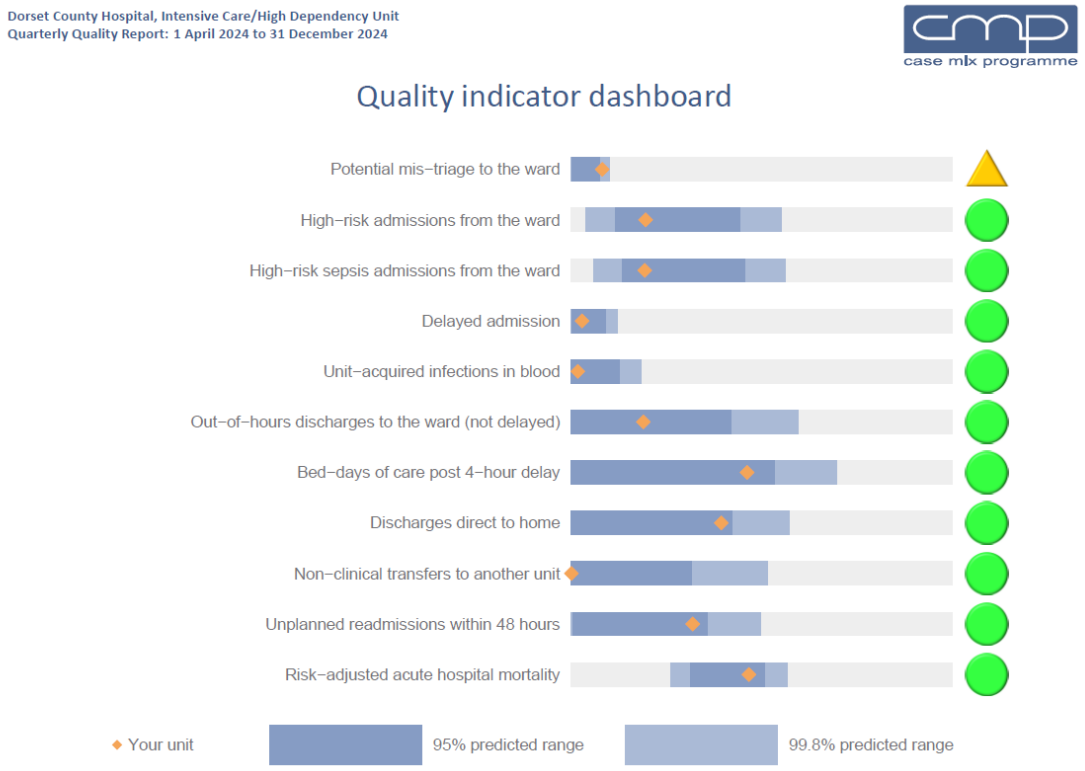
3.1 NCAA Cardiac Arrest data

No new NCAA data has been published since the quarter 3 learning from deaths report. The NCAA data is repoted in 6 monthly periods with the next data release covering 1/10/24-31/03/25. This data is discussed at the resuscitation committee.

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.

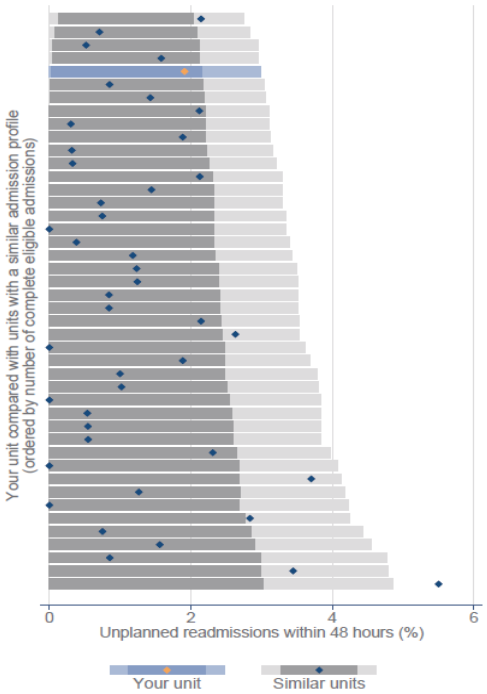
3.3 ICNARC Intensive Care survival data for Q2 dates 1 April 24 – 31 Dec 2024

All but 1 of the indicators remain in the GREEN area. An amber for potential mis-triage to ward has been consistent in the last two data releases, comment is awaited from the intensive care team.

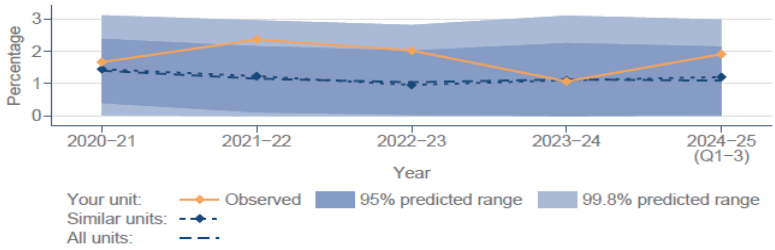


Unplanned readmissions to the unit were higher than expected in this data release:

Unplanned readmissions within 48 hours



	Eligible n	Complete n (%)		Observed n (%)	Expected %	95% predicted range	99.8% predicted range	
Quarter 1	131	131 (100.0)		1 (0.8)	1.1	(0.0, 2.8)	(0.0, 4.4)	
Quarter 2	121	121 (100.0)		2 (1.7)	1.2	(0.0, 3.1)	(0.0, 4.8)	
Quarter 3	114	114 (100.0)		4 (3.5)	0.9	(0.0, 2.6)	(0.0, 4.3)	
Quarter 4								
Year to date	366	366 (100.0)		7 (1.9)	1.1	(0.0, 2.1)	(0.0, 3.0)	



Definition

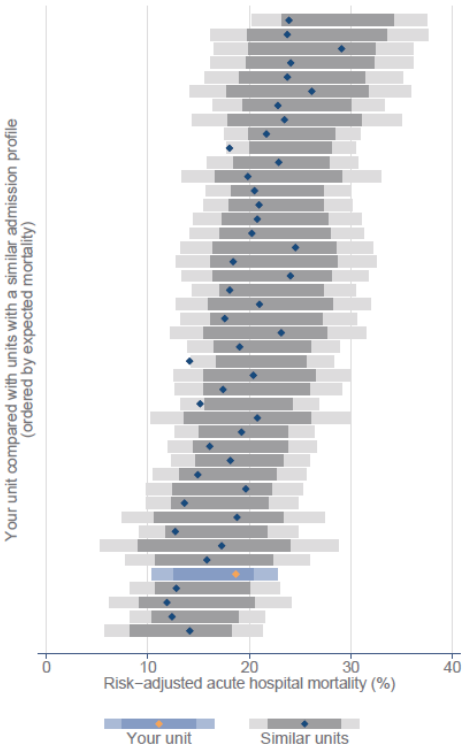
- Eligible: Critical care unit survivors discharged to a non-critical care location in your hospital
- Complete: The number and percentage of eligible admissions with sufficient data to identify unplanned readmissions
- Observed percentage: The number and percentage of complete eligible admissions subsequently readmitted (unplanned) to your unit within 48 hours of discharge
- Expected percentage: The overall percentage of unplanned readmissions within 48 hours across all critical care units participating in the CMP
- 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

Mortality is within the expected range:

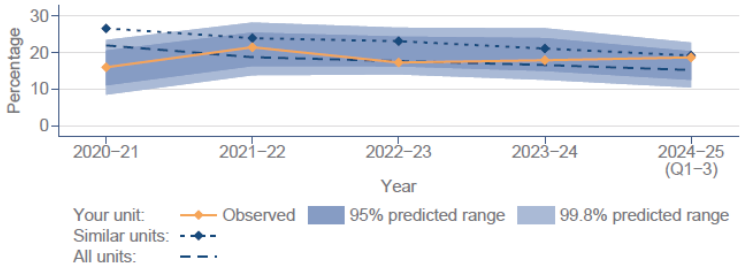
Dorset County Hospital, Intensive Care/High Dependency Unit
Quarterly Quality Report: 1 April 2024 to 31 December 2024

case mix programme

Risk-adjusted acute hospital mortality



	Eligible n	Complete n (%)		Observed n (%)	Expected %	95% predicted range	99.8% predicted range	
Quarter 1	171	171 (100.0)	●	29 (17.0)	15.4	(9.9, 20.7)	(7.2, 24.2)	●
Quarter 2	172	171 (99.4)	●	30 (17.5)	15.6	(10.0, 20.9)	(7.3, 24.4)	●
Quarter 3	170	167 (98.2)	●	36 (21.6)	18.5	(12.5, 24.3)	(9.5, 28.0)	●
Quarter 4								
Year to date	513	509 (99.2)	●	95 (18.7)	16.5	(12.5, 20.3)	(10.4, 22.7)	●



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

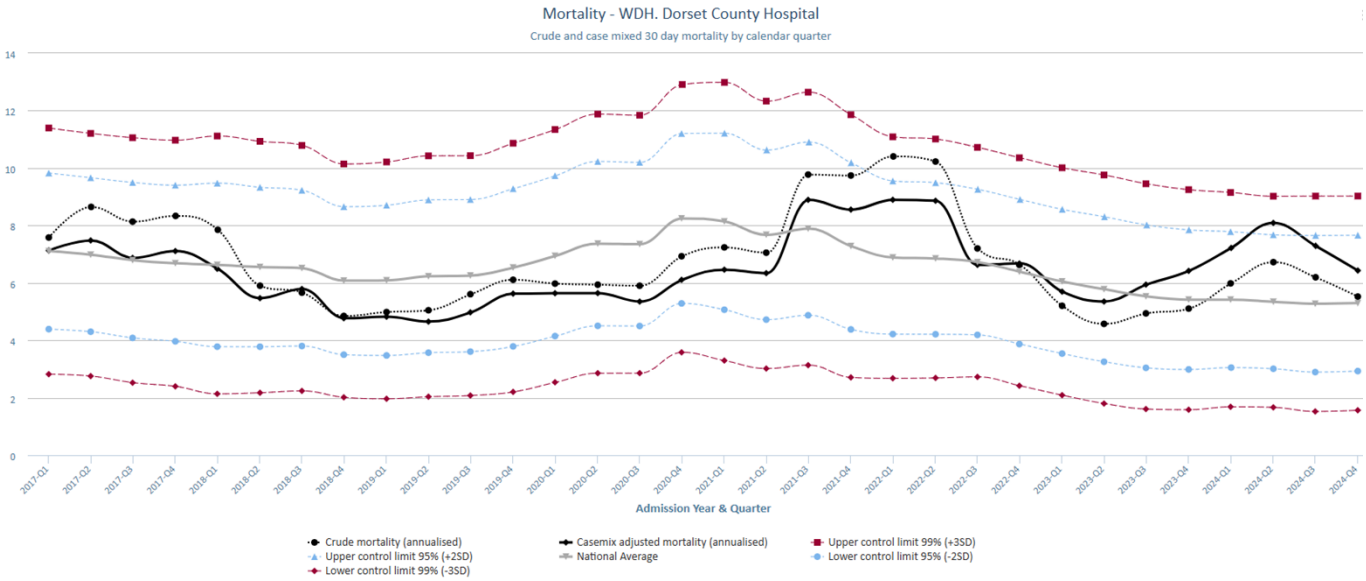
Date of report: 12/02/2025 21 ©ICNARC 2025

The ICNARC data is discussed in the intensive care clinical governance meeting, and the team are awaiting the publication of the next results before determining whether further work is required.

3.4 National Hip Fracture database

The National Hip Fracture database is run by the Royal College of Physicians, and includes a range of performance data and mortality which I have focussed on below. The annualised case mix adjusted mortality has been above the national average but is showing a sustained improvement from quarter 2 to quarter 4. This is felt to be linked to recording of complexity of case, a data quality issue which has now been resolved. We would expect to see our performance to remain within the expected boundaries, and based on data over time we would expect to track closer to the national average in future.

Our filtered SHMI data for hip fractures show that we are within the expected control limits.



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

- Work is ongoing to ensure that the external review database is up to date to inform reports to committees, and an update will be included in the next report
- Quarter 4 GiRFT reviews/reports
    - There has been a GiRFT report with regards litigation and aspects of this relevant to this report will be included in LfD Quarter 1 25/26 report.
    - Paediatric rheumatology – not applicable to mortality report

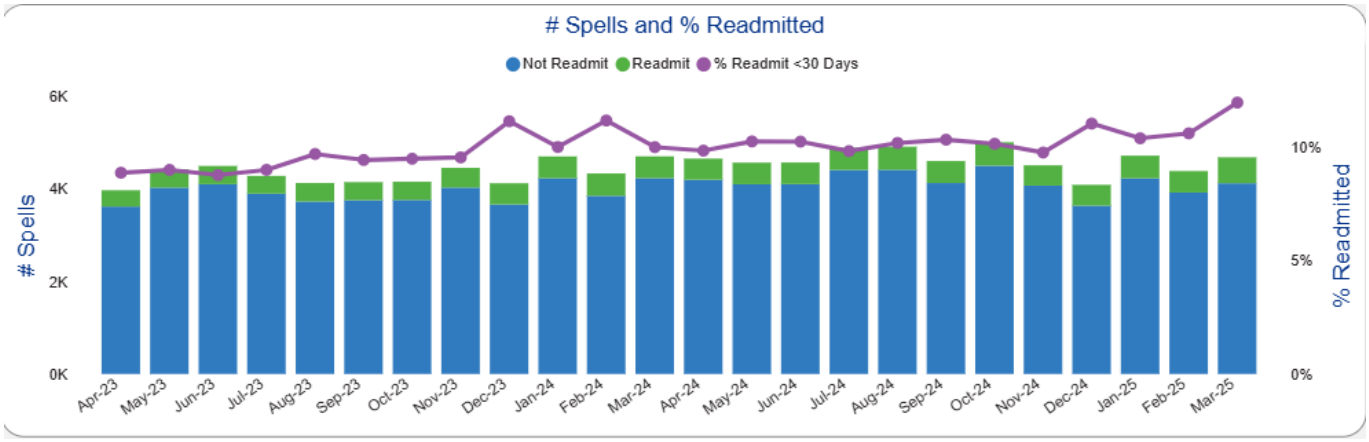
3.7 Trauma Audit and Research Network

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. An update has been requested from the DCH trauma lead to look at what data could be included in future learning from deaths reports.

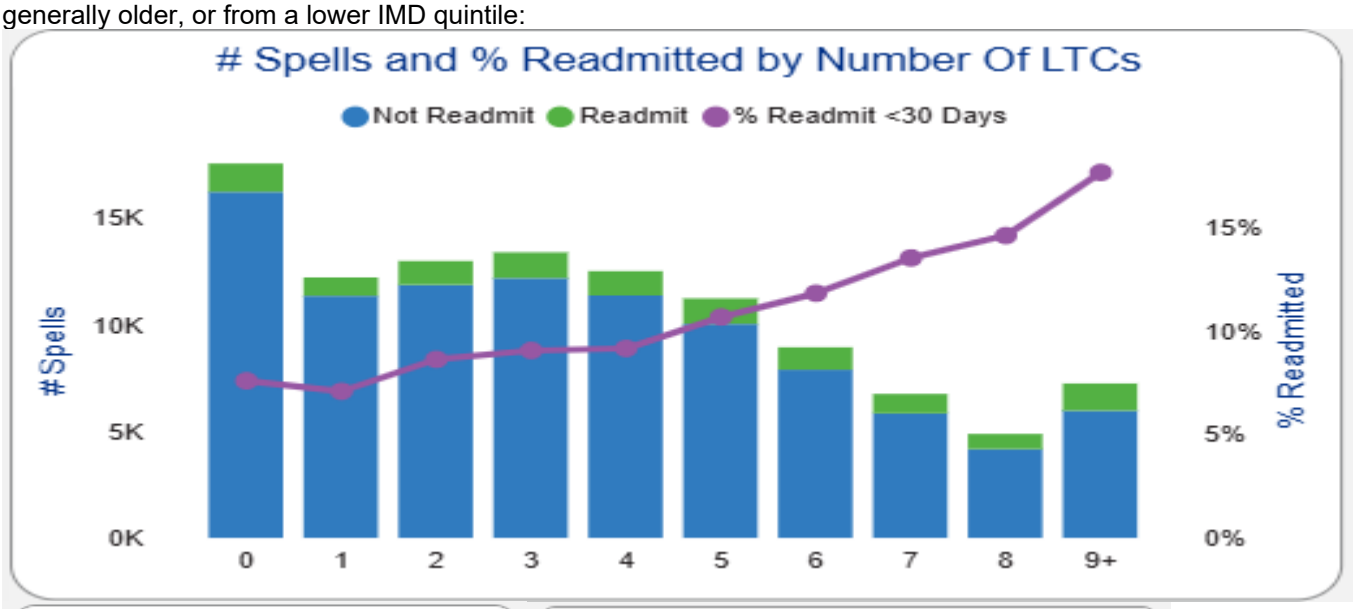
3.8 Readmission to hospital within 30 days

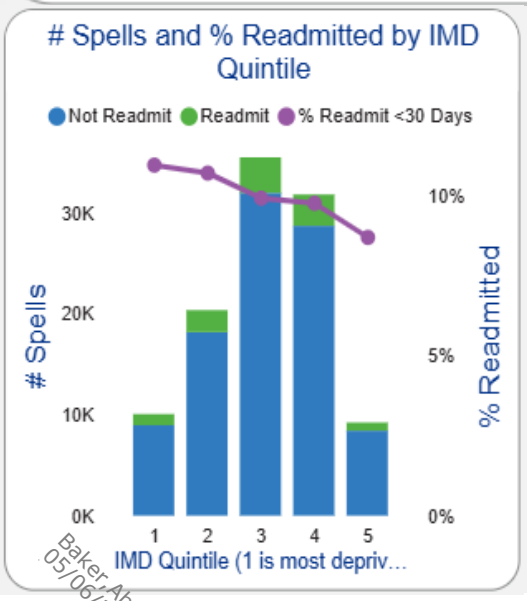
A readmission to hospital within 30 days suggests either inadequate initial treatment or a poorly planned discharge process.

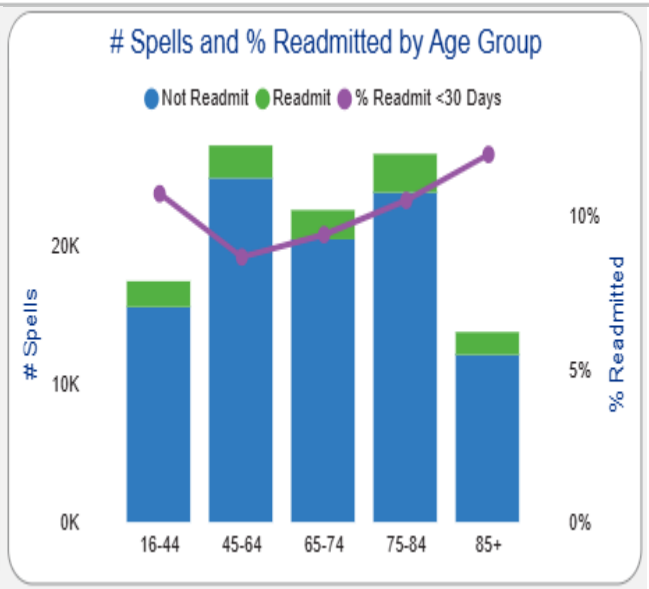
Our readmission rate is rising as shown below, and was 12% in March:



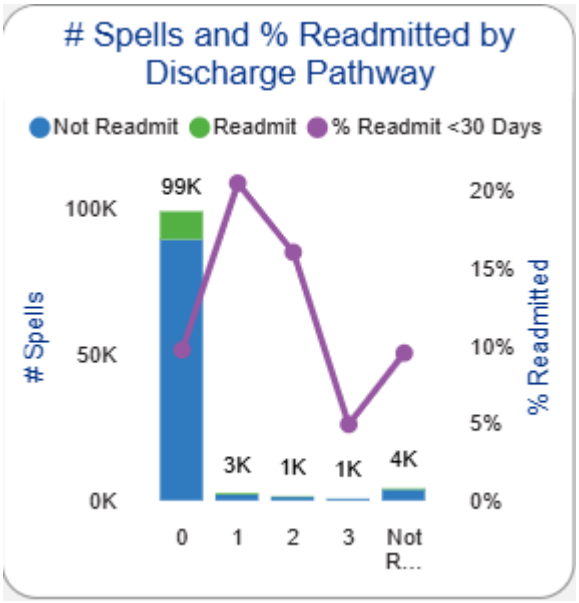
Readmissions are more likely to occur in patients who live with a greater number of long term conditions, are generally older, or from a lower IMD quintile:



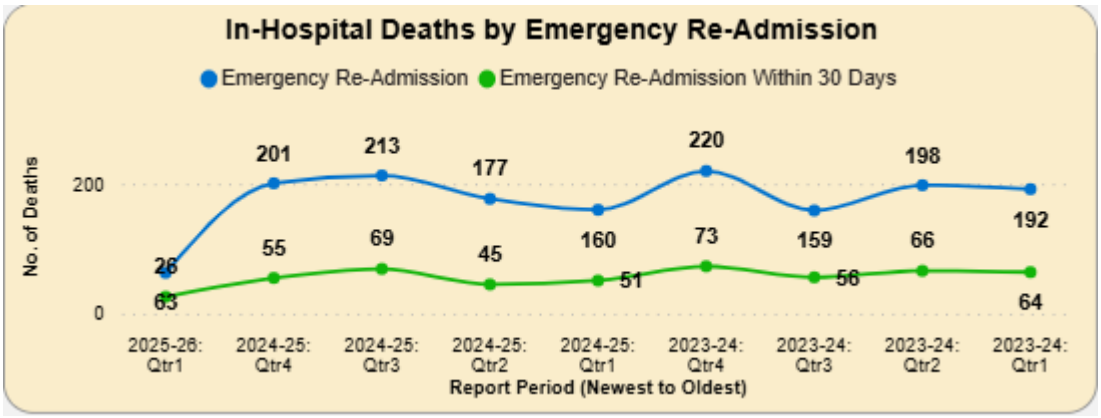




Readmissions are most likely to happen in patients who are discharged requiring short term home based rehabilitation, or social care support at home (pathway 1).



In hospital deaths for patients with an emergency readmission is fairly static, and more work is needed to understand this in the context of the national picture.



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 2024, which covers child deaths notified and reviewed up until 31 March 2024. https://www.ncmd.info/publications/child-death-review-data-release-2024/.

There has been no further data published in quarter 4.

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/

There have been 0 perinatal deaths occurring at DCH reported to MBRRACE-UK via the PMRT in Quarter 4. There has been one late neonatal death reported by a tertiary centre pertaining to a pregnancy booked for care by DCH. This case was reported at the end of Quarter 4, and we are awaiting assignment from the tertiary centre for DCH to input antenatal care.

3.11 National Perinatal Mortality Review tool
Reports | PMRT | NPEU

This is reported separately to board via quality committee in the perinatal mortality review report.

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. New process in Division A for completion of SJRs
2. Quality improvement work has started to ensure appropriate learning from claims/litigation

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:

- Consider early NG tube in patients vomiting with SBO on CT. –
- Avoid repeated attempts at NGT insertion by one healthcare professional. Escalate after a couple of attempts. –
- Two patients with raised lactates of >7 weren't discussed with ICU. Please consider early referral in appropriate patients with lactate >4, especially if it isn't clearing on repeated measurement. –
- An initial CT brain was reported as unremarkable by Hexarad. On further review by local radiologist, there was clear evidence of severe hypoxic brain injury. If the Hexarad report doesn't fit the clinical picture, consider getting it looked at again. –
- EOL care – consider using EOLCP once decision to palliate made and remember to write up PRN meds in patients who have a syringe driver.

- Haematology: Delayed diagnosis despite referral to Neurosurgery in UHS. Biopsy took approximately 6 weeks from initial presentation which should have been the next day – this is a key factor which potentially affected outcome.
- DNACPR not following a patient through to ED and subsequent action taken as this decision wasn't known.

6.0 LEARNING FROM CORONER'S INQUESTS Q4

DCH has been notified of **28** new Coroner's inquests being opened in the period 01 January 2025 – 31 March 2025. We have seen a huge increase in the complexity of the cases.

14 inquests were held during Quarter 4. **10** inquests were heard as Documentary hearings, not requiring DCH attendance. **3** required a clinician to attend court in person. **1** remote. **0** inquests were held hybrid (some clinicians attending remotely, whilst others attended in person).

0 pre-Inquest review hearings were held.

We currently have **56** open Inquests. The Coroner has reviewed all outstanding cases to decide whether any can be heard as documentary hearings. No Regulation 28 (Preventive Future Death Notices) have been given during this quarter, and we have not required Representation on any of the cases.

We continue to work with the Coroner's office, and will continue to support staff before, during and after these hearings.

We met with the coroner at the beginning of May, who suggested that Interested Person status does no longer need to be requested in order to gain access to the inquest bundle. The disclosure can be requested under Regulation 27, which means less responsibility for the Coroner and the Trust. The Coroner also confirmed, that where they can they will identify cases that can be open and closed quickly, without the clinician(s) having to hold a date to attend the inquest. This will ensure that clinics do not have to be unnecessarily cancelled.

Clinical Leads have been attending inquests to ensure there is some resilience within the Risk Team. Jodie Crabb, Sonia Gamblen, Dr Rachel Wharton, Dr Adam Nicholls and Miss Audrey Ryan have all now attended at least one inquest each.

Learning Identified:

- Family upset around the lack of communication, being notified 2 hours following a cardiac arrest. Resus team contacted and will include the need for good family communication in their mandatory training sessions. Fedback to Ward Leaders.

7.0 LEARNING FROM CLAIMS Q3

Legal claims are facilitated by NHS Resolution, who also produce a scorecard of each Trust's claims pattern and costs. The GIRFT pack for this year has been released and we are working towards the 5 point Action Plan.

Claims pattern Quarter 4 FY 24/25.

New potential claims	11 clinical negligence, 0 employee
Disclosed patient records	39 (21 disclosure for claims inc updated records, 18 disclosures to the coroner)
Formal claims	7 clinical negligence, 0 employee claim
Settled claims	4 clinical negligence, 0 employee claims (Failure to remove an infected dialysis cuff, inappropriate handling of patient causing skin tear, excessive removal of foreskin, delay in diagnosing bowel obstruction)
Closed- no damages	7 clinical negligence, 0 employee claims

8.0 SUMMARY

The latest SHMI publication from NHS England is for the period December 2023-November 2024. The Trust's figure remains in the expected range.

Coding remains a challenge, and the clinical coding risk is rated as high on the risk register. The team have implemented strategies for risk mitigation.

We have started to see improvements in the completion of SJRs in division A and a new process is in place and will be monitored.

No other metrics of in-patient care suggest that excess mortality is occurring at DCH. The ICNARC data has highlighted that readmissions to ITU are higher than expected – this data will be monitored and reported in the next learning from deaths report..

More work is required to look into the details of emergency readmissions, although there is no signal at present that we are seeing excess deaths as a consequence of emergency readmissions.

Dorset County Hospital
NHS Foundation Trust

Report to	Board of Directors, part 1	
Date of Meeting	10 June 2025	
Report Title	Patient Safety Incident Response Plan	
Prepared By	Dominic Sheehy, Patient Safety Lead	
Approved by Accountable Executive	Dawn Dawson – Chief Nursing Officer	
Previously Considered By	Quality Governance Group 15.04.25 Patient Safety Committee 17.04.25 Quality Committee in Common 23.04.25	
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		No
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 Quality and Safety	
Financial	No implication	
Statutory & Regulatory	The trust is required to have a Patient Safety Incident response Plan as directed by NHS England Patient Safety Response Framework and associated Standards. NHS Dorset is required to review the plan once approved.	
Equality, Diversity & Inclusion	PSIRF principles are for early involvement with patients and families, ensuring they become partners in their care.	
Co-production & Partnership	No implication	

Executive Summary

This patient safety incident response plan (PSIRP) sets out how Dorset County Hospital NHS Foundation Trust (DCHFT) will seek to learn from patient safety incidents reported by staff and patients, their families, and carers as part of our work to continually improve the quality and safety of the care it provides. The plan also describes the various approaches that can be utilised to review reported incidents and events, ensuring that the organisation embeds a proportionate response.
The trusts first PSIRP was intended to be reviewed after a year. That review has now been completed and this revised version will be formally reviewed in 2029 (if not indicated earlier) in line with PSIRF standards, with progress being reported quarterly via Patient Safety Committee and annually to Quality Committee.
The following patient safety priorities have been identified:

i) **Reducing avoidable** harm to include:
hospital acquired pressure ulcers
falls prevention & management
early recognition and escalation of deteriorating patients

ii) **Treatment & procedures** to include:
safer administration of insulin
delays in transfer of care

iii) **Maternity & Neonates** to include:
Post natal incidents during admission
Post natal incidents requiring readmission

These themes are in line with Quality Priorities and encompassing existing workstreams.

Please note some minor amendments have been made to the plan in response to feedback received at Quality Committee in Common.

Recommendation

Members are requested to:

- **Approve** the Patient Safety Incident Response Plan for the organisation.

Dorset County Hospital
NHS Foundation Trust

PATIENT SAFETY INCIDENT RESPONSE PLAN

Policy Title	Patient Safety Incident Response Plan		
Policy Number	**2283**	**Plan Version Number**	**2**
Applicable to	All Trust staff.		
Aim of the Policy	The development and maintenance of effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.		
Next Review Due Date	**25 March 2029**		
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Dorset County Hospital
NHS Foundation Trust

Patient Safety Incident Response Plan

March 2025

V2 DOM SHEEHY – PATIENT SAFETY LEAD
APPROVED BY PATIENT SAFETY COMMITTEE 17/04/2025
FOR REVIEW MARCH 2029

Contents

Executive Summary

The Patient Safety Collaborative (meaning the wider teams) aim to lead on the following;

- Focus thematic reviews of areas of care to align with the Quality Priorities

  i) **Reducing avoidable** harm to include:

  hospital acquired pressure ulcers

  falls prevention & management

  early recognition and escalation of deteriorating patients

  ii) **Treatment & procedures** to include:

  safer administration of insulin

  delays in transfer of care

  iii) **Maternity & Neonates** to include:

  Post natal incidents during admission

  Post natal incidents requiring readmission

- Create monthly thematic summary of patient safety incidents for escalation to patient safety committee in order to provide assurance that existing priorities are being examined, and that emerging themes are being considered.
- Continue supporting with the pan-Dorset risk management software procurement
- Explore areas for collaboration of patient safety activity across the Dorset federation
- Continue with current Division A/B and Hospital Wide PSIRF Learning Huddles and explore areas for further development aligning with the PSIRF culture.
- Review and grandstand the existing latent patient safety processes that are ongoing within the Trust

- Actively promote the education and use of the range of system-based approaches to learning from PSIs;
    i) Hot debrief programme of education in place
    ii) Mandatory training in place via ESR
- Undertake reviews of the quality of patient safety investigations using the national audit tool
- Develop the intranet site for patient safety to include
    i) Description of the risk reporting pathway and variables
    ii) Demonstrate the Quality Assurance pathways
    iii) As a portal for all patient safety documentation, including policies, plans, standard operating procedures, 'how to' guidance
    iv) To publish learning from patient safety events
    v) To publish action trackers from the learning from PSIs
    vi) Re-invest in the Learning From Excellence QI of recent years.
- Explore efficiencies of working in a collaborative model with Dorset HealthCare NHS Foundation Trust, Patient Safety Team.

1. Purpose, scope, aims and objectives

1.1 Purpose

1.1.1 This patient safety incident response plan (PSIRP) sets out how Dorset County Hospital NHS Foundation Trust (DCHFT) will seek to learn from patient safety incidents reported by staff and patients, their families, and carers as part of our work to continually improve the quality and safety of the care it provides.

1.1.2 This plan will help us measurably improve the efficacy of our response to local patient safety incidents (PSIs) by:

a. Refocusing review of PSI's towards a systems approach[1] and the rigorous identification of interconnected causal factors and systems issues.

b. focusing on addressing these causal factors and the use of improvement science[2] to prevent or continuously and measurably reduce repeat patient safety risks and incidents.

c. transferring the emphasis from the quantity to the quality of incident reviews such that it increases our stakeholders' (notably patients, families, carers and staff) confidence in the improvement of patient safety through learning from incidents, but importantly, making changes based on what is discovered

d. demonstrating the added value from the above approach.

1.2 Scope

1.2.1 A PSIRP is a requirement of each provider or group/network of providers delivering NHS-funded care. The planning aspects of this PSIRP have been

[1] The approach is broken down into units to make it easier to understand the complexity, interactive nature and interdependence of the various external and internal factors.

[2] "Improvement science is about finding out how to improve and make changes in the most effective way. It is about systematically examining the methods and factors that best work to facilitate quality improvement." Health Foundation (2011) https://www.health.org.uk/publications/improvement-science.

developed with the assistance and approval of our local commissioner(s). The aim of this approach is to continually improve. Our first PSIRP was published in 2024 and was intended to be reviewed after a year. This review has now been completed. Going forward the Trust PSIRP will be formally reviewed on a four yearly basis unless otherwise indicated.

1.2.2 This document should be read alongside the introductory Patient Safety Incident Response Framework (PSIRF) 2020, which sets out the requirement for this plan to be developed.

1.2.3 A PSI is defined as;

'something unexpected or unintended that has happened, or failed to happen, that could have or did lead to patient harm for one or more person(s) receiving healthcare' (NHS England, 2022).

Some unexpected events may result in identifiable levels of harm, others may be where the potential for harm is identified, so called 'no harm' or 'near miss' events. An incident is the system showing us symptoms that something can potentially be improved.

1.2.4 There is no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement.

1.2.5 Responses covered in this Plan include:

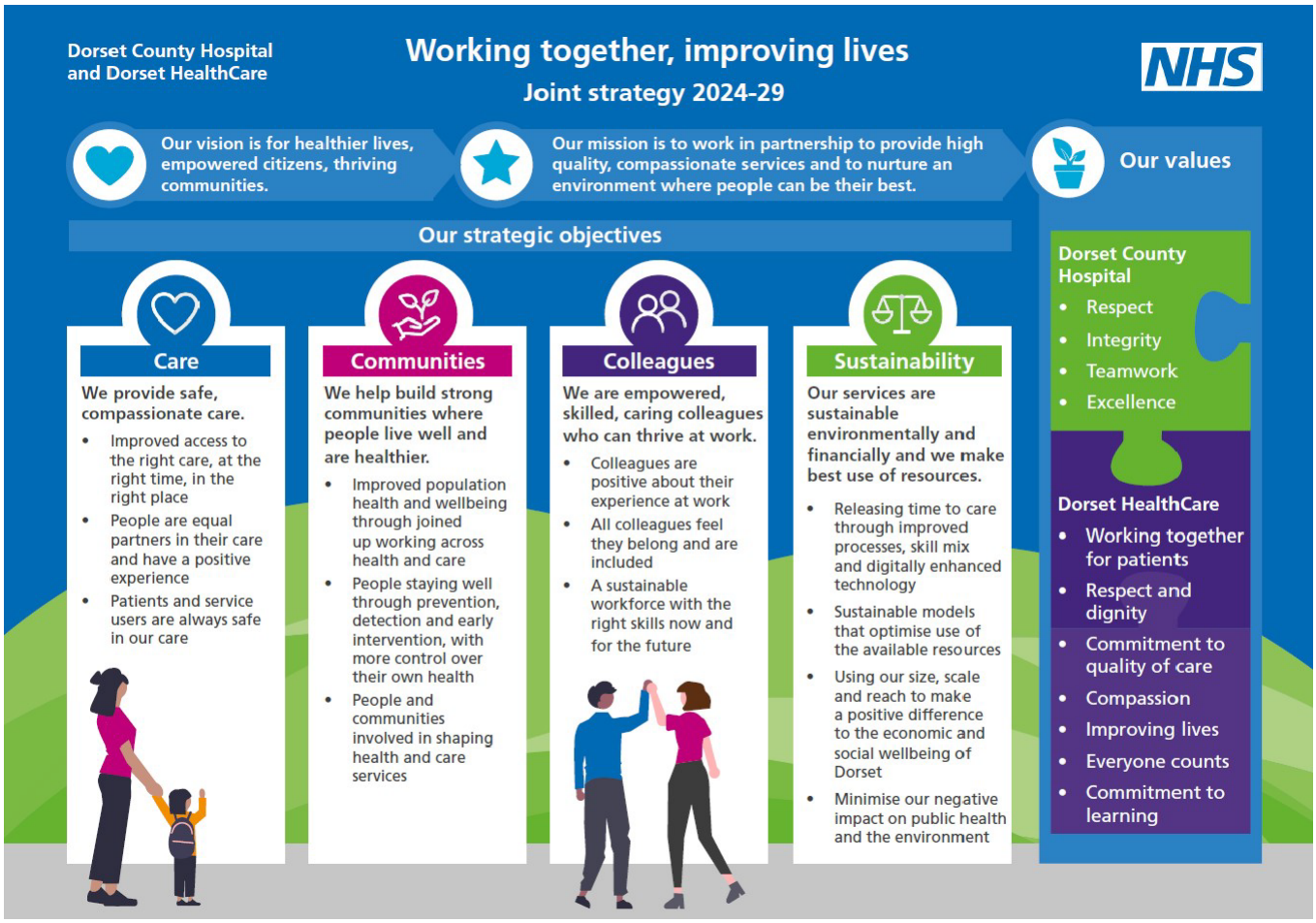
- Hot debriefs
- After Action Reviews (AARs)
- Case Reviews
- Thematic Reviews
- Patient Safety Incident Investigations (PSIIs)
- Medical Examiner Reviews
- Internal professional reviews, including;
    - Mortality and Morbidity Meetings (M&Ms)
    - Structured Judgement Reviews (SJRs)

1.2.6 Other types of response exist to deal with specific issues or concerns. Examples of such responses include complaints management, claims handling, human resources investigations into employment concerns, professional standards investigations, coroners inquests or criminal investigations. The principle aims of each of these responses differ from the aims of a patient safety response and are outside the scope of this Plan.

1.2.7 To be effective in meeting their specific intended purposes, responses that are not conducted for patient safety learning and improvement are separate entities and will be appropriately referred as follows:

- human resource (employee relations) teams for professional conduct/competence issues and if appropriate, for referral to professional regulators
- legal teams for clinical negligence claims
- medical examiners, SJRs and, if appropriate, local coroners for issues related to the cause of a death
- the police for concerns about criminal activity

1.3 Strategic aims and objectives



1.3.1 In order to meet the strategic aims we will;

- Demonstrate a climate that supports a just culture and an effective learning response to patient safety incidents.
- Aggregate and confirm validity of learning and improvements by basing patient safety reviews on a number of similar repeated incidents.
- Develop system improvement plans based on the learning from patient safety reviews
- Support, involve and act on feedback from patients, families, carers, and staff with regard to patient safety incident responses.
- Focus on the quality rather than the quantity of reviews in order to learn from and develop meaningful actions in response to patient safety events.

2. Situational analysis – national

2.1 The patient safety incident response framework (PSIRF) promotes an approach of reviewing patient safety incidents from a learning and improvement perspective.

2.2 We need to remove the barriers in healthcare that have frustrated the success of learning and improvement following a patient safety incident (e.g., mixed investigation remits, lack of dedicated time, limited investigation skills). We also need to increase the opportunity for continuous improvement by:

a. improving the quality of future safety reviews
b. conducting reviews purely from a patient safety perspective
c. reducing the number of reviews into the same type of incident
d. aggregating and confirming the validity of learning and improvements by basing reviews on a small number of similar repeat incidents.

2.3 This approach will allow us to consider the safety issues that are common to similar types of incidents and, on the basis of the risk and learning opportunities they present, demonstrate that these are:

a. being explored and addressed as a priority in current patient safety work or
b. the subject of current improvement work that can be shown to result in progress or
c. listed for safety work to be scheduled in the future.

2.4 There are a variety of options that can be considered for review of patient safety events, depending on the specific circumstances of the safety event(s); these are listed in Section 5.

2.5 As part of this approach, incidents requiring other types of investigation and decision-making, which lie **outside the scope** of this work, will be appropriately led by other partner agencies as follows:

- professional conduct/competence – referred to human resource teams.
- establishing liability/avoidability – referred to claims or legal teams.
- cause of death – referred to the coroner's office.

- criminal – referred to the police.

3. Situational analysis – local

3.1 Results of a review of activity and resources

3.1.1 Situational Analysis of Resources

A review of the Trust's local system was undertaken to understand the systems and people involved in patient safety activities across DCH, as well as the underpinning structure.

Within DCH, the central Patient Safety Team works alongside the Risk Management, Patient Experience & Public Engagement and Clinical Effectiveness Teams within the Nursing and Quality directorate.

The majority of patient safety responses happen at a very local level, through the individual care groups, with oversight from the Divisional Directorates.

Other activities within the Trust that provide insight into patient safety include our incident reporting system, Structured Judgment Reviews (SJR), Learning from Deaths reports, complaints, patient and family feedback and inquest responses.

3.1.2. Situational Analysis of Patient Safety Activity

A review of patient safety incidents undertaken from April 2024 to March 2025, to understand the amount of patient safety activity ongoing (appendix 1). Patient safety activity is reviewed to dynamically inform this plan so that priorities can be amended in the light of current evidence of patient safety risk, which we would expect to alter in response to changing activity, and as a result of quality improvements.

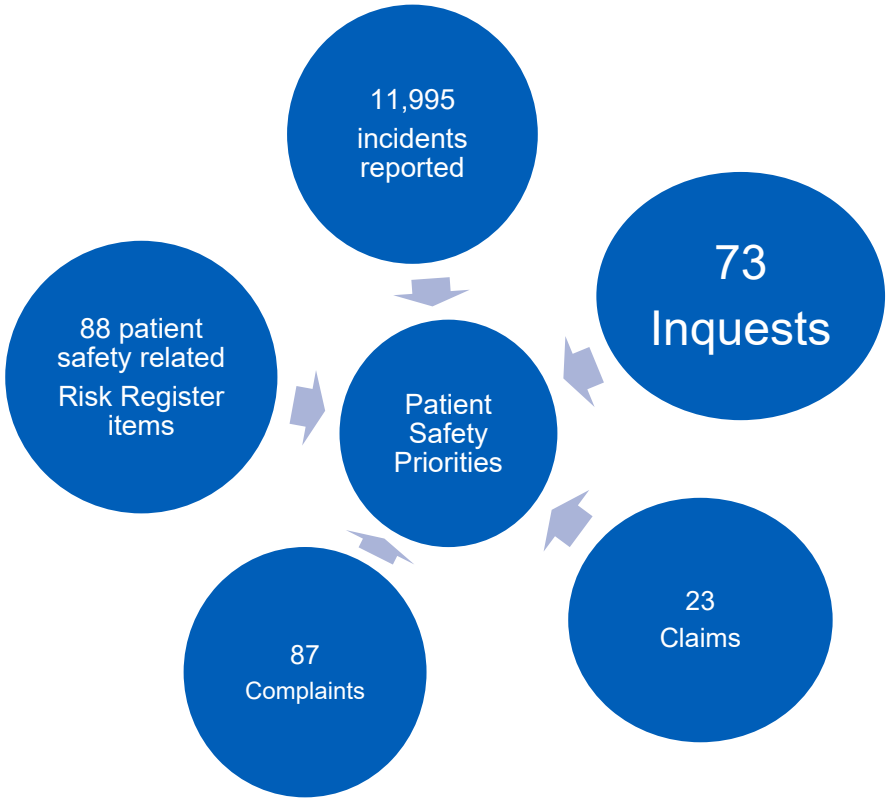
3.2 Patient Safety Incident Risks

3.2.1. The patient safety incident risks for this organisation have been profiled using organisational data from recent patient safety incident reports, complaints, mortality reviews, case note reviews, staff survey results, claims.

Resources examined for this data include:

- staff survey explorer tool results:
  - https://dchftnhs.sharepoint.com/sites/HR/SitePages/Staff-Survey.aspx
  - Datix risk management database (patient safety incidents, SJR's and complaints)
  - Claims database – locally held
  - Coroners database – locally held

3.3 Review of the local patient safety incident profile



3.3.1 The current top 10 local priorities for patient safety investigation were selected through gap analysis and stakeholder approval utilizing the number of types of incident and themes from those areas outlined in 3.2.1.

The top 10 incidents (no harm to severe) include:

	Incident Type	Most Common Sub-causal factor	
1	Patient Tissue Viability/Pressure Ulcer/Skin Damage	Acquired Pressure Ulcer (Pressure areas on arrival excluded)	2100
2	Patient Slip, trip or fall	Fall or slip from standing	894
3	Medicines	Administration: Missed or delayed medication	1056
4	Patient Care - Treatment and Procedure	Delay or failure to monitor a patient (Including deteriorating patient specific)	1012
5	Admission, Transfer and Discharge	Discharge delay or failure to discharge	764
6	Maternity and Neonatal	All events	578
7	Documentation Management	Missing or inadequate or illegible healthcare record	388
8	Staffing/Workforce Capacity	Unfilled bank or agency staff request	415
9	Aggression, violence, theft and security	Non-physical assault (inc verbal) Patient/other to Employee/other	556
10	Communication and Consent	Communication failure – outside of immediate team	1056

The top 6 themes form the basis of our patient safety priorities as the remaining areas are being covered by other programs of work.

3.3.2 Findings from the Staff Survey 2023-2024

The Staff survey asked for agreement rating of specific questions around the Trust's management of patient safety responses; The available responses were categorised as;

1. Strongly disagree
2. Disagree
3. Neither agree nor disagree
4. Agree
5. Strongly agree

The questions posed were;

- My organisation treats staff who are involved in an error, near miss or incident fairly.
- My organisation encourages us to report errors, near misses or incidents.
- When errors, near misses or incidents are reported, my organization takes action to ensure that they do not happen again.
- We are given feedback about changes made in response to reported errors, near misses and incidents.
- I would feel secure raising concerns about unsafe clinical practice.
- I am confident that my organization would address my concern.

In terms of staff responses, it is encouraging that the majority of staff veered broadly towards agreeing with the statements. However, it must also be noted that a significant proportion of staff (on aggregate) expressed ambivalence or overt disagreement with the statements. (See Appendix II).

There was a significant majority of staff respondents who felt the organisation encourages reporting. Conversely there was a significantly aggregated proportion of staff who felt that feedback was lacking after events were reported. The majority of staff felt secure in reporting incidents, however, psychological safety is a major foundation of PSIRF, and we cannot underestimate the importance of raising the profile of a safe environment for reporting, to encourage those who do not yet have that confidence.

For significant numbers of staff to feel they may not be treated fairly when reporting/being involved in an incident, feeling that the organization does not fully encourage reporting, that the organization does not take action or give feedback regarding the response, and that they would not feel confident or secure that the response would be appropriate, gives significant weight to the argument that the tenets of PSIRF are not entirely embedded into the culture of reporting across DCH. This will be included in the actions going forward.

3.4 Gap analysis

3.4.1 Referral to the national PSII standards to identify gaps in dedicated PSII personnel, seniority, PSII skills, etc. to enable delivery of the potential PSII programme; that is:

a. National priorities:

- Never Events
- 'Learning from Deaths' - related incidents (identified via structured judgement review to be more likely than not due to problems in care)
- unexpected incidents which signify an extreme level of risk for the patients, families and carers, staff or organisations, and where the potential for learning and improvement is so great (within or across a healthcare service/pathway) that they warrant the use of additional resources to mount a comprehensive PSII response.

b. Local priorities identified in 3.3.1 above.

c. Excluding incident types that are already part of an active improvement plan that is being monitored to determine efficacy and for which incremental improvement can be demonstrated.

3.5 Strategic plan

3.5.1 National guidance recommends that 3-6 PSIIs investigations per priority are conducted per year. When combined with patient safety incident investigations from the national priorities this will likely result in 20-25 investigations per year. At DCH we do not have the personnel capacity to manage a planned workload of this magnitude. We continue to utilise a pragmatic approach to selection of incidents/themes for PSII as described below.

3.5.2 The following will need to be in place as part of the process for managing investigations under the PSIRF framework.

a. Acknowledge that, wherever available, review findings and analysis from more than one similar incident provides an opportunity to identify common causal factors by cross-referencing and corroborating them. Robust thematic analysis can be achieved by selecting a few very recent and typically similar incidents and investigating each one individually with skill and detail to determine the causal factors so that effective improvements can be designed to address change. Review/investigation of recent rather than historical incidents allows information gathering and analysis of the system as it currently is.

b. Agree the PSIIs to be conducted for each very themed cluster of safety events, depending on emerging themes.

c. Remove the need to declare the number of each of these incident types and the total number of PSIIs planned for the period of the plan, and take the approach of carrying out PSIIs according to need and in agreement with the Executive team

d. Agree interventions for incidents that fall outside the incident review plan but require action or new insight, e.g.:

- incident report or timelines (for Duty of Candour disclosure)
- audit (to measure/ monitor compliance against policy/ guidance)
- HR investigations (for concerns about individual competency/ performance)

3.5.3 For each comprehensive PSII:

a. Ensure each PSII is conducted separately, in full and to a high standard, by a team whose lead investigator is an experienced Band 8 and has received a minimum of two days' training.

b. Refer to training and the national PSII standards and conduct PSIIs as per the plan and in line with national good practice for PSII.

c. Use the national standard template to report the findings of the PSIIs.

d. Identify common, interconnected, deep-seated causal factors (not high-level themes or problems).

3.5.4 For each group of incident reviews dedicated to a similar/narrow focus incident type:

a. Design strong/effective improvements to sustainably address common interconnected causal factors.

b. Develop an action plan for implementation of the planned improvements.

c. Monitor implementation of the improvements.

d. Monitor effectiveness of the improvements over time.

3.5.5 Monitor the quality of incident review findings and progress against this PSIRP using the national tool.

4. Selection of incidents for patient safety incident investigation

4.1 Aim of a patient safety incident investigation (PSII)

4.1.1 PSIIs are conducted for systems learning and safety improvement. This is achieved by identifying the circumstances surrounding incidents and the systems-focused, interconnected causal factors that may appear to be precursors to patient safety incidents. These factors must then be targeted using strong (effective) system improvements to prevent or continuously and measurably reduce repeat patient safety risks and incidents.

4.2 Selection of patient safety incidents for PSII

4.2.1 In view of the above, the selection of incidents for PSII is based on the:

a. actual and potential impact of the incident's outcome (harm to people, service quality, public confidence, products, funds, etc.)
b. likelihood of recurrence (including scale, scope and spread)
c. potential for new learning in terms of:
   - enhanced knowledge and understanding of the underlying factors.
   - improved efficiency and effectiveness (control potential).
   - opportunity to influence wider system improvement.

Evidence of emerging themes provided by the patient safety/risk team on a monthly basis and reported to the Patient Safety Committee.

4.3 Timescales for patient safety PSII

4.3.1 Where a PSII for learning is indicated, the investigation must be started as soon as possible after the patient safety incident is identified.

4.3.2 PSIIs should ordinarily be completed within one to three months of their start date.

4.3.3 In exceptional circumstances, a longer timeframe may be required for completion of the PSII. In this case, any extended timeframe should be agreed between us and the patient/family/carer.

4.3.4 No local PSII should take longer than six months. A balance must be drawn between conducting a thorough PSII, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant. (Where the processes of external bodies delay access to some information for longer than six months, a completed PSII can be reviewed to determine whether new information indicates the need for further investigative activity.)

4.4 Nationally defined priorities to be referred for PSII or review by another team

4.4.1 The national priorities for referral to other bodies or teams for review or PSII (described in the PSIRF) are:

a. **maternity and neonatal incidents:**
   - incidents which meet the 'Each Baby Counts' and maternal deaths criteria detailed in Appendix 4 of the PSIRF must be referred for Maternity and Newborn Safety Investigation (MNSI). (Home (mnsi.org.uk)
   - all cases of severe brain injury must also be referred to NHS Resolution's Early Notification Scheme
   - all perinatal and maternal deaths must be referred to MBRRACE

b. **mental health-related homicides by persons in receipt of mental health services or within six months of their discharge** must be discussed with the relevant NHS England and NHS Improvement regional independent investigation team (RIIT)

c. **child deaths** (*Child death review statutory and operational guidance*):
   - incidents must be referred to child death panels for investigation

d. **deaths of persons with learning disabilities:**
   - incidents must be reported and reviewed in line with the Learning Disabilities Mortality Review (LeDeR) programme

e. **safeguarding incidents:**

- incidents must be reported to the local organisation's named professional/safeguarding lead manager and director of nursing for review/multiprofessional investigation

f. **incidents in screening programmes:**
   - incidents must be reported to Public Health England (PHE) in the first instance for advice on reporting and investigation (PHE's regional Screening Quality Assurance Service (SQAS) and commissioners of the service)

g. **deaths of patients in custody, in prison or on probation** where healthcare is/was NHS funded and delivered through an NHS contract:
   - incidents must be reported to the Prison and Probation Ombudsman (PPO), and services required to be registered by the Care Quality Commission (CQC) must also notify CQC of the death. Organisations should contribute to PPO investigations when approached.

4.5 Nationally defined incidents requiring local PSII

4.5.1 Nationally defined incidents for local PSII are set by the PSIRF and other national initiatives. These are:

a. **incidents that meet the criteria set in the** Never Events list 2018

b. **incidents that meet the** 'Learning from Deaths' criteria; that is, deaths clinically assessed as more likely than not due to problems in care - using a recognised method of case note review, conducted by a clinical specialist not involved in the patient's care, and conducted either as part of a local Learning from Deaths plan, or following reported concerns about care or service delivery. Further, specific examples of deaths where a PSII must take place include:

   i. **deaths of persons with mental illness whose care required case record review as per the Royal College of Psychiatrist's** mortality review tool and which have been determined by case record review to be more likely than not due to problems in care.

   ii. **deaths of persons with learning disabilities** where there is reason to believe that the death could have been contributed to by one or more patient safety incidents/problems in the healthcare provided by the NHS. In these circumstances a PSII must be conducted in addition to the LeDeR review

iii. **deaths of patients in custody, in prison or on probation** where there is reason to believe that the death could have been contributed to by one or more patient safety incidents/problems in the healthcare provided by the NHS

c. suicide, self-harm or assault resulting in the death or long-term severe injury of a person in state care or detained under the Mental Health Act.

4.6 Locally defined incidents requiring local PSII

4.6.1 Based on the local situational analysis and review of the local incident reporting profile, local priorities for PSII have been set by this organisation.

a. **Locally-defined emergent patient safety incidents requiring PSII.** An unexpected patient safety incident which signifies an extreme level of risk for patients, families and carers, staff or organisations, and where the potential for new learning and improvement is so great (within or across a healthcare service/pathway) that it warrants the use of extra resources to mount a comprehensive PSII response.

b. **Locally predefined patient safety incidents requiring investigation.** Key patient safety incidents for PSII have been identified by this organisation (through analysis of local data and intelligence from the past three years), and will be agreed with the commissioning organisation as a local priority in line with the following guidance:

- **Criteria for selection of incidents for PSII:**

  a. actual and potential impact of outcome of the incident (harm to people, service quality, public confidence, products, funds, etc.)

  b. likelihood of recurrence (including scale, scope and spread)

  c. potential for learning in terms of:

  - enhanced knowledge and understanding
  - improved efficiency and effectiveness (control potential)
  - opportunity for influence on wider systems improvement.

A number of incident types such as in-patient falls, and development/deterioration of pressure damage have active improvement delivery plans in place, based on learning identified from previous patient safety incident investigations. Delivery of these improvement plans will be monitored by the central patient safety team and via their respective specialist subgroup. A

combination of both process and outcome metrics will be utilised to measure their effectiveness once fully complete.

4.7 Thematic analysis following the completion of a small number of individual investigations of similar patient safety incidents

4.7.1 A valuable and thorough way of accomplishing thematic analysis of patient safety incident findings is to select a few (three to six) recent and very similar incidents and **investigate each individually** with skill and rigour to determine the interconnected contributory and causal factors.

4.7.2 The findings from each individual investigation are then collated, compared and contrasted to identify common **causal factors** and any common interconnections or associations upon which effective improvements can be designed.

4.7.3 Importantly, investigation of recent incidents allows more accurate information gathering from properly specified, good quality PSIIs, and detailed analysis of the system as it currently stands.

4.8 Patient safety improvement plans underway

4.8.1 DCH will continue to review existing processes and governance pathways, to build upon and share existing good practice which already algins with the principles outlined in the national PSIRF. We will compare our progress against the national PSIRF standards to highlight where we are meeting the requirements and where we can focus our efforts towards meeting these standards ongoing.

4.8.2 Ongoing patient safety improvement plans developed in response to our identified priorities are detailed below:

	Local patient safety incident improvement plans	Specialty	Monitoring forum
Reducing avoidable harm			
1	Hospital acquired pressure Ulcers	Trust wide	Patient Safety Committee
2	Falls prevention & management	Trust wide	Patient Safety Committee
3	Early recognition and escalation of deteriorating patients	Trust wide	Patient Safety Committee
Treatment & procedures			
4	Safer administration of insulin	Trust wide	Patient Safety Committee
5	Delays in transfers of care	Trust wide	Strategy & Transformation
Maternity and Neonates			
6	Post natal incidents during admission	Maternity & Neonates	Divisional Governance & Patient Safety Committee
7	Post natal incidents requiring admission	Maternity & Neonates	Divisional Governance & Patient Safety Committee

5. Working with Patients and Families.

5.1 The PSIRF recognises that meaningful learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. The PSIRF supports development of a patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents.

5.2 Patients and families should be given every opportunity to be involved at every step and have the process explained to them. Involvement should be flexible and adapt to changing needs as each situation will be different. The Trust will apply the following principles when working with patients and families:

5.3 Communication should be a two-way dialogue to allow the imparting and receipt of helpful and accurate information. The use of plain language and avoiding jargon or acronyms will aid understanding. Where appropriate, checking understanding and summarising can ensure the intended message has been received and is understood.

5.4 Good communication must continue throughout any patient safety review, providing updates where appropriate and as agreed with those affected.

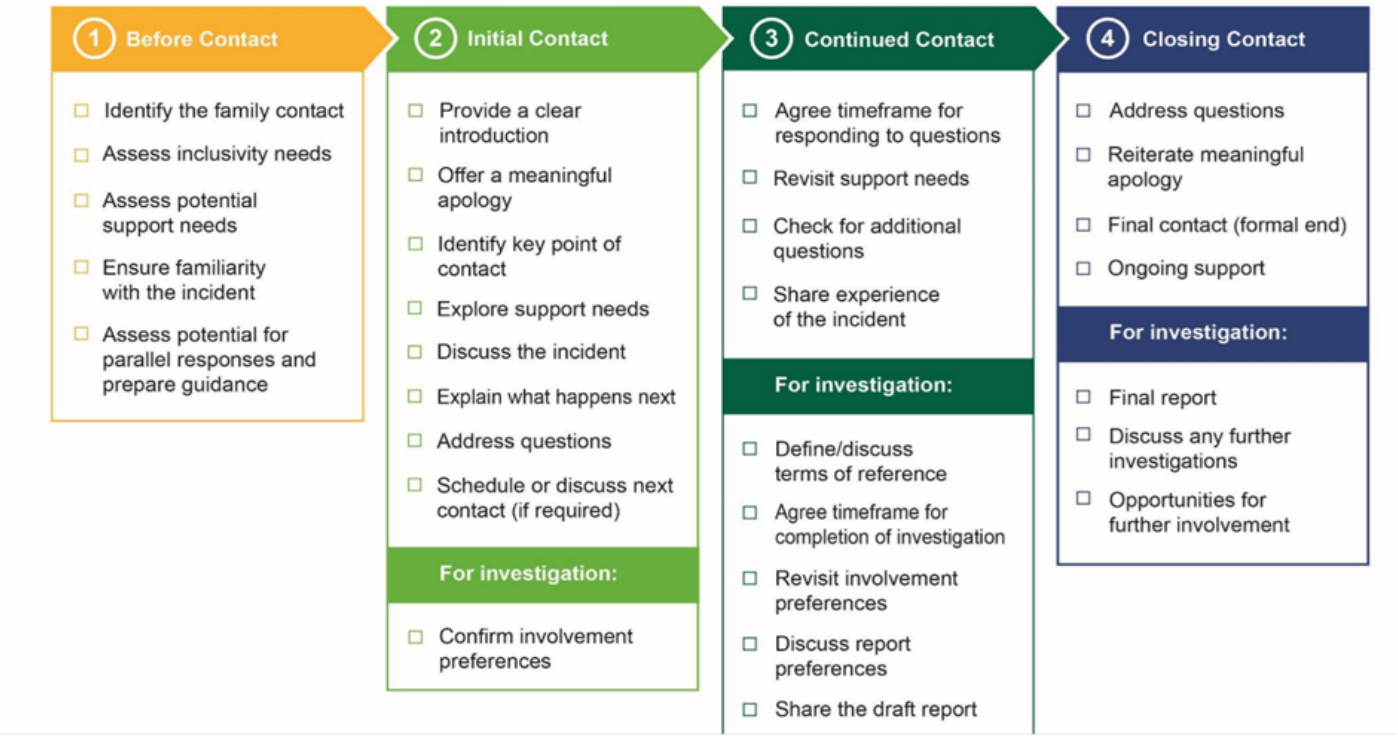
5.5 Resources for engaging and working with families are available at learn-together.org.uk – Serious Incident Investigation resources and these should be read alongside the Trust: Being Open and Duty of Candour Policy (Ref 0979)

5.6 Families and staff may need to be signposted to support at any point during engagement or involvement in a learning response. Our process should ensure there is equity in the support offered to families and staff, and that systems exist for internal and external support so that those affected can access support in the way they prefer, wherever possible.

5.7 Engagement and level of involvement must be in keeping with the wishes of those affected as far as possible.

5.8 We will use the overarching framework described below as a guide in building systems and processes in collaboration with patient partners and/or those with lived experience.

5.8.1 Not all steps may be required, some steps may need to be repeated and the process may not be as linear as implied. The DCH approach must be adapted to meet the circumstances of each patient safety incident and the individuals affected.



6. Selection of incidents for review

6.1 Different review techniques can be adopted, depending on the intended aim and required outcome. The most commonly used are:

Technique	Method	Objective
Immediate safety actions	Incident recovery	To take urgent measures to address serious and imminent: a. discomfort, injury, or threat to life b. damage to equipment or the environment.
'Being open' conversations	Open disclosure	To provide the opportunity for a verbal discussion with the affected patient, family or carer about the incident (what happened) and to respond to any concerns.
Case record/notes review	Clinical documentation review	To determine whether there were any problems with the care provided to a patient by a particular service. (To routinely identify the prevalence of issues; or when bereaved families/carers or staff raise concerns about care.)
Hot debrief	Debriefing	To conduct a post-incident review as a team by discussing and answering a series of questions.
Safety huddle	Briefing	A short multidisciplinary briefing, held at a set time and place and informed by visual feedback of data, to: • improve situational awareness of safety concerns. • focus on the patients most at risk. • share understanding of the day's focus and priorities. • agree actions. • enhance teamwork through communication and collaborative problem-solving. • celebrate success in reducing harm.
Incident timeline	Incident review	To provide a detailed documentary account of an incident (what happened) in the style of a 'chronology'.
After-action review	Team review	A structured, facilitated discussion on an incident or event to identify a group's strengths, weaknesses and areas for improvement by understanding the expectations and perspectives of all those involved and capturing learning to share more widely.
LeDeR (Learning Disabilities Mortality Review)	Specialist Review	To review the care of a person with a learning disability (recommended alongside a case note review).

Technique	Method	Objective
Perinatal mortality review tool	Specialist review	Systematic, multidisciplinary, high-quality audit and review to determine the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies in the post-neonatal period having received neonatal care.
Mortality review	Specialist Review	Systematic, multidisciplinary, high quality audit and review to determine the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies in the post-neonatal period having received neonatal care.
Clinical audit	Outcome audit	A quality improvement cycle involving measurement of the effectiveness of healthcare against agreed and proven standards for high quality, with the aim of then acting to bring practice into line with these standards to improve the quality of care and health outcomes.
Risk assessment	Proactive hazard identification and risk analysis	To determine the likelihood of an identified risk and its potential severity (e.g., clinical, safety, business).

6.2 Priorities for 'being open' conversations and Duty of Candor include:

- all patient safety incidents leading to moderate harm or above (Duty of Candor)
- all incidents for which an investigation is undertaken. (Being Open)

7 Roles and responsibilities

7.1 DCH has held a series of workshops to clearly identify the investigation processes and at what level of staff need to be involved at each stage. This work aims to clearly describe roles and responsibilities in relation to its response to patient safety incidents, including investigator responsibilities and upholding national standards relating to patient safety incidents.

7.1.1 The Trust will be looking to align its processes with the other local NHS Providers, as many patients have a number of services involved within their care. It is acknowledged that using common language and templates will assist with the investigation process.

7.2 Training

7.2.1 The Patient Safety Strategy includes a patient safety syllabus which is accessible via the elearning for health portal, augmented by externally provided training as detailed below. The Patient Safety Team will deliver trust wide training for staff focusing on the appropriate use of incident review tools (see section 6.1). Training compliance is reported through the Patient Safety Committee.

Topic	Provider	All staff	Clinical Staff	Learning response leads/managers	PSRIF lead roles	Oversight roles
National Patient Safety Level 1: Essentials for Patient Safety	eLearning for health	✓	✓	✓	✓	✓
National Patient Safety Level 2: Access to Practice	eLearning for health		✓	✓	✓	✓
Involving those affected by Patient	External Provider			✓	✓	

Safety Incidents						
Approach to Patient Safety Reviews	3 day course – external provider			✓	✓	
Systems approach to learning from Patient Safety Incidents	External provider				✓	
Oversight of Learning from Patient Safety Incidents	External provider					✓

8. Evaluating and monitoring outcome, Reviews/Investigations

8.1 Robust findings from reviews provide key insights and learning opportunities, but they are not the end of the story.

8.2 Findings must be translated into effective improvement design and implementation. This work can often require a different set of skills from those required to gain effective insight or learning from patient safety reviews and PSIIs.

8.3 Improvement work should only be shared once it has been tested and demonstrated that it can be successfully and sustainably adopted, and that the changes have measurably reduced risk of repeat incidents, in line with quality improvement methodology.

8.4 Regular reports to the Board will include aggregated data on:

- patient safety incident reporting
- audit and review findings
- findings from safety reviews
- progress against the PSIRP
- results from monitoring of improvement plans from an implementation and an efficacy point of view.
- results of surveys and/or feedback from patients/families/carers on their experiences of the organisation's response to patient safety incidents
- results of surveys and/or feedback from staff on their experiences of the organisation's response to patient safety incidents.

	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Total
Admission, Transfer and Discharge	54	72	65	64	55	41	65	55	92	59	59	83	764
Communication and Consent	14	27	16	28	20	29	25	18	19	29	18	25	268
Diagnostic imaging management	1	4	4	6	5	2	7	9	5	6	9	9	67
Documentation Management	26	30	31	28	38	34	30	49	23	31	39	29	388
DOLS	1	0	1	1	1	0	0	2	0	0	0	2	8
Estates and Facilities Incident	149	76	96	154	167	76	99	63	38	21	22	15	976
Final Fate Blood products	5	3	2	5	2	0	3	2	1	6	2	5	36
Fire Safety Incidents	0	2	4	4	1	0	0	2	3	2	3	2	23
Infection Prevention	13	6	13	15	13	20	25	11	13	12	14	12	167
Information Governance and Breach of Confidentiality	14	13	16	30	15	16	18	23	12	18	28	19	222
Inoculation injury	4	5	6	8	4	7	4	5	6	10	7	6	72
Major Trauma	0	0	0	0	0	0	0	0	0	0	0	2	2
Maternity and Neonatal	46	41	47	41	56	60	49	53	39	55	39	52	578
Medical Devices	15	14	15	23	11	23	17	34	22	37	22	26	259
Medicines	75	92	96	82	98	86	84	94	83	107	76	83	1056
Mixed sex accommodation	23	23	29	25	14	15	22	9	22	9	5	15	211
Mortuary Quality Management	0	0	1	0	0	1	0	0	4	1	0	0	7
Non Medical Devices	20	10	10	10	10	12	14	14	13	12	13	8	146
Other type of incident	1	1	2	2	0	0	4	3	6	3	1	2	25
Partner Agency Incident	54	61	38	86	85	74	82	61	53	42	42	47	725
Pathology Management	5	16	17	11	19	19	14	14	15	24	13	17	184
Patient Care - Deteriorating Patient Care	4	4	3	8	10	7	9	8	6	3	2	6	70
Patient Care - Treatment and Procedure	87	85	77	94	56	78	84	75	73	67	81	85	942
Patient Slip, trip or fall	77	68	62	72	62	87	66	68	84	77	73	98	894

Patient Tissue Viability/Pressure Ulcer/Skin Damage	133	191	187	186	182	160	187	175	188	207	149	155	2100
Privacy, Dignity and Diversity	8	1	7	2	1	6	1	2	3	3	2	1	37
Radiation incidents involving ionising radiation	3	7	7	4	4	2	2	2	10	2	4	1	48
Rejected/Duplicated Incident	0	1	0	0	0	0	0	0	1	1	0	0	3
Resuscitation 2222 call out and End of Life	3	5	7	6	14	7	7	9	8	4	4	5	79
Safeguarding Adult Concern	1	1	1	4	1	1	2	1	3	2	1	3	21
Safeguarding Child Concern	1	0	0	0	0	0	2	0	0	1	0	0	4
Staffing/Workforce Capacity	43	29	19	19	31	30	67	29	24	37	36	51	415
Sterile Services Department (SSD)	2	1	13	8	8	6	4	3	5	8	6	10	74
Transfusion incident	8	3	4	3	2	5	8	3	4	3	7	4	54
Violence, Aggressive, Property offences and Security events	30	51	43	55	46	41	73	58	34	43	37	45	556
Incident accident	13	12	18	15	24	19	17	22	18	21	12	23	214
Mental Health	2	1	1	3	3	4	3	3	2	0	2	3	27
Structure Judgement Review (SJR)	49	27	13	29	8	44	4	23	22	5	36	13	273
Total	984	983	971	1131	1066	1012	1098	1002	954	968	864	962	11995

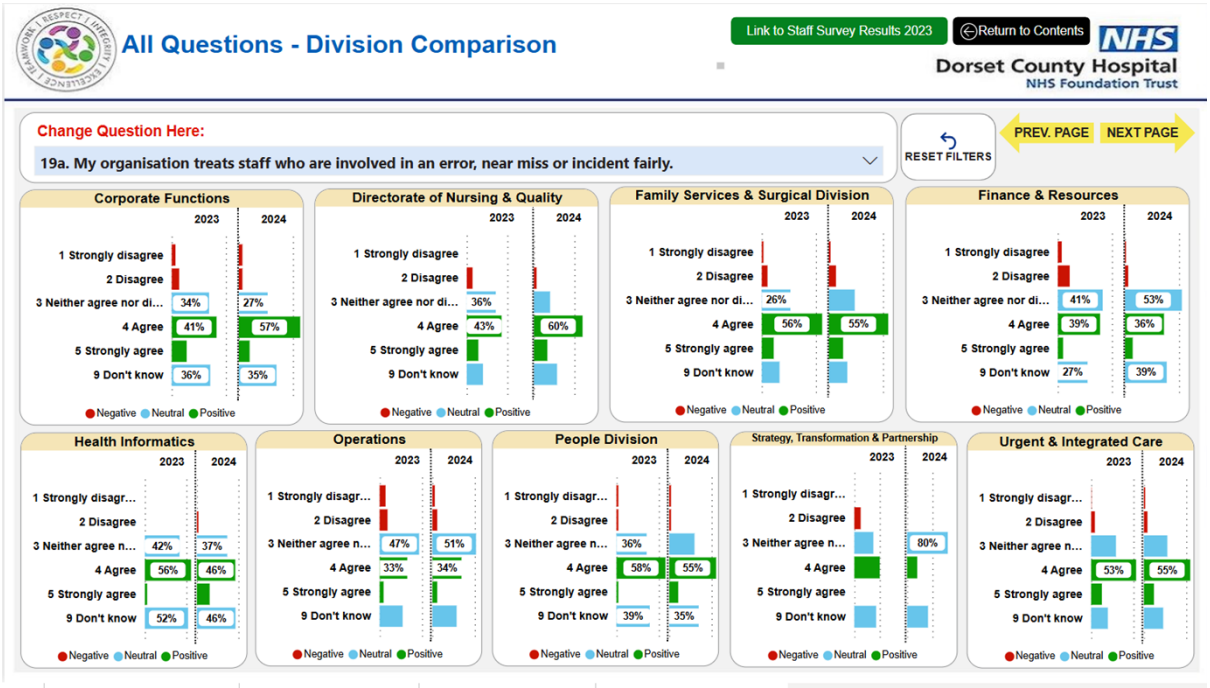
Appendix 1

Incidents recorded on local risk management system, by frequency, 01 April 2024-31 March 2025

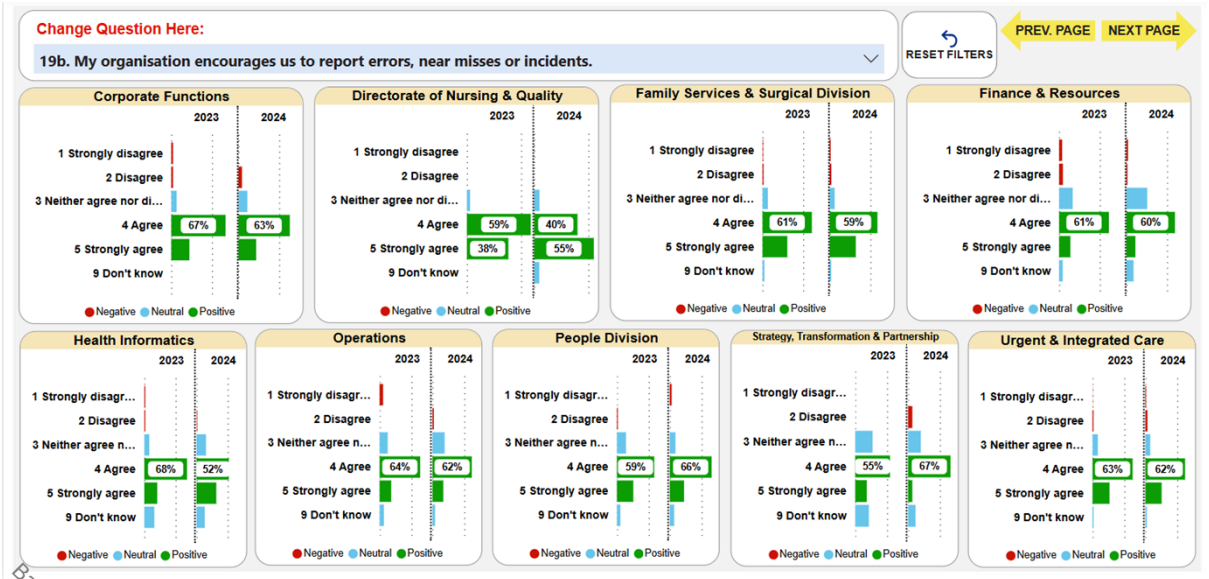
Appendix II

Summary Results from DCH Staff Survey 2023-2024

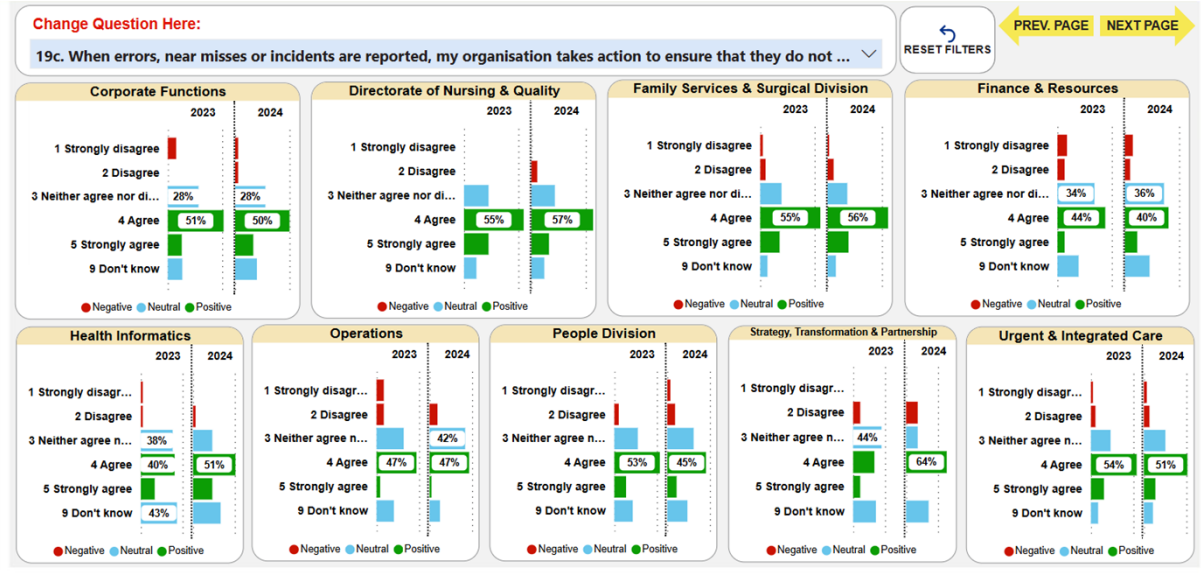
My organisation treats staff who are involved in an error, near miss or incident fairly.



My organisation encourages us to report error, near misses or incidents.

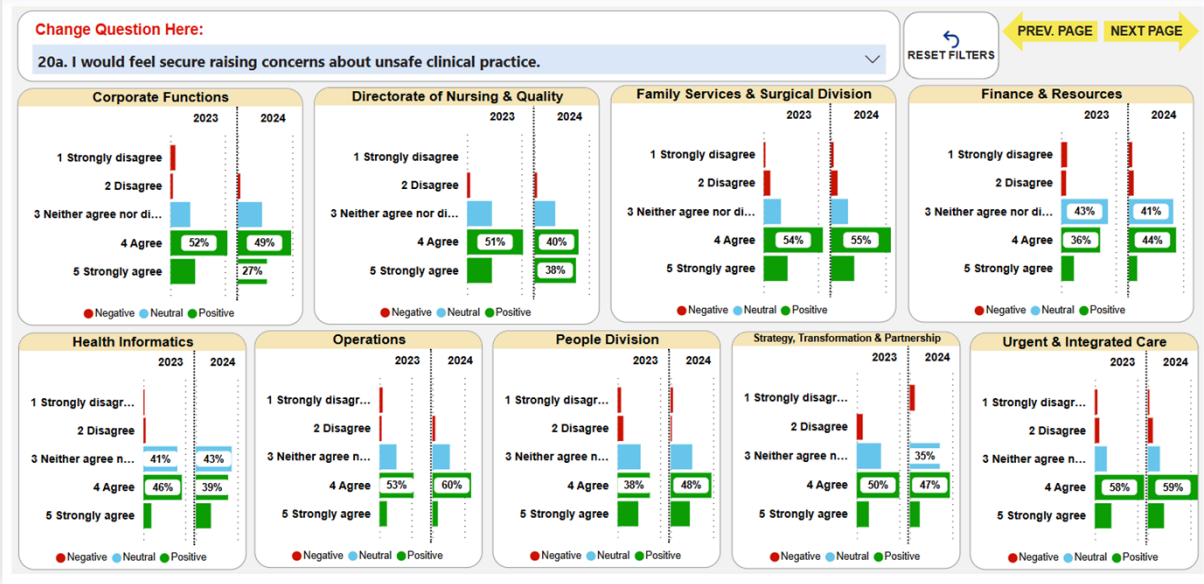


When error, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again

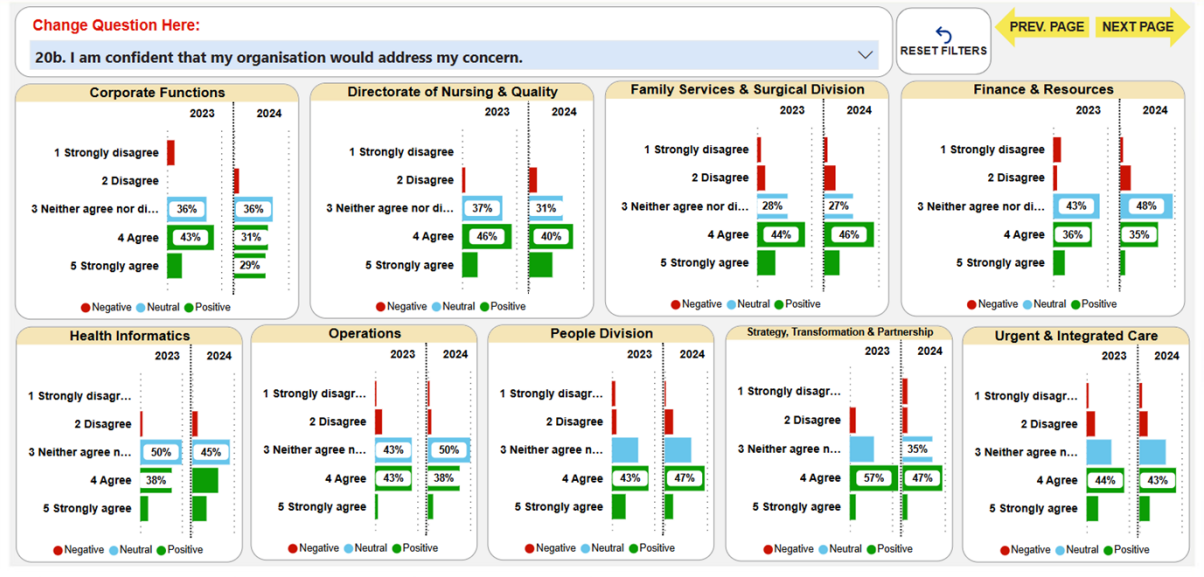


We are given feedback about changes made in response to reported errors, near misses and incidents.

I would feel secure raising concerns about unsafe clinical practice.

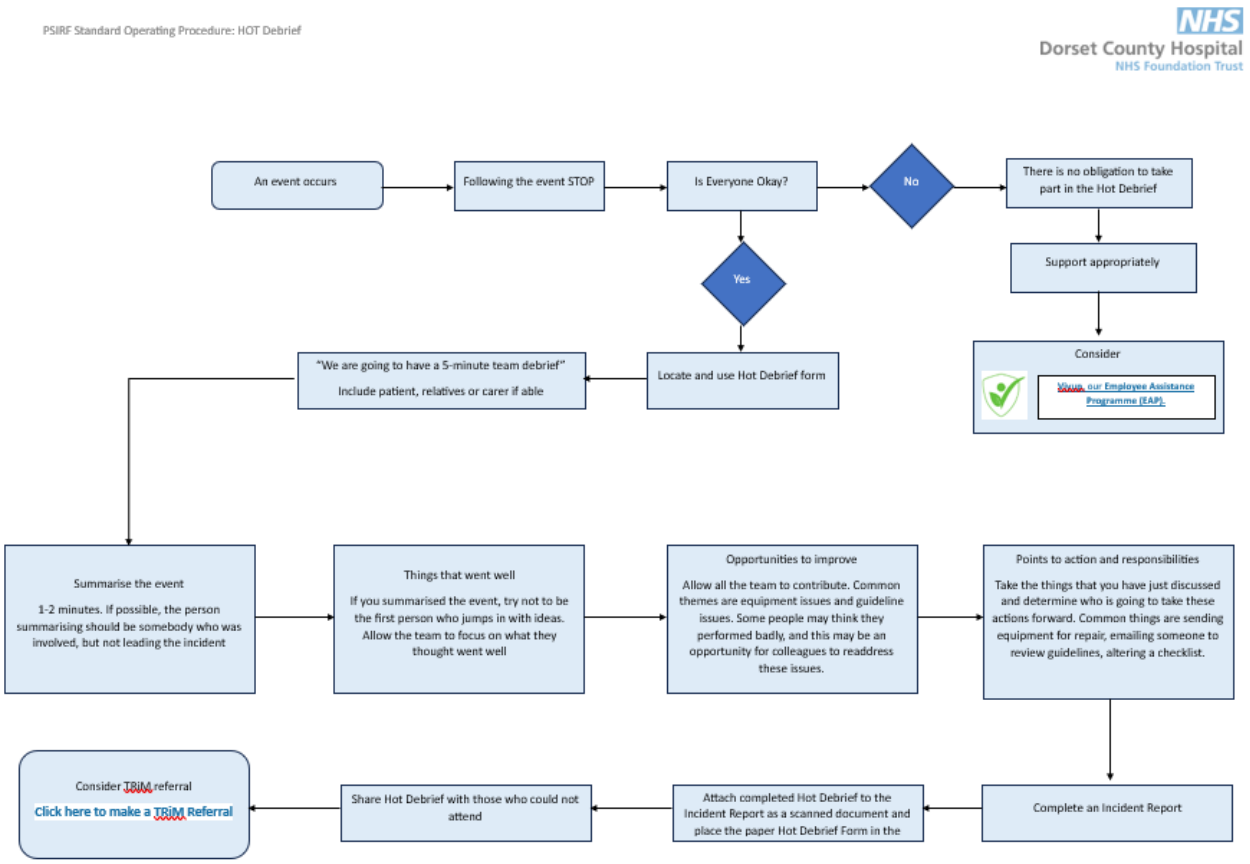


I am confident that my organisation would address my concern.



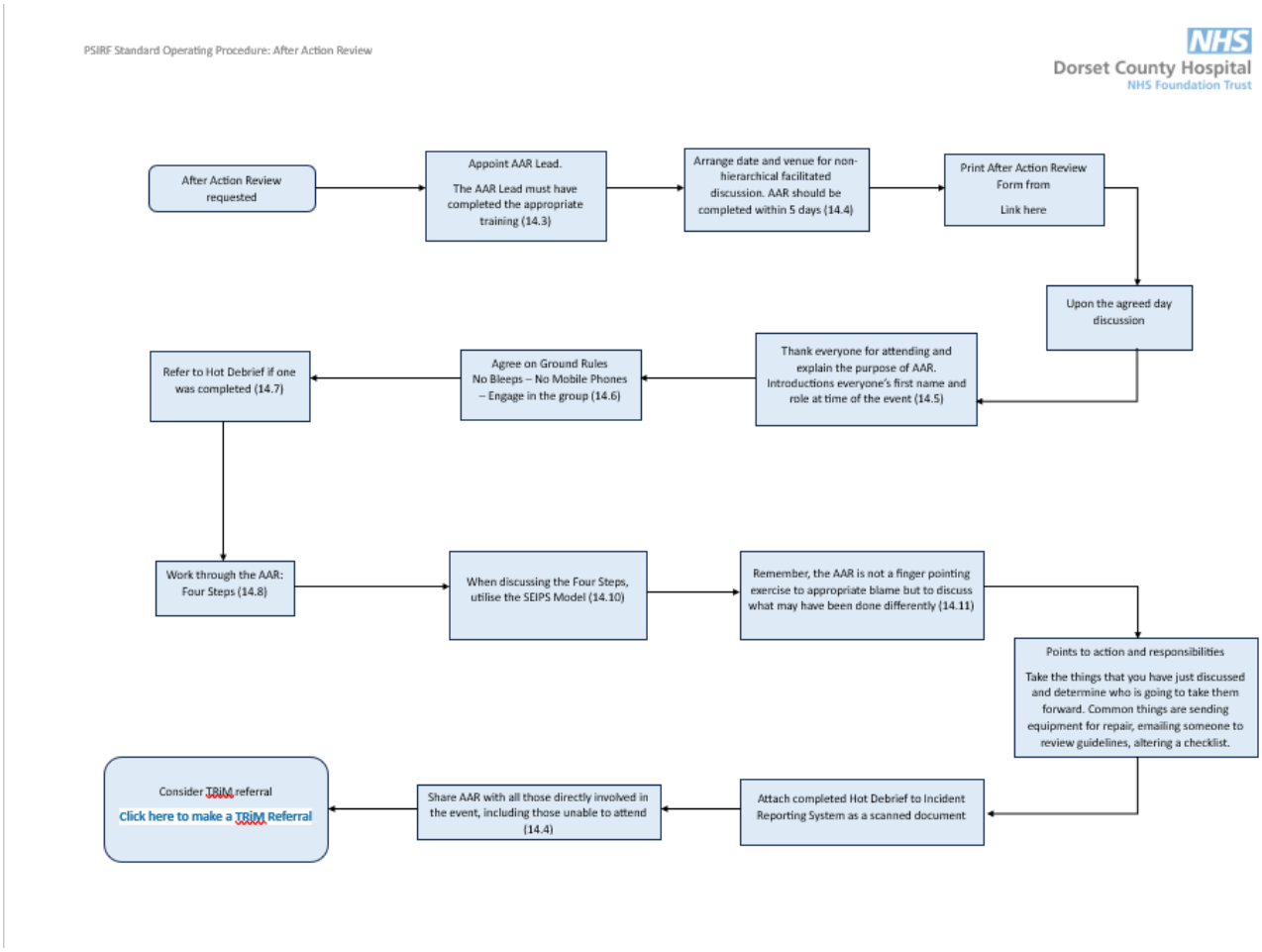
Appendix III

Hot Debrief SoP Flowchart



Appendix IV

After Action Review SoP Flowchart



NHS
Dorset County Hospital
NHS Foundation Trust

Report to	Board of Directors, part 1	
Date of Meeting	10 June 2025	
Report Title	Bi-Annual Safe Staffing Report	
Prepared By	Trudy Goode Safe Staffing Lead & Louisa Way Interim Deputy Director of Nursing	
Approved by Accountable Executive	Dawn Dawson – Chief Nursing Officer	
Previously Considered By	Quality Committee in Common 27.05.2025 Quality Governance Group 13.05.25	
Action Required	**Approval**	Y
	Assurance	
	Information	

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	Impact on Temporary Staffing spend	
Statutory & Regulatory	CQC regulatory standards	
Equality, Diversity & Inclusion	N/A	
Co-production & Partnership	N/A	

Executive Summary

This paper outlines the process and governance within inpatient services to ensure that the Board has assurance that Dorset County Hospital met all of the national workforce requirements for safe staffing within inpatient wards.

This 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.

In addition to the formal review, staffing levels, patient acuity and dependency, and effective utilisation of resources is discussed twice daily at the internal bed/operational flow meetings and 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 that area.

Since the Annual Safe Staffing Report (November 2023) the Safe Care project commenced in line with recommendations from the previous report and was completed in January 2025, with all areas competent in its' use, with the exception of Maternity, SCBU, Theatres and ED. Acuity census will occur 2 twice daily using the Safe Nursing Care Tool (SNCT 2023). It is intended that for the next Acuity and Dependency audit that Safe Care will be utilised by the wards for the purposes of the audit as well as for review by Matrons when considering redeployment of staff.

Alternative roles in the clinical area have also been explored and a pilot project for Ward Housekeepers was undertaken on 2 wards. This was successful with improvement demonstrated during a PLACE assessment during the project. This has been evident with bed area preparation, management of

allergens 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. Consideration of a review of existing domestic housekeeper roles and responsibilities, level of cover and opportunities to revise the current model should be considered. This is likely to be delayed whilst SubCo development is underway.

Summary

The Trust has reviewed the acuity and dependency audits results for the inpatient ward areas and has identified that this bi-annual review has not indicted the need for additional staff, noting the ongoing reliance on temporary workforce, however there is a need to review the use of escalation areas and the related staffing requirements, alongside bed reconfiguration plans. The Trust remains within the expected limits of the Model Hospital data in relation to nursing and midwifery staffing.

A Lead Nurse for Safer Staffing has been substantively recruited following a successful secondment period.

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

- Appointment of a Safe Staffing Clinical Lead to develop and support the 'Safe Staffing Strategy' - Actioned and in place, with the post holder successfully completing the Interrater Reliability Assessment training 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, professional judgement and care hours per patient day data. This now needs to embed as business as usual.
- The requirement to manage safe staffing via allocate and the roster to meet level 2 Standards of Attainment.

Recommendation

The recommendation of this report is to:

- Acknowledge the national standards for headroom, in line with the recommendations of the annual review 2024 and previous business case. Noting the current review with NHS England colleagues, bed modelling and agency reduction plans
- **Approve** the bi-annual review May 2025

TRUST BOARD

Bi - 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 January 2025 for a period of 30 days (1/1/2025 – 30/1/2025). The last audit was completed in July 2024, and that report was presented to Trust Board in November 2024. It is acknowledged that the audit should be twice yearly (January and June) which is the planned audit programme going forward.

Maternity staffing was subject to review using professional judgement and review of activity and complexity in Quarter 3 2023/24 and the Better Births 3 yearly staffing review were undertaken in the second half of the financial year. The results and recommendations were included in the Annual Safe Staffing report November 2024.

As this is the bi-annual report there are no financial requests and recommendations will be managed in budget by the Divisional Heads of Nursing, but consideration needs to be given to the use of in extremis beds and the requirement for extra staff currently an agency cost pressure. It should be noted that the SNCT audit tool and results are based on 22% uplift whilst NQB recommends 22.2%. The templates for wards remain at 20%.

This will meet the patient care and safety needs that the Trust is providing. This will be reviewed again in line with NICE requirements in June 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. Trusts should report on this to their board every month.
- 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 adult inpatient wards at Dorset County Hospital.

Critical Care, Maternity Services, Special Care Baby Unit (SCBU), and the Emergency Department (ED) 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. Senior staff in ED are due to undertake updated training on the use of the ED SNCT toolkit May 2025, prior to undertaking the ED audit.

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 (RCN) 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.

Care Hours per Patient Day DCH comparison with our peers (the average number of actual Registered Nursing care hours spent with each patient per day (which includes both substantive, bank and agency RN's

Name of Acute Trust	2025	2024	2023
DCH	**5.2**	**4.8**	**4.5**
UHD	4.5	4.5	4.8
Salisbury	5.1	5.3	5.1
Somerset	4.6	4.6	4.2
R D & Exeter	5.0	No data	4.2
Royal Cornwall	4.5	4.3	4.6
North Bristol	5.4	5.0	4.7
RUH Bath	5.8	5.6	5.9

Improvements in CHPPD can be attributed to improved recruitment processes, centralised recruitment, Internationally Educated Nurses recruitment since 2023 whilst also growing our own future Registered Nurses through the Registered Degree Apprenticeship route and the Temporary Staffing Team.

Whilst there has been successful recruitment to vacancies the templates for establishments remain below national guidance. The current gap of 2% is being filled by bank and agency staff and over template causing a cost pressure as well as, continued use of incentive payments and for some areas the use of off framework agencies.

The cost of good care is CHPPD at 5.2 in 2025 vs 4.5 in 2023.The table below demonstrate the improvements year on year of increased fill rate from the temporary staffing team for bank staff whilst reducing agency staff.

Combined Nursing	Bank	Agency	Unfilled
2023	48.89%	30.45%	20.66%
2024	63.53%	22.25%	14.22%
2025	67.97%	20.63%	15.24%

The table below demonstrates steady increase of bank registered burses and reduced agency nurse usage and unfilled rate reducing.

Registered only	Bank	Agency	Unfilled
2023	29.99%	56.47%	13.54%
2024	44.10%	45.94%	9.96%
2025	51.27%	39.40%	10.55%

The table below demonstrates our bank unregistered shifts steadily increasing in fill rate and unfilled reducing.

Unregistered only	Bank	Agency	Unfilled
2023	71.01%	0.00%	28.99%
2024	82.43%	0.00%	17.57%
2025	80.36%	0.00%	19.64%

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.

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 January 2025.

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.

Current uplift for ward nursing establishments is 20.5% (for training, annual leave etc), of which 2% is kept centrally for sickness absence cover using temporary staffing. This uplift is currently below nationally recommended levels and Safe Staffing toolkits (including SCNT) are unable to accurately calculate below 22% uplift. The current uplift for the Critical Care and Emergency Departments is the same as the inpatient wards and below national benchmarks. The recommendations are to align budgeted establishments with the national recommendations (see below).

	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 2024/2025 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 annual review in July 2024 and reported November 2024, alternative roles in the clinical area have been explored and a pilot project for Ward Housekeepers was undertaken on 2 wards. Early indications were 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 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. This should be a phased roll out recommendation in partnership with our Catering and Domestic Facilities teams.

3. Additional In-Extremis Beds

Over 2023/2024 additional in-extremis beds were open by exception to support additional admission demand. This fluctuated 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 was taken to de-escalate the in-extremis beds as soon as possible. Over the course of 2024/2025 action was taken to reduce these extra beds with the Mary Anning beds largely

closed and as part of a Quality Improvement programme the bed base was further reduced from 46 to 38 in-patient beds.

During the audit period the Mary Anning beds remained open at 46 beds. Purbeck wards extra beds were closed, and the Dayroom area has been restored to an area to provide activities and distraction to those patients more cognitively impaired.

Moreton and Fortuneswell wards continue to have unfunded extra beds with Moreton at times having 4 extra beds open.

Ward	Extremis Beds	Additional Staff Required
Moreton Ward	3/4	1RN & 1 HCSW LD & ND 7/7
Fortuneswell Ward	3	1HCSW LD&1 RN ND 7/7

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% uplift	Current Vacancies (WTE) **as at 12.5.25**	Recommendations
Abbotsbury Ward (29 Beds)	44.79	43.44	Vacancies: HCA 2.46 but have RNDA 4.0 in post	No change to current establishment but it is recommended that to improve the nurse-to-patient ratio there remains a need for an off-duty review to achieve 4RN's both day and night.
Lulworth Ward (31 beds)	42.95	41.30	Vacancies: RN 0.55 HCA's nil RNDA 2.00 in post	No change to current establishment but it is recommended that to improve the nurse-to-patient ratio there remains a need for an off-duty review to achieve 4 RN's for both day and night. Currently 1:6 day and variable 1:10/1:7 night depending on professional judgement demands a higher ratio due to acuity.
Purbeck Ward (27 beds)	38.81	47.06	Vacancies: RN 0.88 HCA1.86 RNDA 1.63 in post	In-extremis beds closed.
Portesham (10 beds + 4 frailty SDEC beds) Currently being used to support Frailty SDEC patients streamlined from the Emergency Department	30.40		Vacancies: HCA 1.84 Over RN's 1.17	Ward was not audited as it was in the process of transitioning back to Ridgeway with Evershot staff moved to Portesham to cover the area as Frailty SDEC. This will require audit in June 2025.

Ridgeway Ward (20 beds) Planned Orthopaedic patients only	39.24	34.77	Vacancies: RN 1.45 HCA 3.83 but have RNDA 3.00 in post	No change recommended, the ward also manages its' Surgical Admission lounge within the footprint of staff.
Ward	Current WTE Establishment (Excluding Band 7 and Admin Roles)	SNCT Results with 22% uplift	Current Vacancies (WTE)	Recommendations
Kingfisher Ward (14 beds + PAU)	31.32	34.76	No vacancies	No change to current establishment – Smaller unit principles applied. Occupancy of the ward can vary with the average for January 2025 being 6.9 occupied beds.
Fortuneswell Ward (17 beds) + 3 additional beds open for the duration of the audit	27.39	27.45 17 beds would equal 23.33	Vacancies: HCA 2.67 but RNDA 2.0 in post	Recommended increase to establishment of 2 RN's and 3 HCA's if beds are to remain open. **It is noted that 5 days of data were missing in this audit period.**
Moreton Ward (23 beds) + 3 and sometimes 4 additional beds open for the duration of the audit and historically since Covid-19 pandemic began.	32.16	41.52	Vacancies: HCA 0.67	If 3/4 extra beds remain open, an additional 3 RN's and 3 HCAs are required to manage the geographical spread of the ward, the acuity of patients and to meet the nurse-to-patient ratio. Beds may be reviewed as part of bed reconfiguration plans. **The ward is currently working in a Quality Improvement Programme and reducing the bed base would form part of this and the Quality Nursing Indicators.**
Evershot Ward (14 beds)				Area not audited as staff and patients moved during the period of audit to Portesham and now has a different

				functionality and cohort of patients. Maud Alexander Ward staff and patients moved across. Small ward principles applied.
Cardiac Care Ward (18 beds)	32.86	29.71	Vacancies: HCA 2.64 but 4.0 RNDA in post	No change to current establishment – smaller unit principles applied – the area functions as both a ward and, CCU providing 1:2 patient care.
Ilchester Ward (33 beds)	49.18	51.39	Vacancies: RN 0.65 HCA 4.71 but 1 RNDA in post	No changes to establishment required nurse: patient ratio currently 1:8 plus a NIC. Functionality restored to general medical ward.
Ward	Current WTE Establishment (Excluding Band 7 and Admin Roles)	SNCT Results with 22% uplift	Current Vacancies (WTE)	Recommendations
Mary Anning Unit 46 beds audit completed on 46 beds	68.38	80.44 (70.00 for 38 beds)	Vacancies: RN 1.44 HCA 6.0 but have 2.0 RNDA in post	Recommend staff to be redeployed to the Unit from within the Division, if bed reconfiguration allows or recruit and reduce the bed base back to footprint. **Note that the Unit is currently undergoing a Quality Improvement Programme and reducing the bed base to consistent 38 beds support this and the Quality Nursing Indicators.**
Maud Alexander Ward (10 beds)	13.42	14.72	Vacancies: HCA 2.09 with 1RNDA	No recommendations for change and small ward principles applied. Ward moved to Evershot and gained 4 extra beds, and this will be reaudited June

				2025 on 14 beds as a higher turnover ward to support ED flow.
Stroke Unit (23 beds)	49.13 + ACP 9-5 Mon-Fri, Outreach B6 08:00-20:00 Daily Nurse Consultant M-F	40.40	Vacancies: Band 6 7.34, RN 2.82 HCA 5.59 but have 3.00 RNDA in post	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. The HASU will provide 1:2 patient care in the acute phase.
Prince of Wales Ward (13 beds)	30.81	16.40	Vacancies: HCA 3.33	No change to current establishment – smaller unit principles applied and noting regional emergency dialysis unit status.

Summary of Recommendations:

- Further investments required to increase budget uplift at 22% headroom particularly in high agency usage areas (Moreton, Lulworth, Purbeck) and to 25% for ED (RCEM recommends 27%), increase substantive posts and offset agency use and spend 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 Birth Rate Plus during Q3 24/25 for Maternity Services – completed.
- Completion of reviews for Critical Care and ED for assurance and noting the investment requirements for the New Hospitals Programme and to acknowledge NQB recommendations for CRCU & ED uplift of 25%, whilst RCEM recommends 27% for ED to support agency reduction, use of incentive payments and ensure “corridor care” is safe when used.
- SCBU business plan requires implementation to meet the Supervisory requirements in line with BAPEM standards to support further reduction in off framework agency expenditure and the use of incentive payments.

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, which acknowledges ward type, number of single rooms and ward layout, skills and experience of staff, and enhanced care requirements.

In addition to the formal review, staffing levels, patient acuity and dependency, and effective utilisation of resources is discussed 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.

The Trust has reviewed the acuity and dependency audits results for the adult inpatient ward areas and there are no recommendations for increase to establishments in this report. 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 and this position is now recruited to substantively.
- 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 implemented Safe Care project with all adult wards trained in the use of the tool and now needs to become business as usual.
- To manage safe staffing via allocate and scrutiny of rosters.
- Encourage Safe Staffing Fellowship access by senior nurses – Deputy Director of Nursing substantive post holder has completed.

5. Recommendations

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

To acknowledge the uplift business case for recommended headroom from **20.5 % to 22%** (NQB recommends 22.2%) in inpatient areas and as part of the reorganisation of the bed base and opportunities for staff redeployment.

For transparency the Director of Nursing has requested an independent review of the Trusts’ staffing outcomes.

Trudy Goode, Workforce and Safe Staffing Lead, May 2025.

Dorset County Hospital
Dorset HealthCare

Finance and Performance Committee in Common Assurance Report for the meeting held on Thursday 29 May 2025

Chair	Dave Underwood
Executive Lead	Chris Hearn – Joint Chief Financial Officer Rachel Small – Chief Operating Officer, DHC Anita Thomas – Chief Operating Officer, DCH
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	• With regard to the scale of the agreed 25/26 Efficiency challenge, additional external support is being provided to check, challenge and apply rigour to the financial efficiency plan across the federation.

Key issues / matters discussed at the meeting	The committee received, discussed and noted the following reports: Board Assurance Framework (DCH/DHC) – Assigned Risks • Three risks assigned to this Committee: - SR4 Capacity and Demand - SR5 Estates - SR6 Finance • DCH - There have been no changes in the scores. The financial risk score of 20 is the highest, recognising the significant challenges for 25/26 • DHC - Finance risk score has increased to 16 to reflect the 25/26 challenge. Estates risk score has decreased to reflect recent strengthened compliance work. • It was recognised that shared services subco is themed throughout the BAF and may become a separate distinct risk depending on the outcome of Board conversations in coming weeks. Corporate Risk Register – Assigned Risks The Committee received the report for assurance. There are 3 risks rated 20+ including 1 new risk from last quarter. 15 risks have been closed last quarter. All risks continue to be actively managed and mitigated where possible. Further assurance was provided specifically on the actions and mitigations relating to medical device replacement and paediatric waiting times risk for DCH.

DCH Performance Report

- The first half of month 1 was positive in Emergency and urgent care with good flow and closed escalation areas followed by a challenging period
- Performance against the 4-hour standard in April 2025 improved to 82% (including UTC's
- Some RTT standards are being met against the backdrop of a growing waiting list
- Theatre capacity remains a challenge due to staffing. Task and finish group in place for a forward view on standing up/down activities and redeploying staff resource to other areas such as outpatient or clinical validation where appropriate.
- Additional pressure in breast radiology being resolved through insourcing and additional capacity from the independent sector is being used to ease pressures in neurophysiology.
- Further assurance was provided on actions being taken to address high levels of inpatients with no criteria to reside.

DHC Performance Report

- The Committee received the report for assurance.
- Early intervention service is in business continuity with a recovery plan in place and resumption of business as usual planned from June 2025.
- Out of area placements exceeding plan continues to be a challenge.
- Community hospital flow has been positive in Month 1.
- IUCS Call back over 20 minutes standard is considerably off the national requirement.
- Diagnostic plan is behind trajectory mainly attributed to Audiology with a long term mitigation plan in place relating to workforce and alternative patient access points.

DCH & DHC Finance Reports

- The CFO briefed the committee on plans to appoint additional external support to provide check, challenge and rigour to the financial efficiency plan across the federation given the size of the challenge for 2025/26 with immediate effect. This has not been imposed on the organisation from a regulatory perspective.
- DCH - At month 1, DCH delivered a deficit of £2.3million which is broadly in line with plan. Agency expenditure has continued at lower than budgeted levels. There has been increased usage of Bank workforce which will require close monitoring. The DCH efficiency target for the year is £29.1 million which is 9% of expenditure budgets. At month one, schemes identified stand at £24.5 million with £4.5 million of unidentified schemes. Within the identified schemes submitted to NHSE, 56% were classed as high risk at £16.4m. The cash position as at 30 April was £26.4million, £8.4 million ahead of plan. Capital plan spend is ahead of plan by £0.2 million.

- DHC - At month 1, DHC delivered a deficit of £0.65 million. Significant cost pressure remains in out of area placements. Savings of £172k have been delivered against a plan of £434k, leading to a deficit against the target of £263k. Strong cash balance of £36.8 million. Capital expenditure was more than plan n month 1 due to externally funded NHP items.

Case for the Extension of the Stroke HASU (DCH)

The committee received a detailed summary of the business case. The transfer of Somerset Hyper Acute patients to Dorset County Hospital supports DCH in becoming a sustainable Hyper Acute Stroke Unit (HASU) and enables:

- DCH to establish a flagship model for Hyperacute stroke care for more than 800 patients per year
- Safe, sustainable and high-quality stroke care, 24/7
- A cross-system model for pathways, governance and workforce incorporating training, education and informed by patient experience
- A refurbished stroke unit with a total increase of 6 beds (4 HASU beds, 2 ASU beds) and associated services capable of accommodating additional patients,
- Further investment in workforce, across the pathway, to support the number of stroke patients in an acute setting, from attendance in ED to discharge.

Assurance was provided that a full quality impact assessment has been undertaken of this significant service change. The committee approved the commitment to the revenue costs for 2025/26 and the recurring revenue costs subject to written assurance from Somerset and Dorset ICB Commissioners that income to cover these costs will be provided. The committee also delegated approval to award contract for works to Chief Financial Officer, subject to confirmation of capital affordability.

Novation of the Yeovil Dialysis Unit Contract (DCH)

The contract had previously been considered and agreed by the FPC some time ago. The committee provided retrospective approval as the contract commenced on 1st April 2025 but note was made to discourage future retrospective approvals in the future.

Generator Critical Infrastructure Finding Release (DCH)

The committee approved the allocation of the £1.8m critical infrastructure funding to the generator replacement project.

Estates Compliance Report (Joint)

The Committee received the report for assurance noting the good progress being made to date and recognising the challenge in collating all the evidence to demonstrate compliance.

Health and Safety (including fire and water) Compliance Report (DCH)

The Committee received the report for assurance. Following committee discussion, further assurance was provided on the how connections between health and safety incidents/audit findings and and the risk register are managed.

DCH SubCo Ltd – Terms of Reference (DCH)
The amended terms of reference were approved by the committee.

Keyworker Housing Unilateral Undertaking (DCH)
The committee approved the Planning Obligation by way of Unilateral Undertaking under section 106 of the Town & Country Planning Act 1990 in relation to land known as Dorset County Hospital, Williams Ave, DT1 2JY.

Committee Effectiveness Evaluation
A summary of the report was provided. The Committee has formally met four times since becoming a committee in common (September 2024 to March 2025) and discharged its responsibilities in all areas. Overall, the committee effectiveness evaluation was very positive with some areas of improvement identified. The refreshed Terms of Reference and committee workplan were approved for 2025/26.

The following escalation reports from sub groups were received for assurance by the committee members:

- DHC
  - Capital Investment Meeting
  - Better Quality, Better Value
- DCH
  - Capital Planning and Space Utilisation Group
  - Value Delivery Board
  - SubCo Ltd - Escalation report and performance report
- Joint
  - National Cost Collection (Approach approved by the committee)

Decisions made at the meeting

Approvals by DCH and DHC committees:

- Case for the extension of the Stroke HASU
- Novation of the Yeovil Dialysis Unit Contract
- Generator Critical Infrastructure Funding Release
- Committee Terms of Reference and 2025/26 Workplan
- Approach to National Cost Collection

Issues / actions referred to other committees / groups

- None

Quoracy and Attendance				
	29/05/2025			
Quorate?	Y			
Dave Underwood	Y			
Frances West	N			
Stephen Tilton	Y			
Andreas Haimbock-Tichy	Y			
Chris Hearn	Y			
Nick Johnson	N			
Rachel Wharton	N			
Anita Thomas	Y			
Lucy Knight	Y			
Rachel Small	N			

Report to	Board of Directors	
Date of Meeting	10th June 2025	
Report Title	Balanced Scorecard- An integrated report for the reporting month of April 2025	
Prepared By	Adam Savin, Director of Operational Planning and Performance	
Approved by 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 Louisa Way, Deputy Director of Nursing	
Action Required	**Approval**	
	Assurance	X
	Information	X

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	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 increased from 10.1% to 11.6%. This is below the 13% target but is special cause variation of a concerning nature, with a mean of 8.5%.
- Electronic Discharge Summary sent within 24h of discharge remains below target at 75.38% but it has improved by 12% since December, which was at 63.73%. The metric is special cause variation of a concerning nature, with a mean of 76.95%.
- SHMI has remained within the expected range and continues to show as special cause variation of an improving nature, with a value of 1.07 and a mean of 1.13.

Performance

- UEC performance against the 4 hour standard, did meet the national planning guidance of 78% and is showing as common cause variation with a mean of 81.69%.
- Cancer performance did not achieve the 28 day to diagnosis standard but the 31 and 62 day treatment standards were met.
- The total waiting list size is larger than plan, but the waiting time measures did achieve the standards. It is forecasted that for May, there will be no patients waiting over 65+ days for treatment.
- Bed occupancy was higher than plan, but the number of occupied beds was lower. While attendance were above plan, admissions were below, driving the need for few occupied bed days.

People

- Essential skills rate improved to 88.75% and is now 2% below target
- Appraisal rate improved from to 77% at the last report, to 79.12%
- Vacancy rate increased from 3.1% to 4.19% and remains better than the target
- Turnover increased slightly to 9.49% from 9.3% and remains better than target
- Sickness rate reduced to 4.19% from 4.8%, and is better than the target

Finance

- Adjusted financial plan is £44k ahead of plan
- Agency spend reducing and under spent, with improved medical and nursing agency spend.
- Capital expenditure is slightly ahead of plan, due to timings of spend for the stroke works design fees

Recommendation
The Board are asked to receive this report for **assurenace**

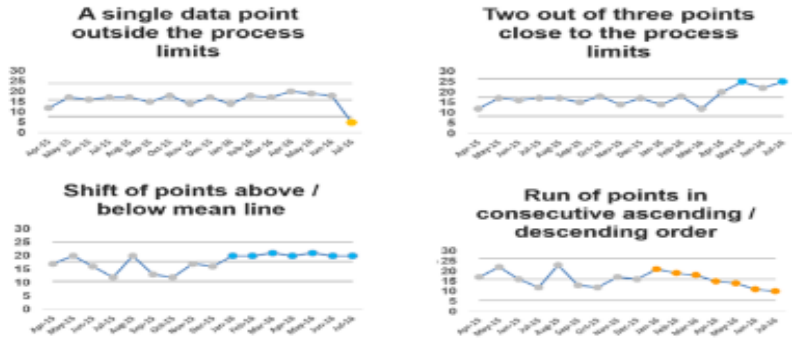
1) Understanding Statical Control Charts (SPC)

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?

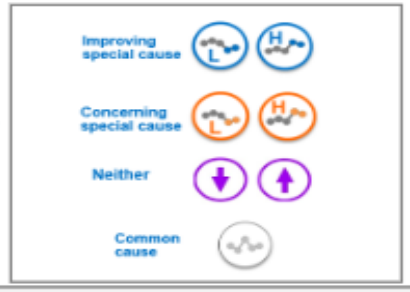
Blue icons indicate significant improvement or low pressure.

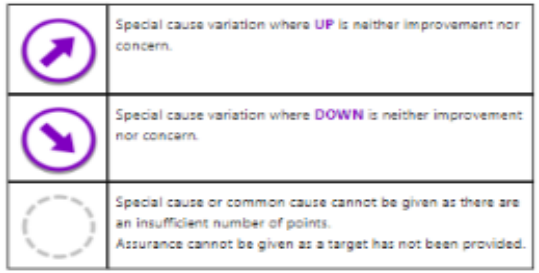
Orange icons indicate significant concern or high pressure.

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.

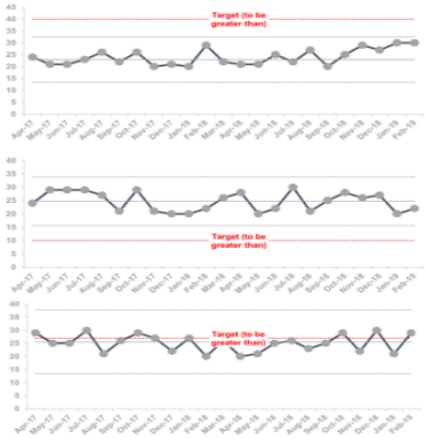
The centre line is the average value of all moving ranges.

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

2) Executive Summary

For the reporting month of April 2025, there are 3 indicators have an assurance rating of fail and a variation of special cause of a concerning nature.

This may mean 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.

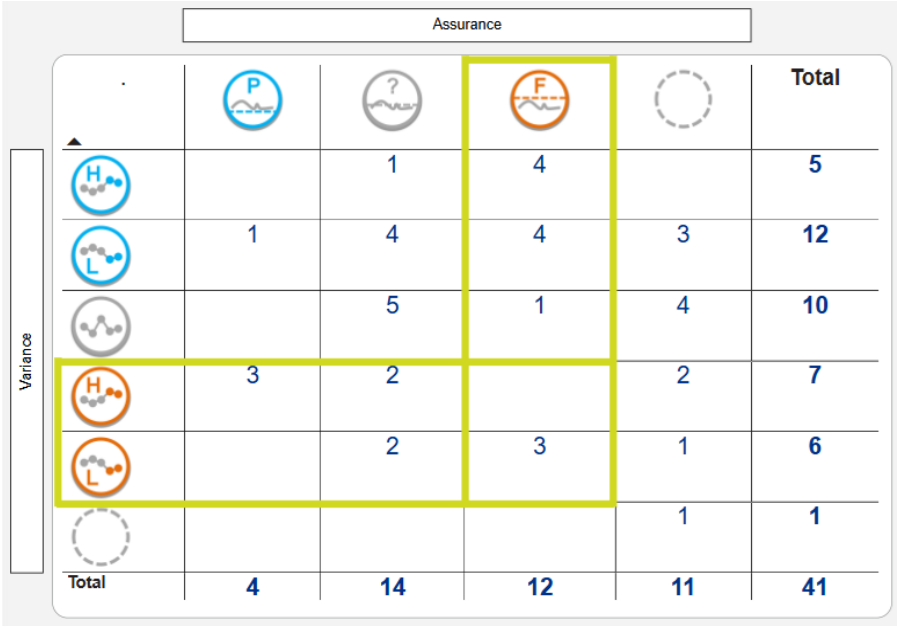
For the people dashboard, 1 metric has an assurance of fail and a variation of special cause of a concerning nature. Staff turnover and vacancy rate, both have a variation of special cause of an improving nature.

Finance has 4 metrics of assurance fail, 3 hit and miss and 1 that due to limited date points, no assurance either way, can be provided. The cash position has only been reported via the scorecard since December 2024.

Of the 13 quality metrics, 8 have an assurance rating of fail but 6 have a variation of special cause of an improving nature.

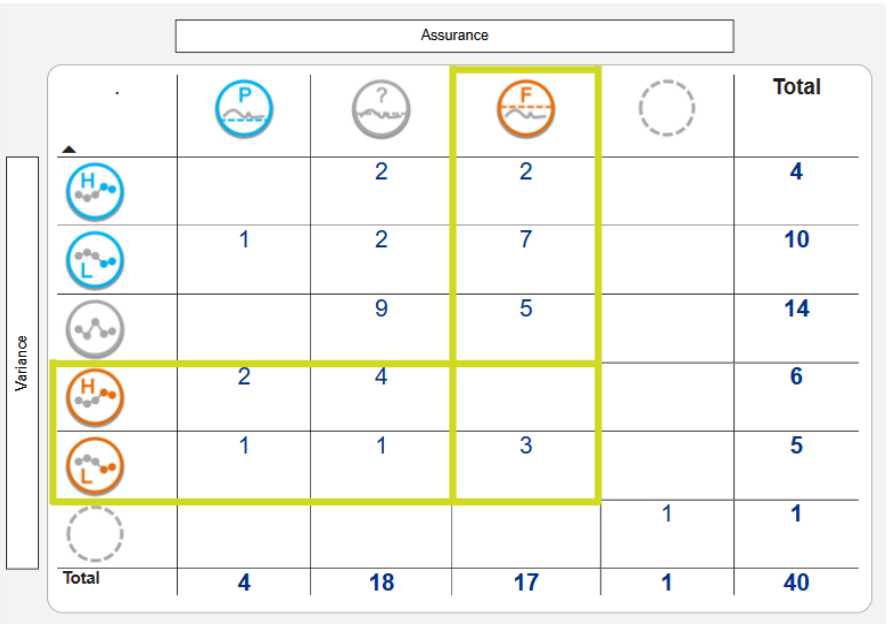
For performance, the dominate assurance rating is hit or miss, and 5 metrics have special cause variation of a concerning nature, 6 of common cause variation and 3 of an improving nature.

February 2025 data



Variance \ Assurance	P	?	F		Total
H		1	4		5
L	1	4	4	3	12
		5	1	4	10
H	3	2		2	7
L		2	3	1	6
				1	1
Total	4	14	12	11	41

April 2025 data



Variance \ Assurance	P	?	F		Total
H		2	2		4
L	1	2	7		10
		9	5		14
H	2	4			6
L	1	1	3		5
				1	1
Total	4	18	17	1	40

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	Apr-25	75.38%	90%	-14.62%	76.95%		75.38%		
Effectiveness	Inpatient - EDS % Available < 7 Days of Discharge	0 - Total	Apr-25	84.49%	100%	-15.51%	87.35%		84.49%		
Effectiveness	Inpatient - Emergency Re-Admissions % (1 month in arrears)	0 - Total	Mar-25	11.6%	13%	-1.40%	8.5%		11.6%		
Experience	Complaints - All Complaints Received	0 - Total	Apr-25	77	0	77.00	72.17		77		
Experience	Friends and Family - Overall % Recommendation Rate	0 - Total	Apr-25	99.04%	94%	5.04%	92.3%		99.04%		
Safety	Incidents - Confirmed Never Events	0 - Total	Apr-25	0	0	0.00	0.07		0		
Safety	Incidents - Falls Resulting in Severe Harm or Death by Incident Date	0 - Total	Apr-25	0	0	0.00	0.11		0		
Safety	Incidents - Medication Incidents by Incident Date	0 - Total	Apr-25	57	0	57.00	85.69		57		
Safety	Incidents - Pressure Ulcers Category 4 Hospital Acquired by Incident Date	0 - Total	Apr-25	0	0	0.00	0.1		0		
Safety	Incidents - Serious Incidents Investigated and Confirmed Avoidable by Pan...	0 - Total	Apr-25	0	0	0.00	0.38		0		
Safety	Infection Control - C-Diff Hospital Onset Healthcare Associated Cases	0 - Total	Apr-25	3	3	0.00	2.59		3		
Safety	Infection Control - Gram Negative Blood Stream Hospital Onset Infections	0 - Total	Apr-25	4	5	-1.00	2.9		4		
Safety	Inpatient - SHMI Value	0 - Total	Nov-24	1.07	1	0.07	1.13		1.07		

- Electronic Discharge Summary – Qi project being refreshed aiming to widen membership to join the resident doctors. Representation from pharmacy and AHPs now identified. Further work continues to include nurse specialists as well.

- Emergency readmissions – (data is 1 month in arrears) we remain below the upper threshold of 13%, however we note the upward trend reflective of activity during March.

- Standardised Hospital Mortality Index – (data is 6 months in arrears) continues to be a downward trend towards the target of 1. Mapping has occurred against new parameters and we remain in line with trajectory.

- Falls – There were no falls in April that resulted in severe harm or death.

- Medication incidents – the number of reported incidents has increased over recent months. This is evidence of a positive reporting culture as the vast majority have been near miss or no harm. We are working with the BI team to realign the SPC parameters

Baker, Abi
05/06/2025 15:15:16

Narrative provided by Louisa Way, Deputy 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	Apr-25	71.19%	75.07%	-3.88%	71.34%		71.19%		
Cancer	Cancer - 31 Day Decision to Treatment Standard Performance	0 - Total	Apr-25	93.4%	90.83%	2.57%	95.83%		93.4%		
Cancer	Cancer - 62 Day Referral to Treatment Standard Performance	0 - Total	Apr-25	78.57%	70.08%	8.49%	71.29%		78.57%		
Outpatient	RTT - 52+ Week Waits % of Waiting List	0 - Total	Apr-25	1.99%	2%	-0.01%	6.82%		1.99%		
Outpatient	RTT - Patients % Waiting < 18 Weeks	0 - Total	Apr-25	58.9%	58.7%	0.20%	55.95%		58.9%		
Outpatient	RTT - Patients % Waiting < 18 Weeks for First Activity	0 - Total	Apr-25	64.61%	63.13%	1.48%	62.15%		64.61%		
Outpatient	RTT - Waiting List Size	0 - Total	Apr-25	22486	21542	944.00	19923.58		22486		
UEC	ED - Ambulance Handovers Average (Minutes)	0 - Total	Apr-25	21.57	16.57	5.00	14.72		21.57		
UEC	ED - DCH 4 Hour Performance %	0 - Total	Apr-25	65.72%	65.98%	-0.26%	68.68%		65.72%		
UEC	ED - ED Attendances % Waiting 12+ Hours	0 - Total	Apr-25	6.71%	6.57%	0.14%	4.7%		6.71%		
UEC	ED - Overall 4 Hour Performance %	0 - Total	Apr-25	82%	78%	4.00%	81.69%		82%		
UEC	ED - Unplanned ED Attendances	0 - Total	Apr-25	4761	4644	117.00	4420.67		4761		
UEC	Inpatient - Adult General and Acute (G&A) % Bed Occupancy	0 - Total	Apr-25	97.5%	92%	5.50%	97.8%		97.5%		
UEC	Inpatient - Average Adult General and Acute (G&A) Bed Occupancy	0 - Total	Apr-25	306	312	-6.00	299.72		306		

For the reporting month of April 2025, 3 metrics had failed assurance, 9 were hit or miss and 1 were pass. All metrics have a target, which is included in the 2025/26 operating plan.

Cancer- Performance of the 28 days to diagnosis standard did not meet the target, with capacity shortfalls in Endoscopy and Breast. Recovery plans are in place for both, with Breast recovery possible in June. The FDS metrics has a variation of common cause and an assurance of hit or miss. The 31-day cancer indicator did not achieve the target, but the assurance rating has moved to being capable of consistently hitting the target. The trust did achieve the 62-day treatment standard with a variance of common cause and an assurance rating of hit or miss.

The waiting list size was larger than planned and has a variation of special cause of a concerning nature, but an assurance rating of pass. The waiting list size has been impacted by the reallocation of the validation team to support Ophthalmology, but this comes to an end at the end of May. The three waiting list performance metrics all have special cause of an improving nature, as all hit the

target, but an assurance rating of either fail or hit or miss. This is because the achievement of the percentage targets, was possible due to the larger than planned waiting list size (the denominator).

For all Urgent and Emergency Care (UEC) metrics, the assurance rating is hit or miss, apart from bed occupancy which is fail. Bed occupancy, 12-hour breaches and ambulance handover delays all missed the target and have a variation rating of special cause of a concerning nature. This is due to high levels of no reason to reside and as a result, length of stay is higher than plan. In turn, this impacts flow, which is why there are higher than planned, 12-hour breaches and longer to offload ambulances. Despite this, the 4-hour standard was met.

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	Apr-25	88%	90%	-2.00%	88.75%		88%		
Looking After our People	Appraisal rate	0 - Total	Apr-25	79.12%	90%	-10.88%	75.84%		79.12%		
Looking After our People	Sickness Rate (1 month in arrears)	0 - Total	Mar-25	4.29%	3.75%	0.54%	4.06%		4.29%		
Looking After our People	Staff Turnover Rate	0 - Total	Apr-25	9.49%	12%	-2.51%	9.67%		9.49%		
Looking After our People	Vacancy Rate	0 - Total	Apr-25	4.19%	5%	-0.81%	6.42%		4.19%		

- Essential skills rate improved to 88.75% and is now 2% below target
- Appraisal rate improved from to 77% at the last report, to 79.12%
- Vacancy rate increased from 3.1% to 4.19% and remains better than the target
- Turnover increased slightly to 9.49% from 9.3% and remains better than target
- Sickness rate reduced to 4.19% from 4.8%, and is better than the target

Essential skills increased from87% to 88.75%, 2% short of achieving the target. At present this is special cause variation of a concerning nature and an assurance rating of fail without process redesign. Recovery plans are underway in the five training elements where individual compliance is under 80%. The overall appraisal rate has improved, this remains common cause variation with no significant change. The assurance classification remains as fail, without process redesign. 80.5% of staff survey respondents stated that they had had an appraisal in the past 12 months, indicating that a small proportion of appraisals are not being recorded once completed. This is being investigated further. Feedback relating to the quality of appraisals remains good, both in the appraisee follow up survey and the relevant staff survey questions. Both the turnover and vacancy rates remain largely unchanged in month, these indicators remain special cause of an improving nature, with processes capable of consistently passing the target for turnover but hit or miss for vacancy rate. The overall sickness percentage decreased in month 10 (January) to 4.8% but remains above target, indicating special cause of a concerning nature, although the trend matches the usual seasonal pattern of absences. The rolling year sickness figure is 4.6%.

**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	Apr-25	1490	1324	166.00	1966.96		1490		
Capital	Cash Position	0 - Total	Apr-25	26395	17985	8,410.00	11190.54		26395		
Revenue	Adjusted Financial Position	0 - Total	Apr-25	2279	2323	-44.00	58.4		2279		
Sustainability	Local Supplier % of Catering Spend	0 - Total	Apr-25	17.32%	25%	-7.68%	21.92%		17.32%		
Sustainability	Local Supplier % of Total Spend	0 - Total	Apr-25	5.99%	30%	-24.01%	6.62%		5.99%		
Value Board	Agency Spend	0 - Total	Apr-25	365.26	464	-98.74	924.67		365.26		
Value Board	Efficiency Delivery	0 - Total	Apr-25	717	1029	-312.00	435.68		717		
Value Board	Off Framework Agency Spend	0 - Total	Apr-25	36	0	36.00	78.04		36		

- **Adjusted Financial Position (against control total)**
  £44k ahead of M1 plan - underspend see in non pay however not non recurrently released to CIP pending timing confirmation.

- **Agency Spend**
  Agency underspend vs plan of £99k - continued strong performance across nursing and medical spend down from prior months. Total agency as % of pay at 2.1% in month.

- **Off Framework Agency Spend**
  Off framework usage in SCBU and critical care - daily safe staff meeting to break glass in exceptional circumstances

- **Efficiency Delivery**
  KEY ACTION AREA. Undelivered must be recovered - detailed weekly reporting to JEMT and Value Delivery Board oversight with weekly support meetings in place with key areas.

- **Cash**
  Receipt of NR £13m NHSE funding plus careful cash management. Continued risk of cash shortfall expected to be challenging during H2 with system conversations ongoing.

- **Capital expenditure (total)**
  Ahead of plan timing of expenditure (digital and medical equipment replacement, along with stroke works design fees.

*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.

Dorset County Hospital
NHS Foundation Trust

Report to	DCH Board of Directors	
Date of Meeting	10th June 2025	
Report Title	DCH Finance Report – Month 1 2025/26	
Prepared By	Claire Abraham, Deputy CFO DCH	
Accountable Executive	Chris Hearn, Chief Finance Officer	
Previously Considered By	Finance and Performance Committee in Common	
Action Required	**Approval**	N
	Assurance	Y
	Information	N

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 £9.8 million deficit plan as part of the wider Dorset system break even plan to NHS England (NHSE) on 30th April 2025 for the financial year 2025/26.

Key Messages

Month one delivered a deficit of £2.279 million after technical adjustments, being £0.04 million better than plan of £2.323 million deficit.

Agency expenditure has continued at lower than budgeted levels, with total month spend of £0.365 million being £0.1m better than plan. This is an ongoing improvement area which is being extended to medical agency and also bank expenditure focus.
Increased bank usage has been seen in ED, Mary Anning and Ilchester wards, along with SCBU, Kingfisher and Theatres. Clinical coding and Estates and Facilities, in particular catering and security have also seen increased usage this month. Enhanced workforce controls are in the process of being determined to support pressures in bank overspends.
Break glass Off Framework expenditure is being incurred each month, with £0.03 million incurred in month one, with NHS England expecting nil Off Framework spend from July 2024.

The Trust wide efficiency target for the year stands at £29.1 million and is circa 8.7% of expenditure budgets in line with peers and national planning expectations.
As at month one, schemes identified stand at £24.5 million with £4.5 million of unidentified schemes. Within the identified schemes submitted to NHSE, 56% were classed as high risk at £16.4m (including unidentified value), £9.1m as medium risk being 31% and the remaining 12% classed as low risk at 12%.

Within the efficiency programme, £9m relates to pay schemes with associated 232 WTE associated reductions. Equality Impact Assessments (EQIA) review is required as part of each scheme within the programme and is overseen by the Chief Nursing Officer to ensure close scrutiny of these and all other relevant efficiency schemes to ensure no detrimental impact on quality and safety.

Month one efficiency has delivered £0.7 million (2%) being £0.3m away from the in month plan of £1m. Weekly meetings have been established for all areas off plan noting essential to remain on track for the year.
Efficiency delivery remains a significant challenge and key focus area for the Trust.

The cash position as at 30 April was £26.4million, £8.4 million ahead of plan. Improvement to cash levels are the result of; £3.0 million received from Dorset ICB relating to 2024/25 M12 system transactions, a timing benefit of £2.4m for Q1 Health Education Income paid in April and timing benefit on capital payments of £2.0 million. Cash remains a significant focus area for the Trust with daily monitoring in place for active mitigations where appropriate.

Cash remains a high risk area for the Trust with modelling indicating cash support will likely be required for the next financial year pending confirmation of the 2025/26 funding allocation confirmations.

The Trust is progressing with the capital programme for 2025/26 with month 1 spend totaling £1.5 million, which is ahead of plan by £0.2 million.
Externally funded projects are £0.05 million ahead of plan due timing of expenditure in the New Hospital Programme (NHP) construction works.
Included in the capital plan are bids that the Trust has made to NHS England for Critical Infrastructure (CIR) £2.7 million, Constitutional Standards Diagnostics £0.6 million, Constitutional Standards Elective £0.9 million and Constitutional Standards Urgent & Emergency Care £2.9 million.

The Trust is awaiting the outcome of the Critical Infrastructure Bids and is in the process of preparing and submitting business cases to NHS England for the Constitutional Standard Bids.

Whilst the Trust remained within the planned position for month one, there are a number of challenging areas which requires significant focus and active delivery to ensure the Trust remains on plan throughout the year. Further Executive led oversight is in place with active interventions to help ensure delivery of plans as the year progresses.

Recommendation

The Board is recommended to:

Receive the report for **assurance**

1) NOTE the month one financial position for the financial year 2025/26.

Dorset County Hospital
NHS Foundation Trust

Financial Position Update 2025/26

April 2025 - Month 1

Chris Hearn
Chief Financial Officer

Healthier lives Empowered citizens Thriving communities

Financial Position Update - April 2025

Executive Summary

A summary of progress is presented for the period of April 2025 and is compared with the plan submitted on 30th April 2025 to NHS England (NHSE) with a £9.8 million full year deficit plan submitted for the Trust as part of a wider break even position for the Dorset system.

In April 2025, Dorset County Hospital NHS Foundation Trust (DCHFT) has delivered a month 1 deficit of £2.279 million after technical adjustments, a favourable performance of £0.04 million against a plan of £2.323 million deficit.

DCH has achieved £0.7 million of the £1 million efficiencly target for month 1, with the remaining £0.3 million underspend driven by general supplies and consumbles.

The Trust wide efficiency target for the year stands at £29.1 million and is roughly 9% of expenditure budgets. While Exec led meetings are driving the efficiency schemes forward, £4.5m remains unidentfied. Of the £24.6 million of identified schemes, £10.2m are rated high risk and there is significant work being priotirised at pace to lower this risk and identify the remaining £4.5 million of savings needed to achieve the 2025/26 plan.

Agency expenditure has maintained a reduction against 2024/25 for M1 and is £100k below planned levels for April 2025. Medical agency reduction is a strong focus for the Trust alongside continued work on Nursing agency. Reduction in bank expenditure is also a key focus area nationally with Workforce engagement in place in this area to deliver enhanced controls across the Trust.

The Trust is progressing with the capital programme for 2025/26, month 1 YTD spend totaling £1.5 million, which is ahead of plan by £0.2 million. Externally funded projects are £0.05 million ahead of plan due timing of expenditure in the New Hospital Programme (NHP) construction works. Included in the capital plan are bids that the Trust has made to NHS England for Critical Infrastructure (CIR) £2.7 million, Constitutional Standards Diagnostics £0.6 million, Constitutional Standards Elective £0.9 million and Constitutional Standards Urgent & Emergency Care £2.9 million. The Trust is awaiting the outcome of the Critical Infrastructure Bids and is in the the process of preparing and submitting business cases to NHS England for the Constitutional Standard Bids.

The cash position as at 30 April was £26.4million, £8.4 million ahead of plan. Improvement to cash levels are the result of; £3.0 million received from Dorset ICB relating to 2024/25 M12 system transactions, a timing benefit of £2.4m for Q1 Health Education Income paid in April and timing benefit on capital payments of £2.0 million. Cash remains a significant focus area for the Trust with daily monitoring in place for active mitigations where appropriate.

Financial Position Update - April 2025

Key Risks

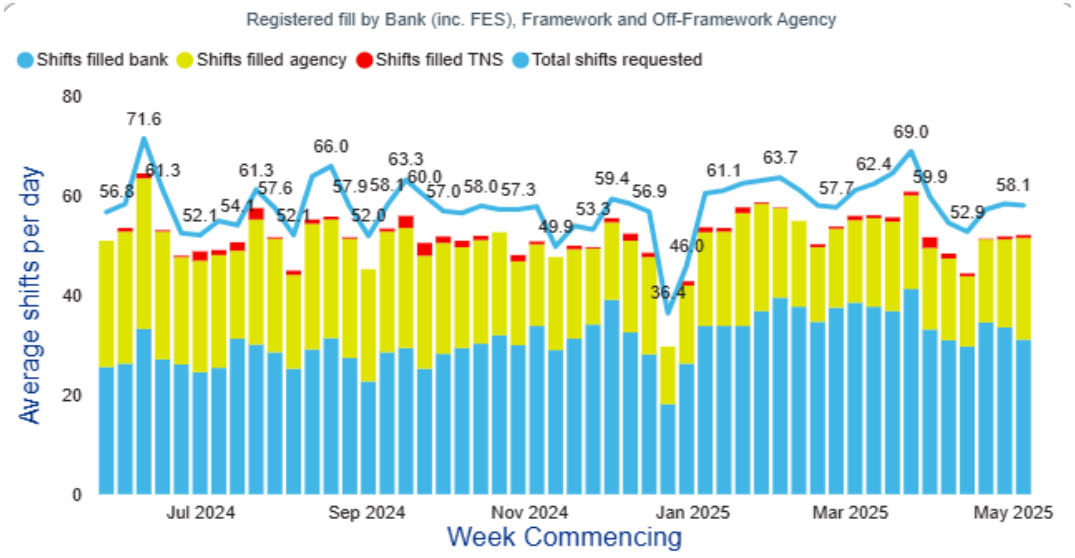
Dorset County Hospital
NHS Foundation Trust

Red Risks:

The Trust has an efficiency delivery requirement of £29.1 million in order to reach the planned full year break even position. Two nationally mandated schemes within this target are a 30% reduction in agency spend and a 10% reduction in Bank Spend. DCH have submitted a plan to meet this agency reduction ,and with an increased bank target of 20%.

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. Active plans in place as part of the internal High Cost Agency Reduction group, which was primarily focused on nursing in last financial year, but will now also focus largely on medical agency, are continuing to help prevent further deterioration of the position against plan. The table below shows registered nursing shift fill by bank, on framework agency and highest cost off framework agency. The Trust is beginning to increase bank usage whilst decrease agency usage (maintaining patient and staff safety and quality levels). Agency notice has now reduced to 48 hours in order for Bank Staff to access the shifts in the first instance. So far, this has not impacted fill rates.

Bank expenditure has deteriorated in month 1 due to continued approach to utilise bank before resorting to agency. Further work streams have been requested to ensure bank is utilised under the appropriate circumstances and effective Standing Operating Procedures are in place ahead of booking.



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.

Key Risks

Dorset County Hospital
NHS Foundation Trust

Red Risks:

Financial Forecast Risk

There is a risk of delivering the break even position due to the challenging financial envelopes and significant efficiency plans. The Trust is actively deploying targeted support towards acheivemeny, 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, bank and agency to the end of the financial year.

System Elective Services Recovery - income performance

The Elective Services Recovery Funding (ESRF) available to each Integrated Care Board (ICBs) has been included in contract envelopes for 2025/26. The financial year 2025/26 national target is to see a 27% reduction in the elective activity levels seen in 2024/25 and is consistent with the operational plan. While providers are technically still on full ERF contracts, NHSE has imposed ERF caps at ICB levels and so it is crucial the Trust work within these constraints to deliver our system position.

Activity levels will be monitored throughout the year to ensure the Trust stays in line with the operational plan.

Cash Position

There is a risk to cash levels throughout the year due to deficits in the first 9 months of the year and challenging efficiency targets. Detailed cashflow workings are in place to provide granular monitoring of cash levels and to give early indication of cashflow problems. While further discussions are ongoing to identify a longer term cash solution with System and Regional colleagues, there is no immediate short term risk, however Trust focus on careful cost controls and efficiency delivery is essential.

Dorset County Hospital
NHS Foundation Trust

Key Risks

Amber Risk:

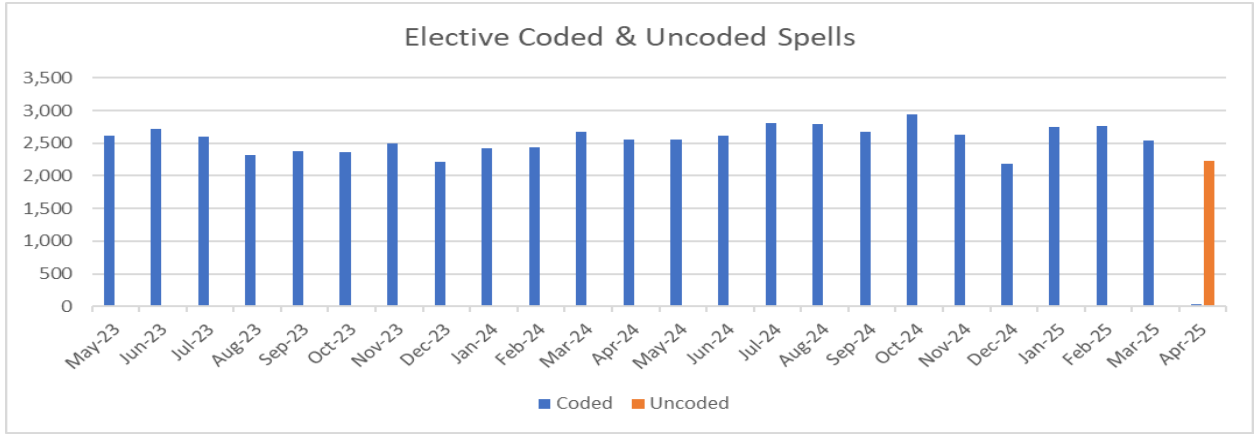
From 2023/24 NHS England introduced the Aligned Payment and Incentive (API) approach to all NHS standard contracts. This approach splits the payment mechanism for the majority of NHS contracts into two envelopes, Fixed and Variable.

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 April 2025 the Trust has 2,234 uncoded Elective Spells. 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.



Month	Flex	Freeze
Apr-25	20 May 25	18 Jun 25
May-25	18 Jun 25	17 Jul 25
Jun-25	17 Jul 25	19 Aug 25
Jul-25	19 Aug 25	17 Sep 25
Aug-25	17 Sep 25	17 Oct 25
Sep-25	17 Oct 25	19 Nov 25
Oct-25	19 Nov 25	16 Dec 25
Nov-25	16 Dec 25	20 Jan 26
Dec-25	20 Jan 26	18 Feb 26
Jan-26	18 Feb 26	18 Mar 26
Feb-26	18 Mar 26	21 Jan 26
Mar-26	21 Apr 26	20 May 26

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.

Healthier lives Empowered citizens Thriving communities

Financial Position Update - April 2025

Key Focus Actions

Dorset County Hospital
NHS Foundation Trust

'**Focus on delivery of existing plans – weekly focus and rigour**
- DCH Delivery Group being re-established at pace
- Essential not to lose pace on non pay & income efficiency delivery noting focuson pay elements
- Productivity analysis, development and embedding per efficiency scheme, utilising GIRFT, Model Hospital, relevant benchmarking
- Interdependencies required for all schemes to understand and prioritise resources effectively
- EEQIA focus linked to all relevant efficiency schemes

Close the unidentified gap
- Revisit all system workstreams clarity & pace, including unpalatables
- Consider bringing forward schemes at pace/acceleration
- NHSE challenge for pay to go further
- WF enhanced controls – essential (bank/rostering/job planning/targeted freeze or delays)
- Wider grip & control focus – controllable spend and overspending mitigations essential to remain in budget
- Critical not to lose sight of underlying recovery required

Dorset County - non delivery impact on cash shortfall H2 – essential Trust action required

Key KPIs for weekly reporting to JEMT/Delivery Group
- Activity key performance against plan - focus on escalated bed numbers
- Workforce performance against plan – WTE & £ reduction, focus on further controls implemented 25/26
- Efficiency delivery/unidentified – fully developed/plans in progress/opportunities/unidentified reporting
- Monthly financial performance vs plan & forecast trajectory
- Cash (noting daily cash reporting to CEO/CFO)

Financial Position Update - April 2025
Income & Expenditure

Dorset County Hospital
NHS Foundation Trust

Income and Expenditure

The overall revenue position of the Trust in Month 1 is a deficit of £2.279 million after technical adjustments, a favourable performance of £0.04 million against a plan of £2.323 million deficit.

The Trust has a challenging plan for 2025/26, including current CIP plans of c£29m (approx 9% of expenditure budgets). This includes mandated guidance on reducing Agency spend by a further 30%, Bank Spend by a further 10% with the Trust driving a further push to 20%, and with NHSE focused corporate cost savings of c.£3.5m.

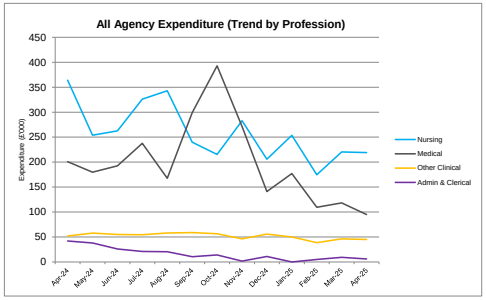
There also remains challenge around schemes not delivered in 2024/25, including WTE review and ongoing producitivy work which have been rolled forward to support delivery of 2025/26 plans.

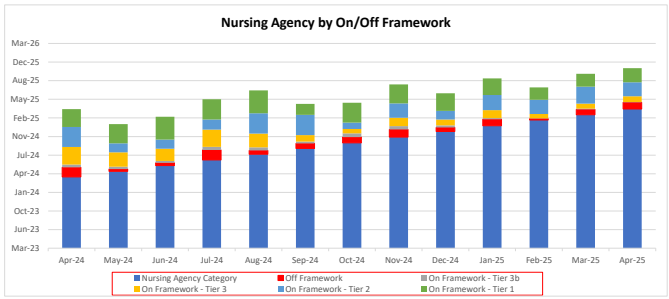
STATEMENT OF COMPREHENSIVE INCOME	In Month (£'000)			Year to Date (£'000)		
	Plan	Actual	Variance	Plan	Actual	Variance
Operating income from patient care activities	22,972	23,299	327	22,972	23,299	327
Private Patients	92	16	(76)	92	16	(76)
Other clinical revenue	2	(37)	(39)	2	(37)	(39)
Other non-clinical revenue	2,036	2,268	232	2,036	2,268	232
Operating Income	**25,102**	**25,546**	**444**	**25,102**	**25,546**	**444**
Total Income	**25,102**	**25,546**	**444**	**25,102**	**25,546**	**444**
Raw materials and consumables used	(4,501)	(4,577)	(76)	(4,501)	(4,577)	(76)
Employee benefit expenses:						
Substantive	(16,315)	(16,158)	157	(16,315)	(16,158)	157
Bank	(830)	(1,187)	(357)	(830)	(1,187)	(357)
Agency	(464)	(365)	99	(464)	(365)	99
Other operating expenses (excl. depreciation)	(3,834)	(4,078)	(244)	(3,834)	(4,078)	(244)
Operating Expenses	**(25,944)**	**(26,365)**	**(421)**	**(25,944)**	**(26,365)**	**(421)**
Profit/(loss) from Operations (EBITDA)	**(842)**	**(818)**	**24**	**(842)**	**(818)**	**24**
Other Non-Operating income (asset disposals)	0	0	0	0	0	0
Total Depreciation and Amortisation	(1,048)	(1,048)	0	(1,048)	(1,048)	0
PDC Dividend expense	(417)	(486)	(69)	(417)	(486)	(69)
Total finance income	50	141	91	50	141	91
Total interest expense	(61)	(64)	(3)	(61)	(64)	(3)
Total other finance costs	0	(0)	(0)	£0	(£0)	(0)
SURPLUS/ (DEFICIT)	**(2,318)**	**(2,275)**	**43**	**(2,318)**	**(2,275)**	**43**
Technical Items Adjusted for:						
Donations Non-Cash Assets	(5)	(39)	(39)	(5)	(39)	(40)
Depreciation Donated Assets	0	36	36	0	36	36
SURPLUS/ (DEFICIT)	**(2,323)**	**(2,279)**	**40**	**(2,323)**	**(2,279)**	**40**

Financial Position Update - April 2025
Trust Wide Performance: Agency

NHS
Dorset County Hospital
NHS Foundation Trust

Pay Analysis - Agency
Agency costs in month 1 were £0.365 million against a plan of £0.465 million. This is a further improvement against prior month spend and also April last year - where agency spend was reported at £0.659million. Current year plans include a further 30% reduction in agency spend from 2024/25 outturn (£6.5million). Meaning a reduction of nearly £2million across the year.
Although there is continued improvement in agency expenditure, Medical Agency spend is an area of focus to reduce spend, which is supported through the safer staffing and high cost agency working groups, along with system working groups. M1 has already seen an improvment in this area.





Agency Spend by Profession (£'000)	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
Nursing	364	254	263	326	343	240	215	283	206	254	175	220	219
Medical	201	180	193	238	167	299	393	271	141	177	110	118	95
Other Clinical	52	58	55	54	58	59	56	46	56	50	39	46	45
Admin & Clerical	42	38	26	21	21	10	14	2	11	0	5	9	6
Totals 2023/24 & 2024/25 YTD	**659**	**530**	**536**	**639**	**589**	**608**	**679**	**602**	**414**	**481**	**328**	**394**	**365**

YTD Actual	YTD Plan	Variance
219	223	4
95	206	111
45	35	-10
6	0	-6
365	**464**	**98**

Nursing Agency Category	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
Off Framework	52	12	15	54	20	27	31	41	21	35	7	29	36
On Framework - Tier 3b	15	13	10	17	17	10	20	18	12	6	2	4	2
On Framework - Tier 3	94	77	66	93	74	35	23	45	31	43	23	27	30
On Framework - Tier 2	107	48	49	54	109	108	34	77	46	81	77	92	75
On Framework - Tier 1	96	104	123	109	123	59	107	102	94	89	66	69	76
Plan	640	454	460	469	506	493	530	546	562	581	543	543	223
Orders awaiting allocation	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals 2024/25 & 2025/26 YTD	**364**	**254**	**263**	**326**	**343**	**240**	**215**	**283**	**206**	**254**	**175**	**220**	**219**

Pay Metrics	In Month Actual	YTD Actual
Agency expenditure as % of total pay	2.1%	2.1%
Off framework expenditure as % of total agency	9.8%	5.4%

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

Area	Off Framework	On Framework	of which: RNMH	Total Nursing Agency	%
Emergency Dept Main Dept	-	37		37	17%
SCBU	29	-		29	13%
Moreton Ward - Respiratory	-	20		20	9%
Ilchester Integrated Assessmen	-	17		17	8%
Day Surgery Unit	-	16		16	7%
Purbeck Wd	-	15	4	15	7%
Lulworth Ward	-	14		14	7%
Surge Area	-	13		13	6%
The Mary Anning Unit	-	9		9	4%
CRCU	7	2		9	4%
Ridgeway Wd	-	8		8	4%
Stroke Unit	-	7		7	3%
Fortuneswell Ward	-	7		7	3%
Abbotsbury Ward	-	5		5	2%
Kingfisher Ward	-	4	3	4	2%
Prince Of Wales	-	3		3	2%
Cardiology Care Ward	-	3		3	2%
Frailty SDEC	-	2		2	1%
Paediatric DSU	-	0		1	0%
Total Nursing Agency YTD	**36**	**184**	**7**	**219**	

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Financial Position Update - April 2025

Insourcing

NHS
Dorset County Hospital
NHS Foundation Trust

Insourcing Narrative
The insourcing budget of £8.0 million is planned to provide insourcing activity set as presented to Committee during the 2025/26 planning round. Currently the forecast trajectory shows total spend of £7.9m which is £0.1m improvement on plan to deliver 65 week wait activity and Elective Recovery activity. The Trust is required to achieve an activity reduction of 27% against elective activity levels achieved in 2024/25 to align to funding envelopes available.

	Actual	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast		Forecast
	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD	Outturn
Budget:	**658**	**679**	**658**	**679**	**679**	**658**	**679**	**658**	**679**	**679**	**616**	**679**	**658**	**8,000**
Spend:														
Breast	13	0	0	13	0	0	13	0	0	13	0	0	13	**52**
Dermatology	144	118	118	118	118	118	118	118	118	118	118	118	144	**1,447**
Endoscopy/Gastro	131	107	107	107	107	107	107	107	107	107	107	107	131	**1,310**
ENT	91	50	50	50	50	50	50	50	50	50	50	50	91	**642**
General Surgery	6	6	6	6	6	6	6	6	6	6	6	6	6	**69**
Gynaecology	29	29	29	29	29	29	48	48	48	48	48	48	29	**464**
OMF	147	106	120	84	84	103	84	84	103	84	84	103	147	**1,184**
Ophthalmology	25	54	37	37	37	37	52	52	52	52	52	52	25	**540**
Orthopaedics	83	83	83	83	83	83	83	83	83	83	83	83	83	**999**
Urology	11	11	11	11	11	11	11	11	11	11	11	11	11	**138**
Theatre Staffing	0	177	89	89	89	89	89	89	89	89	89	89	0	**1,063**
Total spend	**680**	**743**	**652**	**628**	**615**	**634**	**662**	**649**	**668**	**662**	**649**	**668**	**680**	**7,909**
Surplus/(Deficit)	**(23)**	**(63)**	**6**	**51**	**64**	**24**	**17**	**9**	**11**	**17**	**(34)**	**11**	**(23)**	**91**

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Financial Position Update - April 2025
Sustainability & Efficiency

NHS
Dorset County Hospital
NHS Foundation Trust

Efficiency & Sustainability Programme Update

The annual efficiency target for the Trust is £29.1 million, made up of the following elements:
- 5% core annual requirement £18.1 million
- 3% central stretch linked to 2024/25 non-recurrent CIP £7.9 million
- 1% System stretch £3.1 million

In month delivery of c£0.7 million has been achieved, delivered from agency cost reduction of Off Framework and the remainder largely from COVID and finance income and workforce pay savings. This is £0.3 million behind plan.

While £24.6 million of CIP plans have been identified, further schemes of £4.5 million remain unidentified. In addition to the £4.5 million unidentified a further £11.9 million of the identified schemes are highlighted as high risk, bringing total high risk schemes to £16.4 million (56%). Further work is ongoing led by Exec's to progress at-risk schemes, find plans to address the full £29.1 million requirement and complete development of identified projects.

EEQIA monitoring has been established led by the CNO and is required for all relevant schemes with careful assessment in place alongside the overall efficiency programme.

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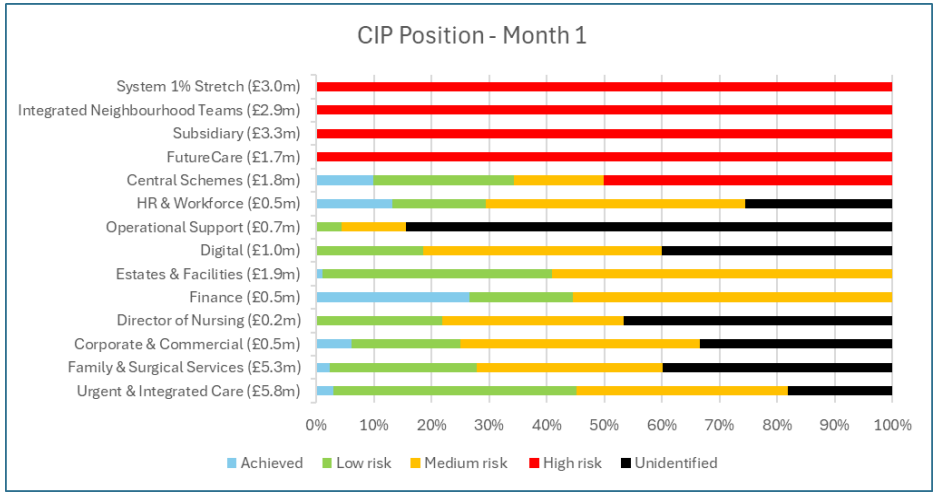
Area	Operating Expenditure £'000	Corporate Stretch to 10% £'000	Total 2025/26 Efficiency Target £'000	Identified £'000	Pay specific Indicative Targets £'000	Total Identified £'000	Unidentified £'000	Delivered £'000
Core main - 5%								
Urgent & Integrated Care	5,757	-	5,757	1,482	2,757	4,239	1,518	171
Family & Surgical Services	5,347	-	5,347	322	2,390	2,712	2,635	121
Corporate & Commercial	277	183	460	-	298	298	162	28
Director of Nursing	117	117	234	-	74	74	160	-
Finance	244	244	488	267	220	487	1	130
Estates & Facilities	942	905	1,847	1,078	769	1,847	-	21
Digital	518	471	989	163	409	572	417	-
Operational Support	673	-	673	-	74	74	599	-
HR & Workforce	304	208	512	68	230	298	214	68
NR slippage	-	-	-	1,164	-	1,164	- 1,164	-
Central Schemes	-	-	1,796	1,796	-	1,796	-	177
	14,179	**2,128**	**18,103**	**6,340**	**7,221**	**13,561**	**4,542**	**716**
Central NR stretch - 3%								
FutureCare - pending detailled modelling			1,700	-	1,700	1,700	-	-
Subsidiary - indicative FYE			3,300	3,300	-	3,300	-	-
Integrated Neighbourhood Teams - indicative TBC			2,900	2,900	-	2,900	-	-
	-	**-**	**7,900**	**6,200**	**1,700**	**7,900**	**-**	**-**
System Stretch - 1%								
System - WorkStream 4 - RMC			1,300	1,300	-	1,300	-	-
System - WorkStream 4 - Revisit unpalatable list			100	100	-	100	-	-
System - WorkStream 4 - Commissioning for sustainability			600	600	-	600	-	-
System - WorkStream 4 - Virtual wards			200	200	-	200	-	-
System - WorkStream 4 - Balance sheet release			370	-	370	370	-	-
System - WorkStream 4 - system transformation/technical adjustments			500	500	-	500	-	-
	-	**-**	**3,070**	**2,700**	**370**	**3,070**	**-**	**-**
Totals	**14,179**	**2,128**	**29,073**	**15,240**	**9,291**	**24,531**	**4,542**	**716**

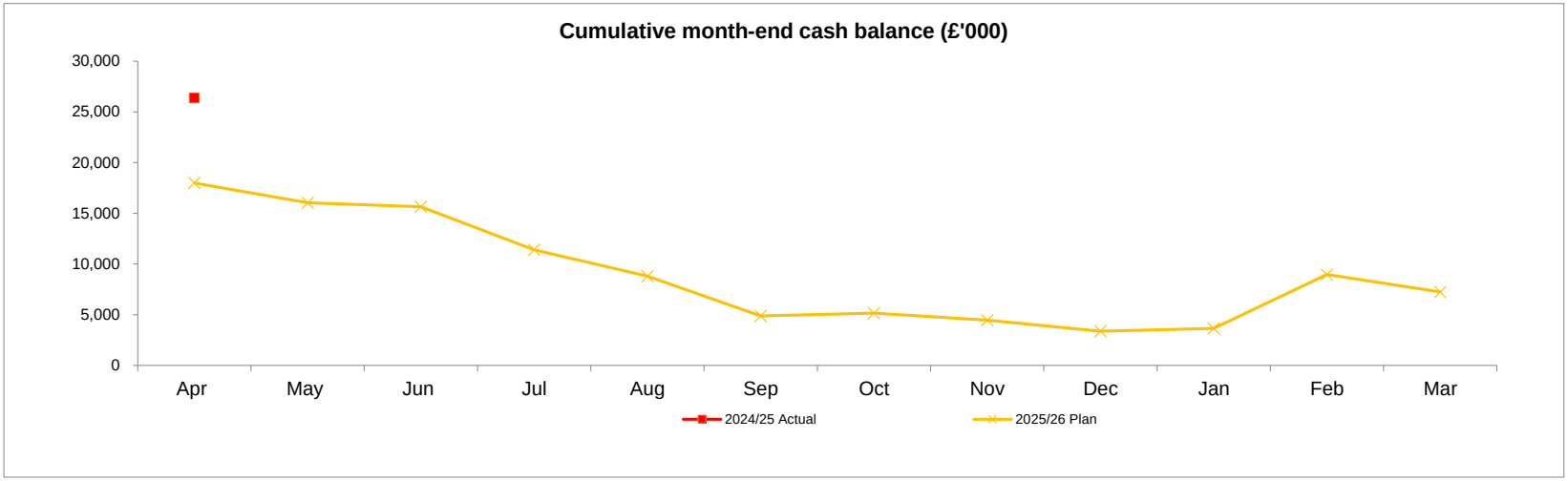


Cost Avoidance Schemes	£ Avoidance YTD
Family & Surgical Services	**-**
Income - Non-Patient Care	-
Pay - Agency	
Pay - Establishment reviews	
Urgent & Integrated Care	**-**
Income - Non-Patient Care	
Non-Pay - Procurement	
Pay - Agency	
Admissions Avoidance	
Pay - Establishment reviews	-
Grand Total	**-**

Financial Position Update - April 2025

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 £26.4 million at end of April, which is ahead of forecasted position of £18.0 million, improvements to the cash position are the result of: -additional income of £3.0 million received from Dorset ICB relating to 2024/25 M12 system transaction. -timing benefit of £2.4m for Q1 Health Education Income paid in April. -timing benefit on capital payments of £2.0 million which will catch up in future months. While the Trust currently has a healthy cash level, there is still a risk to cash flows in 2025/26 as a result of planned deficits in the first 9 months of the year totalling £18.1 million and a challenging CIP programme of £29.1 million of which any to delay of monthly targets will further negatively impact cash. The Trust is continuing to carefully monitor cash inflows and outflows through regularly updating and reviewing the cashflow forecast. System colleagues are being kept up to date and aware of the potential risk.



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
2025/26 Plan	17,985	16,046	15,653	11,395	8,809	4,873	5,152	4,450	3,372	3,656	8,967	7,237
2024/25 Actual	26,395											

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Financial Position Update - April 2025

Capital

NHS
Dorset County Hospital
NHS Foundation Trust

Capital Programme Narrative

Capital expenditure year to date to the end of April was £1.5 million and behind plan by £1.3 million.

Internally Funded schemes and donated schemes are overall ahead of plan at the end of April by £0.1 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 Stroke Unit works design fees and timing of expenditure on other schemes.

Externally Funded capital expenditure was £0.05m ahead of plan due to timings of expenditure on New Hospital Programme (NHP) construction works.

Included within the capital plan are bids that the Trust have submitted to NHS England for the the following:
- CIR external capital funding including the Generator totalling £2.7 million.
- Constitutional Standards Diagnostics external capital funding £0.6 million.
- Constitutional Standards Elective external funding of £0.9 million.
- Constitutional Standards UEC (including Stroke Unit and ED Walk-in/UTC configuration) external funding of £2.9 million.

The Trust is awaiting the outcome of the Critical Infrastructure Bids (CIR) and is in the process of preparing and submitting business cases for the Consitutional Stadnards Bids to NHS England.

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CAPITAL	CURRENT MONTH			YEAR TO DATE			FULL YEAR 2025/26			
	Plan	Actual	Variance	Plan	Actual	Variance	Committed Spend	Forecast	Annual Plan	Variance
Estates	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Generator	-	-	-	-	-	-	-	800	800	-
High Acute Stroke Unit (HASU)	50	91	-41	50	91	-41	91	757	757	-
Estates Schemes	70	166	-96	70	166	-96	669	1,111	1,111	-
Digital Services										
EHR Matched Funding	-	-	-	-	-	-	-	1,781	1,781	-
IT Schemes	124	105	19	124	105	19	1,116	1,219	1,219	-
Equipment										
Other Equipment	-	-	-	-	-	-	20	1,557	1,557	-
Sub-Total Internally Funded Expenditure	**244**	**362**	**-118**	**244**	**362**	**-118**	**1,896**	**7,225**	**7,225**	**-**
Donated										
Other Donations	-	-	-	-	-	-	-	-	-	-
Chemotherapy Unit Refurbishment	40	40	-	40	40	-	480	480	480	-
Sub-Total Planned Donated Expenditure	**40**	**40**	**-**	**40**	**40**	**-**	**480**	**480**	**480**	**-**
IFRS 16 Lease Additions										
Admin Offices	-	-	-	-	-	-	-	1,500	1,500	-
MSCP Lease remeasurement	-	-	-	-	-	-	-	500	500	-
CEF Lease remeasurement	-	-	-	-	-	-	-	400	400	-
One Dorset Pathology	-	-	-	-	-	-	-	750	750	-
Other Leases	-	-	-	-	-	-	-	600	600	-
Accommodation & Vehicle Lease Additions	-	-	-	-	-	-	-	382	382	-
Sub-Total Planned IFRS 16 Expenditure	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**4,132**	**4,132**	**-**
Total Internal & Leased Capital Expenditure	**284**	**402**	**-118**	**284**	**402**	**-118**	**2,376**	**11,837**	**11,837**	**-**
Additional funded schemes										
NHP Works	1,000	1,045	-45	1,000	1,045	-45	27,789	27,789	27,789	-
Digital EHR Funding	40	43	-3	40	43	-3	457	5,482	5,482	-
CIR Funding - Generator	-	-	-	-	-	-	-	1,800	1,800	-
CIR Funding - Renal OP Unit	-	-	-	-	-	-	-	600	600	-
CIR Funding - SSD Plant	-	-	-	-	-	-	-	302	302	-
Constitutional Standards - Diagnostics	-	-	-	-	-	-	-	550	550	-
Constitutional Standards - Elective	-	-	-	-	-	-	-	869	869	-
Constitutional Standards - UEC	-	-	-	-	-	-	-	2,850	2,850	-
Total Externally Funded Capital Expenditure	**1,040**	**1,088**	**-48**	**1,040**	**1,088**	**-48**	**28,246**	**40,242**	**40,242**	**-**
Total Capital Expenditure	**1,324**	**1,490**	**-166**	**1,324**	**1,490**	**-166**	**30,622**	**52,079**	**52,079**	**-**
Expenditure as a % of Plan			113%			113%				100%

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Dorset County Hospital
Dorset HealthCare

People and Culture Committee in Common Assurance Report for the meeting held on Wednesday 28 May 2025

Chair	Margaret Blankson (Deputy chair)
Executive Lead	Nicola Plumb, Joint Chief People 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	• Review of the Board Assurance Framework and Corporate Risk Register, as detailed below • Workforce resourcing issues within the wellbeing team were affecting the delivery of the plan • Joint Strategy Enabling Plan – People Plan. The plan was approved, but the delivery framework (appendix 1) required further development and would be returned to the next formal meeting. • Freedom to Speak Up reports for Board consideration • Guardian of Safe Working reports for Board consideration
Key issues / matters discussed at the meeting	The committee received, discussed and noted the following reports: **Board Assurance Framework (DCH/DHC)** No proposed changes to scores. Some actions outstanding but the reports detailed why, and plans were in place to address these. **Corporate Risk Register (DCH/DHC)** Dorset County Hospital: • Noting the risks arising from the closure of the maternity services at Yeovil District Hospital and the options for secondment for Yeovil staff Dorset Healthcare: • 11 risks overdue for review – this is an area that needs additional focus to ensure is up to date • Discussion re reduction of score for risk 1983 regarding risk of identity fraud due to improved mitigations **Workforce KPI Dashboard (Joint)** • Discussion re alignment of the metrics within the KPI dashboard Dorset County Hospital: • Broadly positive metrics. Quality impact assessments were undertaken to assess the impact of any held vacancies. • Increase in the use of the employee assistance programme, expected to be linked to the whole-time equivalent reduction requirements. • Whole-time equivalent reduction requirements were the area of biggest challenge at present. Discussion around the services from which those reductions were coming. Dorset Healthcare: • A steady picture in key people metrics

- Discussion around the increase in March and then decrease in April of staff turnover. This was not felt to be a cause for concern.
- Discussion around the impact of uncertainty within the NHS on staff mental health

Health and Wellbeing Action Plan (Joint)

- Majority of actions were complete or were now business as usual.
- Workforce resourcing issues within the wellbeing team were affecting the delivery of the plan
- Recognition of the need to align and work together the health and wellbeing teams and provision across the two trusts

People Promise Final Report (Joint) providing an update on the final position of the People Promise Programme, which had now ended, and the recommendations from the programme. The impact of the work was noted and thanks extended to the People Promise team.

Joint Strategy Enabling Plan – People Plan (Joint) detailing the development and alignment in the plan between the key strategic goals and the identified priorities. 11 breakthrough objectives were identified but specific timeframes for delivery of objectives was yet to be determined. The plan was felt to be ambitious, but achievable. The plan was approved, but the delivery framework (appendix 1) required further development in terms of timelines and would be returned to the next formal meeting.

Headcount Reduction (Joint): Thorough discussion around the final position for 2024/25 with further clarity needed about these figures; these would be circulated after the meeting.
For 2025/26 the agreed plans were:

- DCH to reduce headcount by 232.5 whole-time equivalents, equating to £8.9m savings.
- DHC to reduce headcount by 411 whole-time equivalents, equating to £14.5m savings.
- These reductions would come from substantive, agency, and bank staff
- The committee would play a key role in holding executives to account for the delivery of those plans

Freedom to Speak Up Guardian Report (DCH/DHC)

- Manager capability and workplan relationships were two of the highest areas of concerns re behaviours, attitudes and implementing a just and learning culture.

Dorset County Hospital:

- A higher report rate than similar sized trusts - felt to be indicative of a positive reporting culture.

Dorset Healthcare:

- Admin/clerical were currently the highest reporters. This was previously nurses. There was no clear reason for this change.

Quarterly Guardian of Safe Working Reports (DCH/DHC)
Dorset County Hospital:

- Annual report showing an increase in exception reporting, again indicating a positive reporting culture. An update on the action relating to trauma and orthopaedics Is provided in the report.

Dorset Healthcare:

- No increase In exception reporting and no areas of concern identified.

Cultural Maturity Internal Audit Report (DCH/DHC)

- Overall positive reports, highlighting a number of strengths for both trusts. Recommendations were either completed or were in progress or not accepted.

Maternity – Multiprofessional Training Report (DCH)

- Discussed at Quality Committee in Common with a good level of scrutiny, presented to People and Culture Committee In Common. Noted without discussion.

Committee Effectiveness Evaluation (Joint)

- Committee has discharged responsibilities and met terms of reference. Positive comments re committee, with some actions to develop the committee further.

Development of Culture and Inclusion Reference Group (Joint)

- Due to time constraints approval of the groups would be managed outside of the meeting by email.

Assurance reports from below sub-groups of the People and Culture Committee in Common

DCH:

- Partnership Forum
- Equality, Diversity, Inclusion and Belonging Steering Group
- Local Negotiating Committee
- Health and Wellbeing Steering Group

DHC:

- Equality, Diversity, Inclusion and Belonging Steering Group
- Trade Union Partnership Forum

Decisions made at the meeting

- Approval of the Joint Strategy Enabling Plans – People Plan. The development framework would be returned to committee for approval at a later date.
- Approval of the committee terms of reference
- Approval of the committee workplan

Issues / actions referred to other committees / groups

- Nil

Quoracy and Attendance						
	28 May 2025	28 Jul 2025	22 Sep 2025	24 Nov 2025	26 Jan 2026	23 Mar 2026
Quorate?	Y					
Frances West	A					

Suresh Ariaratnam	Y					
Margaret Blankson	Y					
Dawn Dawson	Y					
Eiri Jones	Y					
Lucy Knight	Y					
Nicola Plumb	A					
Rachel Wharton	A					

Report to	DCH Board of Directors, part 1	
Date of Meeting	10th June 2025	
Report Title	Joint People Plan 2025-28	
Prepared By	Catherine Granville, Deputy Chief People Officer (DHC)	
Accountable Executive	Nicola Plumb, Joint Chief People Officer	
Previously Considered By	People and Culture Committee 28/5/25	
Action Required	**Approval**	Y
	Assurance	N
	Information	N

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	SR2 and SR3	
Financial	No implication	
Statutory & Regulatory	No implication	
Equality, Diversity & Inclusion	The People Plan sets out our commitment to ensuring we embed a compassionate, inclusive and fair culture and working environment across both trusts.	
Co-production & Partnership	Extensive engagement with key stakeholders informed the development of the People Plan.	

Executive Summary

The People Plan was presented to the People and Culture Committee in Common on 28 May 2025 and was approved. The Committee have requested a more detailed timeline for the delivery framework and this will be presented back to Committee in July for assurance.

The Committee commented that the Plan was ambitious given the 12-18 month timeframe on delivery of priorities. It also noted the focus on workforce planning and the wider strategic benefits this can bring. The Committee also commented on the importance of recognising the disparity of experience between different staff groups.

This Joint People Plan 2025-8 forms one of five that support our joint strategy, **Working Together, Improving Lives.**

As well as supporting the other four enabling plans, the Joint People Plan works specifically towards the 'Colleagues' objective in the joint strategy, which aims to ensure:

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

Recognising that changes within the NHS nationally, regionally and locally are happening at pace, we have set 12-18 month priorities and will review these in the autumn alongside our monitoring arrangements. This approach allows us to be agile in a quickly changing environment and are focused on building and strengthening our core:

- Improve wellbeing, belonging and inclusion at work
- Grow the capability and confidence of our managers and leaders
- Ensure sustained high quality workforce planning and development to support transformational service change
- Deliver high quality people services with better use of digital and AI

We aim for this plan to be highly adaptable, ensuring responsiveness to evolving operational demands and emerging staffing models. While our focus remains on the three core objectives outlined in the joint strategy, we will continuously assess progress over years 1–3. Additionally, we will actively engage with colleagues to gather further input, ensuring the plan remains relevant and effective.

Recommendation

Board is requested to:

- **Approve** the People Plan

Dorset County Hospital
Dorset HealthCare

NHS

Joint People Plan

2025-2028

Healthier lives Empowered citizens Thriving communities

Contents

1 Foreword

We are pleased to introduce our first Joint People Plan for Dorset County Hospital and Dorset HealthCare. As federated NHS trusts collaborating closely with our health and care partners across Dorset, this plan outlines clear goals and shared ambitions that we can accomplish together.

At the heart of this Joint People Plan is the belief that our staff are central to everything we do. Their motivation, wellbeing, development, and sense of belonging are key to delivering high quality care. By fostering an environment where staff feel valued, we actively support healthier lives, empowered citizens and thriving communities.

With a challenging financial landscape and the increasing demand for our services, we recognise the importance of supporting workforce transformation to meet evolving healthcare demands. Through the development of joint services, we are building a resilient, collaborative workforce that can respond effectively to the challenges ahead.

This plan reflects our collective goal to improve the experience of those who work for us, in all their varied roles, and to foster a culture where every staff member feels they belong, can develop and achieve their potential.

Nicola Plumb
Joint Chief People Officer

2 Context

1.1 National picture

The NHS Long Term Workforce Plan is about empowering staff to thrive, knowing they are valued and supported to deliver exceptional care. It champions wellbeing, growth, innovation, and an inclusive culture.

The NHS People Promise was launched in 2020. Designed with thousands of NHS staff, it makes seven commitments to improving staff experience that in turn improve our retention, productivity and patient safety. In 2024/25 our two trusts were asked to be part of the second wave of People Promise exemplar sites, with additional investment to embed the promise and make it a lived reality for our colleagues. We made significant progress across a range of interventions and we are committed to continuing the legacy of this work as an essential component of being the modern, inclusive and compassionate employers we want to be.

1.2 Dorset picture

We are committed to the Dorset Integrated Care System (ICS) People Plan, which sets out our shared aims to recruit, develop and support staff, creating workplaces where wellbeing, inclusivity, and digital innovation drive outstanding care for the community.

The plan has the vision of: One Dorset workforce delivering the best possible improvements in health and wellbeing.

Together we are developing a workforce that feels looked after, valued and respected, and is reflective of our communities. We want compassionate leaders and opportunities for colleagues to learn, develop and build life-long careers with us.

We want a workforce that can respond to the future needs of our communities, informed through new models of care, population health management and digital innovations that will deliver the priorities of the Integrated Care Partnership (ICP) Strategy.

At the time of writing, we know the NHS organisational landscape is significantly changing and we will continue to contribute to our local partnerships and to evolve this plan accordingly.

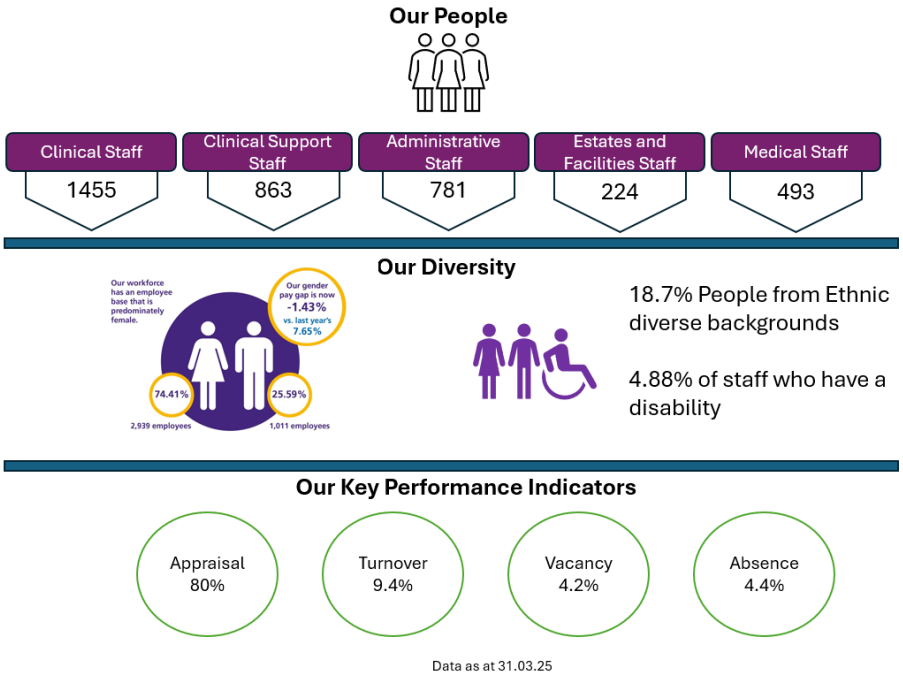
1.3 Our trusts

Our joint strategy Working together, improving lives has more information about our trusts, the communities we serve and our vision for the future. It articulates our joint strategic objectives and sets out how our enabling plans provide a route map to the future. In this plan we focus on our workforce at the most macro level, recognising that more detailed supporting plans, such as our Joint Equality and Inclusion Strategy, provide deeper insights and understanding about our workforce.

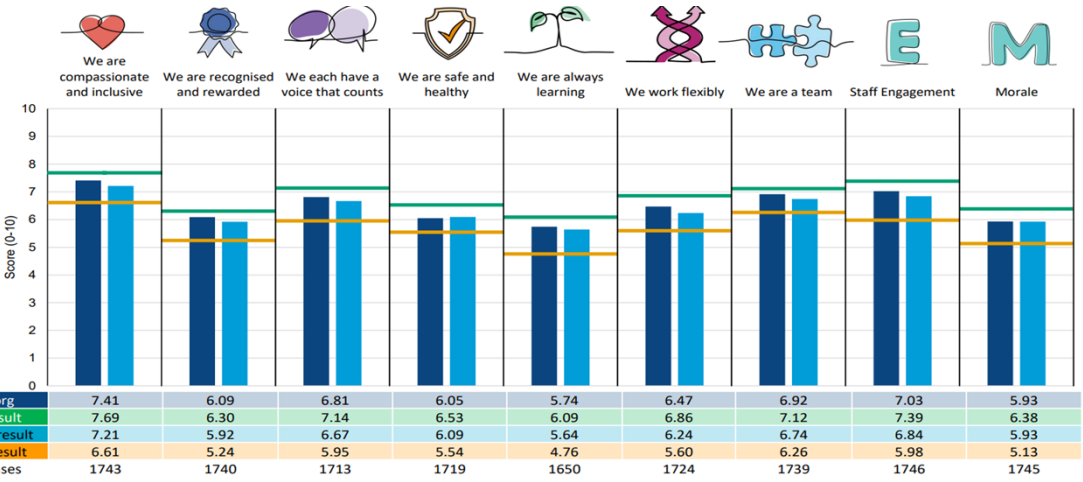
Between Dorset HealthCare (DHC) and Dorset County Hospital (DCH), we employ more than 10,000 staff and have reliable, experienced bank worker arrangements - together they provide a workforce with a wealth of knowledge and expertise. This Joint People Plan is an opportunity to increase the resilience and sustainability of our workforce and to align our resources around common objectives, so that we are fit for now and for the future, and an employer of choice.

1.3.1 Dorset County Hospital

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



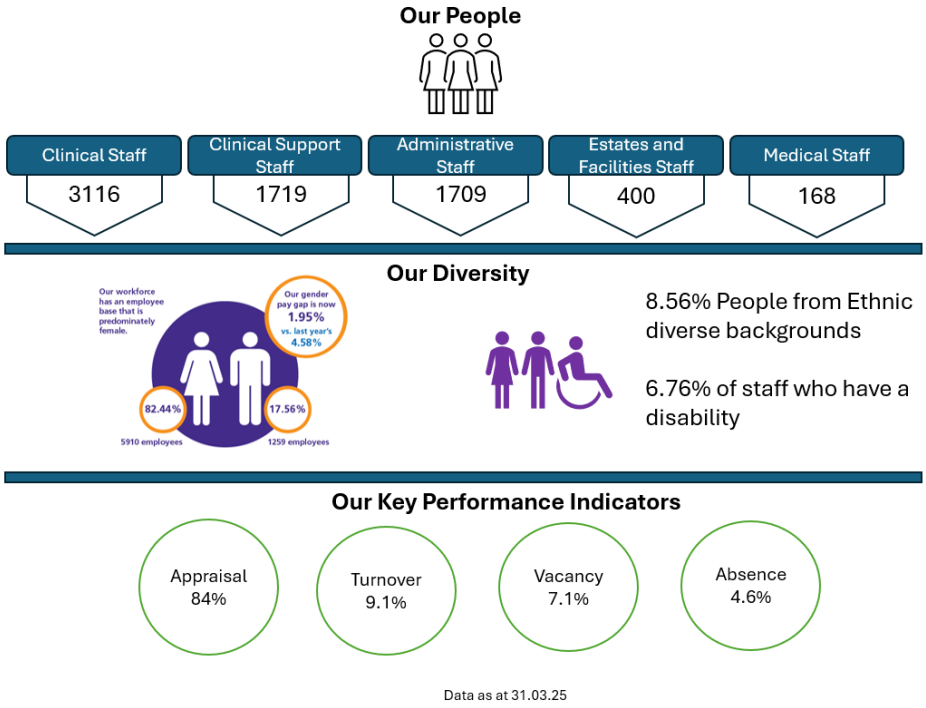
In the 2024 NHS National Staff Survey, more respondents than before reported that they would recommend DCH as a place to work. DCH scored higher than its benchmark group average in 5 of the 7 People Promise elements and the same in one. For the final element – we are safe and healthy – its score was just below the benchmark group average indicating an area for additional focus. Our response rate increased by 5.4% on the previous year and DCH remained above the average for the morale and staff engagement scores. Alongside steady decreases in turnover and sickness absence over the past 12 months, and a significant reduction in agency use, this gives us a stable foundation from which to implement this strategic plan.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.41	6.09	6.81	6.05	5.74	6.47	6.92	7.03	5.93
Best result	7.69	6.30	7.14	6.53	6.09	6.86	7.12	7.39	6.38
Average result	7.21	5.92	6.67	6.09	5.64	6.24	6.74	6.84	5.93
Worst result	6.61	5.24	5.95	5.54	4.76	5.60	6.26	5.98	5.13
Responses	1743	1740	1713	1719	1650	1724	1739	1746	1745

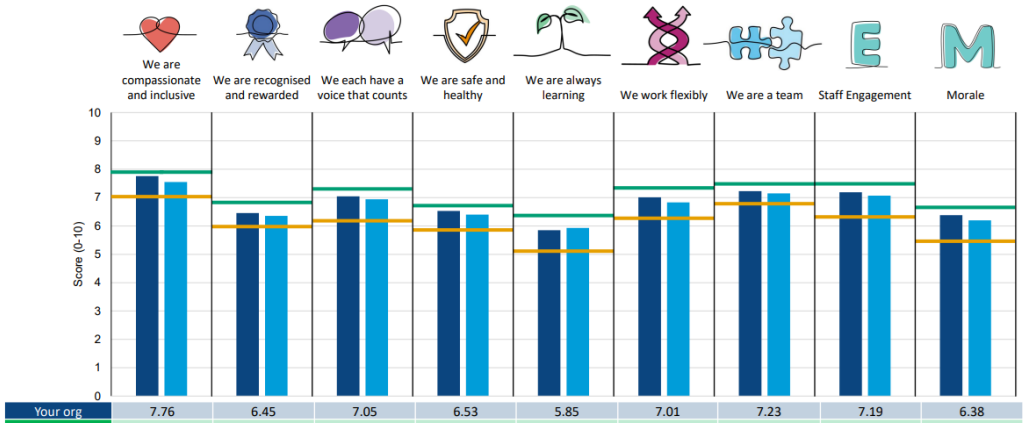
1.3.2 Dorset HealthCare

DHC employs around 7,000 staff with a wide range of expertise and specialisms. They deliver healthcare at over 300 sites, including mental health inpatient hospitals, community hospitals, GP surgeries, village halls, schools, care homes and people's own homes.



Data as at 31.03.25

In the 2024 NHS National Staff Survey, DHC held steady on previous years with small changes in scores. DHC scored higher than the benchmark group average in 6 of the 7 People Promise elements. For the final element – we are always learning – DHC was below the benchmark group average, which was a reflection of comments about appraisal, something already addressed through a new approach to appraisal launched in Spring 2025. A reduction in the overall staff survey response rate of 3% is cause for concern and a continuation of a trend for the past five years. Despite this, DHC scored above the average for both the morale and staff engagement scores, although the latter was down on the 2023 figure. Similar to DCH, there is a stable foundation from which to launch this plan, with steady improvements in turnover, sickness absence and retention figures through the past 12 months and successful recruitment to some of the harder vacancies to fill.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.76	6.45	7.05	6.53	5.85	7.01	7.23	7.19	6.38
Best result	7.90	6.83	7.31	6.72	6.37	7.34	7.48	7.49	6.66
Average result	7.55	6.35	6.94	6.40	5.93	6.83	7.15	7.07	6.20
Worst result	7.03	5.98	6.18	5.86	5.11	6.27	6.78	6.32	5.46
Responses	3288	3282	3264	3275	3158	3267	3283	3292	3290

1.3.3 Ensuring equality and inclusion

It is important to note that in both trusts, in the NHS Staff Survey and via our staff networks, we know that there are still big gaps in experience among people with some protected characteristics and in particular, worse experiences reported by those from our ethic minority communities. One of the most important things this joint plan can do is to address the unacceptable disparity in experience and opportunity that continues to be reported by a significant minority through not only the staff survey but other routes such as our Freedom to Speak Up Guardians. Our joint Belonging and Inclusion strategy will remain one of our top priorities within this plan
Similarly, we are already working to implement the NHS England Sexual Safety Charter, which will make sure that we are clear about zero tolerance of unacceptable sexual behaviour.

1.4 Our people services

The people directorates in both trusts encompass many professional and administrative support services teams with high volumes of day-to-day business activity that supports the trusts, managers, employees and those interested in working for our trusts.

Our commitment is to ensure we provide high quality, efficient, and innovative services and it is important that we continue to improve what we do to maximise the impact that we have.

The federated approach between DCH and DHC means it makes sense to bring our people services together. This will also enable us to reshape our services where it makes sense. This will ensure we are able to adapt to our customers' needs and support both trusts to deliver good patient care in an efficient, effective and sustainable way. Most importantly of all, we are here to support everyone in our organisation to thrive, whatever their role, whoever they are.

3 Developing our plan

This Joint People Plan is one of five enabling strategies that support our joint strategy, Working together, improving lives.

As well as supporting the other four enabling plans, the Joint People Plan works specifically towards the 'Colleagues' objective in the joint strategy, with the following priority areas:

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

In developing this plan we engaged with staff, staff networks and other key groups through presentations, surveys and live polls. We also analysed survey feedback, evaluated key workforce data and performance, and assessed current and future operational needs to identify priority areas for maximum impact. Our operational plans and the wider Dorset operational plans are accounted for in this plan.

In a time when our resources are constrained it is even more important that everything we do is aligned to and supports the strategic direction of travel. This plan needs to be directly linked to our ambitions for and with our patients and communities.

Engagement with colleagues highlighted some key consistent themes in both of our trusts, which are important to them. The most prevalent and most important were:

- Staff wellbeing and psychological safety
- Inclusion, equity and diversity
- Leadership and management
- Career development, progression and training

The overwhelming sentiment is that we all want to feel that we belong, that we are valued and that our wellbeing is a priority. There was a specific consistent message about improving the experience of our colleagues from minority staff groups and taking a more robust approach to this alongside continuing to invest in staff networks.

Underpinning all of this is our experience of our immediate manager and senior team - there is a call for consistently compassionate and capable managers who are visible and fully engaged with their teams. Finally, we want to continue to grow - personal and professional development, career progression and training closely aligned to the future workforce need were all identified as a priority for many colleagues.

These insights are central to our plan, recognising that our colleagues have an important voice in shaping our shared priorities. By aligning resources, learning from past experiences and fostering a shared commitment to improvement, we will work with colleagues to enhance the experience for everyone and ultimately, to improve patient care.

4 Working together, improving lives

While people services will contribute to all four of the strategic objectives, we are particularly focused on the Colleagues objective. Our joint strategy sets out what we want to achieve and our trustwide measures of progress and improvement. From the ambitions it sets, we have now identified our people strategic goals and immediate objectives ('breakthrough objectives') as follows:

Strategic objective	Ambition	People strategic goals	Aligned to our trust-wide priority plans
Colleagues **We are empowered, skilled, caring colleagues who can thrive at work** 	Colleagues are positive about their experience at work All colleagues feel they belong and are included A sustainable workforce with the right skills now and for the future	Improve wellbeing, belonging and inclusion at work Grow the capability and confidence of our managers and leaders Ensure sustained high quality workforce planning and development to support transformational service change Deliver high quality people services with better use of digital and AI	Dorset ICS Future Care Planned Care delivery programme Mental Health Crisis pathway Delivery of Integrated Services Embed the Patient Carer Race Equality framework Single Electronic Health Record Delivery of Integrated Neighbourhood Teams Developing New Pathways of Care (from hospital to community) Co-production and co-design in all we do

5 Our objectives for the first 12-18 months

It is essential that this Joint People Plan is aligned to our operational and day to day reality - to make the best use of our resources, we need to ensure that everything we do has an impact. This means being clear on what we will do and how we will do it. Underpinning delivery of this plan is a commitment to evolving the way that our people services work, to be as multidisciplinary as the many teams we serve and ensure we are investing our expertise and skills into our shared priority areas.

Based on the joint strategy, feedback from staff and managers, the results of the staff survey, our existing workforce performance indicators and our strategic operational planning, this plan is designed to have the maximum impact on positive colleague experience whilst ensuring it is achievable.

Recognising that changes within the NHS nationally, regionally and locally are happening at pace, we have set 12-18 month priorities and will review these in the autumn alongside our monitoring arrangements. This approach allows us to be agile in a quickly-changing environment.

People strategic goals	Breakthrough objectives 12-18 months	Timeframe
Improve wellbeing, belonging and inclusion at work	Deliver in full the actions from the Joint Wellbeing Strategy	June 2026
	Deliver in full the actions from the Sexual Safety Charter	June 2026
	Develop and deliver actions from the Reducing Violence, Aggression and Discrimination Plan.	Dec 2025
	Implement revised staff recognition scheme	July 2025
	Deliver in full actions from the joint Inclusion and Belonging Strategy	June 2026
Grow the capability and confidence of our managers and leaders	Deliver the new appraisal scheme	July 2025
	Deliver a programme of targeted people management skills and leadership development.	June 2026
Ensure sustained high quality workforce planning and development to support transformational service change	Drive the integration of workforce planning across all services and actively strengthen workforce controls.	Mar 2026
	Deliver tailored people services and support for major transformation programs.	June 2026
Deliver high quality people services with better use of digital and AI	Strengthen collaborative working across people services in both trusts to drive improved service delivery.	Dec 2025
	Drive automation of transactions and processes to improve efficiency and service delivery.	June 2026

6 How we will measure progress

Specific measures to track progress are set out in detailed supporting plans and a people directorate delivery framework. Those detailed plans include many of our statutory and contractual commitments, including:

- joint Inclusion and Belonging strategy
- joint Workforce Wellbeing Plan
- Sexual safety action plans
- WRES and WDES
- Equality Delivery System 2
- Gender Pay Gap plan

The Board and Joint People and Culture Committee in Common have strategic oversight of the impact of our People Plan actions through:

- the Integrated Corporate Dashboard and Board Balanced Scorecard in each Trust
- the Board Assurance Framework
- the strategy dashboard
- the forward business plan of the joint People and Culture Committee, which includes regular review of our statutory and mandatory commitments
- the NHS Staff Survey and People Pulse reporting
- Freedom to Speak Up reporting
- Creation of our joint Culture and Inclusion steering group

In assessing progress we will ask: have we done the things we said we would do and, have they had the impact that we expected? We will use our delivery framework and action tracker to assess implementation progress.

We will measure progress against our priorities through a combination of qualitative and quantitative data, enabling us to track the impact of our work. Key metrics will include staff survey results, pulse surveys, retention, sickness and recruitment data, workforce demographics, and employee feedback from engagement forums.

Regular progress reviews, alongside insights from trade unions, staff networks and the Freedom to Speak Up Guardian, will help us assess effectiveness and identify areas for improvement. By continuously tracking this combination of hard workforce measures, staff survey/Pulse data and experiential insight, we can adapt our approach to ensure we meet our strategic objectives.
Appendix 1

7 Impact of the Joint People Plan

The impact of this plan for different groups is shown below:

Patients, service users and carers	Staff
• Highly engaged skilled workforce delivering high quality and compassionate care • Workforce capacity to meet demand • Developing and enhancing new and improved care pathways and services that meet community need • Addressing health inequalities through education and raised consciousness on inclusion	• When staff feel valued, supported, and well-trained, they are more likely to deliver high quality care. This improves patient outcomes and experience. • Ensuring managers receive adequate support and training, and consistently demonstrate trust values in their interactions with staff. • The voice of staff is vital - we want them to feel heard, valued, and empowered as the driving force behind change and making a difference.
Communities/citizens	**Partners**
• A well-supported workforce can focus more on preventative care, education, and community outreach, helping to improve overall public health • The wellbeing of our staff extends beyond the workplace, positively influencing their families and creating a meaningful impact on our communities • Enhancing our role as anchor institution	• Working with partners on widening participation schemes and local recruitment to help communities grow by providing pathways into healthcare careers for young people.

Dorset County Hospital
NHS Foundation Trust

Report to	Board of Directors, Part 1	
Date of Meeting	10 June 2025	
Report Title	**Annual Guardian Report of Safe Working report: Doctors in Training (2024/25)**	
Prepared By	Dr Jill McCormick, Guardian of Safe Working	
Accountable Executive	Dr Rachel Wharton, Chief Medical Officer, DCH	
Previously Considered By	People and Culture Committee in Common, 28/05/2025	
Action Required	**Approval**	-
	Assurance	X
	Information	-

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives	
Care	Yes	
Colleagues	Yes	
Communities		No
Sustainability	Yes	
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

- This is the 6th Annual Report submitted to the Trust Board.
- The number of Resident Doctors in training posts has increased to 180.5 for 2024/2025 from 168.9 (2023/24), and vacancy rate has reduced from 34.1 WTE (2023/2024) to 25.3 WTE (2024/25).
- Total number of Exception Reports has increased since the last annual report. In 2023/24 total 205 (6 ISC), and 268 (26 ISC) in 2024/25 total. This reflects an encouraging and supportive culture of reporting, however, does demonstrate the significant clinical demands. All immediate safety concerns will have a DATIX submitted from April 2025.
- Areas demonstrating the highest numbers of ERs: General / Acute Medicine (related to Medical On-calls mostly), Geriatric Medicine (Half of the ERs are also related to medical On-call), and T&O.
- Within T&O over last quarter the ERs have reduced to 6 (with no ISCs). An Orthopaedic Escalation Flow Chart has been implemented and ongoing business case plans for an Orthopaedic-Geriatric Middle Grade. Giving assurances to the Board improvements are being achieved.

Recommendation
The People and Culture Committee in Common is requested to: • Receive the report for **assurance**

Executive summary

- This is the 6th Annual Report submitted to the Trust Board.
- The number of Resident Doctors in training posts has increased to 180.5 for 2024/2025 from 168.9 (2023/24), and vacancy rate has reduced from 34.1 WTE (2023/2024) to 25.3 WTE (2024/25).
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Introduction

All eligible doctors in training at the Trust in 2024/25 were working under the terms of the 2016 Junior Doctors Contract with 2019 Updates ("the 2016 Contract") and as such have had access to formally report occasions when their actual working pattern diverged from their contracted work schedules, as "Exception Reports", for review by the Trust's Guardian of Safe Working (GoSW).

All work schedules provided to doctors in training within 2024/25 complied with contractual commitments under the 2016 Contract.

The provision of three quarterly reports and one annual report from the Guardian of Safe Working is a contractual requirement outline in the T&CS of the 2016 Contract.

1. High level data

Number of training post (total):	199	(from 203 in 23/24)
Number of doctors in training post (total):	180.5	(from 168.9 in 23/24)
Annual average vacancy rate among this staff group:	25.3	(34.1 in 23/24)

2. Exception reports Annual Total (01/04/2024 – 31/03/2025)

Specialty	No. exceptions carried over from last report (Q3)	No. Exceptions raised (ISCs)	No. Exceptions closed	No. exceptions outstanding (from April '24)
Acute Medicine	0	32 (2 ISC)	12	1
Anaesthetics	0	2	0	0
Cardiology	0	7 (1 ISC)	7	0
Clinical Oncology	0	0	0	0
Dermatology	1	2	0	0
D&E	2	3	2	0
Emergency Dept	0	6	3	0
ENT	0	10 (1	5	0
Gastroenterology	1	5 (4	4	0
General Medicine	1	32	12	0
General Practice	2	11	3	0
General Surgery	0	1	0	0
Geriatric Medicine	6	55 (5 ISC)	24	4 (1 ISC)
Haematology	1	5	4	0
Medical Oncology	0	0	0	0
Obstetrics & Gynaecology	0	11 (2 ISC)	3	3 (1 ISC)
Paediatrics	0	0	0	0

Renal	2	5	1	0
Respiratory Medicine	0	8 (1	7	0
Trauma & Orthopaedics	1	79 (12 ISC)	45	1
Urology	0	11	7	0
Total	**17**	**268 (26 ISC)**	**142**	**9**

Exception reports by grade				
Grade	No. exceptions carried over from last report (Q3)	No. exceptions raised	No. exceptions closed	No. exceptions outstanding (from April' 24)
F1	7	128	74	3
F2	4	70	39	6
CT1	0	14	7	0
CT2	0	8	4	0
CT3	1	12	4	0
ST1	2	20	11	0
ST2	0	0	0	0
ST3	3	12	8	0
ST4	0	1	0	0
ST5	0	1	0	0
Total	**17**	**268**	**145**	**9**

Exception reports (response time) **this is a formal requirement of the annual report*			
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days
F1	45	23	125
F2	19	23	58
CT1	7	14	10
CT2	4	7	7
CT3	8	3	0
ST1	4	4	30
ST2	3	0	0
ST3	3	3	4
ST4 +	0	1	3
Total	**93**	**78**	**237**

Total number of Exception Reports submitted in 23/24)	268	(213 in 21/22; 241 in 22/23; 205
Number of Immediate Safety Concerns	26	(from 9 in 21/22; 23 in 22/23; 6 in 23/24)

Number of Work Schedule Reviews 29 (from 28 in 21/22; 19 in 22/23; 15 in 23/24)

3. Work schedule reviews

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

Exception Reports taken to Level 1 Work Schedule Review

Specialty	**F1**	**F2**	**CT1**	**CT2**	**CT3**	**ST1**	**ST3**
Acute Medicine					2		
ENT		1					
General Medicine	1					1	
General Practice		1					
General Surgery	1						
Geriatric Medicine	4	2					
Haematology							3
Renal Medicine		1	1	1			
Respiratory Medicine		2					
Trauma & Orthopaedics	4	4					
Total	**10**	**11**	**1**	**1**	**2**	**1**	**3**

Rota	**Total**
2022 IMT 1/2 MED 05/04/23-01/08/23	1
2023 F1 Med 06/12/23-02/04/24	3
2023 F1 Surgical 06/12/2023 - 02/04/2024	1
2022 F1 Medical 05/04/23-01/08/23	1
2022 F1 Surgical 05/04/2023 - 01/08/2023	1
2023 F2 (EMB - LTFT 80%) 02/08/23 - 10/10/23	1
2023 F2 GP+ Med OC 02/08/2023 - 05/12/2023	1
2023 Mixed Grade Surgical 02/08/23-05/12/23	2
2023 F2 Surgical Rota 06/12/2023 - 02/04/2024	1
2023 STR Orthopaedics 06/09/2023 - 03/09/2024	1
2023 TD MED 06/12/23-02/04/24	1

2023 F1 Med 06/12/23-02/04/24	1
2024 F1 Med 07/08/2024 - 03/12/2024	1
2024 F1 Surgical 07/08/24-03/12/24	3
2024 F2 MED 07/08/2024 - 03/12/2024	2
2024 F2 Surgical 07/08/24-03/12/24	1
2024 F2 MED 07/08/2024 - 03/12/2024	1
2024 STR GASTRO - Med 04/09/2024 - 02/09/2025	3
2024 IMT Med 04/12/24-01/04/25	3
Total	**29**

There are no open work schedule reviews as of 01/04/2025.

4. Vacancies

Appendix 1 details all vacancies among the medical training grades during the previous year, year reported by quarter, split by specialty and grade.

5. Fines

There were no fines levied during this period

6. Qualitative information

Q4 Data (1st January – 31st March 2025): 61 ERs were submitted. Looking through all ERs individually and the situation (again incorrect data into which specialty was concerned). There were 6 Exception Reports from renal, 15 from Medical On-calls, 14 from Geriatric medicine day shifts, 5 from cardiology, 7 from urology, 2 from Respiratory, 4 from O&G, 1 A&E, 2 from GP, and 6 from T&O during on-call. Half came from FY1s (31), 11 from FY2s, 12 from CT2-CT4 and the 8 remaining from ST1-ST5. 19 TOIL, 23 payments, and 2 no further action. 3 Immediate safety concerns during this period, 1 Medical on- call weekend, staying later due to volumes of patients and no escalation to find locum cover. A report from O&G (with lack for doctors covering, 2 instead of 4), and last from a medical shift at the weekend, staying late to hand over a patient to the medical registrar (who was tied up).

Overall Exception Reporting Annual Report

Part of overseeing the Exception Reporting mechanism involves a constant awareness of under reporting and a constant effort to promote appropriate engagement with the mechanism. Interestingly the number of ERs has increased in the year 2024-2024 (268) reports from an average over the last 3 years of 220 reports (from 116 in 213 in 21/22; 241 in 22/23; 205 in 23/24). This is only 1 year of data, but may reflect a changing cohort of Resident Doctors coming through, especially given the challenges of BMA Industrial Action regarding pay in recent times. We also have a very encouraging and supportive culture to support ERs, and have sent reminders to Educational and Clinical Supervisors. It is also supported by the efforts

on the part of CMO, DME, GoSW, GMC regional liaison officer, and local BMA representatives to encourage exception reporting.

Exception Reporting will however be changing in September 2025, no meeting with an Educational Supervisor required, and therefore an oversight from HR, GOSW, and Director of Medical Education (as agreed in the recent revised Resident Doctors Contract 2024) will be paramount. More discussions around this will follow in the next few months in preparation.

Also noting from the next Quorate Exception Reporting will not be in the Allocate System and has moved over on 1st April 2025 to Health Rota.

Immediate Safety Concerns There has been over the last year an increase in ISC Reports in 2024/2025 (26) in comparison to the year 2023/2024 (6). Immediate Safety Concerns are important, so discussions and escalations occur quicker to implement change. There is no set definition with GOSW framework to suggest what is deemed an ISC. Looking at all the reports for the year it largely comes down to an environment which is overwhelming for clinical work, and not enough cover. Areas have been T&O (although appreciating there were no ISC in the last Q4 which is reassuring. Medical On-calls have also been creating ISCs with the volume of work. I understand there is on-going work from Dr Marianne Doherty (Director of Workforce in Medicine), and a few Resident Doctors to understand the types of calls from wards, and a better or more efficient way of working.

There was an ISC from an FY1 on Fortuneswell Ward in Q2 (covering Medical Outliers / Oncology Patients), and I think this has been under reported thereafter, compared to verbal feedback.

Trauma and Orthopaedics (T&O) have been highlighted in past Guardian's reports. This is a longstanding issue. However, I am pleased to see in the last Quarter 4 (January – March 2025), only 6 ER reports and no Immediate Safety Concerns. To give reassurance to the Executive Board and triangulate with risk, all ISCs will have a DATIX submitted to further investigate any associated safety issues. There is still ongoing work to prepare a business plan for an Ortho-Geriatric Middle Grade, which I fully support. There was also an agreed Orthopaedic Escalation Pathway (agreed by Orthopaedic and Medical Consultants (and other specialties as needed), to give clear guidance for Resident Doctor's. There is satisfactory progress currently, and we continue to monitor reports.

A quorate Resident Doctors Forum (JDF) continues to meet regularly 4-5 times per year. It certainly is a very open forum to express concerns. There is always attendance by a nominated deputy of medical education, CMO, GOSW, Divisional Directors, and Director of Workforce for Medicine and LEDs with a very good turn out of Resident Doctors.

7. Issue Arising

Clinical pressures continue to exist with a vacancy rate WTE 25.3. The Medical and Surgical Specialties continue to require Junior Doctors to work above and beyond their contractual

duties and this is documented in the form of Exception Reports. This is particularly seen within Acute/ General Medicine, Geriatrics and T&O. However other areas (with less reporting) are demonstrating that Rota gaps are causing stress on teams such as Cardiology, renal and Obstetrics and gynecology.

8. Summary

The Guardian of Safe Working acknowledges the Trust's compliance with the safeguarding aspects of the 2016 Contract.

9. Recommendations

The Guardian asks the board to note this annual report, consider it to provide an **assurance** of compliance with the safeguarding aspects of the 2016 Junior Doctors Contract and approve its submission to the Trust Board.

The Guardian acknowledges the significant role that the Trust Board has played in providing and protecting an environment in Dorset County Hospital for Resident Doctors.

APPENDICES

ANNUAL GUARDIAN REPORT ON SAFE WORKING HOURS: DOCTORS IN TRAINING – 2024/2025

Appendix 1 – Trainee Vacancies within the Trust

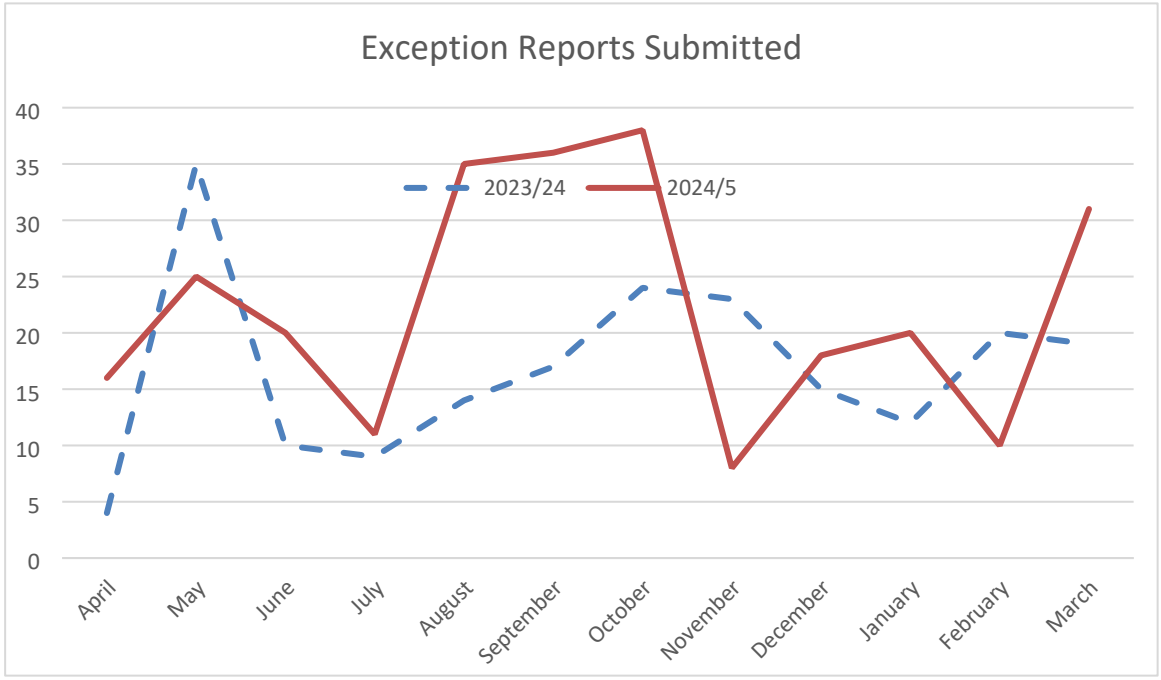
Department	Grade	Q1				Q2				Q3				Q4				Annual Average
	April 24 - March 25	Apr	May	June	Avr Q1	July	August	Sept	Avr Q2	Oct	Nov	Dec	Avr Q3	Jan	Feb	Mar	Avr Q4	
Paediatrics	ST3	0	0	0	0.0	0	0	0.2	0.1	0.2	0.2	0.2	0.2	0.2	0.2	1	0.2	0.5
Paediatrics	ST4+	0.7	0.7	0.7	0.7	0.7	0.7	1	0.8	1	1	2	1.3	1.4	1.4	0.4	1.6	4.4
O&G	ST1	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0.0
O&G	ST3+	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0	0	0	0.0	0	0	0	0.0	1.6
ED	ST3+	0.2	0.2	0.2	0.2	0.2	0.2	0	0.1	0	0	0	0.0	0	0	1	0.0	0.3
Surgery	CT1	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0.0
Surgery	CT2	1	1	1	1.0	1	0	0	0.3	0	0	0	0.0	0	0	0	0.0	1.3
Surgery	ST3+	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0.0
Orthopaedics	ST3+	1	1	1	1.0	1	1	1	1.0	1	1	1	1.0	1	0	0	1.0	4.0
Anaesthetics	CT1/2	1.2	1.2	1.2	1.2	1.2	1.4	1.4	1.3	1.4	2.2	2.2	1.9	2.2	1.4	1.4	2.1	6.6
Anaesthetics	ST3+	1.2	1.2	0.2	0.9	0.2	0.2	1	0.5	0	1	1	0.7	1	1	2	0.9	3.2
Clinical Radiology	ST1/2	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0	1	1	0.0	0.0
Medicine	CT1/2	5.5	5.5	5.5	5.5	5.5	4.1	4.1	4.6	4.1	4.1	4.1	4.1	4.1	5.1	5.1	4.1	18.3
Medicine COE	ST3+	0.4	0.4	0.4	0.4	0.2	1.2	1.2	0.9	1.2	1.2	1.2	1.2	1.2	0.2	0.4	1.2	3.7
Medicine Diab/Endo	ST3+	1	1	1	1.0	1	1	1	1.0	1	1	1	1.0	1	1	1	1.0	4.0
Medicine Gastro	ST3+	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0.0
Medicine Resp	ST3+	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0.0
Medicine Cardio	ST3+	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.8
Medicine Acute Internal	ST3+	N/A	N/A	N/A	N/A	N/A	N/A	0	0.0	0	0	0	0.0	0	0	1	0.0	0.0
Medicine Renal	ST3+	0	0	0	0.0	0	2	2	1.3	2	2	2	2.0	2	1	1	2.0	5.3

Haematology	ST3+	0.4	0.4	0.4	0.4	0.4	0.4	1	0.6	1	1	1	1.0	1	1	1	1.0	3.0
Med/Surg	FY1	4	4	4	4.0	4	2	2	2.7	2	2	2	2.0	2	2	2	2.0	10.7
Med/Surg	FY2	0.6	0.6	0.6	0.6	0.6	1.9	1.9	1.5	2.9	1.9	1.9	2.2	1.9	1.9	0.9	2.0	6.3
GPVTS	ST1	14	14	14	14.0	14	0.4	0.4	4.9	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	19.7
GPVTS	ST2	0.6	0.6	6	2.4	0.6	0	0	0.2	0	0	0	0.0	0	0	0	0.0	0.8
GPVTS	ST3	2.5	2.5	2.5	2.5	2.5	0	0	0.8	0	0	0	0.0	0	0	0	0.0	3.3
Orthodontics	ST3	1	1	1	1.0	1	1	0	0.7	0	0	0	0.0	0	0	0	0.0	1.7
Ophthalmology	ST3	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0.0
Total		36.3	36.3	40.7	37.8	35.1	18.5	19.2	24.3	18.4	19.2	20.2	19.3	19.6	17.8	19.8	19.7	99.5

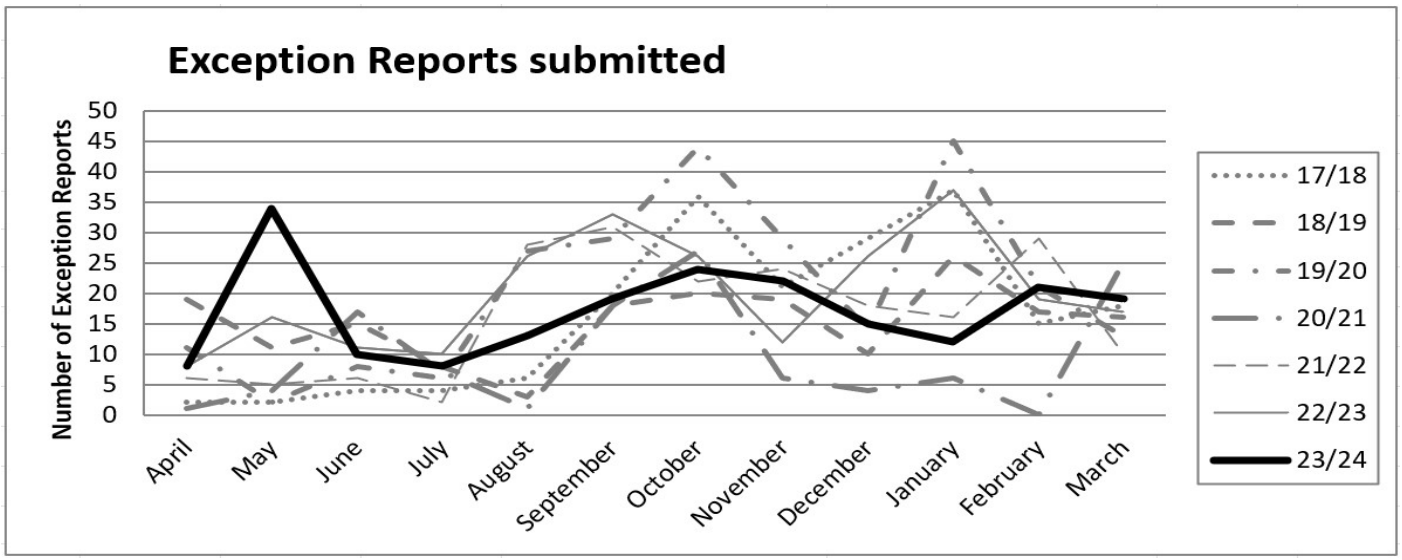
Trainees vacancies outside the Trust overseen by the LET guardian

General Practice	GPTS	5.6	5.6	5.6	5.6	5.6	8.9	8.9	7.8	10.9	10.9	10.9	10.9	11.1	6.3	6.3	7.9	32.2
Public health trainees	FY1/2	0	0	0	0	0	0	0	0.0	0	0	0	0	0	0	0	0	0.0
Total		5.6	5.6	5.6	5.6	5.6	8.9	8.9	7.8	10.9	10.9	10.9	10.9	11.1	6.3	6.3	7.9	32.2

Appendix 2 – Exception Reports submission comparison 2023/24 and 2024/25



Appendix 3 – Exception Report submission since introduction of the 2016 Contract (2017/18 to 2023/34)



Report to	DCH Board of Directors, Part 1	
Date of Meeting	10th June 2025	
Report Title	Freedom to Speak Up Guardian Q3 & Q4 and Annual Report	
Prepared By	Lynn Paterson - Freedom to Speak Up Guardian	
Accountable Executive	Nicola Plumb - Chief People Officer	
Previously Considered By	People and Culture Committee in Common, 28/05/2025	
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	SR2 Culture – The FTSU policy forms part of the controls and assurance sourced through monthly high level dashboard data and bi-annual reports.	
Financial	Potential risk can result where employees take cases to employment tribunal.	
Statutory & Regulatory	The standard NHS contract requires that all trusts and foundation trusts employ a Freedom to Speak up Guardian which is now an established role across the NHS and was a recommendation of the Freedom to Speak Up Review by Sir Robert Francis that was published in 2015. The content of this report is aligned to the guidance set out in the *'Freedom to Speak Up: A guide for leaders in the NHS and organisations delivering NHS services'* (2022), p33-34.	
Equality, Diversity & Inclusion	The reporting methodology includes staff data relating to the protected characteristics where this is known.	
Co-production & Partnership	The report includes data provided by the learning and development team, the Business Intelligence team and benchmarking against Devon Partnership NHS Trust.	

Executive Summary

This is the Q3 & Q4 and Annual report on Freedom to Speak Up (FTSU) in Dorset County Hospital (DCH) for 2024/25.

The Freedom to Speak Up Guardian role has been in place since 2016 as an outcome of the Mid Staffordshire enquiry, led by Sir Robert Francis (2015).

The Guardian has now been in post for almost 2½ years and has been working full-time in the role since July 2024.

Quarterly data returns are sent to the National Guardians Office (NGO) and published on the NGO website, alongside all other NHS Trust returns. Quarter 4 returns have been submitted.

Themes and learning are captured within this report; the FTSU Guardian shares learning with staff and colleagues in a variety of ways in order to promote a positive culture of raising concerns.

The Guardian attends national and regional events to ensure best practice is brought back and embedded within DCH.

The Guardian receives robust supervision and support from the counterpart at Dorset Healthcare Guardian as well as Executive/Non-Executive team members as required.

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

Quarter 2024/25	Number of contacts
Q1	108
Q2	148
Q3	128
Q4	115

Freedom to Speak Up Report

Quarter 3 & 4 and Annual Report

1.0 Introduction

1.1 Sir Robert Francis in his Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry (2013) described the experiences of nurses and doctors who raised concerns about the poor care of some patients at Stafford Hospital. As a result, he was asked to conduct a further review into raising concerns in the NHS.

1.2 'Freedom to Speak Up – an independent review into creating an open and honest reporting culture in the NHS' was published in 2015. The report identified a need for culture change, improved handling of cases, measures to support good practice, particular measures for vulnerable groups, and extending the legal protection. In particular, he recommended that all Trusts should have a Freedom to Speak Up Guardian to 'act in a genuinely independent capacity' and support staff to raise concerns.

1.3 In 2016-17 it became a contractual requirement for all NHS provider Trusts to have a Freedom to Speak Up Guardian. All Trusts in England have made appointments and all Guardians are now in post.

2.0 Main Narrative

Assessment of Cases

2.1 In Q3 & 4 of 2024/25, **243** contacts were made to the FTSU service, a very similar picture to the previous reporting period of 256. This brings the year end position to **499** cases in total, of which 3 remain open. There has been an increase in staff seeking advice/guidance which are quicker to resolve and close, hence the low numbers of cases still open.

Table 1

Reporting period	Contacts	Patient Safety & Quality	Staff Safety & Wellbeing	Bullying & Harassment	Other Inappropriate Behaviours	Anon
Q1 & Q2	256	83	166	38	160	10
Q3 & Q4	243	56	143	19	133	9
Total	499	139	309	57	293	19

2.2 There has been a decrease overall in each category with a distinct link between wellbeing and other inappropriate behaviours (OIB). The predominant themes within OIB are jointly poor communication and colleague behaviour, followed by manager behaviour and lack of support from manager. Similar themes are reported locally via the Dorset and Somerset Network Guardians. Managers need to provide clarity for their staff and close the communication gap which can further create an environment of instability and insecurity in the continuing economic climate.

2.3 In many cases, concerns are attributed to more than one element of perceived risk, for example, a colleague worried about staffing levels might assign both patient safety and worker safety/wellbeing to the concern. To note, all cases are assigned from the perspective of the colleague raising the concern.

2.4 Different approaches are adopted by the Guardian and are discussed with the individual to facilitate a local informal resolution where possible and appropriate. Just over 100 of cases during Q3 & Q4 were for advice/guidance, 80 needed escalation, 37 were listen and log only, 11 required a feedback session, 4 for signposting to partner services and 2 for investigation. This gives reassurance that the FTSU service is being utilised appropriately.

2.5 Over 60% of contacts were met with face to face, a further 14% corresponded via email. Around 9% were met with via Teams, a further 9% contacted by telephone with letter being the least utilised contact to the Guardian.

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

2.7 Anonymous concerns accounted for 3% of contacts made, slightly less than the previous 2 quarters. Colleagues are encouraged to raise a concern by any means they feel most comfortable.

2.8 The Guardian submits data online via the NGO portal quarterly. This data includes number of contacts, professional group, number of anonymous concerns, number of colleagues who suffered detriment and categories eg. patient safety, worker safety/wellbeing.

2.9 Benchmarking against a similar size Trust who employ approximately 3,600 staff, our case numbers of 128 for Q3 are over double the 51 cases they reported. At this time, their Q4 numbers have not been submitted so a comparison cannot be made. This is likely due to those Guardians additionally working for other Trusts, not solely for one organisation.

3.0 Analysis of Trends

Service

3.1 There was an equal number of concerns raised from both Division A and Division B. Work is ongoing to further breakdown services as currently only the 2 Divisions, People, and Corporate Services are recognised.

3.2 The following table illustrate pay grades of staff who have raised concerns in 2024/25:

Table 2

Pay Grade	Headcount	No of Contacts	% of Headcount	% of Total Contacts
Bands 1 – 4	1874	213	11%	43%
Bands 5 – 7	1853	203	11%	40%
Bands 8A and above	215	5	2%	1%
Non AFC	561	34	6%	7%
Not known		44	N/A	9%
Total	4503	499	N/A	100%

3.3 Targeted listening events are held if the Guardian is having several concerns raised within that service, or at the request of the local manager due to lack of engagement from staff or when an area is reporting concerns anonymously, which could indicate staff are feeling psychologically unsafe in their work environment. The risk management team assist the Guardian to flag areas reporting anonymously via Datix.

3.4 During 2024-2025 listening events have taken place for Housekeeping, Radiology, Outpatients Department and most recently the Portering & Security Teams. Staff concerns from these events are collated into themes and anonymised. Action plans are drawn up with the managers and shared with teams to address the themes raised.

3.5 Robust triangulation of data continues to help identify areas that may need additional support. Weekly Patient Safety huddles are attended by the Guardian and relevant stakeholders, in addition to regular meetings with the Safeguarding Lead. The Guardian meets separately every month with the Chief Nursing Officer, Chief People Officer, NED for FTSU and the Heads of Nursing to discuss and escalate matters as necessary. Monthly local intelligence meetings between HR, Workforce Business Partners, Education, Recruitment and the OD Team continue and prove incredibly useful in flagging areas requiring support.

Flagging Services

3.6 One service flagged following several concerns raised is now in a recovery programme monitored weekly with Executive oversight.

3.7 A number of concerns came from a department due to potential changes to working patterns, these changes are currently paused for further consideration.

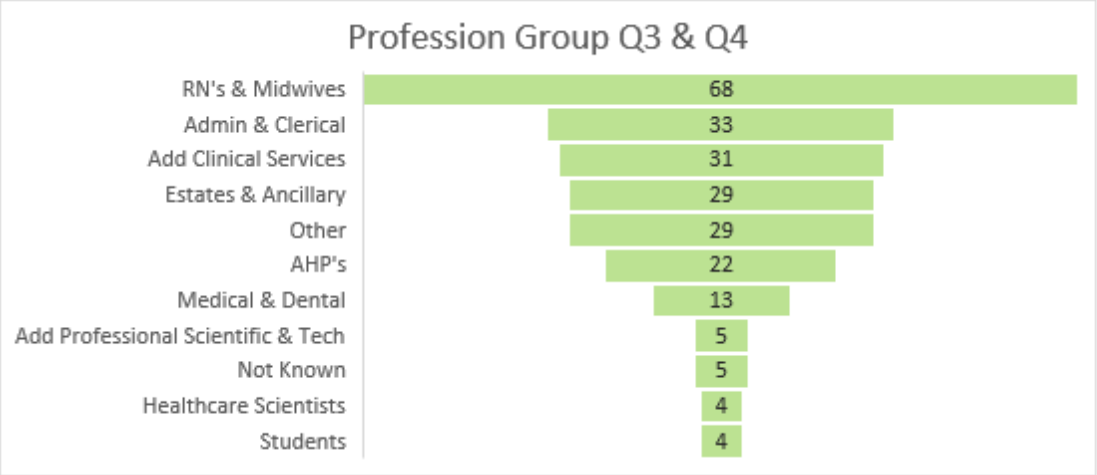
3.8 Concerns were raised within a service following an exit interview and an investigation is now proceeding.

3.9 Several concerns were raised within a department around culture, which appear to be historical but have not been resolved. This has been escalated to both the Service Manager and Matron.

Professional Background

3.10 Roles of staff expressing concerns are listed in Table 3.

Table 3



3.11 Registered Nurses remain the group with the highest number of concerns reported, accounting for 28% of cases. Admin & Clerical roles accounted for 14% of the cases, so a very similar picture to Q1 & Q2. This mirrors the national picture as Nurses are the largest workforce group. Concerns have been raised from every professional group and work can be targeted to those groups with the lower number of contacts.

For the year end position Registered nurses made up 139 of the contacts received, followed by 79 Admin & Clerical.

3.12 Detriment is nationally a growing concern for the NGO who require Guardians to report 'where detriment is indicated'. Prior to seeking clarity from peers, the Guardian used to ask colleagues if they felt there could be repercussions as a result of speaking up. This no longer occurs, and if detriment is reported, it will be documented subsequent to speaking up. The NGO has recognised disparities amongst Guardians to reporting detriment and recently published further guidance.

Detriment-guidance.pdf

3.13 From the 243 contacts, 41 members of staff were from a protected characteristic group that the guardian was aware of (16%). This takes the annual number to 87 (17%). The NGO does not require us to collect this data and we do not ask directly, however it is a recommendation from the 'Insightful Provider Board' guide (Nov 2024) and could inform other workstreams.

https://www.england.nhs.uk/long-read/the-insightful-provider-board/

Contacts That Led to Formal Action

3.14 From the concerns raised in Q3 & Q4, all bar 2, have been or are in the process of being resolved informally through supportive discussions, facilitated meetings, referring onto coaching/mediation or speaking to the relevant manager to seek a resolution. 2 are being managed formally and awaiting an outcome.

4.0 Learning and Improvements

4.1 In collaboration with the DHC Guardian a joint single policy document for Freedom to Speak Up has been developed, currently awaiting ratification.

4.2 Several improvement initiatives have been undertaken by the Guardian in collaboration with the DHC Guardian:

- A newsletter has been developed which will be published quarterly. This will jointly improve sharing and learning from FTSU activity with staff.
- A FTSU audit tool has been created to enable the service to measure standards of speak up practice against KPI's as part of a peer review arrangement across DCH/DHC.
- Data collation has been reviewed to capture the KPI information for audit including time to respond to contacts; time to close cases; failure demand rates; was the contact thanked etc. The database itself will need further work to capture this information.
- The FTSU feedback questionnaire has been updated and unified between DCH/DHC.
- Joint core meetings have been established with the Guardians to expand collaborative working and sharing of resources where possible.
- Report templates between the two organisations have been reviewed/aligned and agreed for consistency.

5.0 Actions Taken to Improve FTSU Culture & Awareness and Guardian Visibility.

5.1 The Guardian continues to visit teams in person and deliver face to face sessions to raise awareness and hold listening events as capacity allows. The Guardian attends Ward Leaders meetings monthly and meets with night duty colleagues when able. Additionally, the Guardian attends various staff network meetings and staff forums including International Nurses forum throughout the year.

5.2 Regular clinical Wednesday walkarounds continue, often with either the Overseas Practice Educator or Practice Educator for HCSW's.

5.3 The Guardian delivers awareness sessions on the Trust Preceptorship programme; Student Nurse Induction, Non foundation Drs Induction and will now be taking ownership of the regular Trust Induction slot previously facilitated by OD.

5.4 A collaboration between the Guardian and NHS Dorset took place to present and introduce the Guardian role at the South West GP Practice Patient Safety Network.

5.5 The Guardian routinely supports OD to deliver Dignity & Respect in the Workplace workshop and following discussion with the Education Centre, will now be leading its introduction into the Preceptorship programme. This supports the FTSU agenda as it incorporates incivility and the impact of colleague behaviour.

5.6 FTSU training is available via ESR on the intranet and was mandated on the 1st September 2024. Since then, there has been a significant increase in uptake from just a few hundred to over 3000, accounting for 68% of staff compliance which is a very encouraging.

5.7 The Guardian monitors how staff knew about FTSU; it is of interest to note that the majority were through word of mouth from colleagues, followed by staff communications/bulletins, then posters and FTSU Champions.

5.8 The **Board Reflective tool** is in development and will be submitted as an Appendix for consideration in the next report. The deadline for completion is January 2026.

5.9 Champion recruitment continues with now over 50 in post. Further recruitment will take place with a view to establishing a Champion in areas currently not represented and the Associate Guardian role will be explored to align with DHC's model.

5.10 The newly developed newsletter will be instrumental in raising awareness further. This will be published on the FTSU page as well as utilising the usual communication channels and staff Facebook group.

5.11 As with previous years we look forward to boosting awareness through FTSU month in October.

6.0 Assessment of The Effectiveness of The Speaking-Up Process

6.1 Current research suggests that employee engagement has a positive correlation with lower patient mortality, lower sickness levels and lower patient complaints.

6.2 The National Staff Survey (NSS) and the National Quarterly Pulse Survey (NQPS) provide insights into how well we are meeting the standards outlined in the People Promise (2020/21). The section 'we each have a voice that counts' is pertinent to the speaking up culture.

6.3 In relation to the 'Raising Concerns' NSS questions, every score was higher than the national average, however not quite back to pre-pandemic levels.

Worker feedback

6.4 As part of the process for closing cases, the Guardian sends colleagues a feedback questionnaire - 100% of staff who responded said it was easy to make initial contact with the Guardian, the initial response was very helpful and they would recommend speaking to the Guardian. 97% said they would speak up again.

Peer review and Audit

6.5 As mentioned in paragraph 4.2, peer review and audit have recently been developed by the team which will enable the service to measure successes and make improvements where needed. This, alongside the colleague feedback questionnaire, will support our continuous improvement cycle. This information will be presented in future reports.

Learning from case reviews

6.6 The NGO have not carried out any case reviews since the Ambulance review in 2023 - published in February 2024; although it is about to commence a review into the experiences of 'trained overseas workers.'

6.7 When case reviews take place there is an expectation that the Guardian will self-assess/benchmark their own organisation against the findings of the review. This will be included in the Board Reflection Tool.

7.0 Actions taken to improve the skills, knowledge and capability of workers to speak Up.

Training

7.1 The NGO developed in association with Health Education England online FTSU training, which is available to anyone who works in healthcare. The training is divided into three modules:

- Speak Up – core training aimed at all NHS staff.
- Listen Up – aimed at all Line Managers/Supervisors.
- Follow Up – aimed at Senior Leaders (8a and above including executive & non-executive Directors).

7.2 Our current compliance is reported in paragraph 5.6 and is a substantial improvement on the previous year.

8.0 Recommendations

8.1 **Board to note** that the Guardian will continue targeted work to improve visibility and psychological safety across the organisation, and support ongoing learning from speaking up cases.

8.2 **Board to endorse** the proposed joint working areas with DHC on FTSU, including a joint strategy, recruitment/training of Champions, and coordinated communications for FTSU month.

8.3 **Board to support** a targeted approach to Champion recruitment in under-represented areas to strengthen FTSU coverage.

8.4 **Board to note** that the Board Self Reflective Tool will be completed by year-end, and agree to receive outcomes or learning from that process once available.

9.0 Message from the Guardian

9.1 There has been lots of activity this year with the number of contacts remaining high so it encouraging that many of our colleagues are speaking up.

9.2 Collaboration with DHC has enabled many of the improvements outlined in this report and have contributed to efficiencies within the service.

9.3 I feel privileged to work for the NHS and am passionate about influencing cultural change, reducing incivility within the workplace and supporting colleagues to raise concerns. The endorsement from the Board is highly valued and I look forward to the year ahead, listening, collaborating and empowering colleagues to respectfully challenge where necessary to promote civility.

Lynn Paterson
Freedom to Speak Up Guardian
April 2025

Dorset County Hospital
Dorset HealthCare

Strategy Transformation and Partnerships Committee Assurance Report for the meeting held on Wednesday 28 May 2025

Chair	David Clayton-Smith, Chair
Executive Lead	Nick Johnson, Chief Strategy, Transformation and Partnerships 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	• Transformation priorities were approved subject to ensuring adequate capacity and resources to deliver those priorities and clear articulation of the expected measurable benefits of delivery. • Shared services work programme has received high levels of media and public interest. • The Committee approved the progression of the Electronic Heath Record business case. • The positive progress of developing a Dorset wide digital strategy has been recognised and all stakeholders including primary care and GPs must be included in its ongoing development and eventual sign-off.
Key issues / matters discussed at the meeting	The committee received, discussed and noted the following reports: • Strategy in Action – Peer Open Dialogue Dorset (Presentation) The committee received an informative presentation on a community based approach that connects the Dorset system. Representatives from Poole CMHT, Mind, Lantern and the Hub shared positive experiences and outcomes from the project. • Strategy Delivery Report (and Dashboard) An update on the development of the joint strategy dashboard was presented which is at concept stage. There is still more work to be undertaken with formulating and approving metrics and outcome measures to track delivery of the strategic objectives. The joint strategic roadmap presents a view of all the federated tangible work currently underway, and is presented chronologically, charting high-level programme deliverables across the 5-year strategy lifespan. • Annual Strategic Plan & Transformation Priorities The top priorities for 2025/26 were presented and approved subject to further assurance that there is workforce capacity to support and deliver those priorities, and that the intended benefits are clearly articulated and deliverable.

- One Transformation Approach Highlight Report (Including NHP Update)
  Committee members received the report for assurance.

- Joint Improvement Framework – Activity Update
  The committee received a comprehensive summary of recent activities to support the Improving Together Programme which has moved from 'discover' to 'define' phase. Engagement has been positive and interactive activity sessions well received.

- Our Dorset Provider Collaborative
  The key activities of the collaborative were summarised including the establishment of a Chairs and Non-Executive Directors oversight group and the shared services work programme which has received high levels of media and public interest.

- Wessex Health Innovation Network 25/26 Plan and Medtech update
  Committee members received the report for information. Assurance was provided that the working relationship with the Health Innovation Network is strong and the network provides good value for money.

- Digital Strategy Update
  A comprehensive update was provided on the development of the Digital strategy for Dorset. A series of system-wide workshops with senior digital leaders from the ICB, DCH, DHC, and UHD have been successfully delivered. A workshop is scheduled for June which will further inform the detailed content of the strategy.

- DHC EHR OBC
  Over the past 12 months both Somerset ICS and Dorset ICS organisations have been working collaboratively to create an Electronic Health Record outline business case, which has been through Trust Board for sign off, through to national review and EPRIB sign off (May 2025). This OBC had descoped Dorset HealthCare due to affordability issues however additional funding is being made available through the Frontline Digitisation Programme which requires Dorset HealthCare to create an additional OBC to align with the overall Dorset/Somerset OBC. If timescales allow, the preferred route through to FBC will be to co-produce one FBC that includes all providers across Dorset and Somerset. The overall approach outlined in the supporting paper was approved by the committee.

- Net Zero Progress Report
  Committee members received the report for assurance. Good progress was reported against the delivery of the sustainable development goals with no items raised for escalation to the Board.

- Green Plan Guidance Refresh
  Committee members received a verbal update. Trusts were given four months to complete a refreshed plan by NHSE which was considered ambitious, therefore an extension has been given and a refreshed plan will be produced in Q3/Q4.

- Senior Information Risk Owner Annual Report
  A summary of the report was provided. Feedback is awaited from the internal auditors on compliance with the Data Security and Protection Toolkit requirements. Workforce capacity is limited in the Information Governance team limiting the ability to deliver all that is required, and mandatory Information Governance and Cyber Security training compliance rates are not reaching the agreed target. SIRO responsibilities are moving from the Joint Chief Finance Officer to the Joint Director of Corporate Affairs.

- Corporate Risk Register Assigned Risks
  The Committee received the report for assurance. There are 3 risks rated 20+ including 1 new risk from last quarter. No risks have been closed last quarter. All risks continue to be actively managed and mitigated where possible.

- Committee Effectiveness Evaluation
  A summary of the report was provided. The Committee has formally met four times since becoming a committee in common (September 2024 to March 2025) and discharged its responsibilities in all areas. Overall, the committee effectiveness evaluation was very positive with some areas of improvement identified. The refreshed Terms of Reference and committee workplan were approved for 2025/26.

- Board Assurance Framework Assigned Risks
  Committee members received the report for assurance.

The following escalation reports from sub groups were received for assurance by the committee members:
DCH:
- NHP Programme Board Assurance Report

Decisions made at the meeting	• Strategy Delivery Dashboard content (metrics and outcome measures) requires further refinement and agreement at July 2025 Committee. • Annual Strategic Plan and Transformation Priorities were approved subject to further assurance that there is workforce capacity to support and deliver those priorities, and that the intended benefits are clearly articulated and deliverable. • The DHC Electronic Healthcare Record outline business case was approved • The committee Terms of Reference and Workplan were approved
Issues / actions referred to other committees / groups	• None

Quoracy and Attendance				
	28/05/2025			
Quorate?	Y			
David Clayton-Smith	Y			
Frances West	Y			
Dave Underwood	Y			
Andreas Haimbock-Tichy	Y			
Claire Lehman	Y			
Nick Johnson	Y			
Chris Hearn	Y			
Dawn Dawson	Y			
Nicola Plumb	N			

NHS Dorset County Hospital
NHS Foundation Trust

Report to	DCH Board of Directors	
Date of Meeting	Tuesday 10th June 2025	
Report Title	Senior Information Risk Owner (SIRO) Annual Report 2024/25	
Prepared By	Diane Gravett, Data Protection Officer	
Approved by Accountable Executive	Chris Hearn, Joint Chief Finance Officer	
Previously Considered By	Strategy, Transformation and Partnership Committee, 28/05/2025	
Action Required	**Approval**	N
	Assurance	Y
	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	SR10 Cyber Security – there is no option for data protection	
Financial	No implication	
Statutory & Regulatory	Compliance with data protection law, and regulatory activity	
Equality, Diversity & Inclusion	No implication	
Co-production & Partnership	No implication	

Executive Summary

The annual SIRO report is identified for inclusion on the Information Governance Group (IGG) Cycle of Business. It provides the Board with assurance that Dorset County Hospital NHS Foundation Trust identifies and addresses key information governance (IG) issues and associated risks, and undertakes all necessary activities to maintain a strong IG and cyber posture.

The information governance management framework shows the leadership and accountability within the Trust for the mandated data protection and information security activities. The NHS England on-line tool, the Data Security and Protection Toolkit (DSPT), provides the mechanism for the Trust to evidence compliance with legal and regulatory requirements. This in turn provides assurance to the public that their personal and sensitive data is always processed in accordance with the Data Protection Act 2018.

The processing of all such data is carefully managed, and any data privacy or information security breaches are initially reported and managed through DATIX, with serious incidents escalated to the Information Commissioner's Officer (ICO) via the NHS England DSPT portal. The quarterly cyber security reports are presented to IGG and the Board and contain the specific details of any information security activities or concerns.

Recommendation

Board are requested to note:

- That we await feedback from the internal auditors on our standard of compliance to the new DSPT requirements.
- That the limited resource (1 WTE) hampers our ability to better audit, evidence and improve IG
- That the mandatory IG and Cyber training are currently below the required compliance rate.
- Receive the report for **assurance**

Senior Information Risk Owner annual report to the Strategy, Transformation and Partnership Committee 2024/25

1. Introduction

1.1 Information Governance is the framework that must be followed to ensure that an organisation's information is processed legally, securely, efficiently, and effectively in accordance with the UK General Data Protection Regulations and the Data Protection Act 2018 whilst also upholding the common law Duty of Confidentiality. Good information governance practice ensures the necessary safeguards for, and appropriate use of, corporate, personal, and sensitive information through data protection and information security.

1.2 This report is designed to provide assurance to the Strategy, Transformation and Partnership Committee that Dorset County Hospital NHS Foundation Trust is identifying and addressing key information governance issues and associated risks.

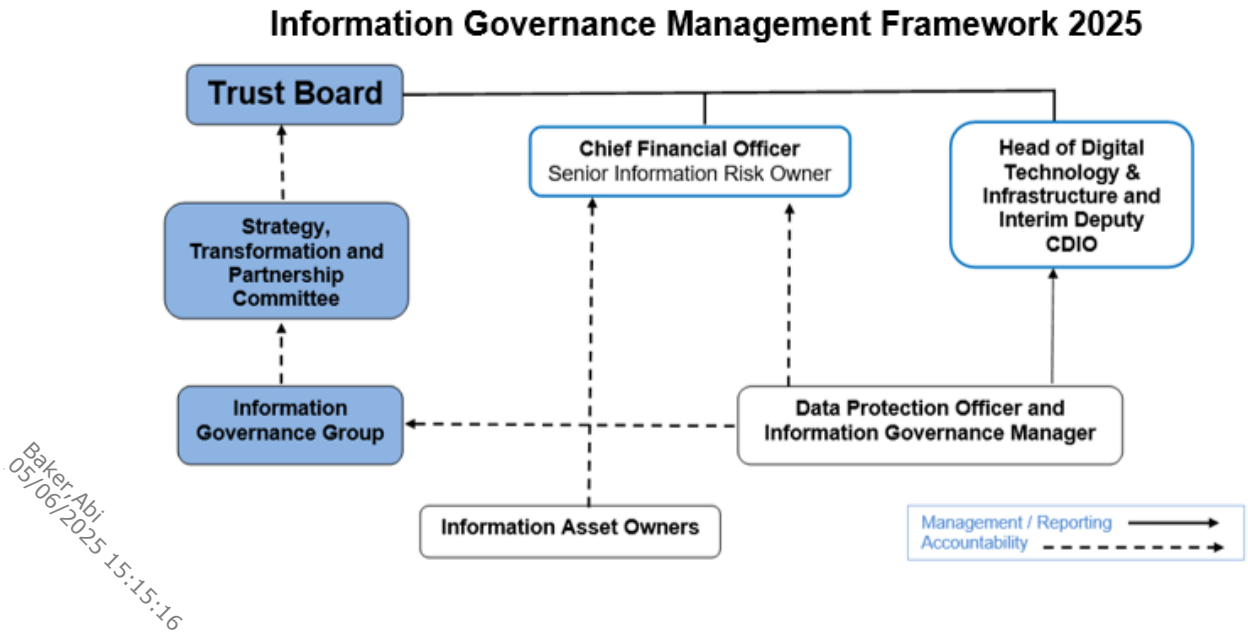
2. Leadership and accountability

2.1 Leadership and accountability for information management is set out in the Information Governance Structure, with the Trust's Senior Information Risk Owner (SIRO), being the responsible person.

2.2 The Chief Finance Officer is the SIRO and is accountable to the Board, via the Strategy, Transformation and Partnership Committee, for information governance within the Trust.

2.3 The Information Governance Group and Information Asset Owners are accountable to the SIRO.

2.4 Information Administrators and Systems Administrators are accountable to their designated Information Asset Owner.



3. Information Governance Group

3.1 The Information Governance Group is a vital platform to ensure transparency and accountability, and to maintain engagement across the Trust.

3.2 The data security and protection toolkit activity is reported at this meeting, as are incident reporting, health record subject access requests, information assurance including data quality and information assets, and information security management framework activities including cyber security. These are all workstreams that provide assurance that the data protection and information security practices of the Trust are being managed and maintained.

4. The Role of the Senior Information Risk Owner (SIRO)

4.1 The SIRO's role must be occupied by a Board member who will be held accountable for identifying and managing the information risks to the organisation. This includes oversight of the Trust's information security incident reporting and response arrangements.

4.2 The SIRO is supported by Information Asset Owners (IAOs) who are divisional, or care group leads and are assigned responsibility for information assets within their control. IAOs are supported throughout their department by nominated Information Asset Administrators (IAAs) and System Administrators (SAs). The Information Assurance Manager maintains the Trust's main information asset and flow register and collates assurance reports from the IAOs to provide ongoing accountability to the SIRO that the personal and sensitive information processed at DCH to provide healthcare is done so lawfully and appropriately.

5. Data Security and Protection Toolkit

5.1 The Data Security and Protection Toolkit (DSPT) is the on-line tool provided by NHS England to enable organisations to measure their performance against the required security standards. This has become increasingly complex as NHS England works to keep it relevant as the digital world changes, the 2024/25 toolkit requirements changed significantly on 1st July 2024 and are now based on the National Cyber Security Centre Cyber Assessment Framework (CAF) standards to focus more acutely on information security rather than data protection.

BDO LLP are conducting an internal audit March/April, recommendations will be made to provide specific guidance to the Trust in a detailed report once completed.

Work continues to meet the 2024/25 requirements in time for submission by 30th June 2025. It is difficult to predict how well DCH will match the new requirements at this time, the outcome of the internal audit should give some indications of how satisfactory our responses are so far. If all assertion points are not met, the Trust will need to provide an improvement plan with timescales to achieve the required standards. An update will be provided at the Information Governance Group on 13th May.

Personal Confidential Data
Staff must ensure that all personal confidential data is processed, stored, and transmitted securely, whether in digital or paper form, and is only shared for lawful and appropriate purposes.

Staff Responsibilities
All staff understand their responsibilities under the Common Law of Confidentiality, UK GDPR and the Data Protection Act 2018, including their obligation to handle information responsibly and their personal accountability for deliberate or avoidable breaches.

Information Governance and Cyber Security Training
All staff are mandated to complete appropriate annual data security training. The DCH level of compliance for information governance training is 90%, which is in line with Trust core elements of statutory and mandatory training - this currently sits at 80%. The new mandatory cyber security training is still being successfully rolled out and is currently at 75% compliance.

Managing Data Access
Personal confidential data is only accessible to staff who need it for their current role and access is removed as soon as it is no longer required. We rely heavily on ESR being kept up to date, and system administration to take actions in a timely fashion. All access to personal confidential data on Digital Technology and Infrastructure (DTI) systems can be attributed to individuals.

Process Reviews
Processes and compliance to policies should be reviewed at least annually to identify and improve any which have caused breaches or near misses, or which force staff to use workarounds that compromise data security. Regular proactive audits should be scheduled and conducted however resource is not available to undertake these checks to provide assurance, instead investigations tend to be retrospective following an incident.

Responding to Incidents
Information governance related data breaches, complaints and concerns are investigated and reported to IG Group. Cyber-attacks against services are identified and resisted and NHSE CareCERT security advice is responded to promptly. Detailed information about our cyber posture is reported in the quarterly Cyber Security Report, which is presented to IGG and the Board.

Continuity Planning
A continuity plan is in place to respond to threats to data security, including significant data breaches or near misses, and it is tested once a year as a minimum, with a report to senior management. A recent ICS-wide cyber security incident exercise helped all parties to identify areas to improve, predominantly on communication and shared awareness.

Unsupported Systems
No unsupported operating systems, software or internet browsers are used within the digital estate, without appropriate documented mitigation actions. Legacy systems are those that are no longer updated and supported by the supplier, which could introduce a risk from cyber criminals.

Digital Technology
In 2023 the DTI department was reaccredited with the ISO27001 security standard, which evidenced our advanced information security practices. However, it has been decided to no longer continue to achieve this formal standard due:

- the lack of perceived benefit – it no longer exempts us from some of the DSPT evidence requirements,
- and the considerable investment in time, money and resource needed to keep the accreditation.

We do continue to use the same framework and high standards in our business as usual activities.

Accountable Suppliers
Trust suppliers of IT services, software and hardware are held accountable via contracts for protecting the personal confidential data they process and meeting the mandatory national security standards. These contracts are monitored by Procurement and DTI, and the new ATAMIS software is very DSPT focussed. The Procurement team undertake checks using the NHS England Digital Technology Assessment Criteria, and work very closely with the DPO to ensure that contracts are appropriate, and data protection impact assessments are conducted whenever necessary.

6. Information Governance Issues and Risks

6.1 The Information Governance Group monitors all data security and data protection breaches that are reported through the DATIX Reporting System. The number of IG related incidents reported remain very similar in number and type. There were two IG incidents reportable to the ICO in this reporting year, both were resolved satisfactorily, no reprimands were given.

6.2 There continues to be good engagement of staff with information governance and issues are being raised promptly, however, there have been a number of incidents relating to systems and suppliers. The rest are mostly simple human errors - documents left where they shouldn't be or sent to the wrong person. The remaining few are incidents of inappropriate access by experienced members of staff who know better.

7. Summary and Recommendations

7.1 In summary, the feedback from the internal audit will inform us about ways to complete our 2024/25 Data Security Protection Toolkit submission on 30th June 2025 to best effect.

7.2 The greatest concern is the resource available to better audit, evidence and improve data protection and information security responsibilities across the Trust.

7.3 Information governance and cyber security mandatory training is currently around 80% and 75% respectively, which is below the compliance rate of 90% in line with core elements of Trust mandatory training.

7.4 The Group is asked to note the current position the Trust holds in relation to information governance.

Dorset County Hospital
NHS Foundation Trust

Audit Committee Assurance Report for the meeting held on 02 June 2025

Chair	Stuart Parsons
Executive Lead	Chris Hearn, Chief Finance 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

- Board Assurance Framework and Corporate Risk Register – as detailed below
- Concerns re some narrative being out of date, review dates being past. Risk owners to review narrative and dates for additional clarity for board
- Draft annual report received with no amendments noted
- Assurance regarding the internal audit plan
- 'Moderate' head of internal audit opinion
- Change of counter fraud provider, undertaken through usual procurement processes
- New counter fraud workplan from SAFE; the quality of the plan was complimented
- Assurance received regarding the LSMS security work, but further support from executives needed for staff to attend conflict resolution mandatory training
- Compliance with the NHS Code of Governance and NHS Provider Licence. The Fit and Proper Persons Test is being undertaken and expected to conclude by the deadline of 30th June

Key issues / matters discussed at the meeting

The committee received, discussed and noted the following reports:

- Board Assurance Framework
  - Increase in risk score for SR7 (collaboration) given the national landscape and level of change within the NHS
  - A number of overdue actions, especially in relation to SR9 (digital infrastructure) and SR10 (cyber-security). A new Chief Digital Information Officer had recently started in post and is expected to address the actions in due course.
  - Discussion about the need to ensure appropriate action deadlines are set.
  - The committee supported the proposal regarding the review of the risk appetite statement.
- Corporate Risk Register
  - One new risk score 20 re inability to undertake necessary clinical systems upgrades

  - Risks scoring over 20 generally related to digital, finance, and staffing.
  - The closure of Yeovil District Hospital maternity service had resulted in some risk scores increasing
  - Concerns re some narrative being out of date, review dates being past. Risk owners to review narrative and dates for additional clarity for board
- Draft Annual Report and Accounts with no amendments raised
- Internal Audit:
  - Progress Report: System workforce controls audit providing moderate assurance in effectiveness and controls, with 4 recommendations received. Data Security Protection Toolkit audit providing high confidence level and high overall risk assessment, with 4 recommendations received.
  - BDO has scoped for 2025/26 q1 audits and are scoping for q2 work. Consideration being given to consultant job planning audit being pushed to 2026/27.
  - Head of Internal Audit Opinion giving a moderate assurance opinion. Report also includes a summary of work undertaken in 2024/25.
  - Follow up Report, with updates on actions from completed audit reports.
  - Discussion re system governance internal audit report. The trust has concluded this audit as far as possible, outstanding actions sit with the ICB and is not expected that those actions will be completed given the changes in the ICB.
- Counter Fraud
  - New Counter Fraud provider, SAFE. Handover from former provider TiAA remains ongoing. There was no gap in provision of counter fraud service to the trust during this handover.
  - Workplan: developed around two strategic objectives relating to counter fraud. Key work for the year relates to participation in the Counter Fraud Authority's Project Athena pilot, and raising awareness of fraud, bribery and corruption. Positive comments re the workplan and approach taken to develop it.
- Counter fraud annual report not yet received, noting that work is ongoing. To be returned to the extraordinary Audit Committee meeting.
- Security LSMS Report noting key areas of progress in relation to security risk management, security operational team, security/violence and aggression and awareness training, and data sharing. Assurance received regarding the work, but further support from executives needed for staff to attend conflict resolution mandatory training.
- Committee Effectiveness Evaluation and Annual Report, noting:
  - The committee has discharged it's duties as outlined in the terms of reference.

	○ Private committee discussions to be offered with internal and external audit, as identified in the process element of the effectiveness review ○ A positive effectiveness report with two areas for development identified • Annual Effectiveness Review of Auditors (External and Internal), noting a positive opinion from all committee members.
Decisions made at the meeting	• Approval of the counter fraud workplan • Approval of the committee terms of reference • Approval of the committee workplan
Issues / actions referred to other committees / groups	• Nil

Quoracy and Attendance						
	02 Jun 2025	25 Jun 2025	04 Aug 2025	01 Dec 2025	02 Feb 2026	30 Mar 2026
Quorate?	Y					
Stuart Parsons	Y					
Stephen Tilton	Y					
Dave Underwood	Y					

Report to	Board of Directors	
Date of Meeting	10 June 2025	
Report Title	Governance Report	
Prepared By	Jenny Horrabin, Joint Director of Corporate Affairs	
Approved by Accountable Executive	Jenny Horrabin, Joint Director of Corporate Affairs	
Previously Considered By	Audit Committee 2 June 2025 and Committees w/c 26 May 2025	
Action Required	**Approval**	Y
	Assurance	Y
	Information	N

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	Board effectiveness includes effective oversight of strategic risks	
Financial	No specific implications	
Statutory & Regulatory	Compliance with statutory and regulatory requirements reported	
Equality, Diversity & Inclusion	Included within NHS Code of Governance and Leadership Competency Framework	
Co-production & Partnership	Included within NHS Code of Governance	

Executive Summary

- This paper outlines the assessments of compliance that have taken place that collectively inform our annual review of board effectiveness.
  - The NHS Code of Governance
  - The NHS Provider License
  - The Annual Governance Statement 2024/25
  - Fit and Proper Person Test, Leadership Competency Framework and Board Member Appraisal Guidance and Board Development Programme
  - Committee Annual Report, Committee Effectiveness Reviews and Committee Terms of Reference

- We have declared compliance under the 'comply or explain' rules related to statutory and regulatory requirements, in particular the NHS Code of Governance and NHS Provider Licence.
- The Committee reviews have confirmed that the Committees are compliant with their Terms of Reference and the annual effectiveness reviews have provided positive feedback on the effectiveness of the Committees with a small number of areas for improvement, with consistent themes across Committees.
- The Annual Governance Statement (AGS) included as part of the Annual Report has concluded that there are no significant internal control issues. The draft report has been reviewed by the Audit Committee.
- There is a full Joint Board Development Programme in place, and this covers strategy, accountability and culture and leadership. This is complemented by individual training and a central record is maintained of this.
- In April 2025 NHS England published 'Board Member Appraisal Guidance'. NHS England » Board member appraisal guidance. The appraisal process for 2025/26 is currently in progress and will be undertaken in accordance with the guidance, with completion within expected deadlines.
- The terms of Reference for Committees have been approved and are presented for approval.

Recommendation

The Board is asked to confirm that the annual review of Board effectiveness has been completed through the reviews described in this report:

- The new NHS Code of Governance
- The new NHS Provider License
- Fit and Proper Persons Test, Leadership Competency Framework and Board Member Appraisal Guidance and Board Development Programme
- Annual Governance Statement
- Committee Annual Report and Effectiveness Reviews

The Board is asked to approve the Terms of Reference for the Committees of the Board (Appendix A).

Governance Report to the Board of Directors – June 2025

1. Introduction

This paper outlines the assessments of compliance that have taken place that collectively inform our annual review of board effectiveness.

- The NHS Code of Governance
- The NHS Provider License
- The Annual Governance Statement 2024/25
- Fit and Proper Person Test, Leadership Competency Framework and Board Member Appraisal Guidance and Board Development Programme
- Committee Annual Report, Committee Effectiveness Reviews and Committee Terms of Reference

2. The NHS Code of Governance

The NHS Code of Governance sets out a common overarching framework for the corporate governance of trusts, reflecting developments in UK corporate governance and the development of integrated care systems. The new version of the code applies from April 2023. The full code can be found at NHS England » Code of governance for NHS provider trusts. Set out in five sections, the code describes principles of good governance and the provisions (based on the principles) with which provider trusts must 'comply or explain'.

A self-assessment has been completed that provides assurance of compliance with the NHS Code of Governance for 2024/25. The trust is fully compliant. All areas for improvement identified in 2023/24 have been addressed and full compliance is reported.

The full self-assessment to demonstrate compliance with the NHS Code of Governance was presented to the Audit Committee for review on 2 June 2025 and there were no updates or amendments arising. In year compliance will continue to be reported to the Audit Committee during 2025/26.

3. The NHS Provider License

The NHS provider licence forms part of the oversight arrangements for the NHS. It sets out conditions that providers of NHS-funded healthcare services in England must meet to help ensure that the health sector works for the benefit of patients, now and in the future.

A new NHS Provider licence was issued on 31 March 2023. The requirements relating to certification of the licence requirements was removed from the provider licence with effect

from 1 April 2023. NHS England does not routinely monitor and assess compliance against each of the individual licence conditions, although there is an expectation that providers should periodically self-assess. In the majority of cases compliance can be assured through reference to existing plans/strategies.

A self-assessment has been undertaken and this provides assurance to the Board that the trust is compliant with all licence conditions. The full licence with all conditions can be found at PRN00191-nhs-provider-licence-v4.pdf (england.nhs.uk).

License condition CoS7 – Availability of Resources, requires that the trust will have access to the necessary resources for the forthcoming 12-month period and to declare any limitations. The Annual Governance Statement within the Annual Report considers the factors impacting the availability and efficient use of resources and outlines the sources of internal and external assurance the trust has received on the use and availability of resources. This informs the Chief Executive's view of the adequacy of the trust's systems of internal control and provides assurance to the Board of compliance with license condition CoS7.

The trust must also review whether their governors receive enough training and guidance to carry out their roles. The governors receive:

- Induction training
- Governor handbook,
- Regular development events each year
- Regular updates and information on key areas
- Offered training provided through the NHS Providers Governwell programme.

The training provided is regularly reviewed and refreshed through annual reviews of the induction and business programmes and through feedback after the development days and other events. Governors also have access to specialist expertise to provide appropriate and objective guidance including the corporate governance team, communications team in relation to membership and engagement and human resources and external support for the Council of Governors' Nomination and Remuneration Committee.

The full self-assessment to demonstrate compliance with the NHS Provider License was presented to the Audit Committee for review on 2 June 2025 and there were no updates or amendments arising. In year compliance will continue to be reported to the Audit Committee during 2025/26.

4. Fit and Proper Persons Test, Leadership Competency Framework and Board Member Appraisal Guidance

NHS England (NHSE) published a new Fit and Proper Person Test (FPPT) Framework in August 2023 following the Kark review undertaken in 2019. The framework is applicable to executive and non-executive directors, alongside guidance for chairs on implementation. The Board received a detailed briefing on the enhanced requirements to ensure that

members of the Board were 'fit and proper' and are of 'good character' in September 2023 with the NHSE expectation of full implementation of the guidance by 31 March 2024.

During the year the trust ensured compliance with the framework and submitted the required confirmation of compliance return to NHSE by the 30th June 2024. During the year a Standard Operating Procedure (SOP) was developed and the new arrangements for undertaking Disclosure and Barring (DBS) checks for all Board members was implemented. The trust has reviewed and established a robust documentary record system to evidence compliance for each Board member, including:

- Identity and employment history checks.
- Training and development.
- Board member references.
- A confirmatory letter of fitness to / from other organisations in respect of joint appointments.
- Appraisals.
- Disciplinary or grievance process involvement.
- DBS and safeguarding checks.
- Social media checks.
- Professional registration (as appropriate).
- Director and charitable trustee disqualification checks.
- Annual attestations that directors remain 'fit and proper' and are of 'good character'.

We are currently in the process of undertaking our annual review of the Fit and Proper Person Checks and these will be completed by the deadline of 30th June 2025 enabling the trust to submit the Chair's statement of compliance to NHSE by that time.

The Kark review (discussed above) also recommended the implementation of a competency framework for board members which is aligned to NHS England's People Promise. The Leadership Competency Framework aims to promote diversity and high-quality care provision and is based on wider industry best practice.

The framework is for chairs, chief executives and all board members in NHS systems and providers, as well as serving as a guide for aspiring leaders of the future. It is designed to:

- support the appointment of diverse, skilled and proficient leaders
- support the delivery of high-quality, equitable care and the best outcomes for patients, service users, communities and our workforce
- help organisations to develop and appraise all board members

- support individual board members to self-assess against the six competency domains and identify development needs.

Appraisals have been undertaken in accordance with the Leadership Competency Framework, and we have reported compliance with this to NHS England during the year.

In April 2025 NHS England published 'Board Member Appraisal Guidance'. NHS England » Board member appraisal guidance. The appraisal process for 2025/26 is currently in progress and will be undertaken in accordance with the guidance, with completion within expected deadlines.

There is a full Joint Board Development Programme in place, and this covers strategy, accountability and culture and leadership. This is complemented by individual training and a central record is maintained of this.

We have in place a Succession Plan for Non-Executive Directors. This includes a skill matrix and references the Workforce Race Equality Standards (WRES) and Workforce Disability Standards (WDES).

5. Annual Governance Statement

The Annual Governance Statement is a mandatory requirement for the Annual Report and provides a statement by the Chief Executive Officer of their review of the governance systems and processes in place across the trust to ensure effective control and mitigation of risks. NHS England's Annual Reporting Manual sets out guidance and mandatory text requirements of the statement.

The statement discusses the systems of internal control in place across the trust and the trust's capacity to handle risks alongside reviews of efficiency and effectiveness and the use of resources. The concluding declaration is informed by a variety of sources of feedback and assurance including the views of internal auditors who have provided a 'moderate' level of assurances regarding the trust's systems of internal control.

No significant internal control issues have been identified for the year ended 31 March 2025. The statement also includes assurance on condition CoS7 of the NHS Provider Licence, as referenced above.

The draft Annual Governance Statement was also presented to the Audit Committee for review on 2 June 2025. The final draft will be presented to the Audit Committee and Board for approval in June 2025.

6. Committee Annual Report, Committee Effectiveness Reviews and Committee Terms of Reference

Committee Annual Reports

An Annual Report has been completed for each Board Sub-Committee to demonstrate that the Committee has effectively discharged its responsibilities. Each Committee (except for the Remuneration and Terms of Service Committee – see below) has received their respective Annual Reports. These reports have provided assurance that each Committee has effectively discharged its responsibilities, as detailed in the Terms of Reference. This assurance is also report through the Committee Assurance Reports on the Board agenda today.

For the Remuneration and Terms of Service Committee this report forms part of the Remuneration Report which is included in the Annual report. This report has been submitted to External Audit for review and has been included in the Annual Report which has been presented to the Audit Committee and circulated to all Board members. It will be presented to the next meeting of the Committee, together with the annual committee effectiveness review.

Committee Effectiveness Reviews

A Committee Effectiveness Review has been completed for each Committee (with the exception of the Remuneration and Terms of Service Review which is in progress and will be reported to the next meeting of the Committee).

The Audit Committee review followed the checklist from the HFMA Audit Committee Handbook which included a self-assessment for process and a separate effectiveness review.

For the other Committees the review focused on the follow areas:

- Focus
- Team working
- Impact
- Engagement
- Leadership
- Process of meeting

There was a good level of engagement in the reviews with very positive responses in terms of the effectiveness of the Committees and the improvements seen over the past 12 months, particularly as we have moved to Committees in Common. Responses rates ranged from 50% to 82% which demonstrated a strong level of engagement.

There were some areas for improvements and there are actions in place to address these. Key themes included:

- Quality and timeliness of Committee papers – improvements in the quality of papers was observed over the last year but further work is required to ensure the reports are succinct and have the required strategic focus.

- Time constraints – it is recognised that the move to Committees in Common has resulted in longer agendas. The production of more strategically focused and succinct reports for Committees will allow the Committee to more time to focus on key areas of strategic importance and key risk areas.

There was positive feedback on the effectiveness of the Committees in Common in overall terms of the benefits of the shared governance were apparent. We are not considering a move to a Board in Common and a proposal will be brought to the August meeting of the Board.

Committee Terms of Reference and Workplan
The Committee Terms of Reference were reviewed and approved at each Committee. **Appendix A** includes the full pack of Terms of Reference for approval.

This includes the Terms of reference for the Mental Health Legislation Committee – it has previously been agreed to create this as a sub-committee of the Board and as a Committee in Common across DCH and DHC. The Terms of Reference have been presented to the Committee with executive approval and review taking place outside of the Committee and Non-Executive approval required at Board.

7. Conclusion and Recommendations

The Board is asked to confirm that the annual review of Board effectiveness has been completed through the reviews described in this report:

- The new NHS Code of Governance
- The new NHS Provider License
- Fit and Proper Persons Test, Leadership Competency Framework and Board Member Appraisal Guidance and Board Development Programme
- Annual Governance Statement
- Committee Annual Report and Effectiveness Reviews

The Board is asked to approve the Terms of Reference for the Committees of the Board (Appendix A).

Dorset County Hospital NHS Foundation Trust Quality Committee-in-Common TERMS OF REFERENCE	
Committees in Common	• The Dorset County NHS Foundation Trust ('Dorset County Hospital) is putting in place a governance structure, which will enable it to work together with the Dorset Healthcare University NHS Foundation Trust ('Dorset healthcare'). • Each Trust has agreed to establish a committee which shall work in common with the other (**Committee in Common** or **CiC**), but which will each take its decisions independently on behalf of its own Trust. • Each Trust has decided to adopt terms of reference in substantially the same form, except that the membership of each CiC will be different. • The CiC shall meet together with the associated committee from Dorset HealthCare as the **Dorset Trust Quality CiCs**
Responsibilities	• The Committee-in-Common has been established by the Board of Dorset County Hospital NHS Foundation Trust as a committee with these terms of reference, to be known as the Dorset County Hospital Quality CiC. • These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Dorset County Hospital Quality CiC. It is supported in its work by other committees established by the Board. • The Dorset County Hospital Quality CiC is authorised to investigate any activity within these terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to cooperate with any request made by the Committee-in-Common. • The Dorset County Hospital Quality CiC is authorised to obtain external legal or other independent professional advice if it considers this necessary, taking into consideration any issues of confidentiality and the Trust's standing financial instructions. • The Dorset County Hospital Quality CiC is a committee of the Trust and therefore can only make decisions binding Dorset County Hospital NHS Foundation Trust. None of the Trusts other than Dorset County Hospital NHS Foundation Trust can be bound by a decision taken by Dorset County Hospital Quality CiC. • The Dorset County Hospital Quality CiC will form part of a governance structure to support collaborative leadership and relationships with system partners and follow good governance in decision making (as set out in the updated Code of Governance for NHS Provider Trusts). The Dorset County Hospital Quality CiC will have regard in their decision-making to the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources.
Role and Purpose	• Paragraph 15(2) and (3) of Schedule 7 of the National Health Service Act 2006 allows for any of the functions of a Foundation Trust to be delegated to a committee of directors of the Foundation Trust. This power is enshrined in Dorset County Hospital NHS Foundation Trust's Constitution. • The Quality Committee CiC will, together with the other Committees in Common, advise, support and assure the Board of Dorset County Hospital NHS Foundation Trust and Dorset HealthCare University NHS Foundation Trust on matters related to:

	○ Oversight of quality, safety, clinical governance and patient and carer experience on behalf of the Board. ○ Overseeing, monitoring and reviewing the governance arrangements underpinning the planning and delivery of care according to the Care Quality Commission's (CQC) key lines of enquiry for assessing healthcare services. ▪ Are they safe? ▪ Are they effective? ▪ Are they caring? ▪ Are they responsive? ▪ Are they well-led?
Responsibilities	The Dorset County Hospital Quality CiC will together with the other Committees in Common advise, support and assure the Board of Dorset HealthCare University NHS Foundation Trust and Dorset County NHS Foundation Trust on matters related to: • Providing specialist advice, support and assurance to the Board on all matters relating to quality, patient and carer experience, clinical effectiveness, safety, clinical governance, clinical / operational risk and incident management. • Consider all matters which affect the quality of the service, effectiveness, experience and safety of patients. This includes work associated with the following programmes of work: a. Clinical Audit and Effectiveness b. Research and Developing c. Mortality and learning from deaths d. Patient and carers experience e. Learning from Complaints/PALs f. Learning from Incidents, including oversight of the Patient Safety Incident Response Framework (PSIRF) g. Infection Prevention and Control h. Drugs, Therapeutics and non-medical prescribing i. Violence and Personal Safety j. Restrictive interventions k. Safeguarding l. Learning arising from claims and inquests m. Risk Register relevant to the work of the Committee n. Compliance with CQC regulations o. Nutrition and Hydration p. Policies relating to the scope of work of the Committee q. Clinical Procedures (system and process) r. Safer staffing s. Maternity Services (DCH only) t. End of Life Care u. Health Inequalities v. Patient Carer Race Equality Framework (PCREF – DHC only) • Scrutinise assurances on a rolling programme throughout the year as to the Trust's governance arrangements being compliant with the law and with CQC registration requirements and those of other bodies that have regulatory oversight of the services and activities of the Trust. • Review and monitor compliance with new and existing statutory standards, legislative requirements and accreditation standards and will consider

	recommendations for the relative priority for implementation of guidance and the timeliness of implementation. • Consider the development of systems of governance to monitor standards and outcomes of care, including benchmarking schemes and indicators, including non-clinical indicators that impact on clinical care. • Consider quality and clinical governance implications to the Trust of the findings and reports of regulatory, professional and independent bodies such as (but not limited to) Care Quality Commission, NHS Improvement, Royal Colleges, etc. • Review, scrutinise and challenge clinical action plans to address failing targets and / or poor quality or safety matters. • Consider and review the outcome of quality impact assessments which arise from service redesign and Cost Improvement Plans (CIP) and which may adversely impact upon quality and safety. • Consider and agree annual priorities for quality and approve the Trust's Annual Quality Account prior to ratification by the Trust Board. • Approve Statutory Annual Reports for Safeguarding, Complaints and Infection Prevention & Control and other Annual Reports as appropriate to the business of the Committee. • Consider and approve statutory annual mixed sex accommodation declarations and any supporting action plans to address improvements. • Consider and recommend to the Board annual establishment reviews. • Receiving and approving the annual clinical audit programme prior to recommending ratification to Trust Board. • Seek assurance on behalf of the Trust Board for the response to safety and quality risks which appear on the Board Assurance Framework and Corporate Risk Register • Receive assurance on the timely review and approval of the policies relevant to the work of the Committee.
Accountability Arrangements	• The Dorset County Hospital Quality CiC is accountable to the Board of Dorset County Hospital NHS Foundation Trust. • The Committee Chair will provide an assurance report following each meeting to the Board of Directors of Dorset County Hospital NHS Foundation Trust. • Dorset County Hospital Quality CiC shall provide such other reports and communications briefings as requested by Dorset County Hospital NHS Foundation Trust's Board for inclusion on the agenda of Dorset County Hospital NHS Foundation Trust's Board meeting.
Membership / Attendance	**<u>Non-Executive</u>** • Three Non-Executive Directors (at least one and no more than two may be Joint NEDS across DCH and DHC) and one of whom will either be the Chair or the Vice Chair of the Committee **<u>Executive</u>** • Joint Nursing Officer

	• Chief Medical Officer • Chief Operating Officer **<u>In attendance</u>** • DCH - Director of Nursing and Quality • Divisional/Directorate Triumvirate • Joint Deputy Director of Corporate Affairs • Nominated Governor(s) • Other staff of the Trust may be requested to attend for specific matters. Where a member is unable to attend routinely an appropriate deputy who will attend on a regular basis should be nominated and notified to the Chair.
Chair	When the Dorset County Quality CiC meets with the associated committee from Dorset HealthCare NHS Foundation Trust as committees in common (**Dorset Trust Quality CiCs**), one Non-Executive Director will be nominated as the Chair and one Non-Executive Director will be the Vice Chair. In nominating to these roles care should be taken to ensure that both trusts are represented.
Quorum	Members of the Dorset County Hospital Quality CiC have a responsibility for the operation of the Dorset County Hospital Quality CiC. They will participate in discussion, review evidence and provide objective expert input as part of the Dorset Trust Quality CiC to the best of their knowledge and ability, and endeavour to reach a collective view. Each Member of the Dorset County Hospital Quality CiC shall have one vote. The Dorset County Hospital Quality CiC shall reach decisions by consensus of the Members present. The quorum shall be three (3) Members. This must include at least two Non-Executive Directors from the Trust (which may include Joint NEDS acting for both Trusts) and an Executive Director representing each Trust (which may include a Joint Executive Director acting for both Trusts). If any Member is disqualified from voting due to a conflict of interest, they shall not count towards the quorum for the purposes of that agenda item.
Administrative Support	• Administrative support will be arranged by the Corporate Affairs Directorate. • Agenda and papers will be circulated one week prior to the meeting.
Frequency of Meeting	• Subject to the below, Dorset County Hospital Quality CiC meetings shall take place bi-monthly. • Any Trust CiC Member may request an extraordinary meeting of the **Dorset Trust Quality CiCs** (working in common) on the basis of urgency etc. by informing the Chair. In the event it is identified that an extraordinary meeting is required the Chair shall give five (5) Working Days' notice to the Trusts.
Conflict of Interest	• Members of the Dorset County Hospital Quality CiC shall comply with the provisions on conflicts of interest contained in Dorset County Hospital NHS Foundation Trust Constitution/Standing Orders and NHS Conflicts of Interest guidance. For the avoidance of doubt, reference to conflicts of interest in Dorset County Hospital NHS Foundation Trust Constitution/Standing Orders also apply to conflicts which may arise in their position as a Member of the Dorset County Hospital Quality CiC. • All Members of the Dorset County Hospital Quality CiC shall declare any new interest at the beginning of any meeting and at any point during a meeting if relevant.

Date Approved	• Approved by Quality Committee 25 March 2025 • Ratified by Dorset County Hospital NHS Foundation Trust Board of Directors 08 April 2025
Date of Next Review	31 March 2026

Dorset County Hospital NHS Foundation Trust
Finance and Performance Committee-in-Common

TERMS OF REFERENCE

1. Committees in Common	• The Dorset County Hospital NHS Foundation Trust has put in place a governance structure, which will enable it to work together with the Dorset HealthCare University NHS Foundation Trust. • Each Trust has agreed to establish a committee which shall work in common with the other (**Committee in Common** or **CiC**), but which will each take its decisions independently on behalf of its own Trust. • Each Trust has decided to adopt terms of reference in substantially the same form, except that the membership of each CiC will be different. • The CiC shall meet together with the associated committee from Dorset HealthCare University NHS Foundation Trust as the **Dorset Trust Finance and Performance CiCs**
2. Duties	• The Committee-in-Common has been established by the Board of Dorset County NHS Foundation Trust as a committee with these terms of reference, to be known as the Dorset County Hospital Finance and Performance CiC. • These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Dorset County Hospital Finance and Performance CiC. It is supported in its work by other committees established by the Board. • The Dorset County Hospital Finance and Performance CiC is authorised to investigate any activity within these terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to cooperate with any request made by the Committee-in-Common. • The Dorset County Hospital Finance and Performance CiC is authorised to obtain external legal or other independent professional advice if it considers this necessary, taking into consideration any issues of confidentiality and the Trust's standing financial instructions. • The Dorset County Hospital Finance and Performance CiC is a committee of the Trust and therefore can only make decisions binding Dorset County Hospital NHS Foundation Trust. None of the Trusts other than Dorset County Hospital NHS Foundation Trust can be bound by a decision taken by Dorset County Hospital Finance and Performance CiC. • The Dorset County Hospital CiC will form part of a governance structure to support collaborative leadership and relationships with system partners and follow good governance in decision making (as set out in the updated Code of Governance for NHS Provider Trusts). The Dorset County Hospital Finance and Performance CiC will have regard in their decision-making to the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources.
Role and Purpose	• Paragraph 15(2) and (3) of Schedule 7 of the National Health Service Act 2006 allows for any of the functions of a Foundation Trust to be delegated to a committee of directors of the Foundation Trust. This power is enshrined in Dorset County Hospital NHS Foundation Trust's Constitution.

	• The Dorset County Hospital Finance and Performance CiC will together with the other Committee in Common advise, support and assure the Board of Dorset HealthCare University NHS Foundation Trust and Dorset County NHS Foundation Trust on matters related to: o reviewing financial and operational performance. This will include operational performance against both internal and external (agreed local, regional, national, regulatory, commissioning and contractual) indicators and reviewing financial performance and delivery of the Trusts financial efficiency / cost improvement plans. o scrutinising and approving enabling strategies, business cases, expenditure, procurement and financial plans in line with the Standing Financial Instructions and Scheme of Delegation. o Oversight of compliance in respect of estates, health and safety (including fire and water) and Emergency Preparedness, Response and Resilience, Subsidiary Companies and Joint Ventures.
Responsibilities	**1. Operational Performance** a) Review performance against key national, local and internal targets and indicators. b) Review exception reports and action plans for those targets and indicators where delivery is at risk. c) Review the contractual risk attached to non-achievement of national and local targets. d) Agree the composition of the performance scorecard on an annual basis **2. Financial Planning** a) Review and recommend to the Board for approval the Trust's Financial Plan, considering alignment with the Trusts strategic ambitions, national requirements, and system plans. b) Review and recommend to the Board for approval the Trust's Budget Setting Policy. c) Consider ad hoc financial issues that arise (e.g. check Private Patient Cap, estate revaluation etc.) **3. Financial Performance** a) Monitor the financial performance of the Trust, including: b) performance against plans; c) delivery of key financial duties; d) any variances against plans, risks to delivery and the adequacy and effectiveness of associated recovery and action plans; e) the development of key financial metrics; and f) the delivery of the Cost Improvement Plan g) Scrutinise arrangements for a working capital facility and other long terms loans if required, and investment of surplus cash. h) Consider such other matters and take such other decisions of a generally financial nature as the Board of Directors shall delegate to it. **4. Capital Planning and Performance** a) Oversee the development and management of the rolling capital programme including scrutiny of the prioritisation process, forecasting and remedial action, and report to the Board of Directors accordingly. b) Review and recommend to the Board for approval the Capital Plan / Programme prior to submission to the Trust Board for approval. **5. Business Cases and Investments** a) Review and approve business cases for investment and investment in accordance with the Trust's Standing Financial Instructions and Scheme of Delegation and Reservation of Powers to the Board, ensuring that outcomes and benefits are clearly defined and

	measurable and support achievement of the Trust's objectives and make recommendations to the Board for approval as appropriate. b) Periodically assess the benefits realisation of business cases and major projects through post-implementation reviews, ensuring that potential learning is shared for future investment and delivery. c) Approve the Treasury Policy in line with national guidance. d) Scrutinise arrangements for a working capital facility and other long terms loans if required, and investment of surplus cash. **6. Procurement** a) Approval of the Procurement Strategies and Plans. b) Ensure compliance with procurement legislation. c) Maintain oversight of contractual matters and approve contract awards in accordance with the Standing Orders and Standing Financial Instructions. **7. Other** a) Review arrangements in respect of estates, health and safety, fire and water and ensure compliance with regulatory and statutory requirements. b) Maintain oversight of the arrangements in place for Emergency Planning, Response and Resilience, including approval of annual submissions and monitoring of actions required to ensure compliance. c) Where the Trust is the lead provider as part of a provider collaborative receive assurance and provide oversight of matters related to finance and performance d) Where the trust establishes either a subsidiary company or a joint venture, the Finance and Performance Committee will be responsible for maintaining oversight of the activity and governance arrangements surround each respectively. The committee will ensure that the Trust's Standing Financial Instructions and Scheme of Delegation reflect the delegated authorities provided under each arrangement and seek assurances of compliance on behalf of the Board. The committee will require the following after a meeting of any subsidiary company or Joint Venture Board: • Summary of activities undertaken and decisions made • A report assuring statutory compliance with applicable regulations and submission of statutory returns • Timely escalation of identified risk and mitigating actions agreed. **8. Governance** a) Seek assurance on behalf of the Trust Board for the response to finance and performance risks which appear on the Board Assurance Framework and Corporate Risk Register b) Receive assurance on the timely review and approval of the policies relevant to the work of the Committee.
Accountability Arrangements	• The Dorset County Hospital Finance and Performance CiC is accountable to the Board of Dorset County Hospital NHS Foundation Trust. • The Committee Chair will provide an assurance report following each meeting to the Board of Directors of Dorset County Hospital NHS Foundation Trust. • Dorset County Hospital Finance and Performance CiC shall provide such other reports and communications briefings as requested by Dorset County Hospital NHS Foundation Trust's Board for inclusion on the agenda of Dorset County Hospital NHS Foundation Trust's Board meeting.

Membership / Attendance	**Non-Executive** • Three Non-Executive Directors (at least one and no more than two may be Joint NEDS across DCH and DHC) and one of whom will either be the Chair or the Vice Chair of the Committee **Executive** • Joint Chief Finance Officer • Joint Chief Strategy, Transformation and Partnerships Officer • Chief Medical Officer • Chief Operating Officer **In attendance** • Directors of Operations (or equivalent for each Directorate) • Director of Nursing • Nominated Governor(s) • Other staff of the Trust may be requested to attend for specific matters. • Where a member is unable to attend routinely an appropriate deputy who will attend on a regular basis should be nominated and notified to the Chair.
Chair	When the Dorset County Finance and Performance CiC meets with the associated committee from Dorset HealthCare University NHS Foundation Trust as committees in common (**Dorset Trust Finance and Performance CiCs**), one Non-Executive Director will be nominated as the Chair and one Non-Executive Director will be the Vice Chair. In nominating to these roles care should be taken to ensure that both trusts are represented.
Quorum	Members of the Dorset County Hospital Finance and Performance CiC have a responsibility for the operation of the Dorset County Hospital Finance and Performance CiC. They will participate in discussion, review evidence and provide objective expert input as part of the **Dorset Trust Finance and Performance CiCs** to the best of their knowledge and ability, and endeavour to reach a collective view. Each Member of the Dorset County Hospital Finance and Performance CiC shall have one vote. The Dorset County Hospital Finance and Performance CiC shall reach decisions by consensus of the Members present. The quorum shall be three (3) Members. This must include at least two Non-Executive Directors from the Trust (which may include Joint NEDS acting for both Trusts) and an Executive Director. If any Member is disqualified from voting due to a conflict of interest, they shall not count towards the quorum for the purposes of that agenda item.
Administrative Support	Administrative support will be provided by the Executive Assistant to the Joint Chief Finance Officer or Chief Operating Officer. Agenda and papers will be circulated one week prior to the meeting.
Frequency of Meeting	• The Dorset County Hospital Finance and Performance CiC shall meet with the associated committee from Dorset HealthCare University NHS Foundation Trust as the **Dorset Trust Finance and Performance CiCs** and discuss the matters delegated to them in accordance with their respective Terms of References. • Subject to the below, Dorset County Hospital Finance and Performance CiC meetings shall take place bi-monthly. • Any Trust CiC Member may request an extraordinary meeting of the **Dorset Trust Finance and Performance CiCs** (working in common) on the basis of urgency etc. by informing the Chair. In the event it is identified that an extraordinary meeting is required the Chair shall give five (5) Working Days' notice to the Trusts.

Conflict of Interest	• Members of the Dorset County Hospital Finance and Performance CiC shall comply with the provisions on conflicts of interest contained in Dorset County Hospital NHS Foundation Trust Constitution/Standing Orders and NHS Conflicts of Interest guidance. For the avoidance of doubt, reference to conflicts of interest in Dorset County Hospital NHS Foundation Trust Constitution/Standing Orders also apply to conflicts which may arise in their position as a Member of the Dorset County Hospital Finance and Performance CiC. • All Members of the Dorset County Hospital Finance and Performance CiC shall declare any new interest at the beginning of any Dorset County Hospital Finance and Performance CiC meeting and at any point during a **Dorset Trust Finance and Performance CiCs** meeting if relevant.
Date Approved	• Approved by Finance and Performance Committee 29th May 2025 • Ratified by Dorset County NHS Foundation Trust Board of Directors xxxx
Date of Next Review	31 March 2026

Dorset County Hospital NHS Foundation Trust **People and Culture Committee-in-Common** **TERMS OF REFERENCE**	
Committees in Common	• The Dorset County Hospital NHS Foundation Trust ('Dorset County Hospital') has put in place a governance structure, which will enable it to work together with the Dorset HealthCare University NHS Foundation Trust. • Each Trust has agreed to establish a committee which shall work in common with the other (**Committee in Common** or **CiC**), but which will each take its decisions independently on behalf of its own Trust. • Each Trust has decided to adopt terms of reference in substantially the same form, except that the membership of each CiC will be different. • The CiC shall meet together with the associated committee from Dorset HealthCare University NHS Foundation Trust as the **Dorset Trust People and Culture CiCs**
Duties	• The Committee-in-Common has been established by the Board of Dorset County NHS Foundation Trust as a committee with these terms of reference, to be known as the Dorset County Hospital People and Culture CiC. • These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Dorset County Hospital People and Culture CiC. It is supported in its work by other committees established by the Board. • The Dorset County Hospital People and Culture CiC is authorised to investigate any activity within these terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to cooperate with any request made by the Committee-in-Common. • The Dorset County Hospital People and Culture CiC is authorised to obtain external legal or other independent professional advice if it considers this necessary, taking into consideration any issues of confidentiality and the Trust's standing financial instructions. • The Dorset County Hospital People and Culture CiC is a committee of the Trust and therefore can only make decisions binding Dorset County Hospital NHS Foundation Trust. None of the Trusts other than Dorset County Hospital NHS Foundation Trust can be bound by a decision taken by Dorset County Hospital People and Culture CiC. • The Dorset County Hospital CiC will form part of a governance structure to support collaborative leadership and relationships with system partners and follow good governance in decision making (as set out in the updated Code of Governance for NHS Provider Trusts). The Dorset County Hospital People and Culture CiC will have regard in their decision-making to the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources.
Role and Purpose	• Paragraph 15(2) and (3) of Schedule 7 of the National Health Service Act 2006 allows for any of the functions of a Foundation Trust to be delegated to a committee of directors of the Foundation Trust. This power is enshrined in Dorset County Hospital NHS Foundation Trust's Constitution.

	• The Dorset County Hospital People and Culture CiC will together with the other Committee in Common advise, support and assure the Board of Dorset HealthCare University NHS Foundation Trust and Dorset County NHS Foundation Trust on matters related to the production and delivery of strategies and plans related to people, culture and organisational development and to oversee key performance indicators relevant to the scope of the work of the Committee. The scope of the Committee will include matters related to Equality, Diversity and Inclusion, annual reporting and compliance with regulatory and legislative requirements.
Responsibilities	**1. Strategies and Transformational Change** a) Oversee progress on the development and delivery of People and Organisational Development Strategies, taking into account relevant best practice and ensuring alignment with the Trust's strategic priorities and objectives. b) Maintaining oversight of workforce changes as a result of transformational change and oversee the aspects of significant service changes relevant to the scope of the Committee. **2. Plans and Performance** a) Receiving and approving relevant People and Organisational Development plans and ensuring that they are consistent with the Trust's strategies and identifying and monitoring where further actions are required. b) Reviewing workforce related performance indicators and ensuring there are plans in place to address key risk areas and monitoring implementation of these plans. c) Maintain oversight of key strategic workforce related equality and diversity compliance requirements, including relevant equality, diversity and inclusion legislation. d) Analysing national and local reports on significant workforce matters and monitoring implementation and resulting action. **3. Culture, Engagement & Education** a) Providing oversight of the delivery of key improvement actions in response to the annual Staff Survey and other engagement survey results and ensuring these are aligned to the People Plan. b) To receive and review quarterly and annual reports of the Guardian of Safe Working c) Provide oversight of Freedom to Speak Up arrangements and ensure the promotion and continuance of a healthy speak up culture and identification and embedding of any learning arising. d) Ensure that effective arrangements are in place to secure the availability of a competent and appropriately qualified workforce to deliver healthcare for the Trust (including workforce safeguards), including education, learning and development. e) Provide oversight of the arrangements in place for the health and wellbeing of the workforce, including monitoring key metrics associated with this. **4. Governance** a) Seek assurance on behalf of the Trust Board for the response to people risks which appear on the Board Assurance Framework and Corporate Risk Register b) Receive assurance on the timely review and approval of the policies relevant to the work of the Committee.

Accountability Arrangements	• The Dorset County Hospital CiC is accountable to the Board of Dorset County Hospital NHS Foundation Trust. • The Committee Chair will provide an assurance report following each meeting to the Board of Directors of Dorset County Hospital NHS Foundation Trust. • Dorset County Hospital CiC shall provide such other reports and communications briefings as requested by Dorset County Hospital NHS Foundation Trust's Board for inclusion on the agenda of Dorset County Hospital NHS Foundation Trust's Board meeting.
Membership / Attendance	**Non-Executive** • Three Non-Executive Directors (at least one and no more than two may be Joint NEDs across DCH and DHC) and one of whom will either be the Chair or the Vice Chair of the Committee **Executive** • Joint Chief People Officer • Joint Chief Nursing Officer • Chief Medical Officer **In attendance** • Director of Finance • One Nominated Governor~~(s)~~ • Other staff of the Trust may be requested to attend for specific matters. • Where a member is unable to attend routinely an appropriate deputy who will attend on a regular basis should be nominated and notified to the Chair.
Chair	When the Dorset County Hospital People and Culture CiC meets with the associated committee from Dorset HealthCare University NHS Foundation Trust as committees in common (**Dorset Trust People and Culture CiCs**), one Non-Executive Director will be nominated as the Chair and one Non-Executive Director will be the Vice Chair. In nominating to these roles care should be taken to ensure that both trusts are represented.
Quorum	Members of the Dorset County Hospital People and Culture CiC have a responsibility for the operation of the Dorset County Hospital People and Culture CiC. They will participate in discussion, review evidence and provide objective expert input as part of the **Dorset Trust People and Culture CiCs** to the best of their knowledge and ability, and endeavour to reach a collective view. Each Member of the Dorset County Hospital People and Culture CiC shall have one vote. The Dorset County Hospital People and Culture CiC shall reach decisions by consensus of the Members present. The quorum shall be three (3) Members. This must include at least two Non-Executive Directors from the Trust (which may include Joint NEDS acting for both Trusts) and an Executive Director. If any Member is disqualified from voting due to a conflict of interest, they shall not count towards the quorum for the purposes of that agenda item.
Administrative Support	Administrative support will be provided by the Executive Assistant to the Joint Chief People Officer. Agenda and papers will be circulated one week prior to the meeting.
Frequency of Meeting	• The Dorset County Hospital People and Culture CiC shall meet with the associated committee from Dorset HealthCare University NHS Foundation Trust as the **Dorset Trust People and Culture CiCs** and discuss the matters delegated to them in accordance with their respective Terms of References.

	• Subject to the below, Dorset County Hospital People and Culture CiC meetings shall take place bi-monthly. • Any Trust CiC Member may request an extraordinary meeting of the **Dorset Trust People and Culture CiCs** (working in common) on the basis of urgency etc. by informing the Chair. In the event it is identified that an extraordinary meeting is required the Chair shall give five (5) Working Days' notice to the Trusts.
Conflict of Interest	• Members of the Dorset County Hospital People and Culture CiC shall comply with the provisions on conflicts of interest contained in Dorset County Hospital NHS Foundation Trust Constitution/Standing Orders and NHS Conflicts of Interest guidance. For the avoidance of doubt, reference to conflicts of interest in Dorset County Hospital NHS Foundation Trust Constitution/Standing Orders also apply to conflicts which may arise in their position as a Member of the Dorset County Hospital People and Culture CiC. • All Members of the Dorset County Hospital People and Culture CiC shall declare any new interest at the beginning of any Dorset County Hospital People and Culture CiC meeting and at any point during a **Dorset Trust People and Culture CiCs** meeting if relevant.
Date Approved	• Approved by People and Culture Committee 28th May 2025 • Ratified by Dorset County ~~University~~ NHS Foundation Trust Board of Directors xxxxx
Date of Next Review	31 March 2026

Dorset County Hospital NHS Foundation Trust **Strategy, Transformation and Partnerships Committee-in-Common** **TERMS OF REFERENCE**	
Committees in Common	• The Dorset County Hospital NHS Foundation Trust has put in place a governance structure, which will enable it to work together with the Dorset HealthCare University NHS Foundation Trust. • Each Trust has agreed to establish a committee which shall work in common with the other (**Committee in Common** or **CiC**), but which will each take its decisions independently on behalf of its own Trust. • Each Trust has decided to adopt terms of reference in substantially the same form, except that the membership of each CiC will be different. • The CiC shall meet together with the associated committee from Dorset HealthCare University NHS Foundation Trust as the **Dorset Trust Strategy, Transformation and Partnerships CiCs**
Duties	• The Committee-in-Common has been established by the Board of Dorset County NHS Foundation Trust as a committee with these terms of reference, to be known as the Dorset County Hospital Strategy, Transformation and Partnerships CiC. • These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Dorset County Hospital Strategy, Transformation and Partnerships CiC. It is supported in its work by other committees established by the Board. • The Dorset County Hospital Strategy, Transformation and Partnerships CiC is authorised to investigate any activity within these terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to cooperate with any request made by the Committee-in-Common. • The Dorset County Hospital Strategy, Transformation and Partnerships CiC is authorised to obtain external legal or other independent professional advice if it considers this necessary, taking into consideration any issues of confidentiality and the Trust's standing financial instructions. • The Dorset County Hospital Strategy, Transformation and Partnerships CiC is a committee of the Trust and therefore can only make decisions binding Dorset County Hospital NHS Foundation Trust. None of the Trusts other than Dorset County Hospital NHS Foundation Trust can be bound by a decision taken by Dorset County Hospital Strategy, Transformation and Partnerships CiC. • The Dorset County Hospital CiC will form part of a governance structure to support collaborative leadership and relationships with system partners and follow good governance in decision making (as set out in the updated Code of Governance for NHS Provider Trusts). The Dorset County Hospital Strategy, Transformation and Partnerships CiC will have regard in their decision-making to the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources.
Role and Purpose	• Paragraph 15(2) and (3) of Schedule 7 of the National Health Service Act 2006 allows for any of the functions of a Foundation Trust to be delegated to a committee of directors of the Foundation Trust. This power is enshrined in Dorset County Hospital NHS Foundation Trust's Constitution.

	• The Dorset County Hospital Strategy, Transformation and Partnerships CiC will together with the other Committee in Common advise, support and assure the Board of Dorset HealthCare University NHS Foundation Trust and Dorset County NHS Foundation Trust on matters related to: o oversight of delivery of the Trusts strategic objectives and priorities and the One Transformation Approach (consisting of four portfolios: Place and Neighbourhood; Sustainable Services; Mental health and; Working Together) o maintaining oversight of the programmes of work in respect of digital; net zero; new hospitals programme and quality improvement and ensuring alignment with the strategic objectives and priorities and the One Transformation Approach. o maintaining oversight of all collaboratives and partnership arrangements, ensuing alignment with the strategic objectives and priorities and the One Transformation Approach
Responsibilities	**1. Strategy and Strategic Performance** a) Receive assurance on delivery of the Trusts strategic objectives and priorities and achievement of key strategic metrics and milestones. b) Consider risks and issues and where is necessary, ensure recovery plans are in place and oversee delivery of these plans. **2. One Transformation Approach** a) Ensure that the Trust has a robust process in place for the identification and delivery of individual schemes within the One Transformation Approach, including the establishment of a gateway process. b) Approve the One Transformation Approach portfolio and priority projects considering strategic fit; clinical prioritisation; affordability and deliverability. c) Monitor delivery of the One Transformation Approach / projects and seek assurance on the benefits realisation through the transformation programmes and achievement of agreed outcomes. d) Monitor escalated risks and mitigations in place in respect of the One Transformation Approach. e) Maintain oversight of the Quality Improvement Programme and monitor delivery of projects and achievement of outcomes f) Specific oversight of the Working Together Programme (as part of the One Transformation Approach) to: o Ensure the implementation of all duties and obligation within the agreed Memorandum of Understanding, including overseeing the review process. o Maintain oversight of the Working Together Programme to ensure achievement of collaborative working practices across DCH and DHC that improve resilience and optimise the use of resources, productivity, and efficiency across both organisations. o Scrutinise risks and mitigations to delivery of the strategic aims of the Working Together Programme, reporting or escalating these to the respective Boards and monitor areas of good practice, benefits realised and learning across both organisations and with key partners and stakeholders. o Approve the alignment of policy where this reduces duplication of effort, reduce costs or simplifies decision-making. **3. Provider Collaboratives and Other Partnerships**

	a) Approve and recommend to the Board any agreements or Memorandums of Understandings that the Trust enters into in respect of partnerships and collaboratives. b) Maintain oversight of the Provider Collaboratives and / or partnerships that the Trust is engaged in, with a particular focus on the different role the Trust plays in each partnership / collaborative and any risks arising from this and monitor delivery of projects and achievement of outcomes. *Where we are the lead provider monitoring of contractual performance will fall within the scope of the Finance and Performance Committee. Monitoring of quality and safety will fall within the scope of the Quality (Governance) Committee.* **4. Digital and Cyber Security** a) Approve Digital Transformation Strategies and Plans, ensuing these are aligned to strategic objectives and the One Transformation Approach b) Receive assurance on plans in place to manage risks associate with cyber security. **4. Net Zero** a) Approve Green / Net Zero Strategies and Plans, ensuing these are aligned to strategic objectives and the One Transformation Approach and meet all statutory and regulatory requirements. b) Maintain oversight of the Green / Net Zero Programme and monitor delivery of projects and achievement of outcomes. **5. New Hospitals Programme** a) Maintain oversight of the New Hospitals Programme and monitor delivery of projects and achievement of outcomes. **6. Governance** a) Seek assurance on behalf of the Trust Board for the response to strategy, transformation and partnership risks which appear on the Board Assurance Framework and Corporate Risk Register b) Receive assurance on the timely review and approval of the policies relevant to the work of the Committee.
Accountability Arrangements	• The Dorset County Hospital Strategy, Transformation and Partnerships CiC is accountable to the Board of Dorset County Hospital NHS Foundation Trust. • The Committee Chair will provide an assurance report following each meeting to the Board of Directors of Dorset County Hospital NHS Foundation Trust. • Dorset County Hospital Strategy, Transformation and Partnerships CiC shall provide such other reports and communications briefings as requested by Dorset County Hospital NHS Foundation Trust's Board for inclusion on the agenda of Dorset County Hospital NHS Foundation Trust's Board meeting.
Membership / Attendance	**<u>Non-Executive</u>** • Three Non-Executive Directors (at least one and no more than two may be Joint NEDS across DCH and DHC) and one of whom will either be the Chair or the Vice Chair of the Committee **<u>Co-Opted Members</u>** • Dorset GP Alliance • Dorset MH Forum **<u>Executive</u>**

	• Joint Chief Finance Officer • Joint Chief Strategy, Transformation and Partnerships Officer • Joint Chief Nursing Officer • Joint Chief People Officer **<u>In attendance</u>** • Director of Strategy • Director of Transformation • Associate Chief Medical Officer - Transformation • Nominated Governor(s) • Other staff of the Trust may be requested to attend for specific matters. • Where a member is unable to attend routinely an appropriate deputy who will attend on a regular basis should be nominated and notified to the Chair.
Chair	When the Dorset County Hospital, Strategy, Transformation and Partnership CiC meets with the associated committee from Dorset HealthCare University NHS Foundation Trust as committees in common (**Dorset Trust Strategy, Transformation and Partnership CiCs**), one Non-Executive Director will be nominated as the Chair and one Non-Executive Director will be the Vice Chair. In nominating to these roles care should be taken to ensure that both trusts are represented.
Quorum	Members of the Dorset County Hospital Strategy, Transformation and Partnerships CiC have a responsibility for the operation of the Dorset County Hospital Strategy, Transformation and Partnership CiC. They will participate in discussion, review evidence and provide objective expert input as part of the **Dorset Trust Strategy, Transformation and Partnerships CiCs** to the best of their knowledge and ability, and endeavour to reach a collective view. Each Member of the Dorset County Hospital Strategy, Transformation and Partnerships CiC shall have one vote. The Dorset County Hospital Strategy, Transformation and Partnerships CiC shall reach decisions by consensus of the Members present. The quorum shall be three (3) Members. This must include at least two Non-Executive Directors from the Trust (which may include Joint NEDS acting for both Trusts) and an Executive Director. least one Non-Executive Directors from the Trust and an Executive Director. If any Member is disqualified from voting due to a conflict of interest, they shall not count towards the quorum for the purposes of that agenda item.
Administrative Support	Administrative support will be provided by the Executive Assistant to the Chief Strategy, Transformation and Partnerships Officer. Agenda and papers will be circulated one week prior to the meeting.
Frequency of Meeting	• The Dorset County Hospital Strategy, Transformation and Partnerships CiC shall meet with the associated committee from Dorset HealthCare University NHS Foundation Trust as the **Dorset Trust Strategy, Transformation and Partnerships CiCs** and discuss the matters delegated to them in accordance with their respective Terms of References. • Subject to the below, Dorset County Hospital Strategy, Transformation and Partnerships CiC meetings shall take place bi-monthly. • Any Trust CiC Member may request an extraordinary meeting of the **Dorset Trust Strategy, Transformation and Partnerships CiCs** (working in common) on the basis of urgency etc. by informing the Chair. In the event it is identified that an extraordinary meeting is required the Chair shall give five (5) Working Days' notice to the Trusts.

Conflict of Interest	• Members of the Dorset County Hospital Strategy, Transformation and Partnerships CiC shall comply with the provisions on conflicts of interest contained in Dorset County Hospital NHS Foundation Trust Constitution/Standing Orders and NHS Conflicts of Interest guidance. For the avoidance of doubt, reference to conflicts of interest in Dorset County Hospital NHS Foundation Trust Constitution/Standing Orders also apply to conflicts which may arise in their position as a Member of the Dorset County Hospital Strategy, Transformation and Partnerships CiC. • All Members of the Dorset County Hospital Strategy, Transformation and Partnerships CiC shall declare any new interest at the beginning of any Dorset County Hospital Strategy, Transformation and Partnerships CiC meeting and at any point during a **Dorset Trust Strategy, Transformation and Partnerships CiCs** meeting if relevant.
Date Approved	• Approved by Strategy, Transformation and Partnerships Committee 28th May 2025 • Ratified by Dorset County NHS Foundation Trust Board of Directors xxxx
Date of Next Review	31 March 2026

Dorset County Hospital NHS Foundation Trust
Audit Committee

TERMS OF REFERENCE

1. Constitution	The board hereby resolves to establish a committee of the board to be known **as the Audit Committee (the committee).** The committee is a non-executive committee of the board and has no executive powers, other than those specifically delegated in these terms of reference.
2. Authority	The committee is authorised by the board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee, and all employees are directed to cooperate with any request made by the committee. The committee is authorised by the board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise, if it considers this necessary.
3. Responsibilities	**A. Governance, risk management and internal control** i. The committee shall review the adequacy and effectiveness of the system of governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical), that supports the achievement of the organisation's objectives. ii. In particular, the committee will review the adequacy and effectiveness of: • all risk and control related disclosure statements (in particular the annual governance statement), together with any accompanying head of internal audit opinion, external audit opinion or other appropriate independent assurances, prior to submission to the board • the underlying assurance processes that indicate the degree of achievement of the organisation's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements • the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications, including the NHS Code of Governance and NHS Provider licence • the policies and procedures for all work related to counter fraud, bribery and corruption as required by the NHSCFA. • Approval of amendments to the Standing Order and Standing Financial Instructions and Scheme of Delegation. iii. In carrying out this work the committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of governance, risk management and internal control, together with indicators of their effectiveness. iv. This will be evidenced through the committee's use of an effective assurance framework to guide its work and the audit and assurance functions that report to it. v. As part of its integrated approach, the committee will have effective relationships with other key committees so that it understands

processes and linkages. However, these other committees must not usurp the committee's role.

B. Internal audit

i. The committee shall ensure that there is an effective internal audit function that meets the *Public sector internal audit standards, 2017* and provides appropriate independent assurance to the committee, accountable/ accounting officer and board. This will be achieved by:

- considering the provision of the internal audit service and the costs involved
- reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework
- considering the major findings of internal audit work (and management's response), and ensuring coordination between the internal and external auditors to optimise the use of audit resources
- ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation
- monitoring the effectiveness of internal audit and carrying out an annual review.

C. External audit

i. The committee shall review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process. In particular, the committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit (and make recommendations to the board when appropriate)
- discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan
- discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee
- reviewing all external audit reports, including the report to those charged with governance (before its submission to the board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses
- ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services.

ii. The Committee shall develop and agree with the Council of Governors the criteria for the appointment, re-appointment and removal of the External Auditors and make recommendations to the Council of Governors in relation to the appointment and re-appointment of External Auditors.

D. Other assurance functions

i. The committee shall review the findings of other significant assurance functions, both internal and external to the organisation, where relevant to the governance, risk management and assurance of the organisation.

ii. These may include, but will not be limited to, any reviews by Department of Health and Social Care arm's length bodies or regulators/ inspectors (for example, the Care Quality Commission, NHS Resolution) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges, accreditation bodies).

iii. In addition, the committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the committee's own areas of responsibility. In particular, this will include any committees covering safety/ quality, for which assurance from clinical audit can be assessed, and risk management.

E. Counter fraud

i. The committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud, bribery and corruption that meet NHSCFA's standards and shall review the outcomes of work in these areas.

ii. With regards to the local counter fraud specialist it will review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans and discuss NHSCFA quality assessment reports.

F. Management

i. The committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

ii. The committee may also request specific reports from individual functions within the organisation (for example, compliance reviews or accreditation reports).

G. Financial reporting

i. The committee shall monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance.

ii. The committee should ensure that the systems for financial reporting to the board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

iii. The committee shall approve retrospectively review losses and special payments.

iv. The committee shall review the annual report and financial statements before submission to the board, or on behalf of the board where appropriate delegated authority is place, focusing particularly on:

- the wording in the annual governance statement and other disclosures relevant to the terms of reference of the committee
- changes in, and compliance with, accounting policies, practices and estimation techniques
- unadjusted misstatements in the financial statements
- significant judgements in preparation of the financial statements
- significant adjustments resulting from the audit
- letters of representation
- explanations for significant variances.

	H. System for raising concerns i. The committee shall annually review the effectiveness of the arrangements in place for allowing staff (and contractors) to raise (in confidence) concerns about possible improprieties in any area of the organisation (financial, clinical, safety or workforce matters) and ensure that any such concerns are investigated proportionately and independently, and in line with the relevant policies. Regular and ongoing review shall be the responsibility of the People and Culture Committee. **I. Governance regulatory compliance** i. The committee shall review the organisation's reporting on compliance with the *NHS Provider Licence*, *NHS code of governance* and the fit and proper persons test. ii. The committee shall satisfy itself that the organisation's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the policy and procedures relating to conflicts of interest. iii. The committee shall satisfy itself that the organisation's policy, systems and processes for the management of Freedom of Information requests are effective including receiving reports relating to non-compliance with regulatory requirements. iv. The Committee will maintain annual oversight of Data Security and Protection compliance (receipt of annual submission).
4. Accountability Arrangements	The committee shall report to the board on how it discharges its responsibilities. The minutes of the committee's meetings shall be formally recorded by the secretary and available for the board, with an assurance report from then Committee provided to the Board. The chair of the committee shall draw to the attention of the board any issues that require disclosure to the full board, or require executive action. The committee will report to the board at least annually on its work in support of the annual governance statement, specifically commenting on the: • fitness for purpose of the assurance framework • completeness and 'embeddedness' of risk management in the organisation • effectiveness of governance arrangements • appropriateness of the evidence that shows that the organisation is fulfilling regulatory requirements relating to its existence as a functioning business. This annual report should also describe how the committee has fulfilled its terms of reference and give details of any significant issues that the committee considered in relation to the financial statements and how they were addressed. An annual committee effectiveness evaluation will be undertaken and reported to the committee and the board.
5. Membership / Attendance	**<u>Membership</u>** • The committee shall be appointed by the board from amongst its independent, non-executive directors and shall consist of not less than three members one of whom shall possess recent, relevant financial experience.

	• The Committee Chair will not be the senior independent director of the Trust or the deputy chair of the Board. **<u>Attendance</u>** • The Joint Chief Finance Officer and appropriate internal and external audit representatives shall normally attend meetings. • The counter fraud specialist (LCFS) will attend a minimum of two committee meetings a year. • The Joint Executive Director of Corporate Affairs may attend meetings. • The Accounting Officer should be invited to attend meetings and should discuss at least annually with the committee the process for assurance that supports the governance statement. They should also attend when the committee considers the draft annual governance statement and the annual report and accounts. • Other executive directors/ managers should be invited to attend, particularly when the committee is discussing areas of risk or operation that are the responsibility of that director/ manager. • Governors will be invited to attend meetings of the Committee, with a nominated Governor assigned to the Committee. • Representatives from other organisations (for example, the NHS Counter Fraud Authority (NHSCFA)) and other individuals may be invited to attend on occasion, by invitation. • A nominated person shall be secretary to the committee and shall attend to take minutes of the meeting and provide appropriate support to the chair and committee members. • At least once a year the committee should meet privately with the internal auditors, external auditors and LCFS either separately or together. Additional meetings may be scheduled to discuss specific issues if required.
6. Quorum	• A quorum shall be two of the three independent members. One of the members will be appointed chair of the committee by the board. The chair of the organisation itself shall not be a member of the committee.
7. Administrative Support	The committee shall be supported administratively by its secretary. Their duties in this respect will include: • agreement of agendas with the chair and attendees • preparation, collation and circulation of papers in good time • inviting additional attendees to meetings as required • taking the minutes and helping the chair to prepare reports to the board • keeping a record of matters arising and issues to be carried forward • arranging meetings for the chair: for example, with the internal/ external auditors or local counter fraud specialists
8. Frequency of Meeting	The Committee will meet at least four times per annum, with a possible additional meeting to specifically review the annual report and accounts at appropriate times in the reporting and audit cycle. The chair of the committee, board, accounting officer, external auditors or head of internal audit may request an additional meeting if they consider that one is necessary. To assist in the management of business over the year an annual workplan will be maintained, capturing the main items of business at each scheduled meeting.

9. Access	The head of internal audit and representative of external audit have a right of direct access to the chair of the committee. This also extends to the local counter fraud specialist, as well as the security management specialist.
10. Date Approved	These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the board for approval. • Approved by Audit Committee 2 June 2025 • Approved by Dorset County Hospital Foundation Trust Board on xxx

Dorset County Hospital NHS Foundation Trust
Mental Health Legislation Committee in Common

TERMS OF REFERENCE

Committees in Common	1.1 The Dorset County Hospital NHS Foundation Trust is putting in place a governance structure, which will enable it to work together with the Dorset HealthCare University NHS Foundation Trust. 1.2 Each Trust has agreed to establish a committee which shall work in common with the other (**Committee in Common** or **CiC**), but which will each take its decisions independently on behalf of its own Trust. 1.3 Each Trust has decided to adopt terms of reference in substantially the same form, except that the membership of each CiC will be different. 1.4 The CiC shall meet together with the associated committee from Dorset HealthCare University NHS Foundation Trust as the **Dorset Trust Mental Health Legislation CiCs**
Responsibilities	2.1 The Committee-in-Common has been established by the Board of Dorset County Hospital NHS Foundation Trust as a committee with these terms of reference, to be known as the Dorset HealthCare Mental Health Legislation CiC. 2.2 These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Dorset County Hospital Mental Health Legislation CiC. It is supported in its work by other committees established by the Board. 2.3 The Dorset County Hospital Mental Health Legislation CiC is authorised to investigate any activity within these terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to cooperate with any request made by the Committee-in-Common. 2.4 The Dorset County Hospital Mental Health Legislation CiC is authorised to obtain external legal or other independent professional advice if it considers this necessary, taking into consideration any issues of confidentiality and the Trust's standing financial instructions. 2.5 The Dorset County Hospital Mental Health Legislation CiC is a committee of the Trust and therefore can only make decisions binding Dorset County Hospital NHS Foundation Trust. None of the Trusts other than Dorset County Hospital NHS Foundation Trust can be bound by a decision taken by Dorset County Hospital Mental Health Legislation CiC. 2.6 The Dorset County Hospital Mental Health Legislation CiC will form part of a governance structure to support collaborative leadership and relationships with system partners and follow good governance in decision making (as set out in the updated Code of Governance for NHS Provider Trusts). 2.7 The overall aim of the Dorset County Hospital Mental Health Legislation CiC is to monitor, review and provide assurance to the Board the adequacy of the Trust's processes to support the operation of mental health

	legislation. This includes the mental health act, the mental capacity act and deprivation of liberty safeguards
Role and Purpose	3.1 Paragraph 15(2) and (3) of Schedule 7 of the National Health Service Act 2006 allows for any of the functions of a Foundation Trust to be delegated to a committee of directors of the Foundation Trust. This power is enshrined in Dorset County Hospital NHS Foundation Trust's Constitution. 3.2 The Mental Health Legislation CiC will, together with the other Committees in Common, advise, support and assure the Board of Dorset County Hospital NHS Foundation Trust and Dorset HealthCare University NHS Foundation Trust: – the Trust is operating and will continue to operate in accordance with the law and best practice in relation to the rights of mental health services users and specifically the legislation below (and any subsequent updates) and care and treatment in the Trust embraces the core values of current mental health legislation and protects service users and the community of which they are members. – the lawful detention and treatment of service users in accordance with the Mental Health Act 1983 and Mental Health Act 1983: Code of Practice; – the appropriate application of Deprivation of Liberty Safeguards and the requirements of the Mental Capacity Act 2005; and – Mental Health Units (Use of Force) Act 2018 and associated statutory guidance.
Responsibilities	The Dorset County Hospital Mental Health Legislation CiC will: 4.1 Monitor, review and report to the Board, on compliance with all aspects of mental health legislation. 4.2 Be assured that there are systems, structures and processes in place to support the operation of mental health legislation, within both inpatient and community settings and ensure compliance with associated codes of practice and recognised best practice. 4.3 maintain oversight of Care Quality Commission (CQC) inspection action plans specifically relating to mental health legislation and any mental health legislation matters arising from routine CQC related activity other external inspections. 4.4 Review national reports related to mental health legislation and consider actions arising for the Trust. 4.5 Be assured that the Trust has in place and utilises appropriate policies and procedures in relation to mental health legislation and to facilitate the publication, distribution and explanation of the same to all relevant staff, service users and manager. 4.6 Ensure that there is a scheme of delegation in place for the Mental Health Act 1983 and receive assurance that the trust is operating in accordance with the Scheme of Delegation. 4.7 Be assured that appropriate staff groups receive guidance, education and training in order to understand and be aware of the impact and implications of all new relevant mental health associated legislation.

	4.8 Provide oversight of the process of recruitment, induction, appraisal and development of Associate Hospital Managers.
Accountability Arrangements	5.1 The Dorset County Hospital Mental Health Legislation CiC is accountable to the Board of Dorset County Hospital NHS Foundation Trust. 5.2 The Committee Chair will provide an assurance report following each meeting to the Board of Directors of Dorset County Hospital NHS Foundation Trust. 5.3 Dorset County Hospital Mental Health Legislation CiC shall provide such other reports and communications briefings as requested by Dorset County Hospital NHS Foundation Trust's Board for inclusion on the agenda of Dorset County Hospital NHS Foundation Trust's Board meeting.
Membership / Attendance	**6.1 Non-Executive** • ~~Two~~ Three Non-Executive Directors (at least one and no more than two may be Joint NEDS across DCH and DHC) and one of whom will either be the Chair or the Vice Chair of the Committee **6.2 Executive** • Joint Chief Nursing Officer (or nominated Deputy) • Chief Medical Officer – DCH • ~~Chief Medical Officer - DHC~~ **6.3 In attendance** • ~~DHC - Director of Nursing, Therapies and Quality~~ • DCH - Director of Nursing and Quality • Joint Director of Corporate Affairs or nominated deputy • Nominated Governor(s) • Other staff of the Trust may be requested to attend for specific matters. • Mental Health Legislation Manager • Deputy Director of Nursing & Quality • Head of Safeguarding • Medical Director for Mental Health 6.4 Where a member is unable to attend routinely an appropriate deputy who will attend on a regular basis should be nominated and notified to the Chair.
Chair	7.1 When the Dorset County Hospital Mental Health Legislation CiC meets with the associated committee from Dorset HealthCare University NHS Foundation Trust as committees in common, one person nominated from the Members of each of the CiCs shall be designated the Chair and one from the other Trusts CiC membership as the Vice Chair. 7.2 The Chair and Vice Chair shall preside over and run the common meetings with the roles then rotating on an annual basis between the Trusts members.
Quorum	8.1 Members of the Dorset County Hospital Mental Health Legislation CiC have a responsibility for the operation of the Dorset County Hospital Mental Health Legislation CiC. They will participate in discussion, review evidence and provide objective expert input as part of the Dorset County Hospital

	Mental Health Legislation CiC to the best of their knowledge and ability, and endeavour to reach a collective view. 8.2 Each Member of the Dorset County Hospital Mental Health Legislation CiC shall have one vote. The Dorset County Hospital Mental Health Legislation CiC shall reach decisions by consensus of the Members present. 8.3 The quorum shall be three (3) Members. This must include at least two Non-Executive Directors from the Trust (which may include Joint NEDS acting for both Trusts) and an Executive Director. 8.4 If any Member is disqualified from voting due to a conflict of interest, they shall not count towards the quorum for the purposes of that agenda item.
Administrative Support	9.1 Administrative support will be arranged by the Corporate Affairs Directorate. 9.2 Agenda and papers will be circulated one week prior to the meeting
Frequency of Meeting	10.1 Agenda and papers will be circulated one week prior to the meeting. 10.2 Subject to the below, Dorset County Hospital Mental Health Legislation CiC meetings shall take place quarterly. 10.3 Any Trust CiC Member may request an extraordinary meeting of the Dorset County Hospital Mental Health Legislation CiC (working in common) on the basis of urgency etc. by informing the Chair. In the event it is identified that an extraordinary meeting is required the Chair shall give five (5) Working Days' notice to the Trusts.
Conflict of Interest	11.1 Members of the Dorset County Hospital Mental Health Legislation CiC shall comply with the provisions on conflicts of interest contained in Dorset County Hospital NHS Foundation Trust Constitution/Standing Orders and NHS Conflicts of Interest guidance. For the avoidance of doubt, reference to conflicts of interest in Dorset County Hospital NHS Foundation Trust Constitution/Standing Orders also apply to conflicts which may arise in their position as a Member of the Dorset County Hospital Mental Health Legislation CiC. All Members of the CiC shall declare any new interest at the beginning of the meeting and at any point during a meeting if relevant.
Date Approved	12.1 Approved by Executive Director members May 2025 12.2 Ratified by Dorset County Hospital NHS Foundation Trust Board of Directors To add date
Date Review	31 March 2026

Dorset County Hospital
NHS Foundation Trust

DCH Charitable Funds Committee Assurance Report for the meeting held on 20.5.2025

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	• **£2.5M Capital Appeal (ED/CrCU) report (Apr 2025)** – £1.1M income and pledges received to date.
Key issues / matters discussed at the meeting	The committee received, discussed and noted the following reports: • **CFC Minutes (18.3.25)** – approved as an accurate record. • **CFC Actions (18.3.25)** – All actions completed or in progress. • **DCH Charity Financial Reports 24/25 (M12)** – reports were received. Total income as of end Mar 2025 £1,434,351 (incl. £800,738 major legacy income pending). Unrestricted funds were £610,729 providing a surplus of £370,729 against the reserves target of £240,000. • **DCHC Risk Register** – Risk 3 'Loss of key Charity staff' agreed to increase to from 12 to 16 'High' due to staff changes, current capacity and recruitment required. • **£2.5M Capital Appeal (ED/CrCU) report (Apr 2025)** – £1.1M income and pledges received to date. • **Fundraising & Communications report** – overview of current key fundraising activities and communications. • **Innovation Fund (proposed) -** committee supported proposal in principle. Key points for consideration - trial pilot scheme, initial level of funding; current uncertain NHS environment; Trust resourcing. Set up working group to take plans forward. • **Lillian Martin legacy -** sale of land completed end Mar 2025. DCHC share £31,416; accrued in 24/25 accounts - awaiting payment.
Decisions made at the meeting	• Innovation Fund: agreed to progress development of new fund and programme.

Issues / actions referred to other committees / groups	• None

Quoracy and Attendance						
	Date 19.11.24	Date 20.1.25	Date 18.3.25	Date 20.5.25		
Quorate?	Y	Y	Y	Y		
Dave Underwood	Y	Y	Y	Y		
Chris Hearn	Y	Y	N	Y		
Jo Howarth	Y	Y	N	Y		
Anita Thomas	Y	Y	Y	Y		
Margaret Blankson	Y	Y	Y	Y		
Stephen Tilton	Y	N	Y	Y		

ICB Board Report

Reporting Committee:	ICB Board
Date of Meeting:	6 March 2025
Meeting Chair:	Jenni Douglas Todd, ICB Chair

Decisions made by the Board	• The Board approved the proposed delegated commissioning arrangements for the ICB to take on delegated responsibility for the Specialised Commissioning 2025/26 Green Services Portfolio in April 2025 and approved the related delegation and collaboration agreements.
Key Messages agreed by the Board	• The Board welcomed hearing the Board story highlighting the workplace experience of a citizen with lived experience of bipolar disorder and psychosis, and received an update on the Get Britain Working white paper and the Connect to Work programme. The Board welcomed the opportunities but noted the complexities of this work and the need for a joined-up approach. The ICB asked the Integrated Care Partnership to take this forward. The important role of public sector organisations as anchor institutions was also highlighted. • The current national context was noted, especially in relation to NHS England leadership changes, 2025/26 planning, and the amended government mandate for the NHS. • In relation to performance, the Board noted the challenges around the reduction in Whole Time Equivalents for NHS partners, the issues facing community pharmacy services, the risks relating to the uptake of the Oliver McGowan Mandatory Training on Learning Disabilities and Autism, and the need for further consideration of cyber risk at a system level. • The Board reiterated the importance of maintaining focus on citizens and communities rather than being overly focused on processes and targets in themselves. • It was noted that work was underway to review the workplans for the ICB Board committees.
Summary of items received by the Board	• Board Story and Deep Dive on the core purpose of social and economic development • Board Assurance Framework • Chief Executive Officer's Report • Committee Escalation Reports • Specialised Commissioning • ICS Quality Framework (consent item – taken without discussion)

Report to	Board of Directors, Part 1	
Date of Meeting	10 June 2025	
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, 08 April 2025 Finance and Performance Committee in Common, 29 May 2025	
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 ended March 2025 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 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.
- Lack of temperature control in the temporary pharmacy presents a potential loss of stock if temperatures exceed 25°C.

Recommendation

Members are requested to:

- Receive the report for **information**

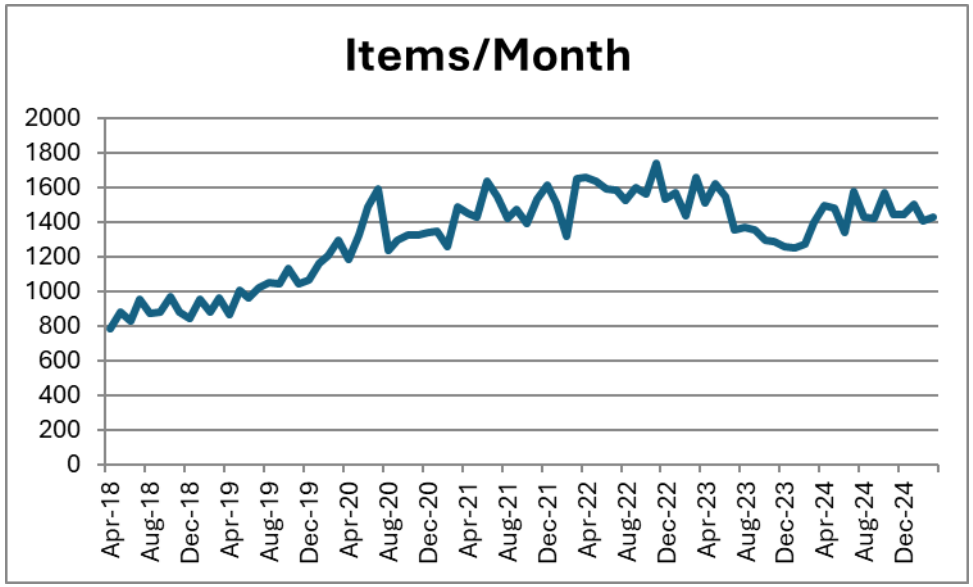
Performance Report

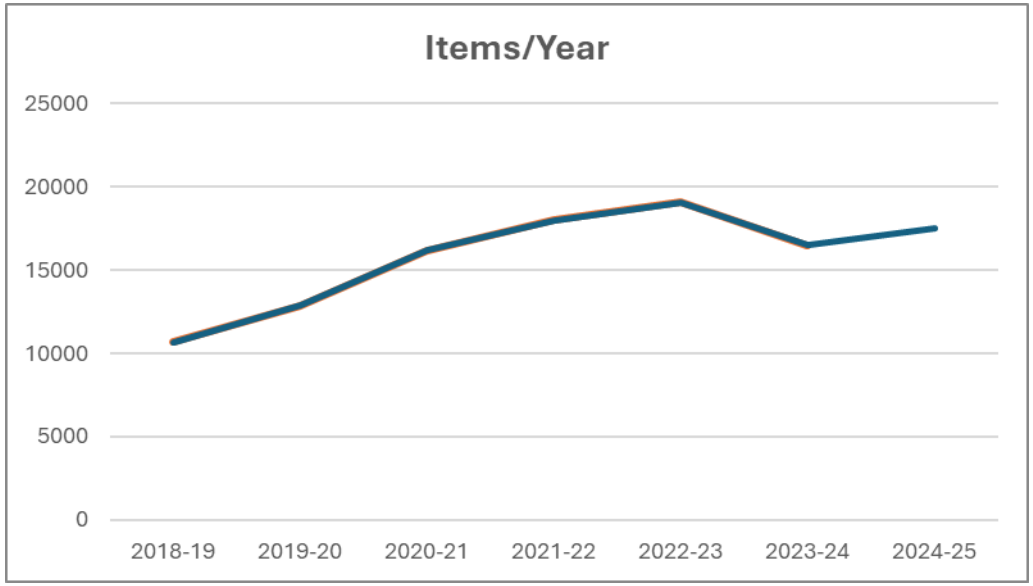
Andrew Harris
Superintendent Pharmacist
Apr 2025

Key Performance Indicators (KPIs)

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Total Number of Customers per Month	172	147	129	169	176	144	142	143	135	152	138	143
Total Items Dispensed	1496	1478	1338	1575	1426	1422	1567	1444	1439	1501	1404	1426
Average Items/day	74.8	70.4	66.9	68.5	67.9	67.7	68.1	68.8	72.0	68.2	70.2	67.9
No. of same day Prescriptions	243	214	213	223	179	259	187	208	228	238	227	193
No. of Advance Prescriptions	493	506	413	549	351	385	481	421	444	463	423	451

Activity levels from April 2018 to current:





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All contractual KPIs year ended March 2025 are green.

Performance measure	Key Performance Indicator	Target performance	Green	Amber	Red	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep–24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Rate of dispensing errors detected post issue	Number of errors made per total volume of prescriptions dispensed that have LEFT the department	<2.0%	<1.0%	1.0-2.0%	>2.0 %	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Near Miss Monitoring	Number of errors made per total volume of prescriptions dispensed that have NOT LEFT the department	<2.0%				0.67%	0.88%	0.90%	0.95%	0.98%	0.91%	0.96%	0.97%	0.83%	0.93%	0.93%	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	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 %	99.87 %	99.58 %	99.65 %	99.67 %	99.79 %	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%	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%	96.5%	95.3%	97.1%	94.4%	96.0%	92.2%
The waiting time for dispensing prescriptions, during a monthly period shall be: (i) 30 minutes or less in respect of 95% of all prescriptions; and (ii) 20 minutes or less in respect of 80% of all prescriptions	The time taken for a patient to wait for their prescription from the time they present it to the Pharmacy.	(i) 30 minutes or less in respect of 95% of all prescriptions (ii) 20 minutes or less in respect of 80% of all prescriptions	For (i) Greater than or equal to 95% For (ii) Greater than or equal to 80%	For (i) 80% - 94.9% For (ii) 65% - 79.9%	For (i) Less than 80% For (ii) Less than 65%	(i) 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%	(i) 99.1% (ii) 98.3%	(i) 98.5 % (ii) 93.4%	(i) 100% (ii) 99.3%	(i) 99.3 (ii) 94.7%	(i) 100% (ii) 98.4%	(i) 100% (ii) 94.6%
Index of customer satisfaction	The patient overall satisfaction level		100% of Customers to be offered Customer Feedback Survey Monthly Reporting on KPIs to record; Total Number of Customers per Month Completion / Uptake Rate (%)			100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Number of complaints	The number of upheld complaints		1 or fewer complaints per quarter	2 or fewer complaints per quarter	Over 2 complaints per quarter	0	0	0	0	0	0	0	0	0	0	0	0

Number of non-agreed non-formulary items supplied	Number of items that appear on total non-formulary supply report	0%	0% - 0.049%	0.05% - 0.099%	> 0.1%	0	0	0	0	0	0	0	0	0	0	0	0
Controlled drug management	Correct procedure against SOPs followed at all times	100%	No Tolerance			100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Provision of financial, clinical and management information	financial, clinical and management information to be provided within 5 working days following the end of the previous month	100%	100% - 99%	98.9% - 97.5%	< 97.5 %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Waste/Expiry management *	Waste Costs below £200 per month - Stock waste to be managed	<£200	<£200			£8.87	£6.25	£0.00	£8.41	£0.04	£3.35	£0.00	£0.00	£42.11	£7.93	£0.00	£95.86

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Month End Stock Value £k (i/c VAT)	266	374	357	407	263	337	337	414	287	315	347	336

Incidents

No dispensing errors have left Fortuneswell Pharmacy in financial year 2024/25

Complaints

Nil

Keys Risks

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- Lack of temperature control in the temporary pharmacy presents a potential loss of stock if temperatures exceed 25°C.

Report to	Board of Directors, Part 1	
Date of Meeting	10 June 2025	
Report Title	DCH SubCo Ltd. Effectiveness Review and Terms of Reference	
Prepared By	Abi Baker, Corporate Governance Manager	
Approved by Accountable Executive	Stephen Tilton, DCH SubCo Chair Nick Johnson, DCH SubCo Director	
Previously Considered By	DCH SubCo Ltd Board meeting, 08/05/2025 Finance and Performance Committee in Common, 29/05/2025	
Action Required	**Approval**	Y
	Assurance	N
	Information	N

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

The purpose of the report is to present the outcome of the annual DCH Subco Ltd review of board effectiveness and to seek approval of the forward work programme for 2025/26 and any proposed revisions to the Terms of Reference arising from the review recommendations.

Public sector good governance practice determines that Boards of Directors should undertake an annual review of their effectiveness to inform changes to their terms of reference, priorities and work programmes for the forth coming year, so demonstrating effective leadership and supporting the development and delivery of the company's overall objectives.

A survey was shared with Board members on 08 April 2025, with responses due by 18 April 2025. This was extended to 25 April 2025 due to the poor response rate. The final response rate was 33%, with one out of three directors answering the questionnaire. At a meeting of the DCH SubCo Board on 08/05/2025 the board agreed that the results were reflective of the views of the full board. The board further discussed how the development of other subsidiary companies might impact the business of DCH SubCo Ltd.

The results of the survey have been analysed and are detailed below.

Areas of good practice

- The Board is clear of its role, delegated authority and has a clear annual programme of work.
- Board members are able to participate in meetings without undue inhibition, and the Board has the right balance of experience, knowledge and skills.

- There is effective communication between the Board and the trust.
- Board meetings are effective appropriately strategic, allowing sufficient time for effective decision making.
- Board members behave with courtesy and respect
- Board members provide real and genuine challenge

Areas for development

- The frequency of meetings has been disturbed by directors' availability which impacts on quoracy. There are ongoing discussions around the desirability of appointing a fourth director to the Board.

Terms of reference

Minor updates have been made to the terms of reference, reflecting changes in Company Secretary and to include provision for a fourth director in line with the Articles of Associate, should the board wish to pursue this.

Recommendation

Members are requested to:

- **Approve** the Terms of Reference

Terms of Reference
DCH SubCo Limited Board of Directors

Constitution

The Board of Directors of DCH SubCo Ltd (the Board) is the key operational decision making body for the company and has delegated authority from the sole shareholder, Dorset County Hospital NHS Foundation Trust, to make operational decisions as outlined within the Business Plan in line with the company's Articles of Association and financial limits established within the shareholder's Standing Financial Instructions.

Authority

DCH SubCo Board is invested with the delegated authority to act on behalf of the shareholder. The limit of such delegated authority is restricted to the areas outlined in the Articles of Association and matters reserved to Dorset County Hospital NHS Foundation Trust Board of Directors as the corporate shareholder. DCH SubCo Board is empowered to investigate any activity within its Terms of Reference, and to seek any information it requires from staff, who are requested to co-operate with the Board in the conduct of its inquiries.

DCH SubCo Board is authorised by the shareholder to obtain independent legal and professional advice and to secure the attendance of external personnel with relevant experience and expertise, should it consider this necessary.

DCH SubCo Board is authorised to establish sub-committees and working groups to support its work subject to Terms of Reference that shall be approved by the Board, but shall not delegate the powers conferred upon it by these Terms of Reference to any other body without the express authorisation of the Shareholder.

Purpose

The purpose of DCH SubCo Board is to review key contract and performance indicators, any safety and governance concerns and financial performance relating to DCH SubCo activity as a provider of Cancer Outpatient pharmacy services. Contract review meetings between DCH SubCo and the shareholder will take place on a quarterly basis and be reported to DCH SubCo Board at the following meeting. DCH SubCo Board will monitor the 5 year contract for the provision of outpatient pharmacy services to the shareholder and monitor the 3 year Service Level Agreement for the provision of services from the shareholder to DCH SubCo.

The Board will keep under review the operating model and take commercial decisions regarding the employment of staff, their terms and conditions of employment and medicines procurement arrangements, ensuring best value for money.

DCH SubCo Board will be responsible for delivery of the DCH SubCo growth strategy.

Membership

As stated in the Articles of Interest, the Board shall be appointed by the shareholder and will comprise the following as Directors of DCH SubCo Ltd:

- At least one Non-Executive Director – Chair
- At least two Directors

The Corporate Governance Manager ~~Head of Corporate Governance~~ (DCHFT) will be in attendance as the Company Secretary.

The Fortuneswell Superintendent Pharmacist will be in attendance at Board meetings.

Deputies

DCH SubCo Directors may appoint an alternative person to exercise Director's powers / carry out duties provided this is notified in writing or at a meeting of Directors and must be approved by the shareholder.

Quorum

DCH SubCo Board shall be deemed quorate if there is representation from three Directors. A duly convened meeting of the Board at which a quorum is present shall be competent to exercise all or any of the authorities, powers and duties vested in or exercised by the Board. No decisions will be made should a meeting not achieve quorum.

Frequency of Meetings

The Board shall meet at least once each quarter. Members the Board must attend at least three of all meetings each financial year but should aim to attend all scheduled meetings.

Duties

The Board has the following duties and functions:

To monitor:

- service contracts with suppliers in order to ensure best value for money
- the contract and performance indicators with DCHFT
- financial performance ensuring a positive year end position is reported for the benefit of the shareholder and that the company remains a going concern.

- to maintain and report on mitigations to identified risks contained within the business plan (Changes to VAT / NHSE model / reductions in cancer drug spending)
- the outpatient lease arrangement
- directly employed staff terms and conditions, making recommendation on changes to the shareholder for approval where this may be necessary
- oversee the development of the company's annual report and accounts ensuring that this is independently audited and submitted to Companies House in a timely manner
- to mitigate risks as these are identified, escalating to the shareholder where necessary
- ensure that the shareholder is assured of the effective governance arrangements in place within DCH SubCo
- to review the Terms of Reference annually

Reporting

The Chair of DCH SubCo Board will report in writing to the shareholder's Finance and Performance Committee meeting that follows the Board meeting via an ~~Performance and~~ Escalation Report. This report will summarise the main issues of discussion and attention will be drawn to any issues, risks or decisions that require escalation to the shareholder for a decision.

DCH SubCo Board will receive reports from the sub-committees that it formally establishes that record key issues and decision making and escalation of risks and issues for the Board's attention. The Board has established the following sub-committees:

- Contract Review Group
- ~~Governance Review Group~~

Administration

The Board will be serviced by the DCHFT Corporate Governance Manager ~~Head of Corporate Governance~~ who will agree the agenda and Board Work Programme with the Chair.

Review

These Terms of Reference will be reviewed annually unless there is a requirement to do so earlier.

Appraisal

DCH SubCo Board will carry out an annual appraisal of its performance and effectiveness in line with the requirements of the public sector Audit Committee Handbook 2018 (fourth Edition – January 2018) and will report this to the Board of Directors and shareholder annually.

Approved by DCH SubCo Board of Directors – 08 May 2025

Ratified by the Shareholder Board –

Report to	DCH Board of Directors	
Date of Meeting	Tuesday 10th June 2025	
Report Title	Estates and Facilities Compliance Report	
Prepared By	David McLaughlin, Director of Estates & Facilities	
Accountable Executive	Chris Hearn, Chief Finance Officer	
Previously Considered By	Finance and Performance Committee in Common	
Action Required	**Approval**	N
	Assurance	Y
	Information	N

Alignment to Strategic Objectives	Describe how this paper contributes to our strategic objectives
Care	Compliance risk affects the safety of our patients
Colleagues	Impacts the safety of our people working within our buildings
Communities	N/A
Sustainability	N/A
Implications	Describe the implications of this paper for the areas below
Board Assurance Framework	SR5 - Estates
Financial	Currently Mitigated within delegated budget
Statutory & Regulatory	Statutory requirement to comply
Equality, Diversity & Inclusion	N/A
Co-production & Partnership	N/A

Executive Summary

1.1 Background

This paper details the status of Estates and Facilities Statutory Compliance within the Trusts, the areas where we have a good picture, and those areas where we are still compiling data, or where levels of Compliance fall below the expected level, along with the context for this.

Within this paper, Compliance measurement data has been drawn using the following data sources:

1) For self-delivered (DEL) Planned Maintenance and Reactive Works – Reports and data has been extracted from the Micad CAFM system.
2) For contractor delivered Planned Maintenance and high level statutory compliance items such as Asbestos and LOLER, the compliance information and evidence documentation are held within the IPR system. For ease of reference, this data has been entered into the Compliance Tracker percentage graphs contained within this report.
3) Within DCH the system tends to use the compliance tracker to hold the data from both self-delivered and contractor maintenance. All of the compliance documentation is held within the system on the S: drive.

This paper is for information and assurance, it also details the mitigations where we have known compliance gaps.

1.2 Statutory Compliance

A large amount of work has been undertaken to populate the Statutory Compliance Tracker. This is a 'live' document, and as such requires to be updated manually on a frequent basis. To ensure that compliance levels for individual sites and buildings can be drilled down and fully evidenced, statutory compliance documentation is also uploaded to the IPR system and tracked within the system in real time up until the date of expiry for the relevant documentation. For example, an annual Gas Safety service of a heating boiler may have been undertaken on 1st March 2025, the engineer will undertake this work and submit the documentation to evidence the outcome of this. This documentation is then uploaded to the IPR and linked to the relevant building and unique asset, the expiry date is set exactly 12 months on from the date the works were undertaken, once this date has elapsed, the compliance element will show as expired, and the front page dashboard will reflect this. This allows for a complete oversight to track our overall compliance, and compliance drilled down to an individual building and asset.

Assurance trackers and auditing

- **Statutory compliance audit and risk tool (SCART)** Is now in place for DHC & DCH against all technical elements.
- **Statutory Compliance Tracker** Has been populated, but most data is available using the populated IPR system compliance dashboards. The tracker is being used by DCH to cover this and the IPR system is not currently used.
- **Compliance Dashboard –** Part of the Compliance Tracker document (above). Some elements still require populating, mainly items around Facilities and Staff, although this data is available via other sources.

1.3 Compliance performance

- **DHC Compliance –** Which measures all areas of compliance including fire, water, electrical, cleaning audits, etc is circa **70%.**
- **DCH Compliance -** Which measures all areas of hard services compliance including fire, water, electrical, etc is circa **64%.** Soft services are not being fully tracked using the tracker, these are mainly tracked by other systems.

1.4 Areas requiring improvement

- **Fixed Wire Testing (EICR)** – Currently for DHC, the aggregate Compliance level for EICR sits at 65%. A large project was undertaken last year by the Compliance Manger to produce a comprehensive contract specification, asset list and pricing matrix, to enable a full contract tender to take place. We are pleased to report that this contract as now been awarded and mobilised with PHS Compliance undertaking all Planned EICR works across the Trust. The contract commenced in February 2025 and PHS are undertaking all overdue properties initially to bring us fully up to date. Remaining properties due this year will be picked up throughout 2025, and a full timetable has been issued for subsequent years ahead. We therefore envisage a significant uplift in compliance this year. These are a major gap with DCH and the current extent of the issue is not fully known. However, compliance will see an improvement once testing commences.
- **Thorough Examinations (LOLER and PSSR)** – Thorough examinations are undertaken by Allianz Engineering, generally at 6 monthly intervals. We continue to experience situations where an engineer either attends site a number of days after the due date or, attends site and issues a Plant Not Available (PNA) notice, this can be for a variety of reasons including no access to the asset. The Compliance Team have raised this with our Authorising Engineer and are now planning to meet with Allianz to address our concerns and seek an acceptable resolution. DCH also has insurance inspections undertaken by Allianz as well and has had a

number of the issues that DHC has suffered with. A meeting occurred with Allianz and there have been some things agreed to improve reporting and assure that there are fewer non-seen issues.

- **Reporting and tracking of remedial works** – Measurement of compliance is generally based on completion and delivery of statutory planned maintenance tasks, within the required timescale, alongside evidence of completion. We are still working to include outstanding remedial works where applicable, depending on the criticality of such works this may require us to reduce a compliant delivery item to 'non-compliant' status pending completion of any remedial works. The Technical Compliance Tracker is populated with outstanding remedial works as far as practicable, but further work is needed to include all elements.
- **Reactive Works** – Attendance within the SLA timescales for Reactive Works requires some improvement. The volume of reactive tasks versus the need for engineers to deliver all of the issued statutory PPM's presents a challenge. With the overhaul and improvements being delivered to the Planned Maintenance schedules and asset lists, this will allow us to deliver an enhanced planned maintenance regime which should see a reduction of reactive calls logged.

1.5 Premises Assurance Model

- **PAM,** E&F will instruct an external specialist to undertake the statutory 2025 Premises assurance Model (PAM)
- LCE is being instructed to undertake the 2025 PAM survey.

1.6 Implications of non-compliance

- The safety of our patients, visitors and staff are reliant on a compliant Estate. Our Statutory Compliance comes in many forms including:
  - Fire
  - Ventilation
  - Cleaning Standards
  - Water management
  - Electrical
  - Pressure Systems
  - Lifts and Lifting Equipment
  - Catering hygiene
  - Working at Height
  - Etc.

Failure to maintain robust systems increases risks of catastrophic failure, possibly resulting in injury or worse to our patients, staff or visitors.

- Any non-compliance which results in an incident could see legal cases brought against the Trust or those responsible to maintain the asset at the statutory levels.
- Also, reputational damage is likely in the event of an incident caused by non-compliance to statutory legislation.

Due to these risks, Estates and Facilities are developing robust audit and tracking processes which will be used to provide assurance to committee, and as part of this process, any significant risk will be identified, escalated and mitigated as far as reasonably possible immediately.

Recommendation

The Board is requested to:

- Receive the report for **assurance**
- Note Estates and Facilities will provide aligned and accurate levels of compliance which can be evidenced in Q4 24/25

Contents

2 Introduction

2.1 Background

Currently Facilities and Estates have populated new audit and measurement tools to understand and track compliance, these tools include a Statutory Compliance Audit and Risk Tool (SCART), Statutory Compliance Tracker, IPR system dashboards, High level Dashboard and an External Premises Assurance Model Audit (Due to take place in 25/26).

The detail within this report is based on actual recorded compliance where documentary evidence is tangible, there are no longer any estimated or assumed figures.

Data has been compiled using the following sources:

1) For self-delivered (DEL) Planned Maintenance and Reactive Works – Reports and data has been extracted from the Micad CAFM system.
2) For contractor delivered Planned Maintenance and high level statutory compliance items such as Asbestos and LOLER, the compliance information and evidence documentation are taken from the IPR system and entered into the technical compliance tracker graphs for ease of reference.
3) For an overall assessment of compliance across the department, the SCART Assessment has been undertaken to identify risk levels against the various areas. Items declared with an outcome of 'Low Risk' have been taken as 'Compliant' for the purposes of the percentages entered in the table below.

Compliance Performance (Aggregated when taking all data into account from items 1 and 2 above - Micad and Compliance Tracker data using data as of Q4).

Area	Current Average Compliance Percentage
DEL Statutory Planned Maintenance	91.6 %
Compliance Tracker Statutory Maintenance (Includes IPR Data)	81 %
SCART (Low Risk Items)	36 %
Aggregated Average Compliance	**70 %**

Please note, that there will still be occasions where a backlog of receipted documentation has not yet been uploaded and administrated to the IPR system to enable the elements to be updated. In this situation, whilst we would technically remain compliant where this is the case, due to the works being completed, until we can satisfactorily evidence the required documentation they will not be included in our measurement and these items will remain as 'non-compliant'. Individual compliance graphs for items contained in the above table are referenced further on within this document.

3.0 Statutory Compliance by Trust

3.1 DHC

Compliance

Various additions have been made to the IPR compliance dashboard to include further elements such as Generator servicing and Fire Dampers. The Technical Compliance Tracker continues to be updated at routine intervals to reflect the changing picture of items delivered and remedial works undertaken. The Compliance Manager is now producing a bi-monthly DEL Planned Maintenance Compliance report, drilled down to each of the Operational Teams (Mechanical, Electrical and Building Fabric), to track ongoing compliance and delivery against Statutory, Mandatory and Best Practice Planned Maintenance Tasks.

Fixed Wire testing (EICR)

DHC have now awarded a contract following a full tendering process to PHS Compliance to undertake all fixed wire testing across the Trust. PHS have begun work and are undertaking all of our overdue sites initially, prior to completing the sites due throughout the remainder of 2025. A five year forward timetable is in place to ensure that sites are picked up prior to their due dates in the coming years. This will see a vast improvement of our compliance position in this area.

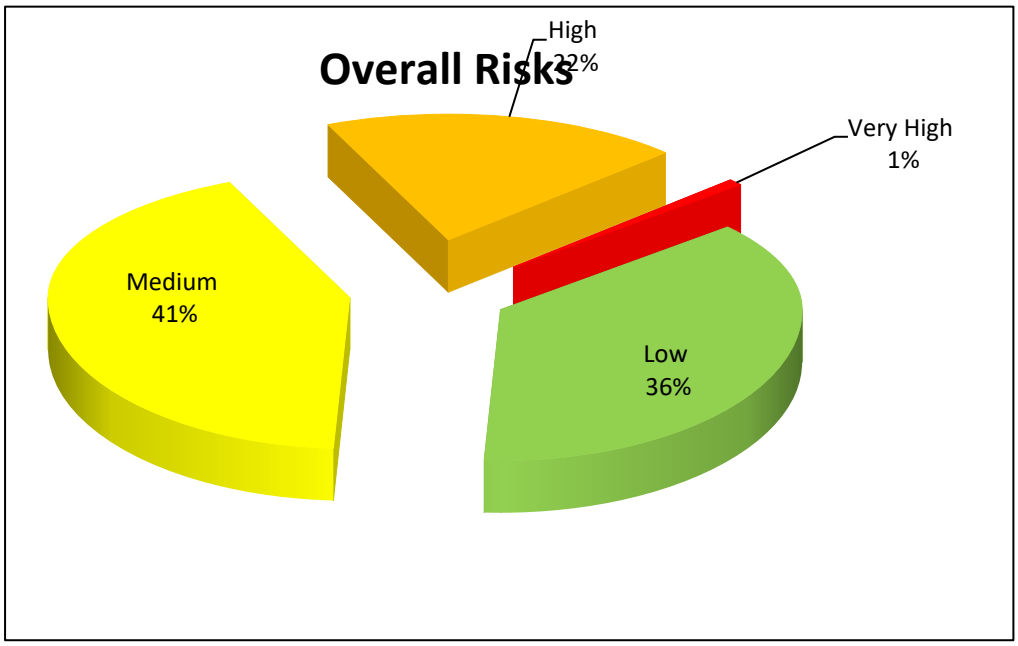
Fire Dampers

As with fixed wire testing, the Trust have now awarded a tendered contract to In-Depth Services for annual inspection and testing of fire dampers. A full round of servicing is now complete, and our operational mechanical team are drawing up a programme of identified remedial works.

SCART

The Compliance Manager has conducted a SCART survey, involving various stakeholders to supply the required answers and risk gradings. This survey is similar to the PAM survey but in more depth over certain areas, this will assist us in providing the required answers and evidence once the PAM survey is in progress via our external partner. The survey has been completed and this can now be benchmarked to look at what areas require more considerable attention.

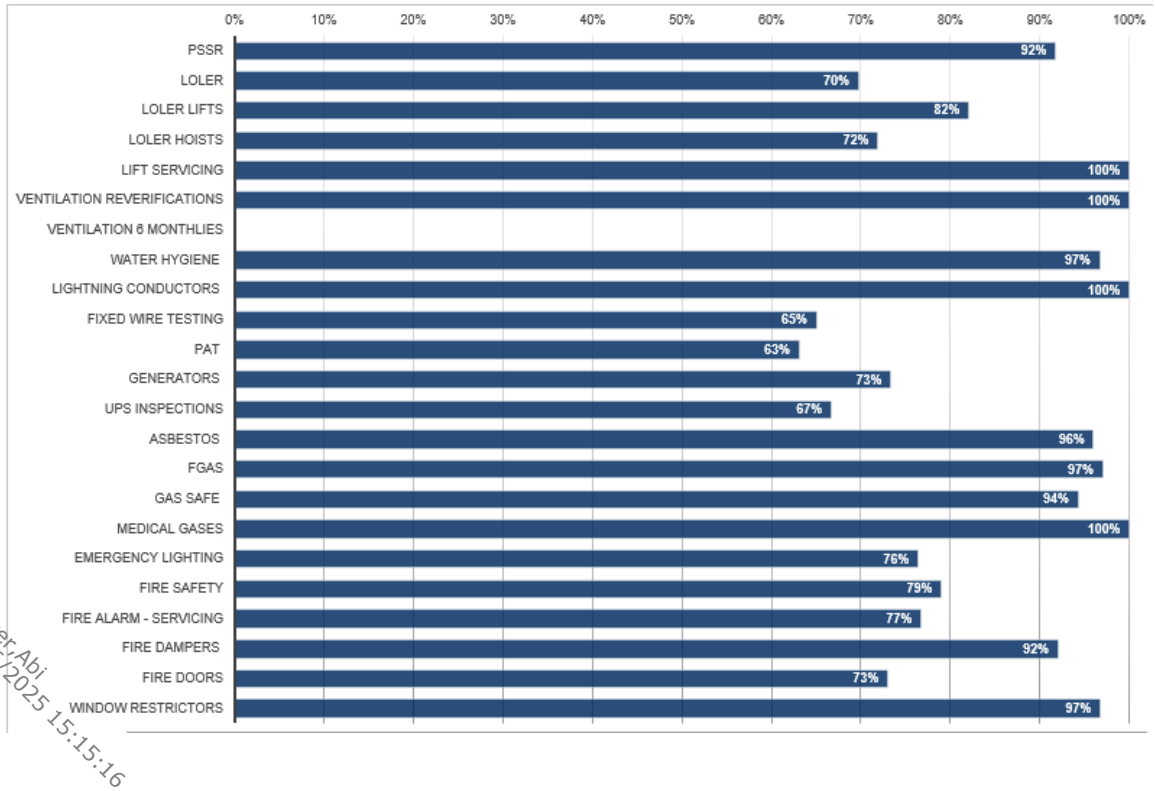
Below shows the Pie Chart of the risk areas split by risk level.



The Bar chart splits these risks by element. For DHC, this shows Water Safety having the highest risk issues, remediation and management of a known issue in one of properties is ongoing and we see this risk eliminated.

This graph will also allow us to compare the current position with that of DCH. Good practice continues to be shared between the Trusts.

Compliance Tracker



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Average compliance = 81 %

The Compliance Tracker is used for all of the physical assets on site. All of the items on this are tangible.

This does require the relevant, correct and comprehensive documentation and certification to be received. In some cases, compliance has been achieved but the documentation cannot prove this. Therefore, from an abundance of caution compliance cannot be guaranteed, in such cases we have assumed a default position of 'non-compliant'. Note: For ventilation six monthly maintenance, these are not currently due and have therefore been omitted.

Electrical Fixed Wire Testing (EICR) - Is now underway via a newly mobilised contract. The initial round of works will see all overdue sites completed first, with the remaining sites of 2025 following on. We therefore expect our compliance position to improve significantly in the coming months in respect of the above.

Fire Doors - The documentation of compliance and evidence of inspection of individual assets is logged via the Zetasafe asset tagging and inspection system. Engineers must scan the QR tag located at each doorset and declare the outcomes of all inspection tasks as work is undertaken. Full auditing of individual assets is therefore available via the Zetasfae system.

Ventilation – A complete resurvey of all ventilation assets is currently in progress via the Operational Mechanical Team. In addition to this a full suite of updated PPM's, aligned to SFG 20 Task Guidance for various frequencies have now also been implemented. This will see a significant improvement to maintenance of our ventilation plant assets.

3.2 DHC

1. **Compliance**
   1.1. Estates and Facilities have undertaken a review of how we measure and record compliance. Further continual reviews will be required to fully refine the different data streams and how these are collated. With the improvements and overhaul of our internal PPM system, this has already allowed for much more reliable reports to be run out of Micad to show completion rates of self-delivered Planned maintenance across all disciplines. The Compliance Manager now issues a bi-monthly internal report to all Estates Officers showing performance across their teams. The most recent report has been included as an annexe document for reference.

   1.2. Currently, compliance data monitoring is split between three Databases, MICAD, Internet Property Register (IPR) and Zetasafe. A project in underway to link these three systems together to produce a single report. The complexities of linking the three systems are very much reliant on improvements to the three software platforms, all of which are owned by Micad. Micad continue to develop connectivity across these packages, and we hope to have this in place as soon as possible. In the meantime, individual reporting continues to take place with manual collation of the data from each.

1.3. The Current IPR remains at approximately 70% average compliance, but this figure is mainly due to a backlog in uploading compliance documents due to

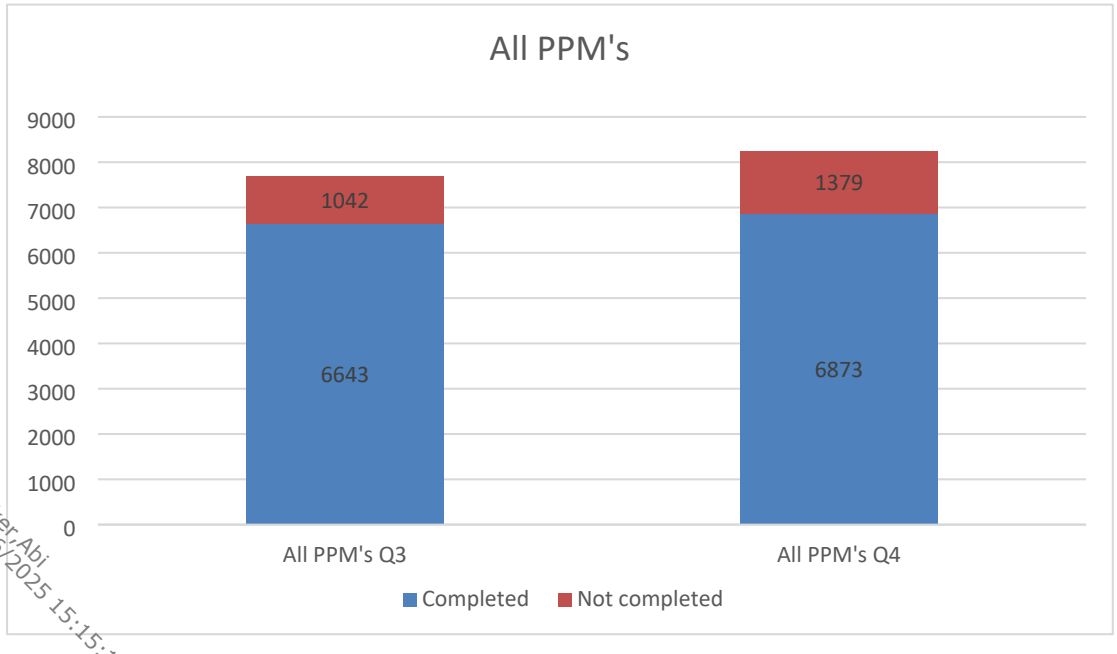
PPM Category	Total Jobs Completed	Total Jobs Failed	Compliance Level*
All Q3	6643	1042	86.4 %
All Q4	6873	1379	83.3%

gap in administration resource. As can be seen from the mean average compliance percentage on the Compliance Tracker, our position is around 87% when all statutory elements are considered. This takes into account other elements contained within Micad, in addition to what is currently in IPR.

2. Planned Maintenance (Estates)

All PPM's - Q3 and Q4

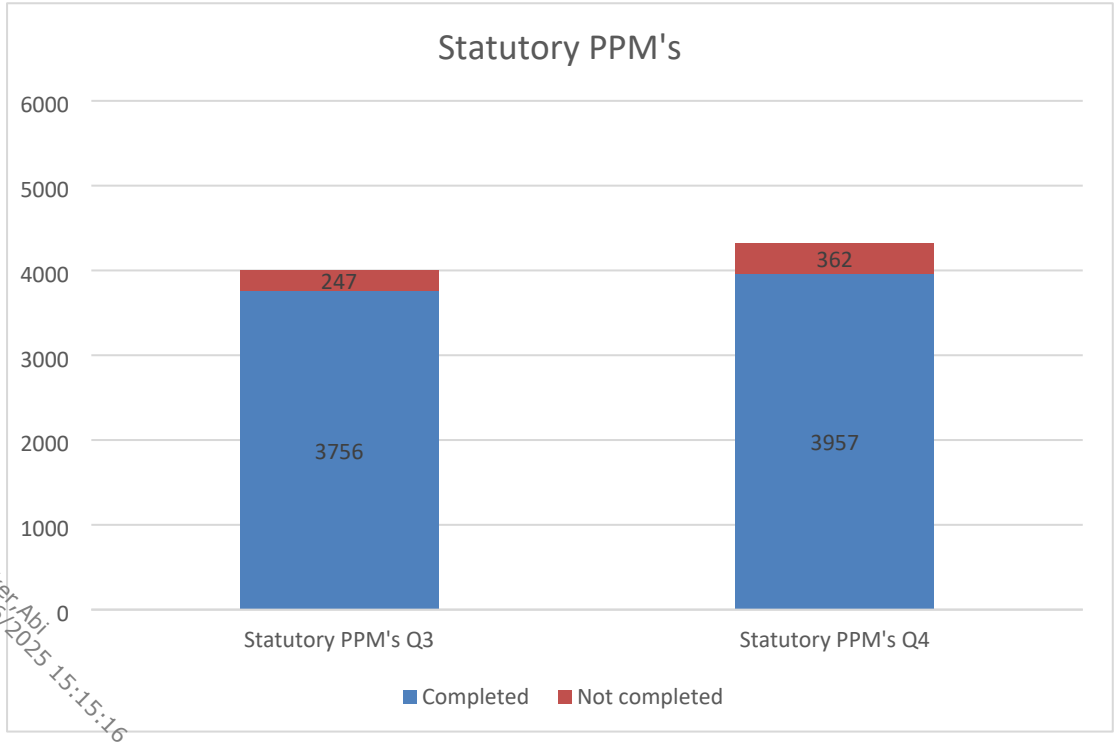
2.1. In Q3 a total of 7685 Planned Maintenance jobs were issued to the Estates team, of those 86.4% were completed. In Q4, a total of 8252 Planned



Maintenance jobs were issued to the Estates team, of those 83.3% were completed.

Statutory PPM's Q3 and Q4

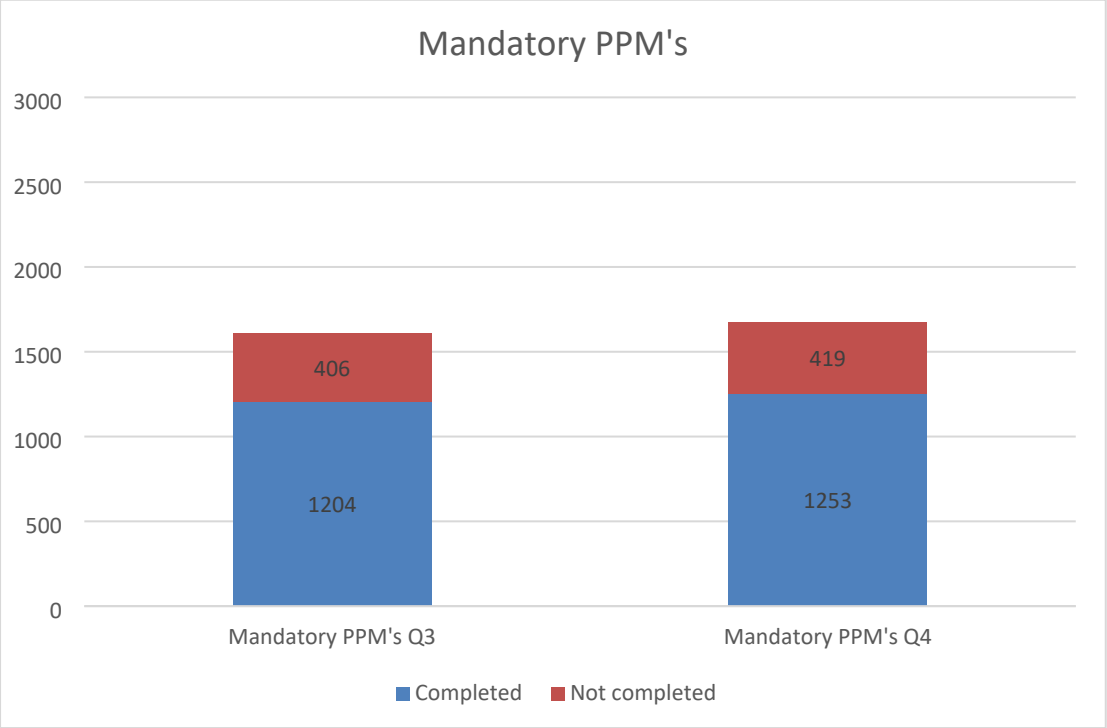
PPM Category	Total Jobs Completed	Total Jobs Failed	Compliance Level
Statutory Q3	3756	247	93.8 %
Statutory Q4	3957	362	91.6 %



2.2. In Q3 a total of 4003 Statutory Planned Maintenance jobs were issued to the Estates team, of those 93.8% were completed. In Q4 a total of 4319 Statutory Planned Maintenance jobs were issued to the Estates team, of those 91.6% were completed.

Mandatory PPM's Q3 and Q4

PPM Category	Total Jobs Completed	Total Jobs Failed	Compliance Level
Mandatory Q3	1204	406	74.8 %
Mandatory Q4	1253	419	74.9 %

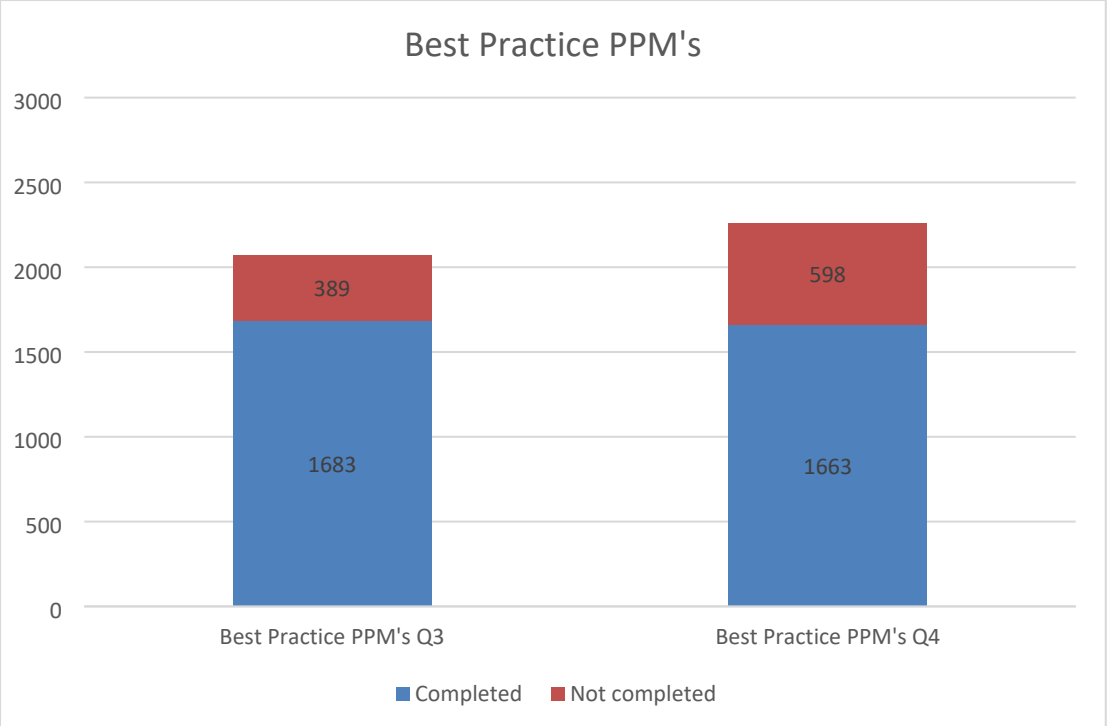


2.3 In Q3 a total of 1610 Mandatory Planned Maintenance jobs were issued to the Estates team, of those 74.8% were completed. In Q4 a total of 1672 Mandatory Planned Maintenance jobs were issued to the Estates team, of those 74.9% were completed.

Best Practice PPM's Q3

PPM Category	Total Jobs Completed	Total Jobs Failed	Compliance Level

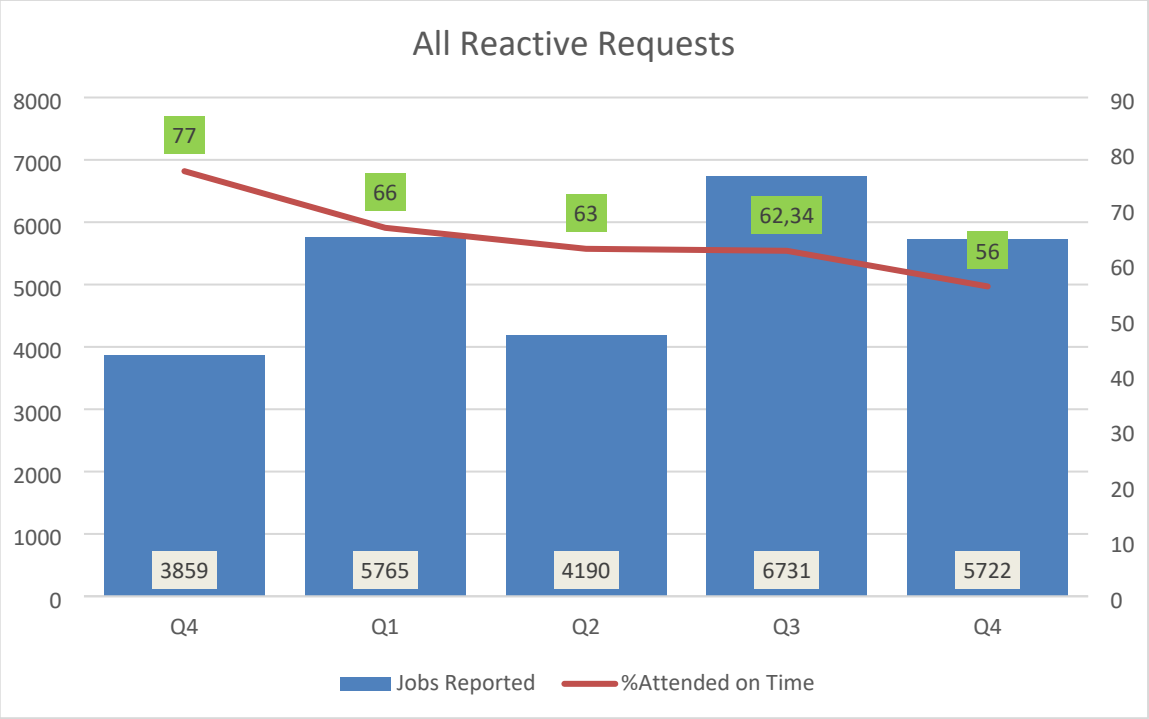
Best Practice Q3	1683	389	81.2 %
Best practice Q4	1663	598	73.6 %

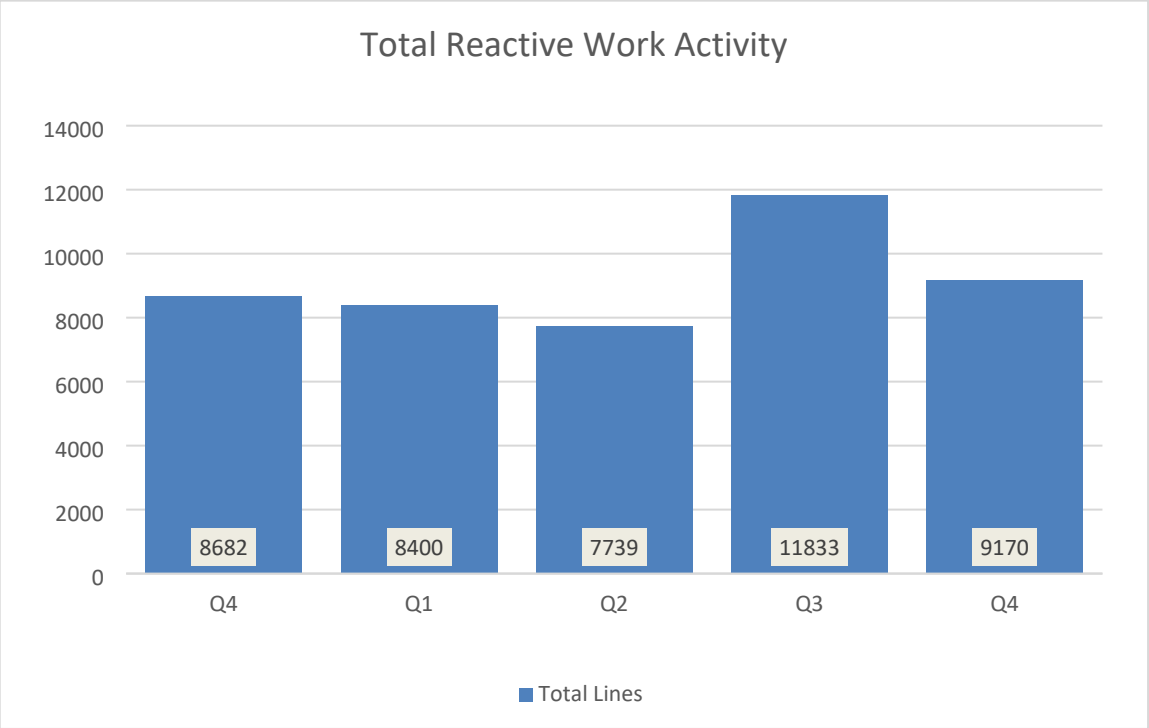


2.4 In Q3 a total of 2072 Best Practice Planned Maintenance jobs were issued to the Estates team, of those 81.2% were completed. In Q4 a total of 2261 Best Practice Planned Maintenance jobs were issued to the Estates team, of those 73.6% were completed.

1.1. Reactive jobs are split across five response times, covering from an emergency 2-hour response, Priority 1 working day, Urgent 3 working days, Routine 5 working days and 28 days for Minor New Works.

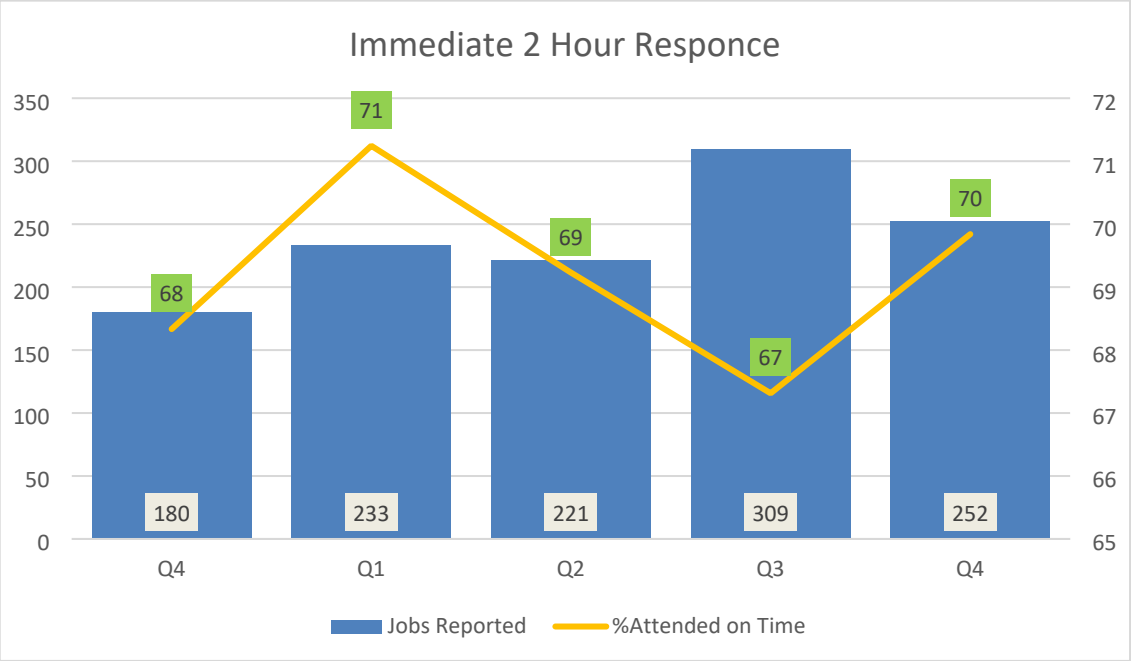
1.2. All Reactive Requests – In Q4 a total of 5722 reactive requests were received by the service desk of these 56% were responded within the time frame allowed, from these requests 9170 separate work activities were generated.



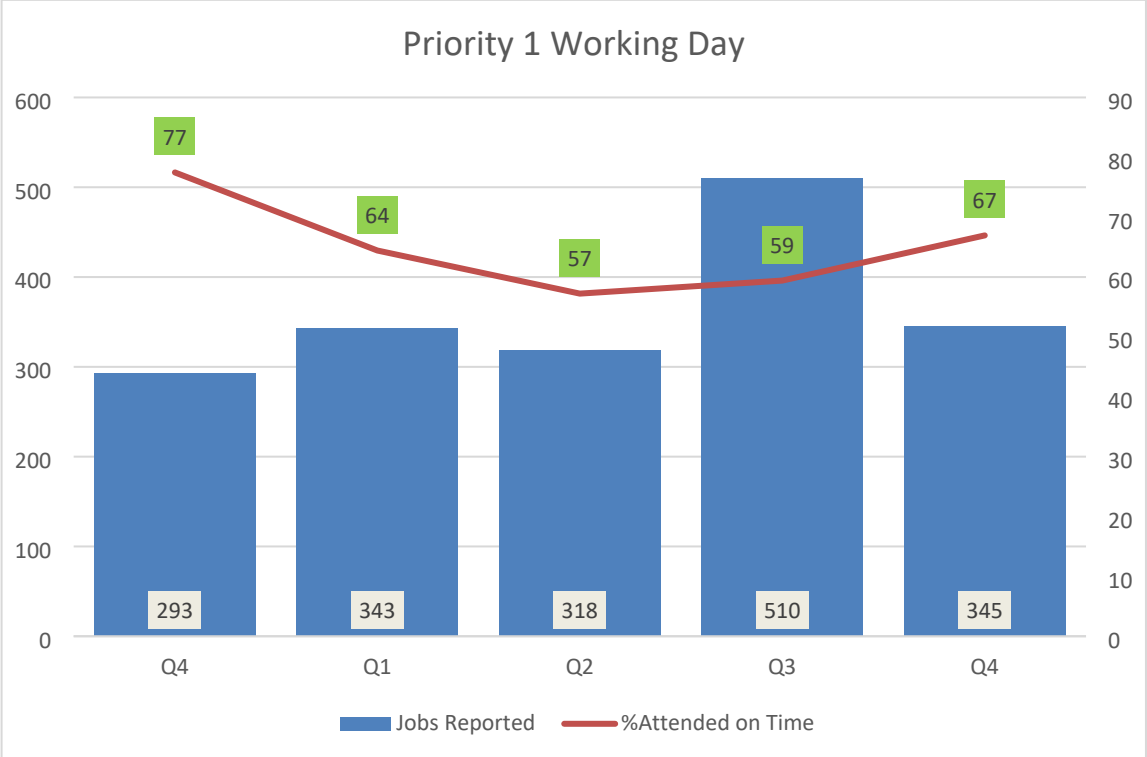


1.3. Emergency - In Q4 a total of 252 reactive requests were received by the service desk of these 70% were responded within the time frame allowed.

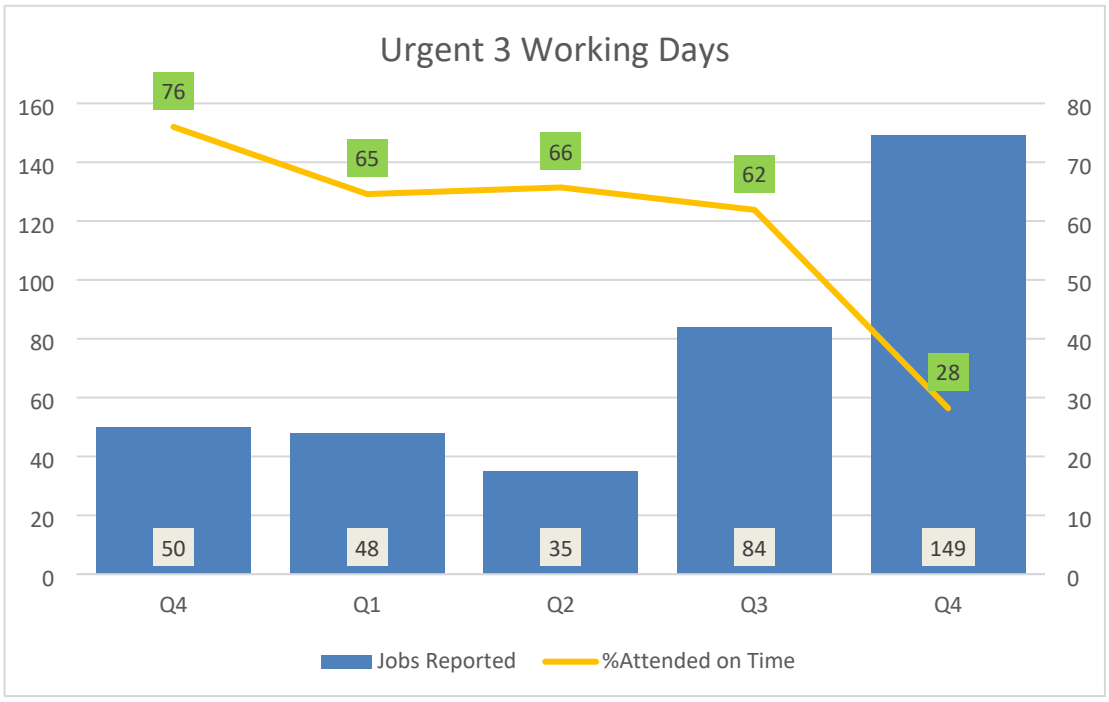
1.4. A significant portion of jobs that are being classed as Emergencies do not fall into the criteria set out in the Priority Classification table work continues with the service desk team to limit the emergency call to better use available resource.



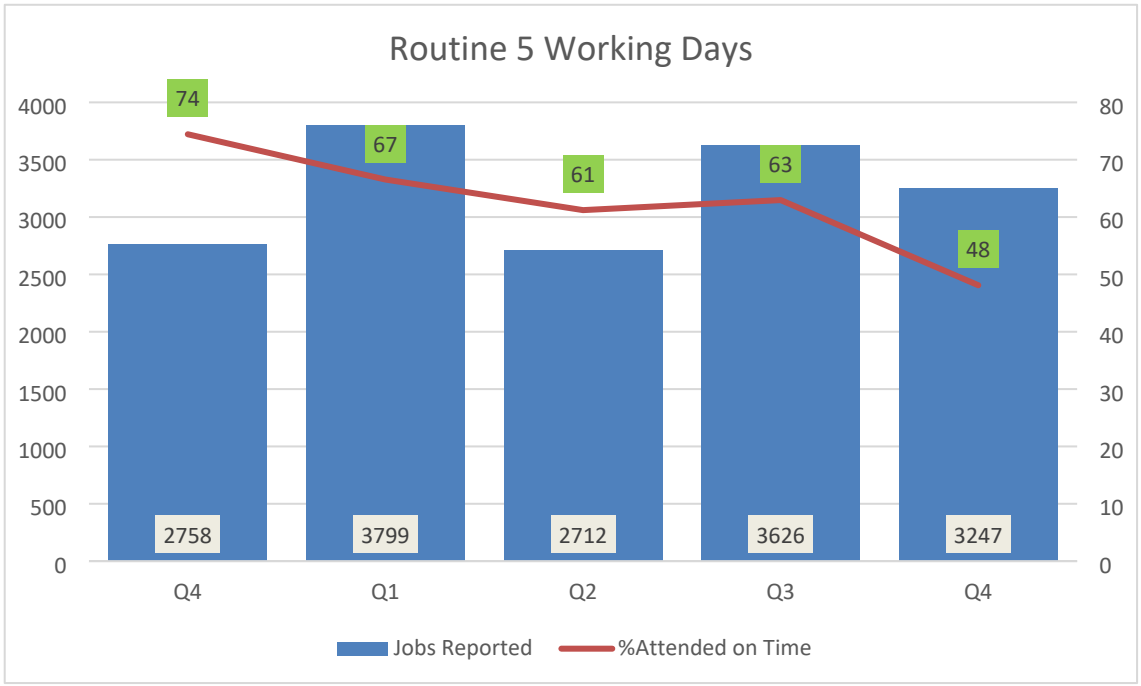
1.5. Priority - In Q4 a total of 345 reactive requests were received by the service desk of these 67% were responded within the time frame allowed.



1.6. Urgent - In Q4 a total of 149 reactive requests were received by the service desk of these 28% were responded within the time frame allowed.

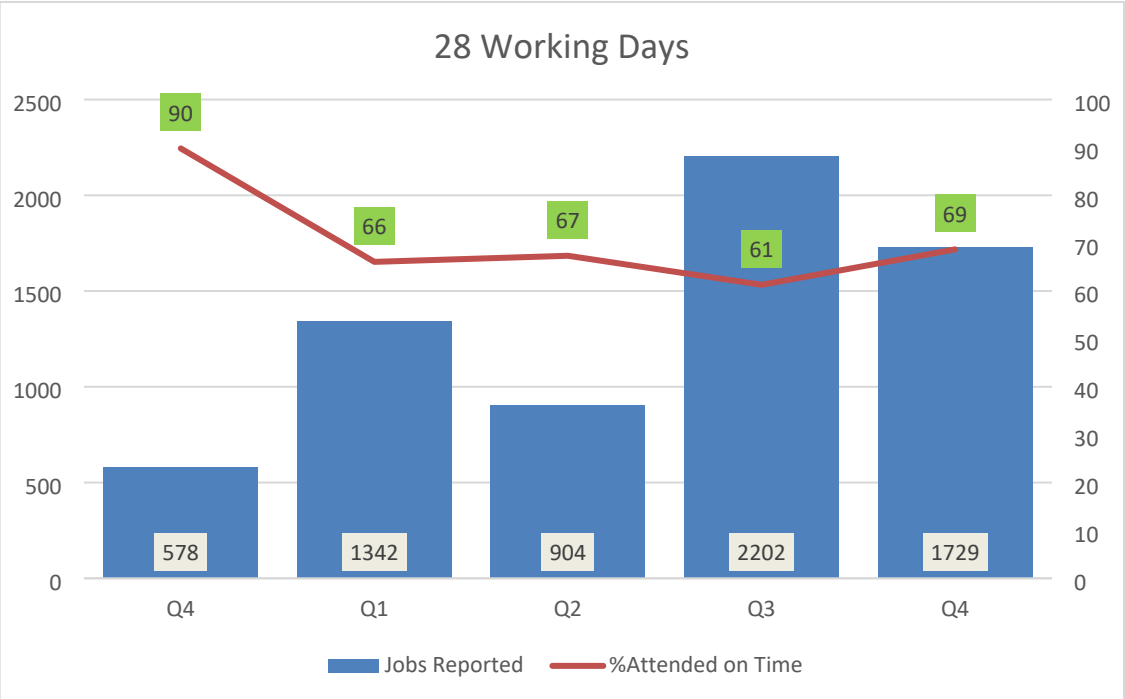


1.7. Routine (default) - In Q4 a total of 3247 reactive requests were received by the service desk of these 48% were responded within the time frame allowed.

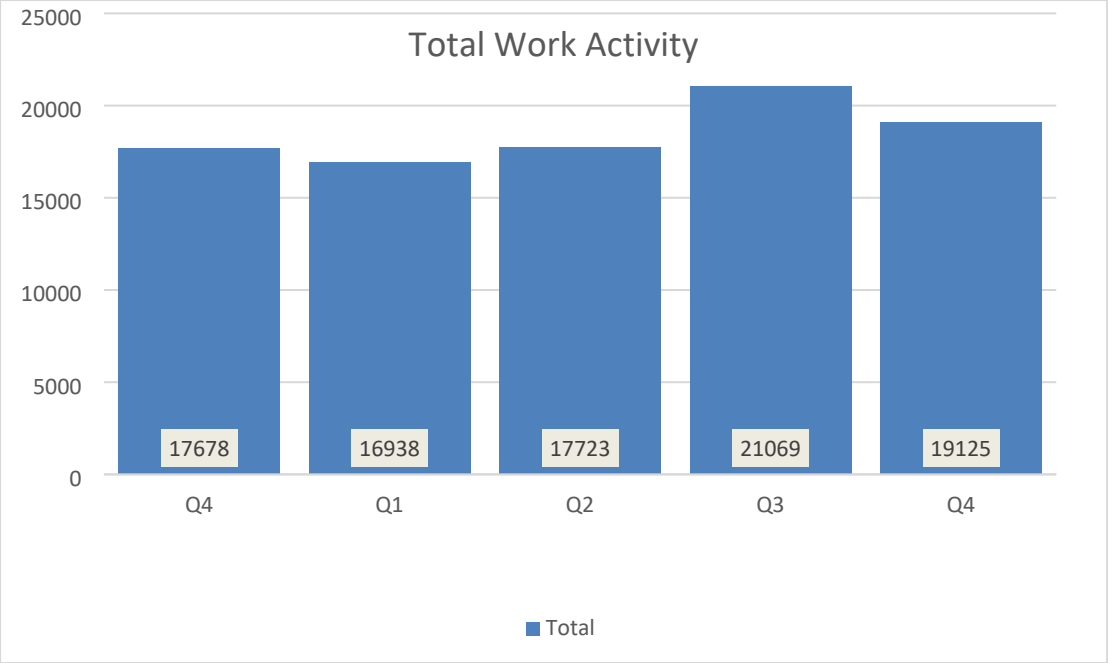


1.8. Miscellaneous - In Q4 a total of 1729, 28 Day response Works requests were received by the service desk of these 69% were responded within the time frame allowed.

1.9. These include, Minor New Works, Uniform Requests, Removals, Collections, etc.



2.3. Total work activities track the total workload covering both planned and reactive requested.



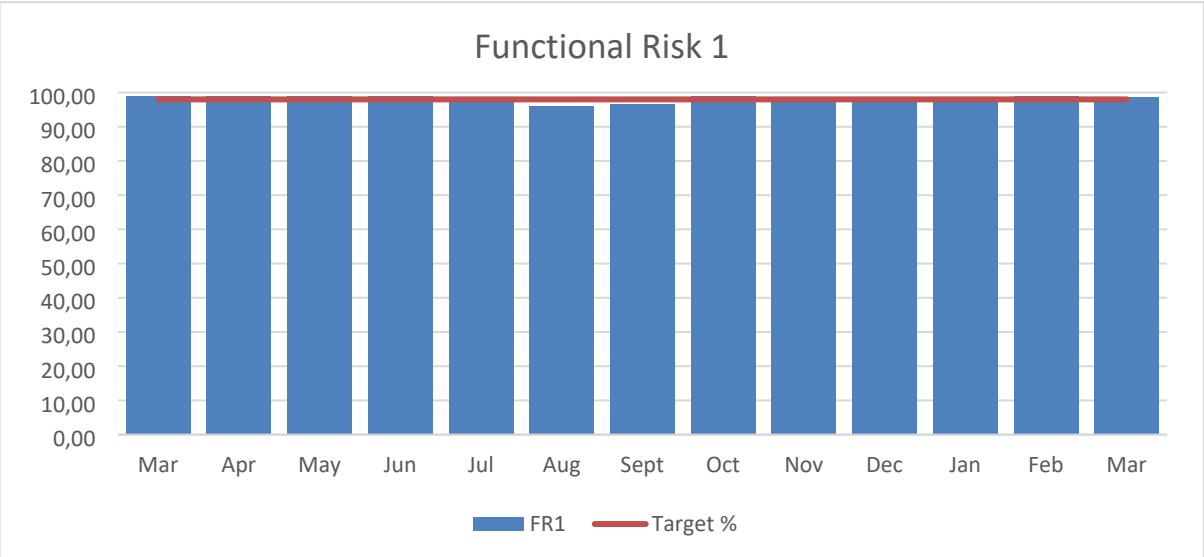
1. Facilities Cleaning Audits

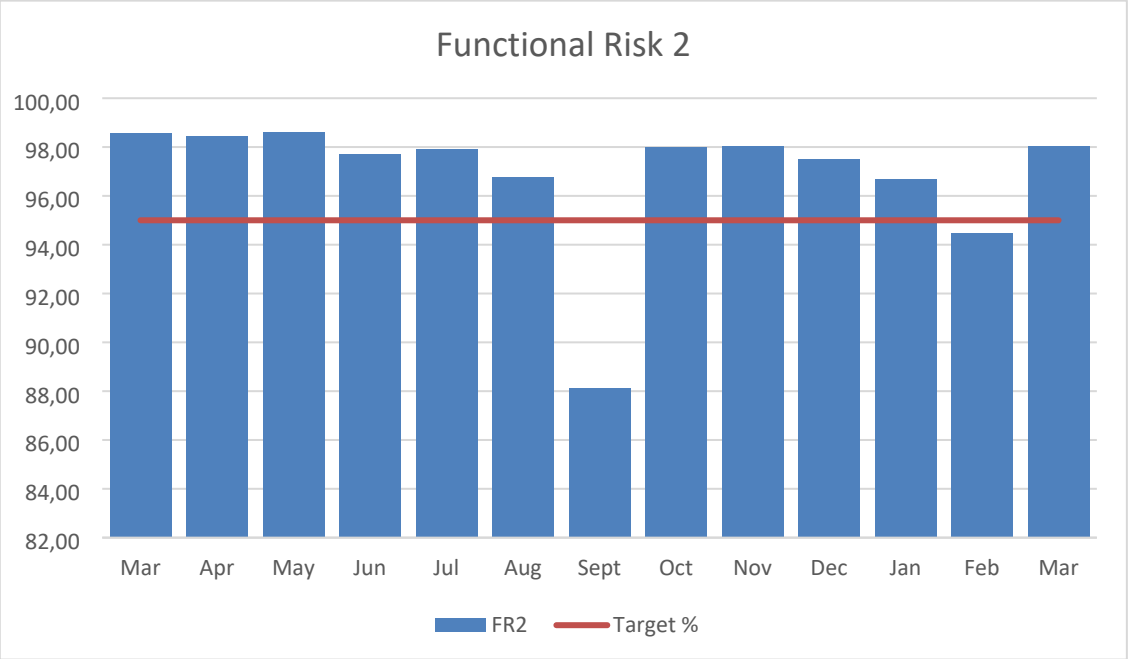
1.1. All healthcare environments should pose minimal risk to patients, staff, and visitors, but because different functional areas do not carry the same degree of risk, they will require different cleaning frequencies and levels of monitoring and auditing. For example, a records storeroom will not require as frequent cleaning as an intensive care unit.

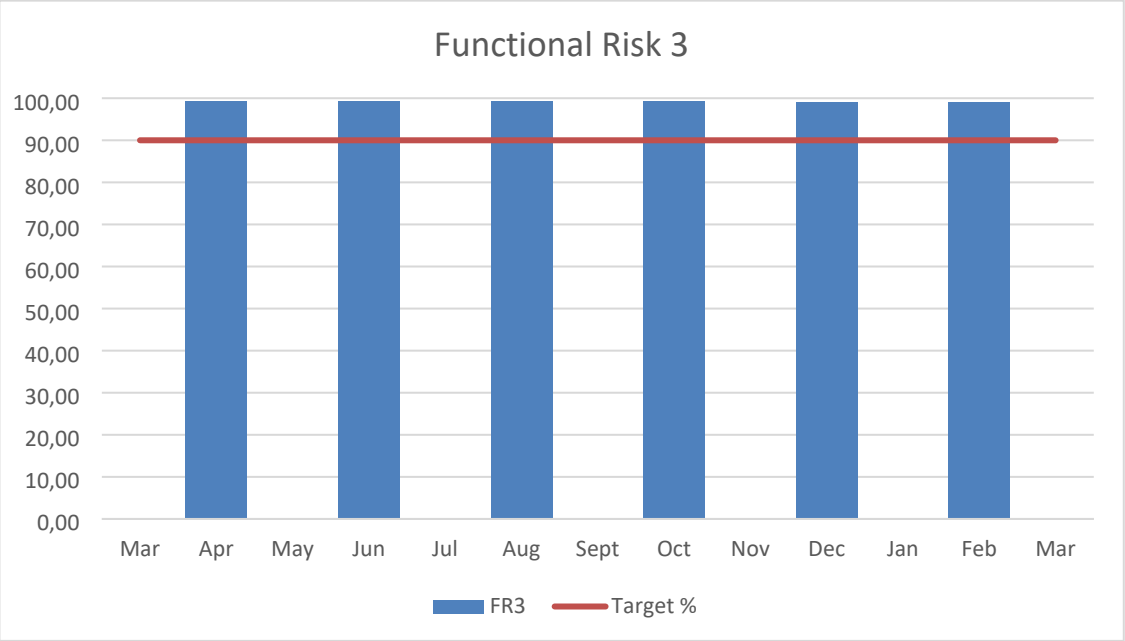
1.2. All functional areas must be assessed and assigned to one of six functional risk (FR1–6) categories

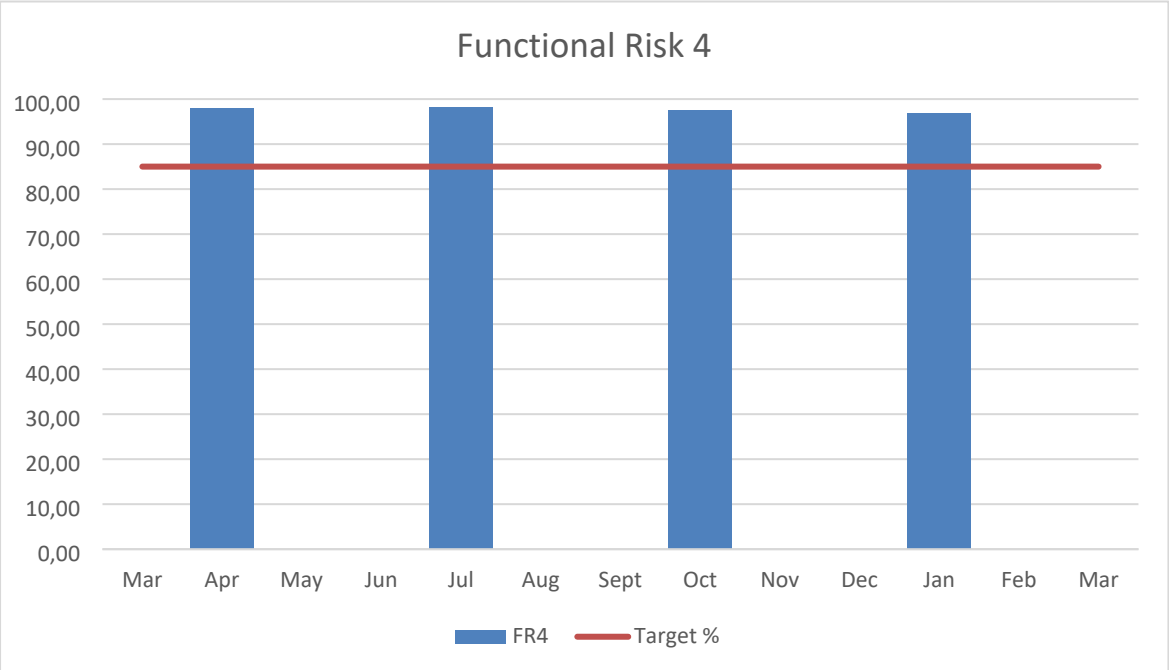
1.3. The Current audit process is under review.

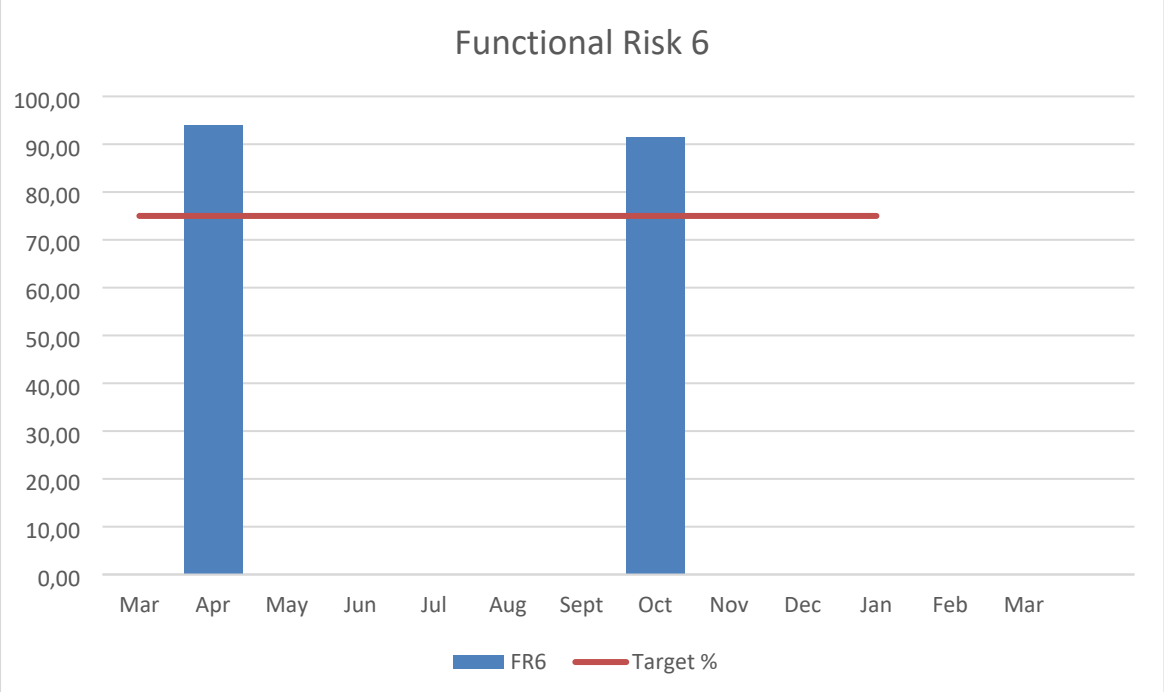
FR Rating	Target %	Audit Frequency
FR1	98%	Weekly
FR2	95%	Monthly
FR3	90%	Bi-Monthly
FR4	85%	Quarterly
FR5	80%	Six Monthly
FR6	75%	Annually*
*DHC Audit FR6 Six Monthly		











4.1 DCH

Compliance

Various additions have been made to the Compliance Tracker to include further elements such as Window restrictors and Ladders. The Technical Compliance Tracker continues to be updated to reflect the changing picture of items delivered and remedial works undertaken.

Fixed Wire testing (EICR)

DCH is working at tendering for all fixed wire testing across the Trust, this is currently held with the contracts manager as it requires a template to be completed. The site is long overdue for this testing and this will be an expensive item not including the remedial work that will be required. A five year forward timetable can then be looked at so that we do not become uncompliant in the future. This will see a vast improvement of our compliance position in this area.

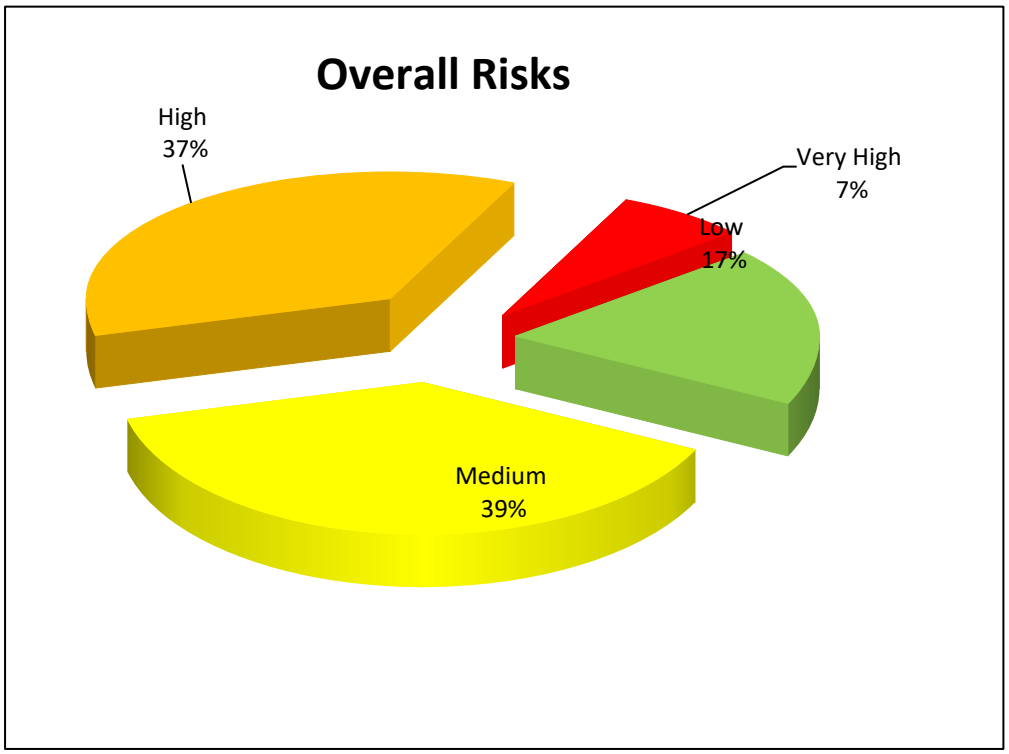
Fire Dampers

The fire dampers have been inspected for 2025 and we are now awaiting the remedial quote for and required repairs. The asset numbering needs to be looked at and this should be resolved by the introduction and preparation of the asset register. The number of dampers that are inaccessible needs to be looked at as it currently appears to be around 40% of the total.

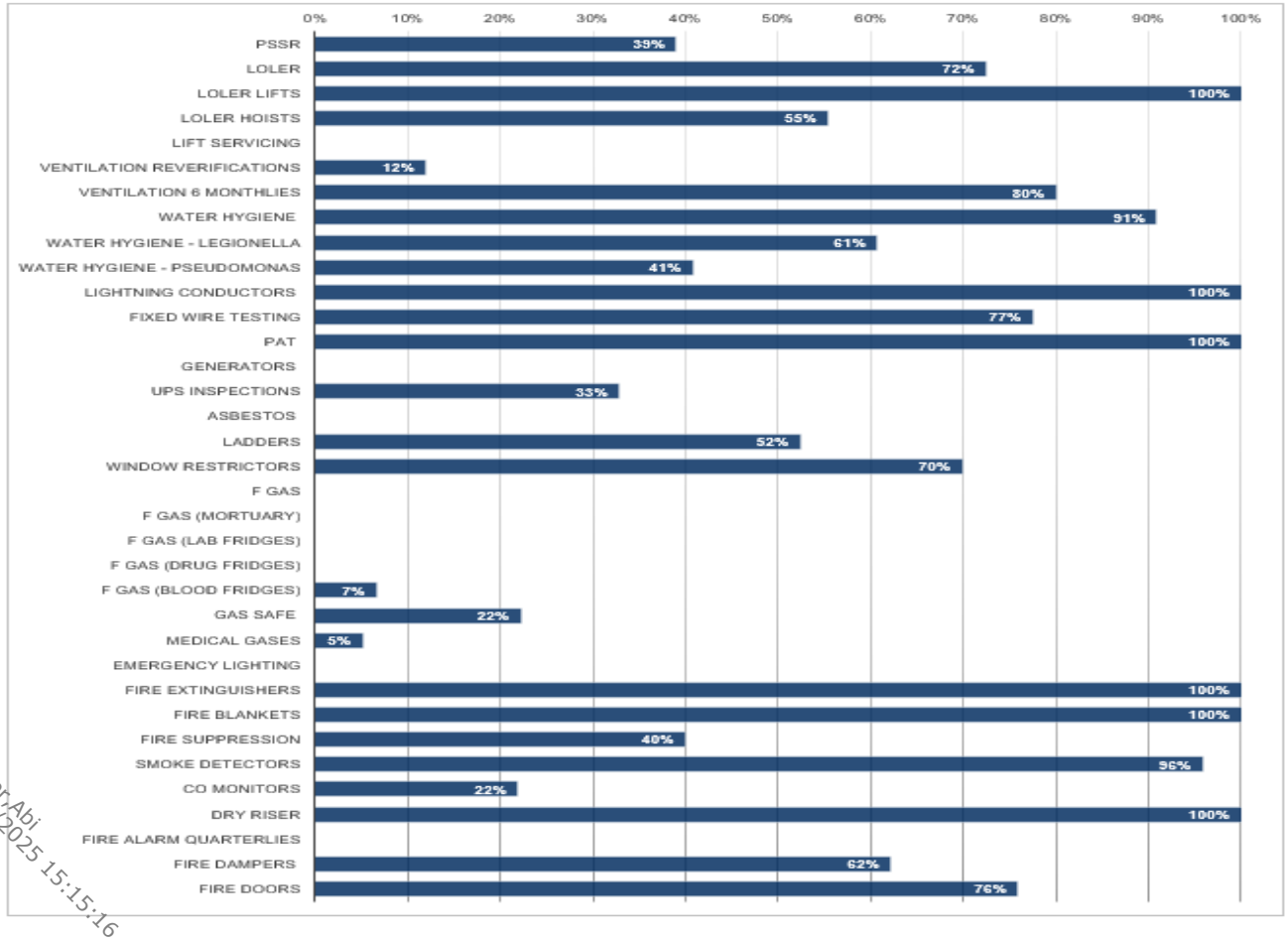
SCART

The Compliance & Asset Officer has conducted a SCART survey, involving various stakeholders to supply the required answers and risk gradings. This survey is similar to the PAM survey but in more depth over certain areas, this will assist us in providing the required answers and evidence once the PAM survey is in progress via our external partner. The survey has been completed and this can now be benchmarked to look at what areas require more considerable attention.

Below shows the Pie Chart of the risk areas split by risk level.



Compliance Tracker



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Average compliance = 64%

The Compliance Tracker is used for all of the physical assets on site. All of the items on this are tangible.

This does require the relevant, correct and comprehensive documentation and certification to be received. In some cases, compliance has been achieved but the documentation cannot prove this. Therefore, from an abundance of caution compliance cannot be guaranteed, in such cases we have assumed a default position of 'non-compliant'. Note: The above graph is only a snapshot of the current compliance condition and changes daily.

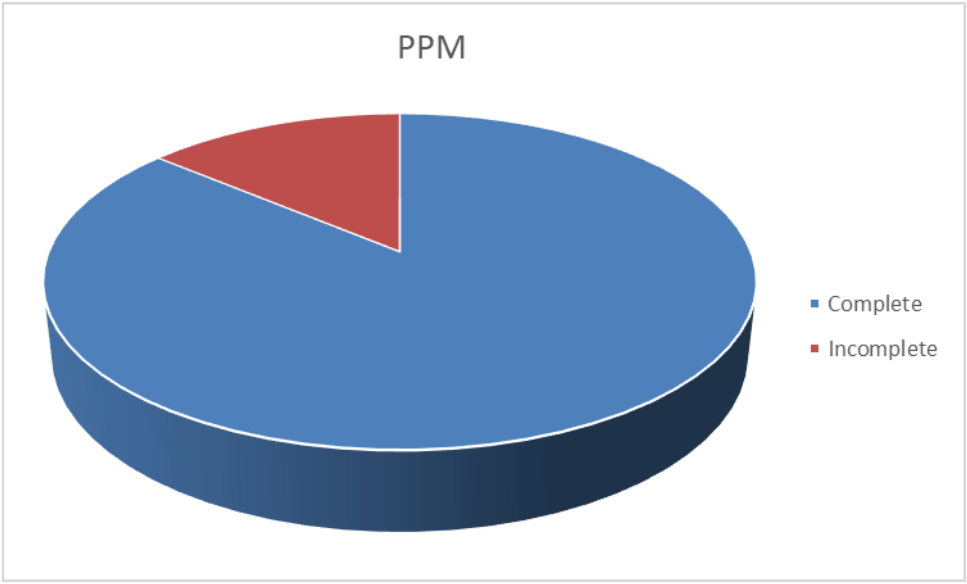
Compliance

2.4. Estates and Facilities have undertaken a review of how we measure and record compliance. Further continual reviews will be required to fully refine the different data streams and how these are collated. This will need to be looked at as how the compliance system can be controlled when it is looking at the separate trusts as a single system.

2.5. Currently, compliance data monitoring is split between a number of different systems. Most of the relevant compliance information is held on the compliance tracker. All of the evidence that is received is held on the S: drive. There will be a move to hold this more on the MICAD suite of programmes as DHC but this will probably not be until the Opco has been established.

2.6. In the meantime, individual reporting continues to take place with manual collation of the data.

Planned Maintenance (Estates)



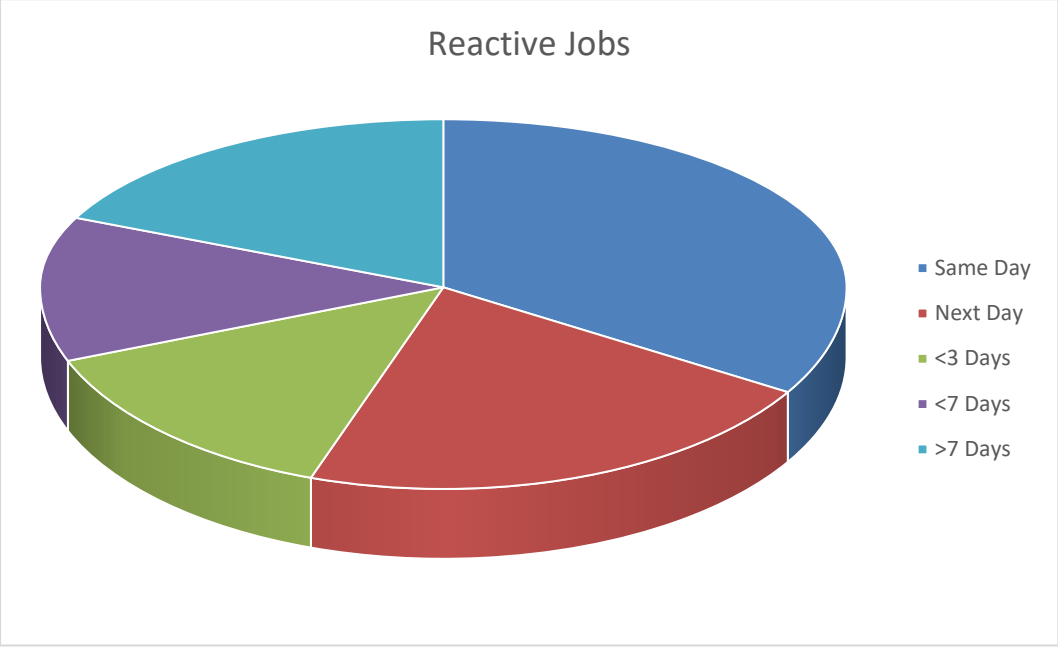
2.7. In Q4 a total of 3466 Planned Maintenance jobs were issued to the Estates team, of those 86.1% were completed.

PPM's Q4

PPM Category	Total Jobs Completed	Total Jobs Failed	Compliance Level
Statutory Q4	2984	482	86.1%

Reactive Works

4.2 All Reactive Requests – In Q4 a total of 3445 reactive requests were received by the service desk of these 69% were responded within the time frame allowed.



We need to look at using the same timescales as DHC and this is an issue that will be addressed with the move to the Opco.

5.0 Conclusion

Both Trusts have worked to align their reporting methodology. Whilst this has progressed well, further ongoing work will take place to refine this and ensure that we can implement a fully aligned process. The Estates Department will continue to focus on asset resurveying and enhancements to the Planned Maintenance schedules. High Risk items will continue to receive priority focus.

6.0 Recommendations

The Finance and Performance Committee in Common is requested to:

- Receive the report for information
- Receive the report for assurance

Report to	DHC Board of Directors	
Date of Meeting	10 June 2025	
Report Title	DCH Health & Safety Compliance Report	
Prepared By	Jason Chambers, Health & Safety Manager DCH	
Approved by Accountable Executive	David McLaughlin, Director of Estates & Facilities Chris Hearn, Chief Finance Officer	
Previously Considered By	DCH Health, Safety, Fire & Security Group Finance and Performance Committee in Common	
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	
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	Compliance with Legislation will ensure that strategic objectives are being met.	
Equality, Diversity & Inclusion	No implication	
Co-production & Partnership	No implication	

Executive Summary

This report provides assurance and information on Health and Safety (incl. Fire and Water) Compliance.

This report includes data for the 4th Quarter of 2024/25 financial year (December 2024 to March 2025) extracted from the Datix electronic risk management reporting database and Occupational Health Reports detailing significant incidents and referrals relevant to Health and Safety issues.

A separate Annual Fire Safety Report 2024/25 and additional paper has been produced by previous Fire Officer, Angus Nairn. The Trust has seen fire safety improvements in many areas over the last 12 months. Fire Risk Assessments (FRA's) have been started with the assistance of our external partner, Dorset Healthcare University NHS Foundation Trust.

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.

Recommendation

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

Health, Safety and Security Report for the period 01.12.2024 – 31.03.2025

Contents

1. Executive Summary

1.1. Aim of this report is to inform the Finance & Performance Committee of the compliance with legal obligations under the Health and Safety at Work Act 1974.

1.2. To inform the Committee of the work undertaken during last quarter of 2024/25 financial year (December 2024 to March 2025) extracted from the Datix electronic risk management reporting database and Occupational Health Reports detailing significant incidents and referrals relevant to Health and Safety issues.

3.5 The Trust has seen fire safety improvements in many areas over the last 12 months. Fire Risk Assessments (FRA's) have been started with the assistance of our external partner, Dorset Healthcare University NHS Foundation Trust. A separate Annual Fire Safety Report 2024/25 and additional paper has been produced by previous Fire Officer, Angus Nairn.

1.3. The Trust has again received no prosecutions or Improvement Notices from any of the enforcing agencies of the HSE, CQC or Dorset & Wiltshire Fire & Rescue Service during this period relating to health and safety matters.

2. Introduction

2.1 Background

Health and safety management is an ongoing process, not a one-off task. It is not enough to just control the risks across the Trust; we must ensure that they stay controlled.

It reflects the Trust's compliance with the Board of Directors approved 'Statement of Intent' and Health & Safety Policy Statement, which requires those responsible for health and safety within the Trust premises and during Trust activities to:

- Comply with health and safety legislation.
- Implement health and safety arrangements.
- Comply with monitoring and reporting mechanisms appropriate to internal and external key stakeholders and statutory bodies.
- Develop partnership working and to ensure health and safety arrangements are maintained for all

To ensure that the health and safety agenda is not only embedded, but embraced throughout the Trust using a variety of monitoring methods, including:

- Health, Safety Fire and Security Group (bi-monthly)
- Divisional Governance (monthly) meetings
- Risk based monitoring groups, such as monthly asbestos and water safety

The Health, Safety, Fire & Security Group acts as the Trust Health and Safety Committee. The reporting structure for this Group was revised in 3rd quarter to report to the Finance and Reporting Committee (FPC).

2.2 Reporting mechanisms

Monitoring for health and safety is broadly categorised by two types:

- Proactive monitoring and reactive monitoring.

  Proactive monitoring is intended to be preventative – identifying and resolving hazards before they lead to incidents. This could include:

  - Conduct external and internal site inspections (of communal areas) to identify hazards and implement corrective actions to eliminate or reduce risks
  - Conduct workplace inspections, and audits, of departments to ensure safe working conditions; advise on corrective actions if needed
  - Support departments across the Trust to implement, maintain and continually improve H&S processes within their work areas
  - Monitor and evaluate health and safety performance data, identify trends and areas where further improvement may be required or can be made.
  - Monitor health and safety related legislation and guidance and ensure the Trust is compliant with current requirements and relevant departments are aware of changes to relevant legislation and respond accordingly
  - Provide H&S training for all staff e.g. included on induction training for new starters and Health and Safety training programme, which includes general health and safety, Control of Substances Hazardous to Health (COSHH), etc.

- Reactive monitoring

  Reactive monitoring is conducted after an incident has occurred, and often seeks to identify root causes, or other process or system causes, of incidents and to prevent recurrence by implementing corrective actions. This could include:

  - Daily review of H&S related incidents (provided by the Trust incident reporting system and related teams)
  - Investigate H&S related incidents and report to relevant department leads / others.

- Report qualifying incidents to the Health and Safety Executive (HSE) under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).

- Provide support and advice to relevant departments for the identification and implementation of suitable control measures and other corrective actions to prevent recurrence of incidents

3. Reporting

3.1 Incident Reporting

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.

Health & Safety incidents are identified from the incident description through screening by the Risk Management Department and forwarded to the H&S Manager.

3.2 The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

3.2.1 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)

3.2.2 For the period 01.11.2024 – 27.12.2024, 2 incidents were RIDDOR reported.
- 1 was a staff injury of a fracture to the nose caused due to slip on wet floor,
- 1 was a staff injury that required more than 7 days off work, due to wrist strain after patient assault.

3.2.3 For the period 01.01.2025 – 28.02.2025, 2 incidents were RIDDOR reported.
- a volunteer agency fractured left leg (Blood bikes Yeovil Freewheelers EVS)
- a patient fall resulting in a fractured hip and wrist

3.2.4 For the period 01.03.2025 – 30.04.2025, 0 incidents were RIDDOR reportable.

3.3 Health and Safety Incidents

The Health and Safety Manager and the Trust Divisions have focused monitoring of incidents including the most prevalent health and safety related incident. In this period between December and March, incidents of note for health and safety included:

3.3.1 Fire related H&S concerns at South Walks House (SWH)

In this SWH incident DCH101448 from 9th December, the patient stuck on the stairs had pressed the refuge alarm button in the stairwell. Library staff raised that the emergency refuge alarm sounded in the Dorset Council Library side but not in the DCH staffed side of SWH. This has been raised with DCHFT Fire Officer and Dorset Council.

DCH101497, 11/12/2024, Fire Alarm at SWH set off during Estates Works, highlighted issues with partial evacuation H&S risks as well as lack of training on alarm system changes for the Dorset Council Library Staff.

In SWH on 28th March during a review of the fire break glass points it was found some were not working this was escalated to Dorset Council.

The annual fire safety report provides a summary of the Dorset County Hospital NHS Foundation Trust fire safety status between the period of 01 April 2024 to 31 March 2025 and provides areas of risks that require improving during the 2025 – 2026 financial year.

The Trust has seen fire safety improvements in many areas over the last 12 months. Fire Risk Assessments (FRA's) have been started with the assistance of our external partner, Dorset Healthcare University NHS Foundation Trust.

3.3.2 Significant Electrical Incidents

IT Server room 2, DCH100894, 25/11/2024, Air con supply switched off after multiple power outages. Required Estates manual checks of all IT server rooms and switch on of powered off air con units was not carried out. Leading to multiple servers shutting down due to over-heating. Resulting in most trust systems going offline including most critical clinical systems such as Vital PAC, ICE, Agyle, EPMA.

3.3.4 Water ingress issues at South Walks House in February

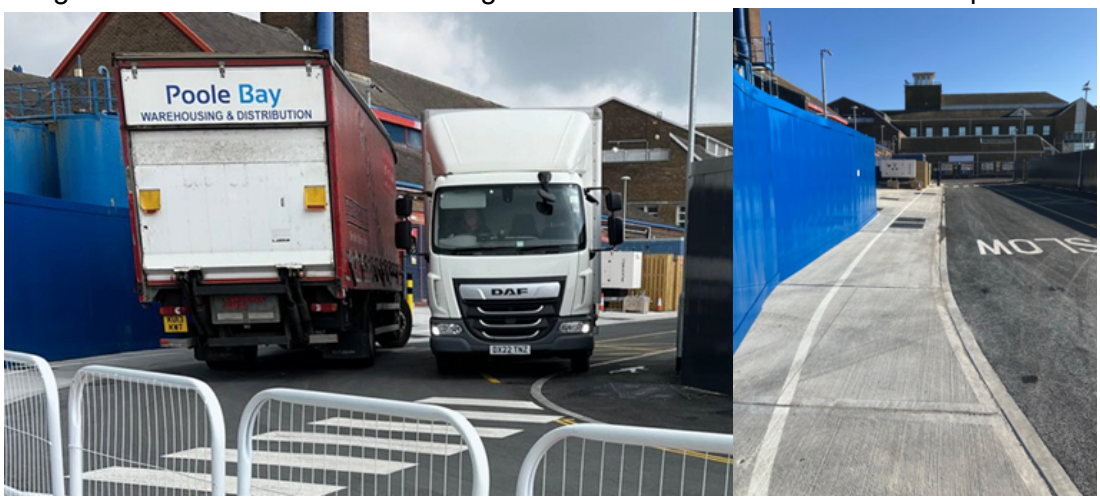
Continuing issues with water ingress at South Walks House (SWH) impacting 1st Floor patient waiting area, DCH 103746 24/02/2025. As leaseholders the Trust escalated to the owner, Dorset Council, and tender was issued and works recently commenced to correct the issue.

3.3.5 NHP Access Road workplace transport safety concerns

Concerns were raised when the NHP access road was first opened with regards to as waste having to be transported on the new NHP access road to the waste management compound and the risk of staff being struck by vehicles. The segregation between pedestrian traffic and vehicles was insufficient, no pavement or protection of staff from traffic. There did not appear to be sufficient separation between vehicles and pedestrians and so additional barriers were installed and concrete bollard removed to increase safe access space.

It is being raised with TD that the road width is not as designed, potentially putting pedestrians at risk on the designated pedestrian path, which is open to the public.

Image shows traffic on the left coming into the site can be on the concrete path.



In the Workplace (Health, Safety and Welfare) Regulations 1992, a 'traffic route' is defined as 'a route for pedestrian traffic, vehicles or both'.

The HSE recommends in its guidance on this legislation that when planning workplace traffic routes, take account of the following requirements from the Regulations:

- They **must** be suitable for the people and vehicles using them and organised so that they can both move around safely.
- Where vehicles and pedestrians share a traffic route, there **must** be enough separation between them (segregation).
- Pedestrians or vehicles **must** be able to use a traffic route without causing danger to the health or safety of people working near it.

In particular, Regulation 17 Organisation etc of traffic routes states that '*traffic routes **shall not satisfy** the requirements of that paragraph unless suitable measures are taken to ensure that where vehicles and pedestrians use the same traffic route, there is **sufficient separation** between them.'*

3.4 Exposure to Blood Bourne Virus Exposure and Needlestick Injuries

3.4.1 Blood Borne Virus (BBV) Data for DCH from Occupational Health

January 2025:

5 BBV incidents were reported to OH - 2 x Theatres, 2 x Endoscopy & 1 x Home Treatment service.

February 2025:

5 BBV incidents were reported to OH – 2 x Theatres, 1 x Portesham Ward, 1 x Cardiac care, & 1 x Ilchester Ward.

March 2025:

7 BBV incidents were reported to OH – 3 x no specific area identified, 1 x Endoscopy, 1 x Ridgeway, 1 x medical & surgical ward and 1 x Prince of Wales.

	Nov 2024	Dec 2024	Jan 2025	Feb 2025	March 2025	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25
Blood bourne virus exposure incidents reported	5	6	5	5	7	15	21	15	16

3.4.3 Numbers for 2024/2025 are similar to previous years recorded data.

Year	2022/2023	2023/2024	2024/2025
Inoculation Injury (needlestick/sharps) Incident	64	68	67

3.6 Control of Substances Hazardous to Health

3.5.1 There have been two incident involving control of substances hazardous substances to health.

3.5.2 COSHH near miss in the waste store, DCH104022 4th March. Pathology staff noted that the bund on which some of the waste is stored was full of fluid, preventing any spillage that should occur to be collected within the bund. The identity of the fluid within the bund is unknown. Highlighted gaps in process for waste management and the emergency plan and risk assessment were revised.

3.5.3 Potential COSHH incident over nitrous oxide (N2o) exposure in DCH Maternity Labour Rooms exceeding workplace exposure limit (WEL) was raised in February.Recent testing report in January 2025 found that: "*Despite the lower than typical usage of Entonox during testing, staff exposure to nitrous oxide in the Labour Ward breached*

the WEL for nitrous oxide for 2 staff members, which is a cause for concern."

The accuracy of the testing is being challenged by Midwifery, as one member of the members staff is a support worker and does not enter a room with Entonox. Tests were also given out randomly.

The room is compliant for ventilation air exchanges, recent unofficial survey found over 16 air changes per hour, more than the 10 required to be compliant. Estates will ask for an official reading be taken from a company working on site this week and provide a full report.

3.7 Risk Assessments

Departments are responsible for producing their own risk assessments but for shared spaces or where additional support and advice is required the H&S Manager provides additional advice. In this period the following risk assessments were provided:

- NHP Access Road for waste transfer risk assessment
- Green spaces gardening risk assessments
- Roof Terrace at SWH risk assessment
- DCH Terrace Café pressure washing risk assessment

3.7 Occupational Health H&S related referrals

The contract for Dorset Healthcare University NHS Foundation Trust to provide Occupational Health services to Dorset County Hospital commenced on 01 January 2024.

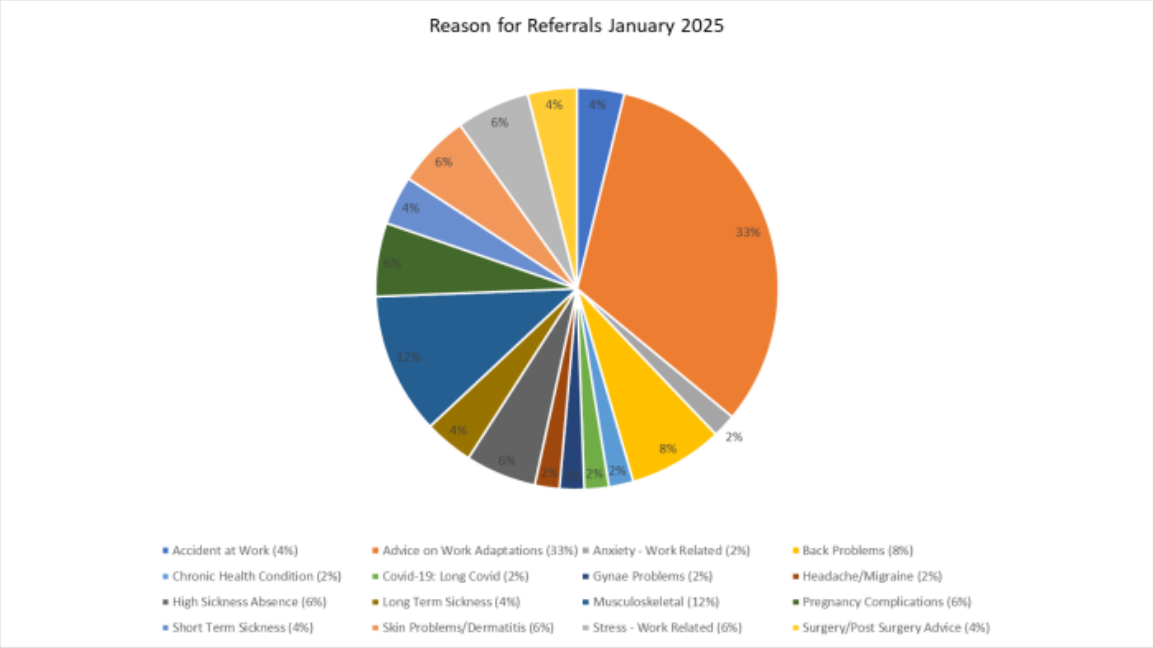
Extracted from Occupational Health Report on activity 2024/25:

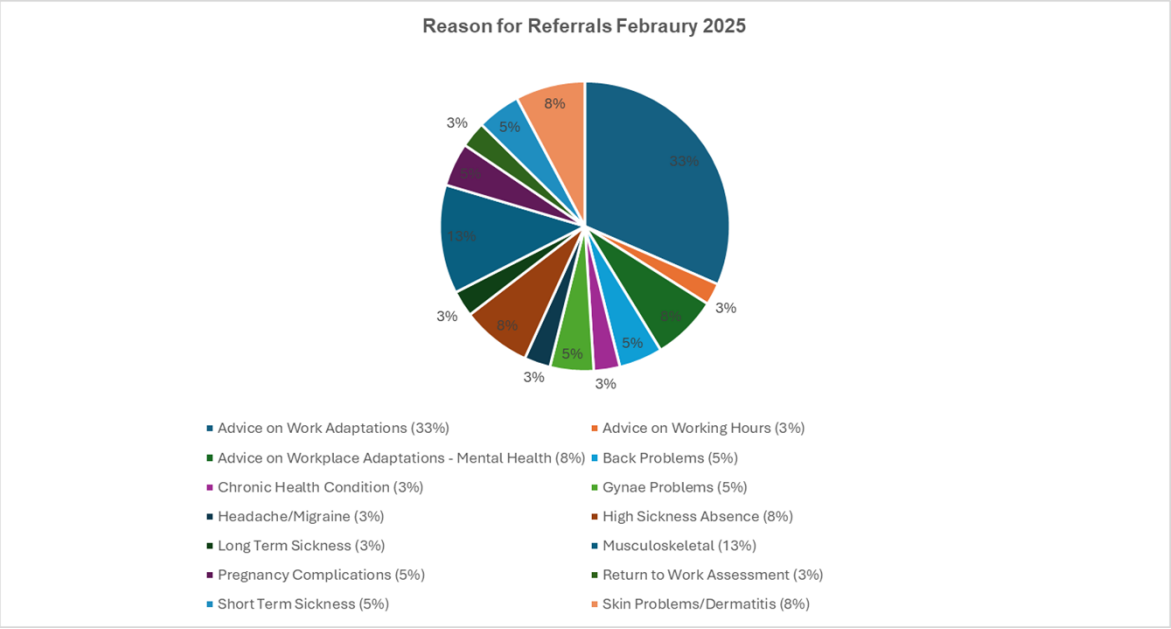
Activity
Monthly activity summary:

	Apr 2024	May 2024	June 2024	July 2024	Aug 2024	Sept 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	**Mar 2025**	% change on previous month	Q1 24/25	Q2 24/25	Q3 24/25	**Q4 24/25**
New Management Referrals received	31	47	37	44	36	40	46	42	32	39	42	**40**	-5%	115	120	120	**121**
Pre-Employment Forms received	66	124	103	83	47	64	41	36	38	58	30	**49**	63%	293	194	115	**137**
Blood Borne Virus Exposure incidents reported	6	6	3	6	9	6	4	5	6	5	5	**6**	20%	15	21	15	**16**

3.7.2 Occupational Health Report trend of 2024/25 highest reasons for Management Referrals being:

- Advice on work adaptations
- Musculoskeletal
- Long Term Sickness
- Back Problems





3.7.3 Following a review of OH referrals, from Jan 2025 to date 6 Management Referrals have been received where concerns have been raised from employees since the introduction of the new soap commenced. This did appear to be an issue with a small mis-order of wrong soap which caused a reaction, this has been removed, and any further incident is being monitored by Divisions, H&S Manager and Occupational Health.

3.8 Training

3.8.1 Preceptorship, COSHH & H&S training taken place.

Providing training for Trust Preceptorship continues every three months as well as presentation at Trust Induction.

COSHH & H&S training continues every two months, and trained staff now is:

- COSHH Assessors – 88 staff
- Health and Safety Representatives – 62 staff

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.

3.9 Inspection

Following this training by the H&S Manager Departments have COSHH Assessors and H&S Reps and they have been able to review and update their risk assessments and audit them. Now that this has taken place, the safety management system requirement to inspect the audit process could take place.

H&S inspection of the Trust's H&S annual audit process continues with a programme of inspections of all clinical areas, until end of March 2025. 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. Lots of good practice found so far and full inspection report should be available with the H&S Annual Audit results for HSFS Group meeting in July 2025.

4 Conclusion

4.1 The Health and Safety report provides information about health and safety processes being delivered across the Trust. These will be implemented at all sites as far as possible, to support health and safety of staff and others.

4.2 Health and Safety incidents for the period have been reviewed and learning from these has been cascaded to all relevant parties. Exposure to blood borne diseases and RIDDOR incidents were within the usual range with no trends.

4.3 The report summarises the progress against strategic and annual objectives for health and safety, noting where additional H&S Manager input was required to support the achievement of these.

5 Recommendations

5.1 The Committee is recommended to:

5.1.1 Receive the report for assurance

Name and Title of Author: Jason Chambers
Date: 14.05.25