

Board in Common - 07/10/2025 - Part 1

Tue 07 October 2025, 09:30 - 14:45

Sentinel House

Agenda

- 09:30 - 09:45
15 min

1. Patient Story
 1. Patient Story - Board Report ICSD.pdf (5 pages)
- 09:45 - 09:50
5 min

2. Transition Report
 2a Board in Committee in Common Transition Report Oct 25.pdf (3 pages)
 2b All Committee Structures V1.pdf (1 pages)
 2c BoD & Comm Dates 2026-27.pdf (1 pages)
- 09:50 - 10:00
10 min

3. Formalities
 3a - Agenda BoD in Common - Part 1 - October 2025.pdf (3 pages)
 3b DCH Draft Minutes BOD Part 1 10 06 2025 Revised.pdf (27 pages)
 3b DCH Draft Minutes BOD Part 1 12 08 2025 DCS.pdf (20 pages)
 3b DHC DRAFT Board Minutes ~ Part 1 13 August.pdf (20 pages)
 3c BoDiC Action Tracker - Part 1.pdf (2 pages)
 3d Board in Common Annual Work Plan 2025-26.pdf (2 pages)
- 10:00 - 10:05
5 min

4. Chair's Comments
- 10:05 - 10:15
10 min

5. CEO Report
 5. CEO Report Oct 2025.pdf (7 pages)
- 10:15 - 10:25
10 min

6. Quality Committee Assurance Report
 Assurance Report QCIC 23 September 2025.pdf (5 pages)
- 10:25 - 10:35
10 min

7. Maternity Safety Report
 6.2a DCH front sheet Maternity Neonatal Report July and August data - September report.pdf (3 pages)
 6.2b DCH maternity neonatal safety quality report July Aug (reported in September) 2025.pdf (34 pages)
- 10:35 - 10:50
15 min

8. Learning from Deaths Report (Q1)
 6.3a DCH 25-26 Q1 Learning from Deaths Report.pdf (17 pages)
 6.3b DHC Learning from Deaths Report - Q1 2025-26 for submission Board.pdf (15 pages)
- 10:50 - 11:00
10 min

9. Patient Carer Race Equality Framework (PCREF)
 6.4 DHC PCREF Update.pdf (13 pages)
- 11:00 - 11:10
10 min

10. Annual Inpatient Survey and Action Plan

Bakerfield
06/10/2025 12:40:16

- 6.4a DCH In-Patient Survey Front Sheet.pdf (2 pages)
- 6.4b RBD Dorset County Hospital NHS Foundation Trust IP24 Management Report.pdf (92 pages)

11:10 - 11:20 Coffee Break

10 min

11:20 - 11:30 11. Finance and Performance Committee Assurance Report

10 min

- 7.1 FPC Sep 25 Assurance Report.pdf (6 pages)

11:30 - 11:40 12. Balance Scorecard

10 min

- 7.2 Integrated Board performance report October 2025.pdf (26 pages)

11:40 - 11:50 13. Integrated Corporate Dashboard

10 min

- 7.3a Integrated Corporate Dashboard DHC - Oct 25 (Aug data).pdf (79 pages)
- 7.3b CYP MHLCD PerformanceSummary_Sept_25 (Aug_25 data).pdf (2 pages)
- 7.3c ICS - Board Report Summary Aug 2025.pdf (1 pages)

11:50 - 12:05 14. Finance Reports

15 min

- 7.4ai Front Sheet DCH FPC M5.pdf (3 pages)
- 7.4aii DCH Finance Report Mth 5 FPC.pdf (14 pages)
- 7.4b DHC Finance Report Month 5 August 2025.pdf (23 pages)
- 7.4c Dorset ICS month 5 financial performance cover sheet.pdf (2 pages)

12:05 - 12:15 15. Emergency Preparedness Resilience and Response (EPRR) Statement

10 min

- 7.5 DCH EPRR Aug 2025.pdf (66 pages)
- 7.5b DHC EPRR Assurance Self Assurance Paper Final V2 Oct 2025.pdf (4 pages)

12:15 - 12:25 16. People and Culture Committee Assurance Report

10 min

- PCCIC September 25 Assurance Report - FW.pdf (4 pages)

12:25 - 12:35 17. Guardian of Safe Working Reports

10 min

- 8.2a DCH GoSW_Front Sheet, Report and Appendices 2526 Q1.pdf (10 pages)
- 8.2b DHC GOSW Report Q1 25-26 for Board.pdf (4 pages)

12:35 - 12:45 18. Workforce Equality Reports

10 min

- 8.3 Joint WRES and WDES Report DCH DHC 24-25 v5.pdf (73 pages)

12:45 - 12:55 19. Mutually Agreed Resignation Scheme

10 min

- 8.5 BoD MARS Update paper Sept 2025.pdf (6 pages)

12:55 - 14:00 Lunch

65 min

14:00 - 14:10 20. Strategy, Transformation and Partnership Committee Assurance Report

10 min

- 9.1 STP Sep 25 Assurance Report.pdf (4 pages)

14:10 - 14:20
10 min

21. Green Plan Guidance Refresh

 9.3 Green Plan Guidance Refresh - DCH and DHC - September 2025 Board.pdf (9 pages)

14:20 - 14:25
5 min

22. Charitable Funds Committee Assurance Report

 10.1 Assurance Report - DCH Charitable Funds Committee (30.9.25).pdf (2 pages)

14:25 - 14:25
0 min

23. DCH SubCo Ltd Performance Report

 11.1a DCH SubCo Assurance Report 06 08 2025 ST.pdf (2 pages)

 11.1b DCH SubCo Performance Report July 2025.pdf (3 pages)

14:25 - 14:25
0 min

24. Medical Appraisal and Revalidation - Statement of Compliance

 11.3a DHC Medical Appraisal Statement of Compliance October 2025.pdf (2 pages)

 11.3b Medical Staff Revalidation Update - Trust Board October 2025.pdf (6 pages)

 11.3c Annex-A-FQAI updated 2025.pdf (29 pages)

14:25 - 14:25
0 min

25. Mental Health Scheme of Delegation

 11.4a DHC front sheet - MHA scheme of delegation.pdf (1 pages)

 11.4b Dorset Healthcare MH Scheme of delegation.pdf (9 pages)

14:25 - 14:30
5 min

26. Questions from the Public

14:30 - 14:35
5 min

27. AOB

Baker, Abi
06/10/2025 12:40:16

Report to	Board of Directors	
Date of Meeting	08 October 2025	
Report Title	Patient Story: Carer Story – Intensive Community Support for Dementia (ICSD) West	
Prepared By	Rachael Pankhurst - Patient Experience Facilitator	
Approved by Accountable Executive	Cara Southgate - Director of Nursing (Mental Health & Community)	
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? <i>Delete as required</i>	
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 SR2 Culture SR5 Estates SR8 Transformation and Improvement	
Financial	No implication	
Statutory & Regulatory	No implication	
Equality, Diversity & Inclusion	No implication	
Co-production & Partnership	No implication	

Executive Summary
This story is being submitted to the Board for consideration, reflection, and to highlight the carers positive experience of the Intensive Community Support for Dementia (ICSD) West service. The carer offers insight into the care his wife received and her own personal struggle with 'Unspecified Dementia' and the impact this had on him as a full-time caregiver. He chronicles remarkable events and describes the challenging behaviours of Dementia. This is an emotive story of courage and strength where the patient, carer, meets ICSD. This story highlights how the intervention of ICSD made the impossible possible and created a future endearing to both the patient and carer. ICSD provides support and treatment for people in Dorset with a diagnosis of dementia who already access Dorset HealthCare secondary mental health care services. The teams provide an urgent care response to needs arising in the community, including residential and nursing homes. The team assesses all referrals to determine the appropriate intervention to enable patients to receive care in their normal place. And offer time limited contact with people with dementia for up to six weeks, to provide the service until the situation has been sufficiently stabilised for ongoing care to be delivered at a lower level of intensity.

Recommendation
Members are requested to: Consider and discuss the patient's story and consider his experience.

Patient Story

1. Executive Summary

- 1.1. This is a positive story and a carer's experience of Intensive Community Support for Dementia (ICSD) West.

2. Introduction

- 2.1. A patient/carers story is produced by the Patient Experience team and is a regular item at Board meetings.
- 2.2. Stories are submitted to and presented by the Corporate Governance Team.
- 2.3. The carer has been supported in giving his story by Rachael Pankhurst, Patient Experience Facilitator.

3. Main narrative

- 3.1. In 2020, the patient received a diagnosis of 'Cognitive Impairment', and later in 2024, Sarah was diagnosed with 'Unspecified Dementia'. Sarah and her husband Trevor, the caregiver, had just settled into retirement when they received the diagnosis; their lives would no longer be the same.

Sarah's health declined, leading Trevor to feel overwhelmed by the difficult behaviours of dementia which led him to seek help from Mental Health Services. They referred Sarah to the Intensive Community Support for Dementia (ICSD) West service, which Trevor states their visits were transformative because they were experts in dealing with patients with dementia. The intervention of ICSD gave both Sarah and Trevor an additional six months in their home together.

ICSD made twice daily visits at home, which Trevor states were for Sarah, but he too, felt supported by the team when he was at his own breaking point. They asked after Trevor's health as much as Sarah's, and this made such a difference to him as a caregiver with their unwavering understanding and patience. ICSD created spaces for Trevor to retreat to, as being the sole caregiver had a significant impact on his own mental well-being.

When asked, Trevor felt informed every step of the way in Sarah's care planning and was given a copy of her wellbeing plan, which he reviews regularly, and states ICSD would discuss all aspects of care with him, and states mental capacity assessment and medication treatments as examples. Trevor felt a part of the team caring for Sarah.

Baker, Abi
06/10/2025 12:40:16

Sarah's memory and cognitive abilities declined which significantly affected daily life to a point where home for Sarah, and Trevor as her husband and caregiver were beyond her memory and home did not feel like home. Trevor sought urgent help from mental health services which led to Sarah being homed the same day.

New adjustments were naturally difficult for Sarah, but she became aggressive and confrontational with all staff at the home. This led to one-to-one care in the evenings.

ICSD was again brought into the system. They supported Trevor, the home and helped Sarah and were able to implement a new medication regime which Trevor claims Sarah to be a changed person.

Following a trial without one-to-one care in the evenings, and after a difficult five days of uncertainty of Sarah's and Trevor's future, she settled, and social care agreed Sarah could remain where she was which was an emotional relief for Trevor.

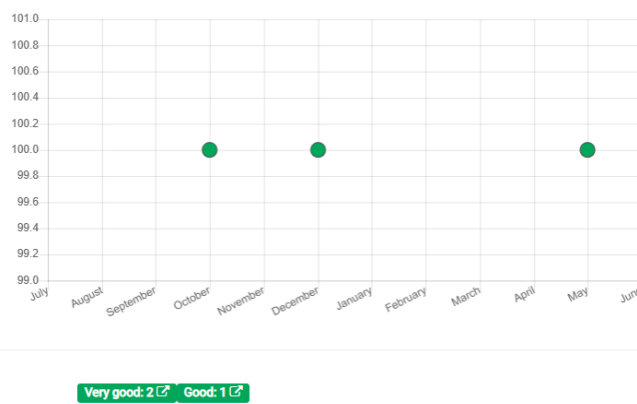
Trevor states he 'learned so much' from ICSD. He acquired knowledge and understanding from them to confidently communicate with Sarah and become non-reactive to her.

When asked if ICSD could have done anything more Trevor stated the opposite, he believes they gave him and Sarah what they have today, the enablement of the right home, accessibility, and a close and enduring relationship with his wife despite dementia.

4. Triangulation data: 01/07/2024 – 30/06/2025

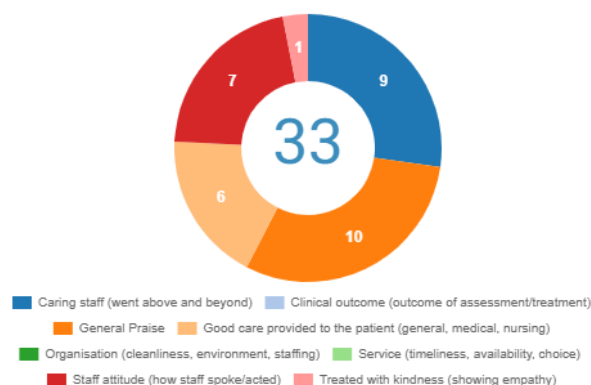
- 4.1. **Friends & Family Test** - Intensive Community Support for Dementia (ICSD West) received a total of three responses from feedback with an FFT score of 100%.

100%
3 responses

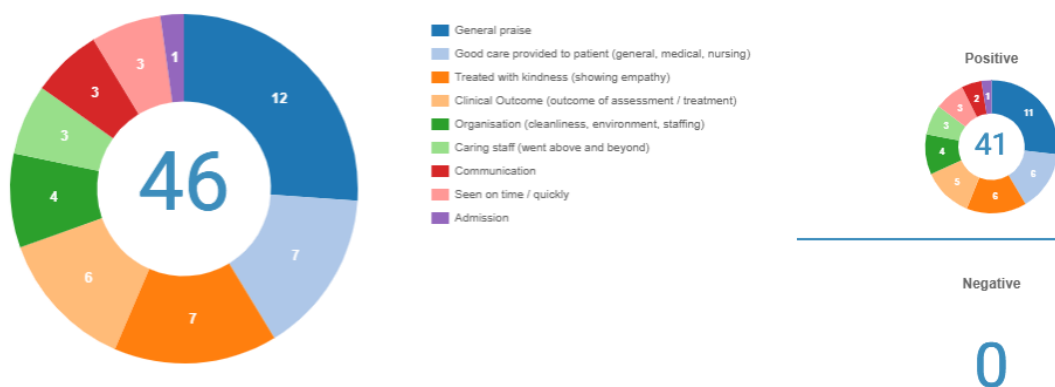


- 4.2. **Complaints** – Nil complaints were recorded.
- 4.3. **Compliments & Categories** A total of thirteen compliments were received for the service.





4.4. **Survey Comments & Sentiment Analysis** - There were 46 survey comments sentiment analysed. These are further broken down by theme.



4.5. **Service Developments & Improvement 'You Said, We Did' (YSWD)** – Nil.
4.6. **Online Comments** – Nil.

5. Conclusion

5.1. Key points raised in the video are:

- Access to service
- Interventions
- Communication
- Caregiver support
- Patient & Carer outcomes
- Felt involved
- Facilitation
- Services internal & external working together

5.2. Response to the story from Ben Holt, ICSD West Team leader.

We are truly grateful to Trevor for sharing such a heartfelt and honest account of his and Sarah's journey. His story highlights the emotional weight of caring

Baker, Abi
06/10/2025 12:40:16

for a loved one with dementia and the importance of support not just for the patient, but also for the carer.

The ICSD team is deeply committed to helping people remain at home wherever possible, and to making carers feel seen, heard, and supported in that process. It is moving to hear that Trevor felt part of the team and that our visits helped ease a very difficult time in their lives.

We are proud that Trevor recognised the care, kindness and teamwork that go into everything we do, and that this support made a real difference to both him and Sarah. His words are a powerful reminder of why our work matters. We thank Trevor for his trust and wish him all the very best.

6. Recommendations

- 6.1. The Board is recommended to:
 - a. Receive the report for **information**

Name and Title of Author: Rachael Pankhurst, Patient Experience Facilitator

Date: 31/07/2025

Baker, Abi
06/10/2025 12:40:16

Report to	Board in Common – DCH and DHC	
Date of Meeting	7 October 2025	
Report Title	Transition to Board in Common	
Prepared By	Jenny Horrabin, Joint Director of Corporate Affairs	
Accountable Executive	Jenny Horrabin, Joint Director of Corporate Affairs	
Previously Considered By	N/A	
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	Implications for all strategic risks	
Financial	No impact from this report	
Statutory & Regulatory	No impact from this report	
Equality, Diversity & Inclusion	No impact from this report	
Co-production & Partnership	No impact from this report	

Executive Summary

Background

Since 2023 Dorset County Hospital (DCH) and Dorset Healthcare (DHC) Foundation Trusts have been working together as a group provider model (described locally as a Federation). This was agreed in 2023/24 and followed the appointment of a joint chief executive and chair at the start of the year. Since April 2024 the Federation has a single executive team working across two trusts (all posts are shared with the exception of a trust specific Chief Operating Officer and Chief Medical Officer roles) and in August 2024 the federated trust's adopted a joint strategy – Healthier Lives, Empowered Citizens, Thriving Communities.

The fundamental purpose of this group arrangement is to achieve the objectives set out in the strategy – of making the most difference we can to population health with the resources that we have by focusing on the objectives of providing safe, high-quality care; a positive environment for colleagues; contributing to strong, healthy local communities and being sustainable – both financially and environmentally.

We know that almost everything we need to achieve is based on partnerships – and steps have been taken to establish new partnerships with primary care, and to strengthen existing relationships with local authorities, other NHS partners including University Hospital Dorset (UHD) and Somerset Foundation Trust (SFT), and with the voluntary and third sector (where we have a range of formal partnership arrangements in place, mostly associated with mental health pathways). Our partnerships with our service users and carers are also at the heart of what we do, and we have strong arrangements in place for these, including working with Experts by Experience and a long-standing partnership with the Dorset Mental Health Forum.

To support this, we have done considerable work on our governance arrangements. Alongside the executive team working as one, we have established a number of board committees in common, being careful to set clear objectives and to reflect on and evaluate their effectiveness in providing assurance

and strategic direction, as well as their impact on culture and what it feels like to be working in our federation.

In August 2025 DCH and DHC Boards approved the move to a 'Board in Common' from October 2025.

As with the sub-committee arrangements, each board retains its own sovereignty and responsibilities and there will be occasions when we need to have organisation specific discussions. However, the majority of strategic discussion, stakeholder and partnership issues, culture and engagement themes will benefit from being discussed together, and having this common forum will enable us to move forward with realising the ambitions of our shared strategy more quickly.

The review and alignment of the trusts two Constitutions earlier in 2025 aligned quoracy and voting rights. These will continue as at present, as set out below

Quorum:

No business shall be transacted at a meeting of the Board of Directors unless at least one third of the whole number of Directors is present, including at least one Executive Director and one Non-Executive Director.

Voting rights:

The Board of Directors is to comprise:

- a Non-Executive Chair;
- no less than 5 and no more than 8 other voting Non-Executive Directors; and
- no less than 5 and no more than 8 voting Executive Directors,
- provided that, at all times, the number of independent Non-Executive Directors (excluding the Chair) equals or exceeds the number of Executive Directors.

Subject to any legal requirements or any requirements of the Constitution, if in the opinion of the Chair, a vote should be required on a question at the meeting, it shall be determined by a majority of the votes of the Directors present and voting on the question and, in the case of any equality of votes, the person presiding shall have a second or casting vote.

All Board members have voting rights except for the Director of Corporate Affairs and, for Dorset HealthCare, any Associate Non-Executive Directors.

Transition Planning

Whilst much work has been undertaken to align our programme of work and reporting, to provide assurance on the transition to the Board in Common the following activities have been undertaken.

- A Board in Common work plan has been devised. This is included with the papers. This will be reviewed and updated on an ongoing basis and will be a standing agenda item. This clearly identifies the reports that are joint and those that are Trust specific. This will support future agenda planning. Where reports are delayed this will be apparent from the work plan.
- The actions from the DCH and DHC Boards have been reviewed and all actions carried forward (identifying which Trust the actions relate to). The significant majority of the actions have been completed. Where actions remain open or not yet due, we will consider whether they apply only to one Trust or should be considered across both Trusts.
- The Register of Interests has been updated. This will be included with all future Board papers to ensure that any potential conflicts of interest can be effectively managed.
- The governance structures below Boards and Committees have been mapped and these have been reviewed by the Committees during September 2025. The joint governance structure is included as Appendix A. There is a full suite of governance structures for each Trust and these will form part of the Governance Manual (see below).

- Dates for 2026/27 are in the process of being set (Appendix B) and agenda planning meetings will be diarised in the coming weeks.
- To support our work we have met with three other Trusts working in group models who have moved to a Board in Common or Joint Board to understand their arrangements and learning.

Next Steps

The following work is planned during quarter three which will further support the Board in Common:

- We have a Memorandum of Understanding (MoU) in place, and this will be reviewed and considered through the Strategy, Transformation and Partnership Committee in November 2025 (as the Committee with oversight of 'Working Together') and presented to Board in December 2025.
- Update and align the Scheme of Reservation and Delegation of Powers across DCH and DHC. This will be presented to the Audit Committees in November 2025 and Board in Common in December 2025.
- Complete our work on the shared risk appetite and review of the strategic risks. This will be presented to Committees in November 2025 and the Board in Common in December 2025.
- Publish a Governance Manual setting out the key governance arrangements for each Trust.

Recommendation

The Committee is requested to:

- Receive the report for assurance on the transition to Committees in Common

Baker, Abi
06/10/2025 12:40:16

Strategy, Transformation
and Partnership
Committee in Common

Audit
Committee

Remuneration
Committee

Quality
Committee in
Common

DCH
Charitable
Funds

DCH
Pharmacy
SubCo

Audit
Committee

Finance and
Performance
Committee in Common

Remuneration
Committee

People and Culture
Committee in
Common

Tier 2

Digital
Transformation and
Assurance Group

Transformation
and Improvement
Board

New Hospitals
Programme
Board

DHC
Quality Governance
Group

DCH
Quality Governance
Group

Financial
Recovery Board

Financial
Recovery Board

Joint
Culture and
Belonging
Group

Joint
Culture and
Belonging
Group

Dorset Digital
Developments
Group

One
Transformation
Approach

NHP Clinical
Assurance
Group

Patient Safety
Oversight Panel

Patient Safety
Committee

Dorset Estates
Partnership

Dorset Estates
Partnership

TUPF

Medical and Dental
Local
Negotiation
Committee

Cyber Security
Group

Joint
Improvement
Framework
Group

Estates
Capital
Group

Clinical
Effectiveness
Group

Clinical
Effectiveness
Group

Sustainability
Working Group

Sustainability
Working Group

JLNC

Partnership
Forum

Digital
Strategy
Group

Innovation
and
Partnerships

NHP
Technical
Assurance
Group

Research and
Development
Group

Research
Committee

Capital
Investment
Group

Elective
Performance
Management
Group

Information
Governance
Assurance
Group

Helipad
Working
Group

Quality Impact
Assessment Panel

End of Life
Group

End of Life
Committee

Emergency
Planning and
Resilience
Group

Emergency
Planning and
Resilience
Group

Clinical
Systems
Programme
Group

Medicines
Management
Group

Infection
Prevention and
Control
Committee

Medicines
Management
Group

Patient Experience
and Public
Engagement

Health and
Safety
Committee
(incorporating
Fire)

Health and
Safety
Committee

Digital
Demand
Group

Infection
Prevention and
Control
Committee

Safeguarding
Group

Infection
Prevention and
Control
Committee

Mental Health and
Learning Disability
Steering Group

DCH
Pharmacy
SubCo

Capital
Planning and
Space
Utilisation
Group

Health
Inequalities

Safeguarding
Committee

Reproductive
Health Clinical
Governance
Committee

Safeguarding
Committee

Health
Inequalities
Group

Capital
Planning and
Space
Utilisation
Group

Capital
Planning and
Space
Utilisation
Group

Tier 3

DCH Senior
Leadership
Group (SLG)

DHC Senior
Leadership
Group (SLG)

Joint Executive
Management
Team

Divisional, Care Group and
Service Governance Groups

	Dorset HealthCare Specific
	Dorset County Hospital Specific
	Joint Meetings
	Supporting Governance Meetings

Formal Committees and Board of Directors Dates and Deadlines 2026/27

Updated Aug 2025

Strategy, Transformation, Partnership CiC (Jim Bailey)			
Bi-monthly 9am to 12pm			
Date of meeting		Paper Deadline	
Th	28th May 2026	W	13th May 2026
M	27th Jul 2026	W	15th Jul 2026
Th	1st Oct 2026	W	16th Sept 2026
M	23rd Nov 2026	W	11th Nov 2026
M	25th Jan 2027	W	13th Jan 2027
M	22nd Mar 2027	W	10th Mar 2027

People and Culture CiC (Abi Baker)			
Bi-monthly, 1pm to 4pm			
Date of meeting		Paper Deadline	
W	27th May 2026	W	13th May 2026
M	27th Jul 2026	W	15th Jul 2026
Th	30th Sept 2026	W	16th Sept 2026
M	23rd Nov 2026	W	11th Nov 2026
M	25th Jan 2027	W	13th Jan 2027
M	22nd Mar 2027	W	10th Mar 2027

Quality CiC (Abi Baker)			
Bi-monthly, 1pm to 4pm			
Date of meeting		Paper Deadline	
Tu	26th May 2026	W	13th May 2026
Tu	28th Jul 2026	W	15th Jul 2026
Tu	29th Sept 2026	W	16th Sept 2026
Tu	24th Nov 2026	W	11th Nov 2026
Tu	26th Jan 2027	W	13th Jan 2027
Tu	23rd Mar 2027	W	10th Mar 2027

Finance and Performance CiC (Jim Bailey)			
Bi-monthly, 9am to 12pm			
Date of meeting		Paper Deadline	
W	27th May 2026	W	13th May 2026
W	29th Jul 2026	W	15th Jul 2026
W	30th Sept 2026	W	16th Sept 2026
W	25th Nov 2026	W	11th Nov 2026
W	27th Jan 2027	W	13th Jan 2027
W	24th Mar 2027	W	10th Mar 2027

Mental Health Legislation Assurance CiC (Jim Bailey)			
Quarterly, 9am to 11am			
Date of meeting		Paper Deadline	
Th	28th May 2026	W	13th May 2026
Th	30th Jul 2026	W	15th Jul 2026
Th	26th Nov 2026	W	11th Nov 2026
Th	28th Jan 2027	W	13th Jan 2027

DHC Audit Committee (Jim Bailey)			
Quarterly, 10am to 1pm			
Date of meeting		Paper Deadline	
F	29th May 2026	W	13th May 2026
F	25th Jun 2026*	W	10th Jun 2026
F	31st Jul 2026	W	15th Jul 2026
F	27th Nov 2026	W	11th Nov 2026
F	29th Jan 2027	W	13th Jan 2027
Th	25th Mar 2027**	W	10th Mar 2027

DCH Audit Committee (Abi Baker)			
Quarterly, 1pm to 3:30pm			
Date of meeting		Paper Deadline	
M	1st Jun 2026	W	20th May 2026
M	29th Jun 2026*	W	10th Jun 2026
M	3rd Aug 2026	W	22nd Jul 2026
M	30th Nov 2026	W	18th Nov 2026
M	1st Feb 2027	W	20th Jan 2027
Tu	30th Mar 2027**	W	17th Mar 2027

Joint Board of Directors (Abi Baker/ Jim Bailey)			
Bi-monthly, all day			
Date of meeting		Paper Deadline	
W	8th Apr 2026	W	1st Apr 2026
Tu	9th Jun 2026	W	27th May 2026
Tu	11th Aug 2026	W	29th Jul 2026
Tu	13th Oct 2026	W	30th Sept 2026
Tu	8th Dec 2026	W	25th Nov 2026
Tu	9th Feb 2027	W	27th Jan 2027

Joint Board Development (Jonquil Williams)			
Bi-monthly, all day			
Date of meeting		Paper Deadline	
Tu	12th May 2026		N/A
Tu	14th Jul 2026		N/A
Tu	8th Sept 2026		N/A
Tu	10th Nov 2026		N/A
Tu	12th Jan 2027		N/A
Tu	9th Mar 2027		N/A

* Extraordinary Audit Committee meetings to approve Annual Report and Accounts. Dates may change once timelines for the Annual Report and Accounts are confirmed

** Additional Audit Committee meetings for year-end items

n.b. May 2026 committee week falls in half term

Informal Committee Dates 2026/27

Informal Strategy, Transformation, Partnership CiC (Jim Bailey)			
Bi-monthly, 9am to 11am			
Date of meeting		Paper Deadline	
M	27th Apr 2026	M	20th Apr 2026
M	29th Jun 2026	M	22nd Jun 2026
	No meeting in Aug		N/A
M	26th Oct 2026	M	19th Oct 2026
	No meeting in Dec		N/A
M	22nd Feb 2027	M	15th Feb 2027

Informal People and Culture CiC (Abi Baker)			
Bi-monthly, 1pm to 3pm			
Date of meeting		Paper Deadline	
M	27th Apr 2026	M	20th Apr 2026
M	29th Jun 2026	M	22nd Jun 2026
	No meeting in Aug		N/A
M	26th Oct 2026	M	19th Oct 2026
	No meeting in Dec		N/A
M	22nd Feb 2027	M	15th Feb 2027

Informal Quality CiC (Abi Baker)			
Bi-monthly, 1pm to 3pm			
Date of meeting		Paper Deadline	
Tu	28th Apr 2026	M	20th Apr 2026
Tu	30th Jun 2026	M	22nd Jun 2026
	No meeting in Aug		N/A
Tu	27th Oct 2026	M	19th Oct 2026
	No meeting in Dec		N/A
Tu	23rd Feb 2027	M	15th Feb 2027

Informal Finance and Performance CiC (Jim Bailey)			
Bi-monthly, 9am to 11am			
Date of meeting		Paper Deadline	
W	29th Apr 2026	M	20th Apr 2026
W	1st Jul 2026	M	22nd Jun 2026
	No meeting in Aug		N/A
W	28th Oct 2026	M	19th Oct 2026
	No meeting in Dec		N/A
W	24th Feb 2027	M	15th Feb 2027

Baker/Abi
06/10/2025 12:40 PM

**Meeting of the Boards of Directors (Part 1) of
Dorset County Hospital NHS Foundation Trust
and
Dorset HealthCare University NHS Foundation Trust
Tuesday 7th October 2025 at 9.30am to 3.00pm
Training room 1&2, Sentinel House, Poole and via MS Teams**

AGENDA

Ref	Item	Trust	Format	Lead	Purpose	Timing
1.	Patient Story	DHC	Presentation	Dawn Dawson	Information	9.30-9.45
2.	Transition to Board in Common	Joint	Enclosure	Jenny Horrabin	Assurance	9.45-9.50
3.	FORMALITIES to declare the meeting open.		Verbal	David Clayton-Smith Trust Chair	Information	9.50-10.00
	a) Apologies for Absence	Joint	Verbal	David Clayton-Smith	Information	
	b) Conflicts of Interests	Joint	Verbal	David Clayton-Smith	Information	
	c) Minutes of the Meetings dated: • DCH 10 June 2025 • DCH 12 August 2025 • DHC 13 August 2025	DCH DCH DHC	Enclosure	David Clayton-Smith	Approve	
	d) Matters Arising: Action Log	Joint	Enclosure	David Clayton-Smith	Approve	
	e) Board workplan	Joint	Enclosure	David Clayton-Smith	Information	10.00-10.05
4.	Chair's Comments	Joint	Verbal	David Clayton-Smith	Information	
5.	CEO Report	Joint	Enclosure	Matthew Bryant	Information	10.05-10.15
6.	Quality					
6.1.	Quality Committee Assurance Report	Joint	Enclosure	Eiri Jones	Assurance	10.15-10.25
6.2.	Maternity Safety Report (September QC)	DCH	Enclosure	Dawn Dawson (Jo Hartley)	Assurance	10.25-10.35
6.3.	Learning from Deaths Report • DCH LFD Q1 • DHC LFD Q1 (September QC)	DCH DHC	Enclosure	Rachel Wharton Lucy Knight	Approval	10.35-10.50
6.4.	Implementing the Patient Carer Race Equality Framework: Bi-annual Update (September QC)	DHC	Enclosure	Lucy Knight (Helena Posnett)	Assurance	10.50-11.00
6.5.	National Inpatient Survey 2024 Report (September QC)	DCH	Enclosure	Dawn Dawson	Information	11.00-11.10
Coffee Break 11.10-11.20						
7.	Finance and Performance					
7.1.	Finance and Performance Committee Assurance Report	Joint	Enclosure	Dave Underwood	Assurance	11.20-11.30
7.2.	Balanced Scorecard	DCH	Enclosure	Anita Thomas	Assurance	11.30-11.40



Healthier lives



Empowered citizens



Thriving communities

				Executives		
7.3.	Integrated Corporate Dashboard	DHC	Enclosure	Chris Hearn Executives	Assurance	11.40-11.50
7.4.	Finance • DCH Finance Report • DHC Finance Report (September FPC)	DCH DHC	Enclosure	Chris Hearn	Assurance	11.50-12.05
7.5.	Emergency Preparedness Resilience and Response (EPRR) Statement • DCH EPRR • DHC EPRR (September FPC)	DCH	Enclosure	Anita Thomas Rachel Small	Approval	12.05-12.15
8.	People and Culture					
8.1.	People and Culture Committee Assurance Report	Joint	Enclosure	Frances West	Assurance	12.15-12.25
8.2.	Guardian of Safe Working Report (September PCC) • DCH GOSW • DHC GOSW	DCH DHC	Enclosure	Rachel Wharton (Andy Macklin) Lucy Knight (Claire Vick)	Assurance	12.25-12.35
8.3.	Workforce Equality Reports • DCH WRES & WDES • DHC WRES & WDES (September PCC)	DCH DHC	Enclosure	Nicola Plumb	Approval	12.35-12.45
8.4.	Reintroduction of Mutually Agreed Resignation Scheme (September PCC)	DCH DHC	Enclosure	Nicola Plumb	Approval	12.45-12.55
Lunch Break 12:55-14.00						
9.	Strategy, Transformation and Partnership					
9.1.	Strategy, Transformation and Partnership Committee Assurance Report	Joint	Enclosure	David Clayton-Smith	Assurance	14.00-14.10
9.2.	Green Plan Guidance Refresh (September STPC)	Joint	Enclosure	Chris Hearn	Approval	14.10-14.20
10.	Audit and Governance					
10.1.	Charitable Funds Committee Assurance Report	DCH	Enclosure	Dave Underwood	Assurance	14.20-14.25
11.	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.					
11.1.	DCH SubCo Ltd Performance Report	DCH	Enclosure	Anita Thomas	Assurance	
11.2.	Medical Appraisal and Revalidation – Statement of Compliance (September PCC)	DHC	Enclosure	Lucy Knight	Approval	

11.3.	Mental Health Scheme of Delegation	DHC	Enclosure	Lucy Knight	Approval	
12.	Questions from the Public	All	Verbal	David Clayton-Smith		14.25-14.30
	In addition to being able to ask questions about discussion at the meeting, members of the public are also able to submit any other questions they may have about the trust in advance of the meeting to Abigail.baker@dchft.nhs.uk or jim.bailey2@nhs.net					
13.	Any Other Business Nil notified	All	Verbal	David Clayton-Smith	Information	14.30-14.35
14.	Date and Time of Next Meeting					
	The next part one (public) Boards of Directors' meeting of Dorset County Hospital NHS Foundation Trust and Dorset HealthCare University NHS Foundation Trust will take place at 9.30am on Tuesday 9th December 2025 in venue to be confirmed.					
	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.					

The quorum of the meeting and voting rights as set out in the Constitution is below. For both Dorset County Hospital NHS Foundation Trust and Dorset HealthCare University NHS Foundation Trust:

Quorum:

No business shall be transacted at a meeting of the Board of Directors unless at least one third of the whole number of Directors is present, including at least one Executive Director and one Non-Executive Director.

Voting rights:

The Board of Directors is to comprise:

- a Non-Executive Chair;
- no less than 5 and no more than 8 other voting Non-Executive Directors; and
- no less than 5 and no more than 8 voting Executive Directors,
- provided that, at all times, the number of independent Non-Executive Directors (excluding the Chair) equals or exceeds the number of Executive Directors.

Subject to any legal requirements or any requirements of the Constitution, if in the opinion of the Chair, a vote should be required on a question at the meeting, it shall be determined by a majority of the votes of the Directors present and voting on the question and, in the case of any equality of votes, the person presiding shall have a second or casting vote.

All Board members have voting rights except for the Director of Corporate Affairs and, for Dorset HealthCare, any Associate Non-Executive Directors.

Part 2 Items

- Chair's Comments
- CEO Update
- Whole Time Equivalent Reduction
- Patient Engagement Portal Procurement
- One Dorset Provider Collaborative Board Minutes
- DCH Renal Business Case
- Capital Plan Update
- Generator Procurement Update (DCH)
- Charitable Funds Annual Report and Accounts (DHC)

**Minutes of a public (Part 1) meeting of the Board of Directors of
Dorset County Hospital NHS Foundation Trust
held at 9.30am on 10th June 2025 at
Board Room, Trust Headquarters, Dorset County Hospital and via MS Teams
videoconferencing.**

Present:		
David Clayton-Smith	DCS	Joint Trust Chair (Chair)
Margaret Blankson	MBI	Non-Executive Director
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
Eiri Jones	EJ	Joint Non-Executive Director (Deputy Chair)
Claire Lehman	CL	Non-Executive Director (via videoconference)
Stuart Parsons	SP	Non-Executive Director
Nicola Plumb	NP	Joint Chief People Officer
Anita Thomas	AT	Chief Operating Officer (until BoD25/076)
Stephen Tilton	ST	Non-Executive Director
David Underwood	DU	Joint Non-Executive Director
Rachel Wharton	RW	Chief Medical Officer
In Attendance:		
Abi Baker	AB	Corporate Governance Manager (Minutes)
Mandy Ford	MF	Joint Deputy Director of Corporate Affairs (via videoconference) (Minutes)
Jo Howarth	JoH	Director of Nursing (Acute Care) (item BoD25/053)
Bev Lagden	BL	Sustainability Manager (item BoD25/053)
Susie Palmer	SP	Communications Manager (until BoD25/076)
Lynn Patterson	LP	Freedom to Speak Up Guardian (item BoD25/076)
Richard Renault	RR	Chief of Strategy and Transformation (University Hospitals Dorset NHS Foundation Trust) (until BoD25/076)
Members of the Public:		
Kathryn Harrison	KH	Lead Governor (via videoconference)
Jean-Pierre Lambert	JPL	Governor (via videoconference)
Isabel Adams	IA	Member of the public
Iain Burden	IB	Member of the public
Jane Bartram	JB	Member of the public
Frank Goodwin	FG	Member of the public
Lynne Hubbard	LH	Member of the public
Debby	D	Member of the public
Georgina Knight	GK	Member of the public
Debbie Powell	DP	Member of the public (via videoconference)
Candy Udwin	CW	Member of the public (via videoconference)
Lee	L	Member of the public (via videoconference)
Apologies:		
Frances West	FW	Joint Non-Executive Director



BoD25/053	Staff and Patient Story	
Baker, Abi 06/10/2025 12:40:16	A number of members of the public were observing the meeting with an interest in the Shared Services agenda item. Before the staff and patient story was presented, DCS accepted questions relating to this item from those observers who needed to leave to attend work, so that they could be answered in that agenda item. The questions asked by public observers were: 1. Does it matter to you that staff deeply oppose the plans? 2. Have you followed NHS England guidance with setting up subsidiary companies concerning engagement with Trade Union representatives and staff? 3. Have you explored any other options apart from this? 4. Given that NHS Improvement did not agree that VAT savings should be the main reason for this, and the government has proposed to close the VAT loophole, are you willing to consult on other options e.g. shared services? 5. In the discussions you had with staff there had not been any discussion about property companies. My understanding is that part of the plan it to set up a number of property companies in which property is transferred to subsidiary companies. If this were to become a private company, it would mean that the NHS would permanently lose its estate and land. We would like more information on exactly what property companies are proposed and believe this poses a risk to the NHS. 6. FG delivered to the Board a pile of postcards which had been signed by members of staff across the trust who were opposed to the formation of subsidiary companies. DCS thanked observers for their questions. Most of the public observers left the meeting, but three remained (two in boardroom and one virtually).	
	<u>Staff and Patient Story</u> The story outlined that a greener spaces group had been created, in order to improve and increase access to green spaces for patients. The Trust had been successful in it's bid for funding for a sensory garden for the benefit of staff and patients, particularly those who were neurodiverse or with mental health requirements. BL described the Trust's social value pledge and reflected on the impact of factors other than quality care on a person's health; this included access to green spaces, housing, environment and employment. Studies had indicated that access to green spaces reduced length of stay in hospital and offered therapeutic benefits to patients. The sensory garden was being built in an underutilised courtyard next to special care dentistry. It had been developed in collaboration with students and lecturers at Kingston Maurward College, with local community groups, a donation for plants and advice from a local garden centre and volunteers to help maintain the garden. BL described that materials already in the garden site had been reused where possible, and resilient and drought resistant plants would be used.	

	A video was shown to the meeting describing the benefits of the garden for patients. It also showed the courtyard before, during, and towards the end of the gardens development. Board members were invited to attend the opening of the sensory garden during the meeting's lunch break.	
	DCS thanked BL for the presentation and BL and JoH left the meeting.	
	Resolved that: the Staff and Patient Story be received for information.	
BoD25/054	Formalities	
	The Chair declared the meeting open and quorate and welcomed governors to the meeting. Apologies for absence were received from Frances West.	
BoD25/055	Conflicts of Interest	
	There were no conflicts of interest declared in the business to be transacted on the agenda.	
	Whilst not a direct conflict, MBr declared that he was a member of Managers in Partnership which was a national branch of Unison. No action was needed in light of this declaration, but the Board would be aware of it during the Shared Services item.	
BoD25/056	Minutes of the Meeting held on the 08 April 2025	
	The Minutes of the meeting dated 08 April 2025 were approved as an accurate reflection of the meeting.	
	Resolved: that the minutes of the meeting held on 08 April 2025 were approved.	
BoD25/057	Matters Arising: Action Log	
	The action log was considered, updates received in the meeting were recorded within the log, and approval was given for the removal of completed items.	
	BoD25/017 (Board gender composition): NP updated that there had been an error in the gender pay gap data presented to the last Board meeting; three female Non-Executive Directors (NEDs) had not been included in the report. The report had been submitted to the government portal and so the version published on the Trust's website would include an addendum identifying the error. The error would also be acknowledged in next year's report.	
	EJ and DCS noted that their declarations of interests included on the register were not correct; this would be addressed outside of the meeting.	AB
	Resolved: that updates to the action log be noted with approval given for the removal of completed items.	
BoD25/058	Chair's Comments	
	No comments were made.	
	Resolved: that the Chair's comments be received for information.	
BoD25/059	CEO Update	
	MBr highlighted the following key points from his report:	

	• The new arrangements for Integrated Care Boards (ICBs) and clustering arrangements. Dorset ICB would be moving to a cluster with ICB's focusing on their strategic commissioning function. • The Performance Assessment Framework was currently being consulted on. CH and the Finance and Performance Committee would continue to monitor this. • The NHS pay award was positive but MBr noted that the pay increase was likely to be higher than the money available to the NHS within the national spending review. • Positive first steps in approval from the national investment board for the electronic health record (EHR) programme • In relation to the shared services paper later on the agenda, MBr acknowledge the level of concern that colleagues had, some of which had been shared today. MBr pledged as Chief Executive Officer to pay attention to making sure that the Board was having conversations properly with staff side and colleagues. This did not mean that they would agree on everything, but they would listen to the gaps in work to date. Given the anxieties of colleagues, MBr reflected on the importance of ensuring there was a single 'version of the truth'. • Thanks were extended to the maternity services teams for their work to meet the increased workload arising from the temporary closure of Yeovil District Hospital (YDH) maternity unit. • A recent ground-breaking ceremony for the Trust's New Hospital Programme, and the opening of the HIVE (Health and Wellbeing, Information, Volunteering and Engagement). • NJ would be leaving the Trust in the coming months, having been appointed the Managing Director of Salisbury Hospital NHS Foundation Trust. The executive team were working through the impact of this and considering options to address the vacancy. DCS added that he had accompanied the High Sheriff for the County around the HIVE, which had been positively received with good feedback. Further to the ICB clustering, a workshop would be taking place to consider the focus of the Integrated Care Partnership (ICP). It was noted that the ICP was now chaired by the two Local Authority leaders.	
	Resolved: that the CEO Update be received for information.	
BoD25/060	Board Assurance Framework	
Baker, Abi 06/10/2025 12:40:16	JH outlined that the strategic risks had been reviewed by their assigned committees, and all risks reviewed by the Audit Committee. There were no changes in score arising from those reviews. The highest scoring risks were SR3: Workforce Capacity, SR5: Estates, SR6: Finance, and SR9 Digital Infrastructure, each with a score of 15 or more. During the reporting period the score for SR7 Collaboration had increased from six to nine, reflecting the current level of structural change and uncertainty within the NHS. There had been some delays in updating actions, but the reason for the delays was deemed appropriate and revised dates had been set. CL noted that it was helpful having the BAF to guide conversations.	

	Committee chairs reflected that the interconnections between various agendas was working well. The establishment of committee chair meetings would support this further. Looking ahead, JeH outlined plans for the 2025/26 Board Assurance Framework. A risk appetite review was planned.	
	Resolved: that the Board Assurance Framework be received for assurance.	
BoD25/061	Corporate Risk Register	
	DD outlined that the risks had been reviewed by the committee they were assigned to, with the full Corporate Risk Register being reviewed by Audit Committee. There was one new risk scoring 20 since the last review of the risk register. Four risks had been identified as not having been reviewed in a timely way and this was being addressed. No questions or comments were asked.	
	Resolved: that the Corporate Risk Register be received for assurance.	
BoD25/062	Shared Services	
	NJ described that the papers and full business case set out the case for the recommendation to establish a subsidiary structure for the estates, facilities, and procurement functions currently provided by the three NHS provider Trusts in Dorset (Dorset County Hospital [DCH], Dorset HealthCare [DHC], and University Hospitals Dorset [UHD]). NJ summarised the key elements and addressed the questions asked by members of the public at the start of the meeting. From the outset of exploring the potential for the proposal, the three Trusts have been committed to three important principles. Firstly, that all current terms and conditions and agenda for change pensions were protected for all staff transferring to the new subsidiary company. Concerns had been raised during staff engagement that the TUPE process was not a strong enough mechanism to protect these elements, and so a triple lock process had been created in which the subsidiary company would need approval from all three Trust Boards before making any changes. The strength of this process within the current context of the NHS was noted. Secondly, the subsidiary company and estate assets would remain wholly owned by the three Trusts and therefore remained in the NHS; they would not transfer into private ownership. All company shares would be retained by the Trusts and the triple lock process with approval from all three Boards would need to be followed if this were to change. Thirdly, that due process would be followed to establish the subsidiary company, including the NHS England process and engaging with staff and trade unions. NJ acknowledged that the latter point had been slow to start, but this had increased in recent months. The introduction of the triple lock in response to staff and union concerns raised about the TUPE process was evidence of this.	

Baker, Abi
06/10/2025 12:40:16

Baker, Abi 06/10/2025 12:40:16	NJ outlined that three property companies would be created, one per Trust, which would be wholly owned by the Trust so that properties remained within the Trusts. There would also be one operating company which is jointly owned by the three property companies (and therefore owned by the Trusts), but which would sit underneath each property company. The scope of services was estates and facilities management and procurement and affected 1,600 staff across three Trusts. Further consideration was being given to including sterile services in the model. This was a change from the previous case. Learning and expertise had been sought from a number of other existing subsidiary companies, including the assurance that needed to be provided to staff and the significant benefits for staff and the Trusts. The paper set out the various alternative options considered, including in-house options, which did not deliver the benefits of the preferred model, and outsourcing, which would not give the Trusts the ownership or benefits desired. In the preferred model any profits would be reinvested in to the delivery of care in the Trusts. The options appraisal outlined that the preferred model was to set up a subsidiary company. NJ recognised the opposition to the plan from staff during engagement and in the room today, but highlighted the below benefits: • Remaining in the NHS with the same protections to the staff terms and conditions. • Working in a company dedicated to delivering high quality estates, facilities and procurement services with board leadership focussed on that delivery. • The possibility of the subsidiary companies taking forward commercial developments and offering services to other parts of the public sector • Financial benefits of increasing the spending power of the three Trusts and economies of scale • The opportunity for the company to develop business and increase headcount, which was currently constrained in the NHS. • A contractual structure which created transparency in performance and service levels • The proposal significantly supported the delivery of the financial plan for 2025/26 and supported the sustainability of the Trust within the context of the current NHS climate. Financial benefits included £270million financial benefits for Dorset over a 10-year period. NJ confirmed that the proposal was delivered benefits even without additional tax benefits, as indicated by these savings. No assumptions had been made about future tax benefits as this was not the basis of the case. However, an assumption of retrospective VAT recovery indicated a saving of £86million.	

Baker, Abi 06/10/2025 12:40:16	The proposed model was also expected to improve quality of service. There was no assumed reduction in headcount, and no assumption to changes in ways of working, except for procurement which had a case to support this change. NJ confirmed that the Trusts were following the necessary processes with NHS England. Subject to the required approvals staff consultations would start in July 2025 with a view to starting the subsidiary company in November. NJ described the case as compelling, particularly within the current financial context. It was recognised that it was not an easy solution or one that was not concerning for staff but given the current environment and benefits and opportunities the recommendation was to approve the proposal. The matter was opened to questions from the Board. SP sought further assurance around the methodology used to identify the cashable benefits, noting the significant value of the figure. RR outlined that procurement made up the biggest share of this and it had been independently validated by Capita; this detail was included in the papers for the confidential part of the meeting, given its commercial sensitivity. The figure was rooted in the proposal to create one procurement team instead of three, which could benefit from scale, transparency and standardisation, and the ability to recruit and retain staff. The degree of benefits could only be provided through a single dedicated team. CH echoed this, particularly noting the economies of scale and opportunities for standardisation across the county. SP noted the need for the Trust to adopt those standardisations as they developed, in order to support the success of the company. MBI noted her support for the recommendations and asked what steps had been taken to ensure equality, diversity and inclusion (EDI) would be embedded within recruitment, staff progression and governance. NP reflected on the impact of the proposal on those staff directly affected and those who depended on the services to deliver patient care. The EDI process and opportunities present in the three Trusts were expected to be replicated in the subsidiary company, as well as local policies, although this had not been considered in detail to date. Consideration should be given to staff networks. NP further reflected on the importance of developing a strong identity for the new company, in order to support staff wellbeing and give a sense of pride and service. CH added that members of the three Trust Boards would also be members of the subsidiary company board and so would ensure alignment with and learning from the Trusts EDI agendas. Asked about the cost of transition, CH confirmed that this had been factored in to the projected savings figures presented today. CL sought further assurance around the downside risks to the proposal. RR outlined that a register of identified risks was included in the papers, as well as a quality impact assessment. RR also highlighted the learning that had been taken from other subsidiary companies within the NHS including cultural differences between the Trust Boards and the company board. There would undoubtedly be currently unknown downside risks that arose over time, and there would be a dynamic mechanism between the Trusts and the company to manage these.	

EJ noted her assurance from the papers that there was no intention to use this as a route to privatisation and that the company would remain in the NHS. However, EJ asked about an assessment of adverse impact on patient care and noted that there was no clinical representative on the appraisal panel. Executive colleagues advised that there would be no changes in the delivery service once the company went live, and that a set of 'go, no go' criteria had been developed to ensure that everything safe and legal before the company went live. NJ undertook to build quality and patient safety considerations into the next stages of the proposal. DD added that all existing policies would transfer to the new company, including quality policies. Recognising that this would entail bringing the policies of three Trusts together, the intention was to draw on the best policies from each Trust.

The Board further discussed the plans to ensure continuity of leadership, a sense of identity and belonging for staff within the company, recognising the importance of this. NP added that we needed to create a sense of belonging and unity and having a uniform would be part of that and that integrity would be developed into that, as well as working collaboratively with the teams to establish that identity.

The Board discussed the external advice received and whether this related to the proposal alone, or if it also related to the assumptions made by the trusts. RR outlined that advice had been received from a legal firm who had experience setting up 30 subsidiary companies across the country, that it was a decision for each trust board to make, and that final approval would be sought by NHS England. The external advice sought related to compliance with legal and regulatory requirements, but the bulk of the work to develop the proposal had been undertaken internally across the three trusts.

Reflecting on the discussions so far, MBr recognised a degree of assurance in order to make the decision asked but also recognised the helpful guidance regarding EDI, company identity, and ensuring clinical and quality standards were a key priority. In relation to the unknown risks, MBr described that the Board of the subsidiary company was comprised to ensure sufficient engagement from the Trust Boards, with two NED representatives from each trust.

MBr noted the important, ongoing conversations with key stakeholders, including members of staff, and that they may not ultimately agree on the outcome, but it was hoped they would find some common ground.

Reflecting strategically, MBr considered the NHS landscape in Dorset and the need to work differently across the three providers in order to affect change. This proposal was at the forefront of change and aligned with the work within the Provider Collaborative. The direction of travel was one of convergence to do the best for the population with the resources available.

NJ returned to the questions from the public to ensure everything had been answered in the course of discussions. The Board recognised that staff were opposed to the plans and would continue with the engagement work. NJ confirmed that the Trusts had followed NHS England guidance in relation to

Baker, Abi
06/10/2025 12:40:16

Baker, Abi 06/10/2025 12:40:16	the proposal and had considered other options. The proposal was not made on the basis of VAT savings; the case stood without those savings. Expanding further on the question relating to property companies, NJ described that the property companies would be wholly owned by the Trusts and the assets transferred to them under lease arrangements. This was required so that the Trusts would continue own 100% of the assets and was the simplest way of achieving this goal without incurring additional legal and transaction costs. This could not be changed without approval via the triple lock process. NJ encouraged Board colleagues to look at the postcards shared by members of staff, recognising the impact the proposal had on staff and the need to improve engagement. MBr noted that he, DCS, and NP had met with GK and other representatives yesterday, with colleagues from UHD, to listen to the concerns of staff and unions. Those concerns were similar to the ones shared today, and the group had agreed to meet again in two weeks' time to discuss the next steps of the proposal. One of the remaining members of the public clarified their question, asking whether the Trust would be prepared to consult on a shared service. NJ advised that an options appraisal process had been undertaken, and the proposal presented today was the preferred option. When speaking to staff about the proposal it would be important to be clear about the other options considered. NJ read through the 11 recommendations for the Board, as outlined on pages 92 and 93 of the papers. Board members noted a number of amendments to the recommendations: • Recommendation four to be clarified to confirm the direction of leasing between the Trust and the property company and to be clear that ownership of assets remains with the Trust • The wording of recommendation nine to be changed to indicate the need for "assurance" not "reassurance" • Recommendation three: the membership of the shadow board to be agreed in principle, but recognising this could change over the coming months The Board approved the proposals as outlined in the paper and subject to the above amendments. In support of the decision made, SP noted that the views of colleagues had been listened to, but that Board members were assured that the triple lock process and other protections went a long way to addressing the concerns raised. SP reflected that the Board members were custodians of public money and were entrusted to spend money wisely. The programme had identified £19million savings as a downside projection. It would be remiss of the Board not to pursue those savings in the light of the issues facing the NHS, and that the proposal made today was the right thing for the NHS. Members of the public left the meeting. Resolved: that the Shared Services proposals be approved.	

BoD25/063	Quality Committee Assurance Report	
	CL presented the assurance report from the first meeting of the Quality Committee in Common. This detailed the transition work from two Committees into one to ensure all items were appropriately transitioned to the new Committee. The following areas were highlighted from the report: • Annual effectiveness reports for the former Trust specific committees were also received. • Review the BAF and the Corporate Risk Register, with assurance provided to Board on the scrutiny of the assigned risks. • The Learning from Deaths report from each Trust was presented and discussed, and this was also on the Board agenda today. • Safe staffing midpoint review was discussed with assurance provided for the processes in each organisation. For DCH, an issue was highlighted in that a previously approved uplift in headroom had not materialised. • There had been an unannounced visit by CQC to Maternity Services, and we were awaiting the report from that visit. • It was noted that there had been a temporary 6-month closure to the maternity service provision at YDH, which has impacted on the DCH team. • An update was provided on the ophthalmology service and the patients that had been lost to follow up. The Committee also sought assurance from AT that no other service had a 'lost to follow up' issue. EJ highlighted that the increased headcount agreed in 2023/24 had not been enacted and this is being discussed with DD as Chief Nursing Officer. She noted that staffing is reviewed daily, but because of financial position and the requirement to reduce headcount, we need to maintain our focus on safety, and this is discussed in both Quality Committee and People and Culture Committee. EJ added that we should be able to reinvest in services, especially as we reduce beds, as the remaining beds will be used for patients with higher levels of acuity and we need to ensure we have the right number of registered nurses and support workers to care for them. DD responded that the biannual safer staffing report was later on the agenda, and this had been discussed at an informal Quality Committee meeting where a deep dive in to safer staffing in both organisations focussed on headcount. DD noted this is something that there will be continuous focus on. AT advised that in terms of ophthalmology we are concentrating on cases with risk of sight loss, noting that 'lost to follow up' is an inherent problem in follow up systems where there are multiple systems and people involved. We are currently undertaking a review of all services follow up processes and working through that service by service to gain assurance that there are not similar issues in other services. In terms of headcount CH provided assurance that DD and himself worked closely with the clinical operational teams, noting that as we are working in	

Baker, Abi
06/10/2025 12:40:16

	restricted financial times, we have to ensure that the monies are directed to the right place. We have seen a reduction in agency spend over the year and that is something that was a focus for both financial and quality agendas to make sure that we are consistently assessing the risks and investing where appropriate. MBr noted from the discussion we are covering the required areas which was positive, but following on from the deep dive we could proactively schedule a point in the summer months to review the risk and issues associated with this to ensure we maintain the required focus. This could be linked into the safer staffing review. MBr also informed members that there is some regional work ongoing in the area. EJ noted that the executive team is very focused on ensuring safe staffing and this is not just in DD remit but relevant to all executives and wanted to thank MBr for his comments about not losing sight of what we need to do. CL added that she is seeing collaboration between the two organisations, especially across quality assurance process in DHC and the benefits of this are being seen in DCH.	
	Resolved: that the Quality Committee Assurance Report be received for assurance.	
BoD25/064	Maternity Safety Report	
	DD presented the Maternity Safety Report and highlighted that incident reports were being received around staffing levels. The risk register had been updated and that had seen an increase in the risk for neonatal staffing and, since the report was written, we have agreed a new post which is currently being advertised. We also have temporary staffing solutions in place. There is also an increased risk in maternity staffing due to maternity leave and long-term sickness. In addition, we are seeing the impact of the temporary closure of the Yeovil District Hospital (YDH) maternity unit at short notice. 186 patients have transferred to our care to date as a result of this. Some staffing solutions have been identified, with a plan for Yeovil staff to be seconded to DCH which will mitigate some of the risk to staffing. CQC undertook an unannounced inspection to the DCH maternity unit the day after we commenced taking YDH maternity patients. The inspection is ongoing, with some information to be sent to CQC today, and we will await the draft report. From initial feedback received there are no significant matters of escalation. EJ advise that on her visits to the unit staff were welcoming and patients were happy to speak to the team. EJ undertook an evening visit around overnight care due to concerns raised by Governors, and spoke to someone post C-section, who confirmed that they were receiving exemplary care. No direct patient safety concerns were identified during this visit. DD noted that post-natal care was one of the priorities for the year ahead.	

Baker, Abi
06/10/2025 12:40:16

	AT advised that she had been invited to take part in the Dorset Council Committee next week and was asked by the ICB to present on our response and our CQC journey. DU asked about maternity support worker sickness level and queried whether there was an underlying cause to that. DD did not have that detail but agreed to feedback.	DD
	Resolved: that the Maternity Safety Report be received for assurance.	
BoD25/065	Learning from Deaths Q4	
	RW reported that the Summary Hospital-level Mortality Indicator (SHMI) data remained steady although there was some concern around the depths of coding which remained static. Division A is making progress against the backlog of Subject Judgement Reviews (SJRs). DU noted the good performance in respect of the SHMI and the good progress that had been made. DU also emphasised the importance of SJRs in providing a richer narrative and the challenges related to depth of coding. RW confirmed that she was confident that we had a robust plan regarding SJRs and reiterated the importance of the qualitative assessment. ST echoed DU's comments relating to SHMI and coding, noting the historical challenges. Whilst it was improving concerns about the availability of coders remain and asked for an update of progress. NJ advised that some recent appointments to substantive posts had not been retained and we continue to be reliant on agency staff for coding. We need to find a sustainable solution for our coding function. We are currently working across DHC, although they do a different type of coding, so this is not a simple solution. We have also enquired whether there might be a solution in the future with UHD, but this is not currently an option. He noted that coding will also be important if we move back to a tariff system as it will be linked to income. SP noted that the readmission rate in ICU was increasing, and we need to maintain a focus on this in the Quality Committee.	
	Resolved: that the Learning from Deaths Q4 be received for approval.	
BoD25/066	Patient Safety Incidence Response Plan (PSIRP)	
Baker, Abi 06/10/2025 12:40:16	DD presented the report and noted that the initial plan was presented to the Board a year ago. A review has been undertaken and the final plan was presented for approval. The plan had been reviewed by the Patient Safety Group, and Quality Committee. It detailed the key priorities for the years ahead as: - Reducing avoidable harm to include hospital acquired pressure damage, falls, and deteriorating patients. - Treatment and procedures to include safer administration of insulin and delayed transfers of care - Maternity and neonates to include post-natal incidents during admission and post-natal incidents requiring readmission. DCS commented that this had clearly been scrutinised at Quality Committee.	

	Resolved: that the Patient Safety Incidence Response Plan (PSIRP) be approved.	
BoD25/067	Safe Staffing Mid-Point Review	
	DD advised that the report was presented for assurance following due process for reviewing the national workforce requirements for safer staffing in inpatient services. This follows the National Quality Board (2016) requirements and the Developing Workforce Safeguards (2018) guidance. We review this on a bi-annual basis. We have twice daily conversations around staffing and the acuity and dependence of patients, ensuring that we are utilising staff effectively. No additional staff requests were identified as part of the bi-annual review, but we recognise the impact that escalation beds can have. There is an ongoing review and investment in stroke services considering the planned increase in Hyper Acute Stroke Unit (HASU) and acute stroke capacity. Work is also ongoing in terms of e-roster and productivity. The Special Care Baby Unit (SCBU) business case was previously approved, and the posts are to be advertised imminently.	
	Resolved: that the Safe Staffing Mid-Point Review be approved.	
BoD25/068	Finance and Performance Committee Assurance Report	
	DU reported he was pleased with how this was becoming established, and it was a real benefit for everyone to see DCH and DHC elements together in the Committee in Common. Significant matters to note were in regard to efficiency challenges, and the additional support that had been brought in (David Moon (DM) and Mark Mansfield (MM)) to undertake an independent review. In terms of key issues discussed, the Committee reviewed the BAF and there were no changes to scores. It was noted that there was a lot of SubCo reference across the agenda items, but we do not need a specific BAF level risk at present. This will be kept under review. In terms of Corporate Risk Register, the Committee sought further assurance around delayed actions and mitigations and highlighted specifically those risks around medical devices and paediatric waiting times. However, good assurance was provided during the course of the meeting. DU advised that a number of approvals were agreed at FPC. These were: • Case for extension of the stroke HASu (DCH) • Novation of the Yeovil Dialysis Unit Contract (DCH) • Generator Critical Infrastructure Finding Release (DCH) • DCH SubCo Ltd (Terms of Reference) • Keyworker Housing Unilateral Undertaking (DCH) • Escalation reports were received and noted. Assurance was also received from the Estates Compliance Report (Joint) and the Health and Safety (including fire and water) Compliance report (DCH).	

Baker, Abi
06/10/2025 12:40:16

	The Committee Annual Report and Effectiveness Evaluation was received which provided positive assurance. The refreshed ToRs and Committee workplan for 2025/26 were approved. DCS asked about the Committees focus on the cost improvement programme (CIP). DU advised that these would be covered within the Finance and Performance reports. NJ noted that the HASU business case was being discussed at Part 2 Board, and that there was a point relating to not progressing until the funding is confirmed.	
	Resolved: that the Finance and Performance Committee Assurance Report be received for assurance.	
BoD25/069	Balanced Scorecard	
Baker, Abi 06/10/2025 12:40:16	AT noted this was the first version of this years Balanced Scorecard and it references the operational submission that MBr made reference to in his report. She noted that we have the draft Performance Assessment Framework (PAF) and the final version is awaited. Once received, we will amend the scorecard to reflect that. AT updated that we have started the new monitoring and oversight arrangements with the ICB and NHSE and now have weekly meetings with regional colleagues against performance against the operational plan. The first meeting took place last week and focussed on Urgent and Emergency Care (UEC) and the measures in the plan relating to No Criteria to Reside over 21 days. This forms part of the 'Future Care' work with partners. There were satisfied with performance against all other standards. AT advised that a meeting had been planned for today to look at elective care but that had been stood down as there was no reason to meet which was positive. It was noted that one month's data does not give us anything in terms of trends, but it will start to build a picture. In terms of performance, UEC was varied across the first two months. In the first three weeks we had good flow, closed all escalation beds and closed some additional beds and had good flow through Emergency Department (ED). However, there was a slow recovery after the bank holidays. When reviewing the month end position, it therefore doesn't provide the full picture in terms of flow, but this may show in the next dataset. There has been growth in the waiting lists for elective services, and the validation team are supporting this work. We have also seen loss of capacity in theatres due to gaps in staffing. However – despite these challenges we did meet the standard. The 28-day standard was missed with Endoscopy and breast radiology due to capacity, but the latter is improving. We will not see the full impact of the improvements until June data. We are focussing on cancer pathways and met the 31- and 62-day treatment targets. NP said in terms of people, there was nothing specific to highlight. The overall position is stable and in context of the discussion of Whole Time	

	Equivalent (WTE) reduction, turnover and vacancies are reducing and contracted headcount is going up. People and Culture Committee will be considering how we monitor this position moving forward. NJ raised a question about the format of the report and AT reiterated this was still in draft format pending the final PAF. NJ clarified he was asking how we are tracking the metrics and AT responded that this would be done in the final version. CH confirmed that we are reviewing compliance and reporting against the revised framework across DCH and DHC. MBr added that AT had described a change in terms of the operating environment and the shift in performance and the engagement with the regional team and highlighted that we are in a positive place. We have had ongoing conversations about the format of the performance reviews within Finance and Performance Committee and whether we could come up with a standard format across DCH and DHC with both reporting on exceptions on the indicators that are not being met, with some detail about how the data is changing over time to understand the trends.	
	Resolved: that the Balance Scorecard be received for assurance.	
BoD25/070	Finance Report	
Baker, Abi 06/10/2025 12:40:16	CH presented the Month one Finance Report and noted that we have an ambitious plan. The full year plan was a £9.8m deficit, which includes a degree of phasing coming in through the second half of the year. Month 1 showed a deficit of £2.3 which was in line with the phased plan. Agency expenditure was lower than planned but we have seen an increase in bank uses across a variety of services. It was noted that when we are looking at vacancies, we need to make sure that we have appropriate tracking and controls in place to understand and implement any changes as required. Simon Fuller from NHSE is working with us from a workforce perspective, who is adding rigour to internal processes and the system. The Trust efficiency target stands at £29.1m and is 8.7% of Trust spend. This is significantly above what we have seen previously. There are risk and opportunities that come through the planning round, however this requires 5% core efficiency across the Trust, plus a 3% additional CIP which we are looking at via transformational means. At month 1 we have in the region of £24.5m identified, with £4.5m currently unidentified. A large proportion of what we have identified is high risk. DU had already mention we had commissioned an independent review and this has commenced and will take approximately four weeks. Findings will be reported through the Finance and Performance Committee and to Board. Month 1 has delivered £700km, which is slightly behind trajectory but there are a number of schemes that will be coming online in the coming months. From a cash perspective, we have a significant risk, ending the month with a cash position of £26.4m, which is above plan. Cash remains a significant focus area and daily monitoring is in place.	

In terms of capital, month one is in line with the plan and the Trust was successful in bidding for £2.7m of national critical infrastructure funding which will help to address some of the critical infrastructure risks.

DCS questioned what was meant by critical infrastructure. CH explained that this was a restricted CDEL envelope on what we can spend our own monies on when maintaining our estate. The national funding is for significant failures in estates. Estates are working closely with AT and the clinical teams and we have been successful in the majority of bids. The £1.8m for the generator has come via those funds.

SP stated that it was positive to note substantive and agency spend coming in under plan and reflected on the safe staffing discussed and whether Finance and Performance Committee could revisit assurance on the controls around agency.

SP raised more specifically page 772, CIP page, and the graph. The first four red lines, the subsidiary is potentially in control, but the other three are holding high risks, total around £11m, which is not in complete control. As we are halfway through June, SP was concerned about the risk to delivery of the overall CIP, and whether there was likely to be drift with the uncertainty regarding the ICB.

CH reiterated why it was important to divide up the 8.7% efficiency. The areas SP raised were core ones that sit within the transformation schemes. When we talk about the system, we need to remember that we are a core part of the system, and we need to focus on these too. We need to continue to work with others to identify opportunities where appropriate. It is important to progress these and the independent financial recovery review work will support this.

MBr said that because of the focus on CIP and how important that is for delivery that going forward we need to make it clearer around the numbers against the categories and the CIP position, quantifying the low and medium risks. When we next meet, we need to have this defined in regard to timing and to be able to answer the questions that SP has raised.

CH agreed and getting the first quarter delivered would be a key checkpoint for understanding the risks and opportunities. This ties in with the Financial Recovery Review.

EJ said there were some good discussions at Board and Committees and although it will be tough a year, it sounded positive culturally. EJ asked if we were in a position where we were mostly off plan at this point, whether we would be getting any specific pressure from the region as she was aware some Trusts are getting a high level of attention. She was not aware of this focus on DCH which was positive.

CH acknowledged that we were all under pressure and we were engaged with the ICB and the region. The work we are doing has been well received. We recognise the scale of ambition that we have to deliver. With the CIP target last year, we did achieved higher than previously at £9.5m but this year is £29m, which is significant. It is positive that we have engaged with

Baker.Abi
06/10/2025 12:40:16

	early review and intervention, but we have not had direct intervention from region. EJ asked if whether as a federation, we are doing enough to maximise all opportunities. In terms of the CIP, we discussed Future Care previously and there were queries in that forum. EJ would like more assurance of what that programme is delivering as we noted that there has not been robust clinical engagement in that work to date. DU remarked that in terms of regional input and shaping, it felt that the region was also in turmoil, not just in Dorset or the Southwest but more widely. MBr added that we should be challenging our own services before others do. However, the change in terms of provider oversight from ICB to region is well underway. AT had described the changes in regard to the operational performance and the region and they have confidence in the operational performance. Financially they have the same information as we are reporting to Board - we need to improve our delivery of savings and demonstrate that the workforce number is coming down. Regarding Future Care, we will be reporting at the next meeting to provide more details on the long-term impacts. There is a suggestion of removing 30 beds from DCH. It may be the case that Future Care can deliver that, but what we lack in the system at the moment is an overall demand and capacity model which works over a multi-year period. We need to focus on this across the system, and the only way we can achieve this is as three providers, working with UHD and the new ICB cluster team. MBr acknowledged that this was work in progress and we will bring this product to Board and ensure we have Chair and NED oversight. DCS asked MBr and CH to ensure we have a route for reporting the outcomes of the Financial Recovery Review to Committee and Board.	MBr / CH
	Resolved: that the Finance Report be received for assurance.	
BoD25/071	Update on Finance and Operational Plan 2025/26	
	CH noted that he had covered respective elements through respective finance and performance items.	
	Resolved: that the Update on Finance and Operational Plan 2025/26 be received for information.	
BoD25/072	People and Culture Committee Assurance Report	
Baker, Abi 06/10/2025 12:40:16	MBI presented the Assurance Report and highlighted the following: • Committee had reviewed the BAF and the corporate risk register - no score changes, but did note that there were a number of actions outstanding, which were being managed. • The Joint People Plan had been approved in terms of the key workforce priorities, but the delivery framework needed further development and will be returned to the July Committee for approval. • There was substantial discussion around the planned headcount reduction and the final figures were to be circulated. The Committee is clear on its role in providing scrutiny and oversight of the WTE reductions.	

	• Noted the Speaking Up Report, which was also on the Board agenda. • The Guardian of Safer Working (GOSW) report was discussed that showed an update on actions. This was also on the Board agenda. • Received a report on the 'People Promise' and experience and progress was shared, along with the process for how this work continues and gets embedded to become business as usual. It demonstrated the benefits of joint working by brings staff together across both organisations for shared working and learning. • Internal Audit provided a report on cultural maturity which gave a positive rating, and the recommendations identified were either completed or underway. DCS asked whether there was any indication of the mood of the workforce in terms of the WTE reduction. MBI responded that we were aware that staff would be anxious and concerned and would want managers to support staff through changes, but there was not a specific conversation around mood. Some things had been picked up in the health and wellbeing conversations. NP added that in terms of the mood of the staff, we have been proactive in communications about this, and MBr had held a briefing for all staff that was well attended and there was positive feedback about the transparency with which he had shared information. MBr noted we need to continue to triangulate the evidence, using the formal feedback such as the Pulse survey and the feedback from networks, Speaking Up Guardian and the Wellbeing Team, to monitor this. We know it is going to be difficult, and we need to understand people's needs, acknowledging that we can always do more.	
	Resolved: that the People and Culture Committee Assurance Report be received for assurance.	
BoD25/073	Joint Strategy Enabling Plans – People Plan	
Baker, Abi 06/10/2025 12:40:16	NP presented the plan and noted that NP is currently bringing the two People Directorates together. The plan sets out how we will engage and is aligned to the Trust priorities set out in the clinical and quality strategy. We have had an era of the directorate making universal offers to all services and we need to ensure we are aligned to take care of people, strengthen wellbeing, ensure psychological safety, and upskill managers to enable them to support staff through periods of change. This will be underpinned by workforce capacity, and the directorate is well set up with the technologies they can use. The report also details the breakthrough objectives. They are a reflection of the plans in place. The Joint Wellbeing Strategy and Sexual Safety Charter are already in place. The plan also includes statutory reporting requirements. The fourth objective is for the directorate to be as good as it can be. There is a high level of ambition to continue and improve service provision, whilst scaling back resources, and focussing on priority areas. DCS commented on the need to focus on how we make these changes rather than what we change. DCS asked NP if they were comfortable with	

	the focus on what we have and how that will be supported in this challenging period. NP said that wellbeing initiatives remain universal and some team leadership provision needed to be more focused. With any change or transformation, there will be concerns and as we bring the two People Directorates together we will work to share best practice across DCH and DHC.	
	Resolved: that the Joint Strategy Enabling Plans – People Plan be approved.	
BoD25/074	Guardian of Safe Work Report incl. Annual Report	
Baker, Abi 06/10/2025 12:40:16	JM attended to presented the report to the Board. JM highlighted that: • An increased in the number of resident doctors in training and a reduction in the vacancy rate • Exception reports have increased year on year. 268 raised this year compared to 205 in the previous year. Immediate safety concerns rose from 6 to 26 within ISC this year. All of these have been reviewed. It demonstrates a good culture of reporting but also the significant clinical demands. • We have implemented a flow chart for escalation if a resident doctor has concerns over patients. • Feedback is positive and incident reports are being submitted to ensure concerns are recorded. • New framework for reporting as resident doctors are now on health rota. RW added that we wanted agreement to enact that each concern is incident reported. RW thanked JM for the report as this would be her final report. Board also added their thanks. JeH asked about Appendix 1, trainee vacancies and the quarter and annual averages. JM concurred that the data did not quite line up, and that she had spoken to the co-ordinator. It looks like 18.3 but should be 45, and the same for GP 19.7. MBr also added his thanks and stated that it was great to see progress in orthopaedics and queried whether there were any issues in geriatrics that we should be aware of. JM advise that she reviews every exception report when compiling the data and at least half are coming from medical, geriatrics is not an outlier. SP queried one point relating to accuracy and one regarding safety. GP Vocational Training Scheme (GPVTs) showed a high vacancy in quarter 1, and queried if that was an inaccuracy, but noted the fall. SP queried if this increased any risk to the resident doctors in coverage and queried whether we needed support to get more vacancies filled. JM responded that we do have to move doctors around and that this does affect the day-to-day educational opportunities. RW clarified that they were not employed to fill the gaps and they are primarily employed to fill the gaps from the Deanery.	

	SP asked if that did fill the gaps or whether there was any risk, he advised he was trying to triangulate information. RW advised that there is not a staffing model for medics, there is minimum staffing but not safer staffing. JM added that minimum staffing has been established, but there could be debate as to whether it was safe. DU questioned how the Deanery decided on the size of cohorts was it dependent on the demand on the Trust. RW explained cohorts were allocated depending on the number of consultants that were trained supervisors, they are not there to fill operational gaps. MBr noted that this has to be seen via a variety of perspectives, we get Deanery feedback which in the main is positive about people's training experience which provides assurance on the work of JM and others in terms of training and supervision. JM added that we get positive external feedback too. EJ recalled that we were asked to take more trainees last year. It is an opportunity as we know resident doctors often apply for consultant posts where they do their training, so that is important for the future.	
	Resolved: that the Guardian of Safe Work Report incl. Annual Report be received for assurance.	
BoD25/075	Questions from the Public	
	Question related to CIP: Were some savings related to headcount reduction? CH confirmed this was the case as three quarters of spend is pay, and a large proportion of CIP needed to come through that. KH made an observation in regard to the Unison letter that the Trust had received and had been circulated to Governors. Many of the questions which had already been dealt with within the discussion earlier in Board. However, KH asked how staff feel about this. Union representatives stated that staff were 'deeply' unhappy, and KH said that the Board were aware of that - what plan did the Trust have to alleviate the fears? DCS noted we all recognise that this is an area where communication and listening, pre-consultation and consultation will be important. NJ added that this had been picked up during the discussion. We recognise that staff are concerned about this, and we need to do more engagement with the staff. For many of the concerns raised we have a response and mitigations in place. It is important to have conversations with staff and recognise their concerns and detailing the benefits in continuation with the engagement process. NP added that it is challenging to make changes across three Trusts as information may come out in one organisation and arrived at a partner organisation in an unplanned way, so there is learning there. All partners	

Baker, Abi
06/10/2025 12:40:16

	have reflected on that, and we will endeavour to coordinate everything our communications where possible and to demonstrate visible leadership and ownership. We need to ensure that staff have confidence in their leaders and managers, acknowledging the challenges in leading through uncertainty and that managers may also have concerns. MBr added that we need to recognise the environment we are in and what we are trying to do. We can improve our engagement and listen to people's experience, acknowledge that there has been gaps and shortcomings, and opportunities where things could have been done better and we need to hear that and pay attention and ensure that informs our actions moving forward. We need to recognise that the Unison stance is opposed to SubCos. In terms of workforce, for the conversations MBr had he reported that staff wanted to work for the NHS with NHS values, and want to remain as part of the NHS, some were worried about their pension, what their job will be, who their manager will be and where they will be working. Those are questions that we would be able to answer, and we should be coming alongside people to provide some certainty. For people that are opposed on principle, we may not be able to respond to that in the same way as it is a difference of opinion. We hope that we can work with partners, including staff side, to recognise the differences and find common ground to support the workforce, but it will be a few difficult months. SP said we needed to be careful with wording. NJ clarified that they would be in an organisation that remains in the NHS. They will be in the NHS family, but not directly employed by DCHFT.	
	AT left the meeting.	
BoD25/076	Freedom to Speak Up Report incl. Annual Report	
Baker, Abi 06/10/2025 12:40:16	LP attended to present the Quarters three and four report and the annual report noting that during Q3 and Q4 234 contacts were made, which was similar to previous quarters, bringing the annual total to 499. Themes were around poor communication, colleague behaviour, manager behaviour and lack of support from manager. The highest group of staff raising concerns remains Register Nurses and Midwives, which is consistent with DHC and UHD, and aligns to the national picture. The number of anonymous concerns raised is slightly down. We triangulate data monthly and liaise with NP, DD, DU and the Heads of Nursing, and also hold local intelligence meetings with people to identify areas that require support. Recommendations and next steps were identified as continuing targeted work to continue visibility and psychological safety and support ongoing learning from speak up cases. There is proposed joint working between DCH and DHC, including a joint strategy, recruitment and training of champions, and coordinated FTSU month. There is a targeted approach to recruitment of champions, especially in underrepresented areas and note the Board self-reflective tool agreed by year end.	

	NP commented on the themes coming through as an area of concern and also the effectiveness and performance of the FTSU function. Over 95% of concerns were acknowledged in 72 hours and actions undertaken within 3 weeks. NP continued that when we look at the number of contacts, it provides rich information and identifies that the service is being used appropriately. The guardian is visible and people understand the purpose of the role and drew attention to the development work ongoing on top of running the day-to-day service. This includes working closely with the DHC and realising the benefits of joined up working. 97% of people said they would speak up again which is a positive indicator. SP commented that when he undertakes patient safety walkarounds he always asks if they know who the FTSU lead is, and they do always know and acknowledged the work that has gone into creating a positive speaking up culture. SP then queried the numbers in the table as they did not add up, LP explained that contacts can have multiple categories. LP added that the FTSU at DCH and DHC had started to peer review each other's cases, to see if anything different could have been done, LP advised that this was now standard practice. SP commended that. CL commended the work done and noted the importance of this from a quality perspective and the importance of being able to raise things without the fear of detriment. DU commended the triangulation undertaken by NP and said the key thing being that we listen, and the number of people who would use the service again is very high, which is not common across the FTSU world. DU commended LP on the work reporting to the national guardian and also comparisons with other Trusts to enhance our understanding. MBr echoed the thanks already given and noted the quality of the report and the response times and the dedication put in to the role. MBr also reflected of the SubCo discussions and reflected on concerns raised by Unison and Estates and Facilities and Procurement colleagues and asked LP if there was anything to add regarding what she was hearing from these staff groups. LP responded that people felt that they were taking a leap of faith and there was nothing tangible to have any guarantees further down the line, for example, if there is a financial loss what is to stop them from privatising. When staff are hearing opposing concerns from Unison, they feel caught in the middle and it is causing confusion. MBr thanks LP and advised that was helpful and reinforces the earlier conversation about the part we play in ensuring staff are communicated with.	
Baker, Abi 06/10/2025 10:40:16	Resolved: that the Freedom to Speak Up Report incl. Annual Report be received for assurance.	
BoD25/077	Strategy, Transformation and Partnership Committee Assurance Report	

	DCS presented the report and advised that it was pleasing how various strands were now being pulled together. He noted we need to look at the benefits of delivery and focus on the ones that can make the biggest difference or those that have interdependencies. It was noted that the shared services transformation was receiving high levels of public attention. DCS highlighted the following from the Committee: • Additional funding had been secured which had enabled DHC to be included in Electronic Health record (EHR). The Committee received a positive report on developing a Dorset-wide digital strategy, including primary care and ongoing development noting it was good to be able to pull the elements together and we need to maintain this focus. • Discussion around the development of the strategy dashboard, and that we needed to see a dashboard to demonstrate what difference the work is making, and where we need to focus. • Since the three-way Board workshop there has been a real openness to working together. A NED overview meeting was planned to look at pulling strands together. • We have established a clinical link with Wessex Health to support what we do. • Committee effectiveness review had been undertaken which provides positive assurance. DCS thanked CH for his work as the Senior Information Risk Owner (SIRO) and advised that this was passing on to JeH. NJ drew attention to the strategy in action item, and the peer open dialogue which was really powerful. NJ also noted that we are behind on the strategy dashboard as focus had been diverted to operational planning. Now that has been completed, focus will be back on the strategic items that we need to bring forward.	
	Resolved: that the Strategy, Transformation and Partnership Committee Assurance Report be received for assurance.	
BoD25/078	SIRO Annual Report	
Baker, Abi 06/10/2025 12:40:16	CH presented the annual Senior Information Risk Owner (SIRO) Annual Report. The Data Security and Protection Toolkit (DSPT) had to be submitted by 30 June, and this had been prepared and was currently being reviewed by internal audit for compliance. The Information Governance (IG) team is essentially one person, and we are trying to gain resilience across the federation. Training on IG and Cybersecurity are below the target compliance rate and 80% and 75% respectively against a target of 90%. The Data Protection Officer (DPO) is preparing an action plan to address this. JeH is taking over SIRO responsibilities from 01 April 2025. JeH asked about reporting as the paper states that this reports to the STP Committee but in the Terms of Reference the DSPT is reported to the Audit Committee (with digital strategy to the STP Committee). CH advised that the	

	split fits in to remit of committees, but formal reporting route was Strategy, Transformation and Partnership for general oversight, but there is a dotted line to Audit Committee for compliance. DU commented that one fifth of staff are not up to date, so IG is not at the forefront of people's minds and about a sixth of staff were not up to date with cyber security. The environment cyber threats was increasingly aggressive. We need to improve training compliance because the UK is a target and the damage that can be caused is serious. DCS noted that this was a serious point, and department heads needed to understand where their teams were with compliance. MBr acknowledged that this as an important point and the plan to address will reported back through STP Committee. NJ added that cyber security provided quarterly reports to STP Committee and Board to provide more details on how we are managing this. MBI asked whether we ran periodic campaigns for awareness. CH conformed that to be the case and in recent weeks staff had received an update on their mandatory training compliance. This will form part of the action plan.	
	Resolved: that the SIRO Annual Report be received for assurance.	
BoD25/079	Audit Committee Assurance Report	
	SP advised that the most significant matters had already been discussed and drew attention to the following: • Review of the BAF and noted there were some delays to actions, specific to digital and cyber, which the new Chief Digital Officer would be picking up. Proposal to review the risk appetite statement was supported. • There was discussion around the risk register and noted the temporary closure of YDH Maternity Unit, and the impact that would have increased the risk in our own service. • Received the Annual report (not accounts) and no amendments were noted. • Updates were provided on the BDO IA reports regarding system workforce controls and moderate assurance on DSPT reflecting stage at which work was undertaken. • BDO had started work for 25/26 and consideration was being given to the timing of the review of consultant job planning and an audit of Quality Impact Assessments. • Head of Internal Audit Opinion provided moderate assurance opinion. • System governance internal audit report - the outstanding actions sit with the ICB and is not expected that those actions will be completed given the changes in the ICB. • New Counter Fraud provider, SAFE. The change occurred quickly but SP assured after meeting with SAFE and looking at the workplan that there was no risk to continuity of service. Workplan was commended. • Committee received a positive update from the LSMS security and noted there had been a lot of improvement in that area.	

Baker, Abi
06/10/2025 12:40:16

	- Annual effectiveness review was discussed and agreed duties had been discharged. - Annual Effectiveness Review of Auditors (External and Internal), was undertaken noting a positive opinion from all committee members. EJ asked about the consultant job planning review. RW responded that work was ongoing at the moment so we were not in a place where an audit would be effective. A new digital system had just been introduced. EJ spoke about the productivity piece and the earlier conversations, and how RW could be supported in that piece of work. MBr noted that work had commenced to strengthen medical leadership.	
	Resolved: that the Audit Committee Assurance Report be received for assurance.	
BoD25/080	Governance Report	
	JeH explained that the paper brought together the annual review of governance related workstreams which inform Board effectiveness and highlighted the following: - Full compliance was reported to the Audit Committee with explanations and evidence. - The completed annual governance statement has also been to Audit Committee and circulated to the Board. Conclusion was that there were no significant control issues. - There was a Board development programme in place an individual training had been completed. In this year we had NHSE Board members appraisal guidance which followed on from the leadership competency framework and compliance. - Through the committee annual reports we had received assurance that each had discharged it's duties and had completed an effectiveness review. There had been good engagement and good feedback, especially in light of establishing committees in common. There were some small areas for improvement identified. - The Remuneration report in the annual report will come back to Board and the annual effectiveness review will come back through to the next meeting. Next year we will bring the reports forward to January, but these were pushed back this year to allow 6 months of committees in common. - The Terms of Reference for each Committee had also been reviewed and amended, clarifying chairing arrangements as the ToRs predated the joint NED appointments. We had moved Health Inequalities to Quality Committee and created a Mental Health Legislation Committee in Common. DCS reflected if we look back a year to where are now with committees in common and joint working, there had been great improvement. EJ expressed her thanks to JeH as there had been a huge improvement in rigour and governance since JeH had come into post. EJ asked for this to be minuted as this has made a big difference. DCS noted a comment from AHT not being comfortable about Mental Health Legislation Committee having a rotating chair, he felt expertise sat in DHC. JeH agreed to amend the TOR relating to the chairing.	

Baker, Abi
06/10/2025 12:40:16

	EJ noted that there was a lot benefit that DCH could learn with how DHC comply with MH Legislation. When people are not as experienced it is really important that we can access that expertise and felt that it should be a Committee in Common because there are patients with mental health needs that come to DCH and times not everyone not fully understand obligations.	
	Resolved: that the Governance Report and accompanying Terms of Reference be received for assurance and approval.	
BoD25/081	Charitable Funds Committee Assurance Report	
	DU presented the report and highlighted the following: - As at April 2025, we had reached £1.1m of the target £2.5m. There had been a record level of income in 2024/25, a sum total of £1.434m, including a significant legacy. - The risk register was reviewed and noted risks relating to staffing - Lillian Martin legacy - in part materialised and we have received £31k but there is still a parcel of land which may generate more income. - Committee agreed to pursue the establishment of an innovation fund. NJ agreed that an innovation fund was positive - we have, across the Trust, a number of strands doing similar things which we need to bring together. DU added that was part of work we are envisaging undertaking in pulling all of this together, and we need be clear of purpose. EJ added this was welcome and could be a boost for morale linking in with Quality Improvement in the broadest sense, not just clinical. ST wanted to note that DU had completed his sponsored swim and it was a fine achievement.	
	Resolved: that the Charitable Funds Committee Assurance Report be received for assurance.	
	CONSENT SECTION	
	The following items were taken without discussion. No questions had been previously raised by Board members prior to the meeting.	
BoD25/082	ICB Board Report	
	Report was noted.	
	Resolved: that the ICB Board Report be received for information.	
BoD25/083	DCH SubCo Ltd Q4 Performance Report	
	Report was noted.	
	Resolved: that the DCH SubCo Ltd Q4 Performance Report be received for information.	
BoD25/084	DCH SubCo Terms of Reference	
	Report was noted.	
	Resolved: that the DCH SubCo Terms of Reference be approved.	
BoD25/085	Estates Compliance Report	
	Report was noted.	

	Resolved: that the Estates Compliance Report be received for assurance.	
BoD25/086	Health and Safety (including Fire and Water) Compliance Report	
	Report was noted.	
	Resolved: that the Health and Safety (including Fire and Water) Compliance Report be received for assurance.	
BoD25/087	Questions from the Public	
	JPL raised a question about the Charitable Funds assurance report, relating to the need to increase capacity and asked whether the staffing issues had impacted on the fund-raising activities. DU responded that staffing numbers were part of the WTE count, and corporate areas are being asked to come up with a plan to make a monetary contribution to support Trust efficiencies which has restricted our ability to recruit at the moment. The team have been restructured and we have a new Head of Fundraising. We have a lot of activity in the community which supports the general funds, and for emphasis on specific areas, we rely on work across the clinical and other teams to support – so we are focussing where to put our resources around the paid elements of the team. KH raised an issue raised during Governor events in the community regarding patient transport. KH sought assurance that with the SubCo initiatives and that this issue is not missed. DD advised that she hadn't heard about issues with general patient transport, she was aware about the renal transport. DD asked to meet outside of the meeting to get details so that this could be reviewed.	
BoD25/088	Any Other Business	
	MBI queried whether the Board could do anything to support the Appeal. She was aware DU done a sponsored swim. It would also be good team building and could be 'Board to Ward'. Suggestions to be submitted to Corporate Governance team.	Board members
BoD25/089	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 the Board Room, Trust Headquarters, Dorset County Hospital, Dorchester and via MS Teams .	
BoD25/090	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.	

Baker, Aht
06/10/2025 12:40:16

**Minutes of a public (Part 1) meeting of the Board of Directors of
Dorset County Hospital NHS Foundation Trust
held at 9.30am on 12th August 2025 at
Board Room, Trust Headquarters, Dorset County Hospital and via MS Teams
videoconferencing.**

Present:		
David Clayton-Smith	DCS	Joint Trust Chair (Chair)
Margaret Blankson	MBI	Non-Executive Director (via videoconference)
Matthew Bryant	MBr	Joint Chief Executive
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
Eiri Jones	EJ	Joint Non-Executive Director (Deputy Chair)
Stuart Parsons	SP	Non-Executive Director
Anita Thomas	AT	Chief Operating Officer
Stephen Tilton	ST	Non-Executive Director
David Underwood	DU	Joint Non-Executive Director
Rachel Wharton	RW	Chief Medical Officer
Frances West	FW	Joint Non-Executive Director
In Attendance:		
Abi Baker	AB	Corporate Governance Manager (Minutes)
Kara Ellis	KE	Corporate Governance Officer (via videoconference) (BoD25/107)
Sandra Firth	SF	Head of Physiotherapy (BoD25/107)
Mandy Ford	MF	Joint Deputy Director of Corporate Affairs (via videoconference)
Jo Howarth	JoH	Director of Nursing (Acute Care)
Hannah Robinson	HR	Head of Patient Experience (BoD25/107)
Rachel Small	RS	Chief Operating Officer (DHC)
Hannah Williams	HW	Highly Specialist Physiotherapist (BoD25/107)
Catherine Youers	CY	Head of People Services (via videoconference) absent between BoD25/117 and BoD25/123
Members of the Public:		
Mike Byatt	MBy	Governor (via videoconference)
Alan Clark	AC	Governor (via videoconference)
Kathryn Harrison	KH	Lead Governor (via videoconference)
Jean-Pierre Lambert	JPL	Governor (via videoconference)
Alex Liggins	AL	Vanguard Healthcare Solutions (via videoconference)
Carol Manton	CM	Governor (via videoconference)
James McMahon	JM	Staff (via videoconference)
Maria Moors	MM	BridgeHead Software (via videoconference)
Lynn Taylor	LT	Governor (via videoconference)
Jan Wagner	JW	Staff Governor (via videoconference)
Apologies:		
Dawn Dawson	DD	Joint Chief Nursing Officer
Claire Lehman	CL	Non-Executive Director
Nicola Plumb	NP	Joint Chief People Officer



BoD25/107	Patient Story	
Baker, Abi 06/10/2025 12:40:16	SF, Head of Physiotherapy, and HW, Highly Specialist Physiotherapist, presented a story showcasing the work of the hydrotherapy service. A video was shared, outlining that Michelle, a patient, had suffered a stroke in 2024. Following a course of physiotherapy Michelle started a course of hydrotherapy, and this proved to have positive impacts for both her physical and mental health, allowing her to return to normal daily activities; most recently Michelle was able to go in to the sea which she had wanted to since her stroke. The service offers excellent treatment for patients and positive outcomes, with hydrotherapy and physiotherapy offering a complementary approach to rehabilitation.	
	HW circulated recent friends and family test feedback from patients and described that it was a privilege to be able to help people return to doing what they loved after an unexpected, catastrophic event, such as a stroke. HW shared a presentation outlining an audit, by way of a survey, that was undertaken to review patient experience of the hydrotherapy service, what was going well and what could be improved. The survey garnered a higher-than-expected response rate, with 97% rating the service they received as excellent, 92% reporting the service was effective in treating their condition, and positive results in relation to increasing activity levels and returning to pre-injury activity levels. HW noted the positive outcome of increasing activity levels of citizens which should have long term benefits.	
	Areas for improvement identified by respondents included the condition of the facilities; whilst functional and safe they were starting to look tired and worn. Wait times and limited capacity of the team was also highlighted, with just 1.7 whole-time equivalent (WTE) staff supporting 300 patients. HW further highlighted plans to set up more classes and to improve discharge paperwork. The social value benefit of hydrotherapy was noted, with some studies finding a £16 value created for every £1 invested in the service.	
	Considering the future of the service, HW highlighted work with Dorset HealthCare NHS Foundation Trust (DHC) learning disabilities team to improve access for patients, the desire to expand the service to inpatients, and to patients with neurological conditions. HW thanked the Board for their time and invited members to visit the service.	
	DCS reflected on the way in which the trust was able to help Michelle, and other patients, achieve what she wanted to achieve and the benefit this had to her wellbeing, in addition to her physical health. A number of Board members noted the benefits their friends, families and neighbours had experienced with water-based therapies. There were questions from Board members related to improving access to local authority pools, with some clinical support, particularly for musculoskeletal patients who might be able to access community services more easily, and to ensure that those who had completed a hydrotherapy course could continue to access water therapies. HW described the use of exercise referral schemes and the introduction of a monthly clinic at a pool in Weymouth by the Dorset stroke and neurological service. Improving access to community pools was an area of focus for the team. HW also	

	ran a weekly session where patients could pay a small fee to use the pool after their hydrotherapy course had ended; this was very popular and generated some income for the trust. DU later noted the option to form ties with the Amateur Swimming Association and of social prescribing. EJ noted the benefits of the service, and that this should be appreciated by the trust as not all trusts had a hydrotherapy pool. The social value of the service was clear, but this was not detailed in the Social Value report which appeared later on the agenda. EJ considered that there may be further work to do to fully scope the social value within the trust. Asked about which parts of the facilities required improving, HW advised that the poolside and showers were the main areas that needed updating. Where patients had reported that the facilities were excellent HW perceived that this related to having a hydrotherapy facility, rather than the condition of the facilities themselves. SP commended HW and the team for reaching outside of the trust to work with colleagues from DHC and encouraged this to continue. FW asked what percentage the pool was in use for. HW outlined that the pool was free for two half days a week and was otherwise in use. HW had worked had to increase this and felt it could be increased further but was limited by staffing. DCS thanked HW, SF and HR for their work and presentation.	
	Resolved that: the Patient Story be received for information.	
BoD25/108	Formalities	
	The Chair declared the meeting open and quorate and welcomed governors to the meeting. Apologies for absence were received from Dawn Dawson, Claire Lehman, and Nicola Plumb. DCS highlighted that this was NJ's last Board meeting with DCH as he would be leaving the trust at the end of the month to become Managing Director at Salisbury NHS Foundation Trust. DCS thanked NJ for his work over the years at DCH, in his many roles, including acting as CEO for a period of time. NJ's legacy would be recognised for years to come.	
BoD25/109	Conflicts of Interest	
	There were no conflicts of interest declared in the business to be transacted on the agenda. The register of interest included in the paper was highlighted; EJ noted that she was the Interim Chair of Salisbury NHS Foundation Trust from 1st July 2025, and this needed to be added to her declaration of interests. If this posed any conflicts she would raise them as they became known.	AB
BoD25/110	Minutes of the Meeting held on the 10 June 2025	
	JeH noted that the minutes were longer than would usually be expected. The minutes were withdrawn from the meeting and would be updated and returned to the October meeting for final approval.	JeH

	Resolved: that the minutes of the meeting held on 10 June 2025 be withdrawn from the meeting for revision.	
BoD25/111	Matters Arising: Action Log	
	The action log was considered, updates received in the meeting were recorded within the log, and approval was given for the removal of completed items. Maternity Support Worker Sickness: An update had been provided by DD, but SP asked what was being done to address the fact that stress was the most frequently reported reason for absence. JoH would provide an update to this within the maternity report item. The action was closed. EJ raised a matter from the previous minutes in relation to quoracy of Mental Health Legislation Committee in Common. JeH advised that this would be discussed within the Mental Health Legislation Committee in Common assurance report, later on the agenda.	
	Resolved: that updates to the action log be noted with approval given for the removal of completed items.	
BoD25/112	Chair's Comments	
	DCS highlighted the following key points: • He had spent time visiting services in both DCH and DHC and had recently visited the DCH Fortuneswell Chemotherapy Unit • NED appraisals were almost completed • He was in discussion with universities, particularly the University of Health Sciences, about the sorts of skills required as the 10-year plan developed, and to support developing skills within the county • Continued, focussed work with University Hospitals Dorset (UHD) and the Integrated Card Board (ICB) to develop the structure of care offered across the county	
	Resolved: that the Chair's comments be received for information.	
BoD25/113	CEO Update	
	MBr took the report as read but highlighted a few key matters. Firstly, the NHS 10-year plan was published in early July and sets out an exciting vision for the way forward for the NHS in England. The extent to which the plan aligned with the trust's strategy was positive. The trust had submitted two bids for neighbourhood health pilots. MBr drew attention to the challenges underpinning the plan, including demographic changes and changes to elements of the social contract in how the cost of care is paid for. An emphasis on technological revolution underpins the 10-year plan, in terms of the type of medicine provided, delivery mechanisms and partnership with citizens. MBr reflected on the current time of huge challenge and change in healthcare and that the environment across the trust would need to change radically over the next three to five years. A focus for the board would be on taking people on that journey of change, whilst delivering business as usual. The 10-year plan would be further discussed in an upcoming Board Development Session.	

Baker, Abi
06/10/2025 12:40:16

Baker, Abi 06/10/2025 12:40:16	Secondly, the quality review led by Penny Dash, which was welcomed by the trust. Within that there was a strong focus on maternity which had been an equally strong area of focus for the trust and the Board. The industrial action from resident doctors was noted. This was a dispute between the British Medical Association (BMA) and the government, but it was disappointing to be in another period of industrial action, as this had an impact on patients and colleagues. MBr extended his thanks to colleagues for their work during the action and recognised that it was a difficult period for patients, families and staff. MBr further highlighted the changes taking place within ICBs, with functions being clarified. The Board would need to maintain focus on these changes and how they impact and link to the 10-year plan, as well as the new foundation trust form and the introduction of integrated health organisations responsible for population health. Locally, the ICB cluster has been agreed, an announcement on chair appointment was expected, and CEO and executive appointment would follow. There would be significant work in this regard in the coming months and would bring the trust in to a new relationship with other providers in the cluster. The trust would need to consider what that means for Dorset and the role of the federation. Noting positive developments within the trust, MBr drew the board's attention to the approval from the cabinet office for the electronic health record (EHR) business case which would support the vision of an integrated health record across acute, community and mental health care. Secondly the new hospital programme building work proper has begun, which would support improved emergency care pathways. The work was proceeding on time and on budget. Finally, the Fortuneswell ward was in operation following a refurbishment and had received positive feedback from patients and colleagues. Finally, MBr provided an update on the NHS company for shared services discussed in detail at the last meeting. This was a proposal at present and would need further board approval to be adopted. The work was a partnership between the three foundation trusts in Dorset as an NHS enterprise. MBr recognised the high level of concern from staff about the proposal and stressed that those employed by the company would be employed on NHS terms and conditions and would have an NHS pension; this was the case for staff who joined the company now and in the future. The company would be wholly owned by the NHS and would remain so. The development of the company had been paused for four weeks throughout July whilst the trusts engaged with Unison and the work was now restarting, with a focus on engaging with and supporting colleagues. In addition, at the beginning of July Unison lodged a complaint with the trust; an approach to deal with this had been agreed and it was hoped the complaint would be resolved. MBr stated that the colleagues concerned were right at the heart of healthcare and how services were provided across the hospitals and the community, and it was important to work together to realise the positive vision of a sustainable service for the future.	

	With regard to the latter point, DCS reflected on the benefits of creating a subsidiary company, including savings of £140 million over 10 years and that the trust would be culpable if it did not pursue the opportunity to put that money in to patient care. The meeting heard that on average 40 resident doctors participated in industrial action, including over the weekend. On the first day 50 participated and on the last day 68 participated; these was the same in pervious action. RW commended the trust and colleagues for how the action was handled. FW sought further detail about how EHR would bridge the gap between acute, community and mental health services. NJ confirmed that the community and mental health elements of EHR would be brought in to the main procurement process once the former business case was approved at a national level. The intention for the EHR to be one system. RW added that work was underway to support resident doctors with the physical environment so that they had space to complete tasks on the patient record where it could be otherwise difficult to concentrate.	
	Resolved: that the CEO Update be received for information.	
BoD25/114	Board Assurance Framework	
	JeH highlighted the following: • The strategic risks had been reviewed by the responsible committees and that any amendments were clearly marked in red • The highest scoring risks were SR3 Workforce Capacity, SR5 Estates, SR6 Finance, and SR9 Digital Infrastructure (each with a score of 15 or more). • The risk for SR5 Estates had increased following the results of the six facets survey (which would be considered in part 2 of today's meeting), with the likelihood increasing from four to five. • Committees had agreed that actions past their original due date would show as overdue, even is a revised date had been agreed • Risk appetite survey had been sent to all Board members for completing. Results would be considered in September's Board Development Session. As Chair of Audit Committee SP stated that he felt assured that there were good discussions about the Board Assurance Framework at committee with representatives on Audit Committee from Finance and Performance Committee and Quality Committee, although it might be beneficial for a member or chair of People and Culture Committee to attend Audit Committee as well. DU suggested that the unmitigated risk score for SR5 Estates be increased, as this was now lower than the mitigated score. Reflecting on SR7 Collaboration EJ suggested this risk might be increasing with the changes to the ICB. In the new clustering arrangements, the trust would be one of a number of small district general hospitals and this may limit the trust's ability to influence within the cluster. DCS considered the difference between collaboration and true partnership.	

Baker, Abi
06/10/2025 12:40:16

	MBr undertook to review the risk score for SR7 in light of these discussions.	MBr
	Resolved: that the Board Assurance Framework be received for assurance.	
BoD25/115	Corporate Risk Register	
	JoH highlighted the following key points: • The risk register had been reviewed by the responsible committees and in full by Audit Committee • The report detailed the position for quarter one, up to end of June 2025. • Four new risks scoring 20+ had been added, as well as seven new risks scoring 15-19. A number of these related to digital, reflecting Board Assurance Framework discussions. • Other risks related to an inability to fund replacement of end-of-life medical devices from capital, fragility of the home enteral nutrition service, and careflow printing and re-scanning. CH updated that there was a capital schedule to replace medical devices, outlining that he was sighted on the risk through governance processes, including the Medical Devices Committee, which was clinically chaired and identified such risks and considered mitigations. The committee reported to Capital Planning Group and CH reflected was well sighted on this risk. It was later noted that regular meetings were held with divisional triumvirates to fully understand the risks. There was a restricted capital envelope but the impact on patient safety and quality care was taken in to account in capital planning. The Board further heard that the DCH Charity was able to offer some funding support to the trust and that the trust was able to bid with external sources for priority upgrades that could not be funded. DU reflected on the number of backlog replacements required and that this would only increase over time, suggesting creating a contingency fund to address any end-of-life equipment failures. CH described that through business planning the risks that were likely to materialise in year were well known and this supported the prioritisation of capital funds. Whilst it was not possible to create a separate contingency fund, there was a degree of flexibility in the capital plan to allow for funds to be diverted to unexpected failures. NED colleagues sought further assurance on some risks which had been closed, as in some cases the mitigations and controls did not appear to justify closure. The number of risks that had out of date updates was further noted. MBr thanked board members for the thorough discussion, noting the robust process for capital replacements. He asked CH to provide the board with further detail about the extent of the capital funds shortfall for replacing end of life equipment over the next 18 months and the next two to three years, and to identify areas where newer equipment would offer an enhanced service that was now expected. This should be reviewed by Finance and Performance Committee in Common in the first instance, with cross referral to Quality Committee in Common as needed.	CH

Baker, Abi
06/10/2025 12:40:16

	Resolved: that the Corporate Risk Register be received for assurance.	
BoD25/116	Quality Committee Assurance Report	
	EJ presented the report on CL's behalf, highlighting the following key points: • This was the second meeting of the committee in common, with good progress being made in the running of the meeting • Update received on the ophthalmology backlog with thanks extended to the teams involved in the due diligence of checking the safety of patients who had been lost to follow up. The number of patients lost to follow up was within the known tolerance set by the CQC. • In maternity, Apgar scores of less than seven at five minutes is significantly higher than the national rate. Positively, there was a lot tolerance within the department to deviation from expected performance. • New risk related to the reading of 24-hour tapes. This was related to capacity of staff with the technical ability to read the tapes, but there was a potential digital solution.	
	Resolved: that the Quality Committee Assurance Report be received for assurance.	
BoD25/117	Maternity Safety Report	
	JoH noted the increase in incident reporting which coincided with the increase in activity from the closure of the Yeovil hospital maternity unit. There were no particular safety concerns, but a Patient Safety Incidence Response Framework (PSIRF) approach was being used to analyse those incidents. The main cause for escalation was staffing but mutual aid had been provided from Somerset NHS Foundation Trust in the form of 13 midwives from the closed unit. In relation to the previously discussed action about maternity support worker sickness, JoH advised the wellbeing team were providing support, a weekly tea and cake round was provided, and regular advocacy sessions were offered through the professional midwifery advocates. A specific advocates group had been set up for Yeovil midwives. Additionally, evidence continued to be submitted internally to support the Maternity Incentive Scheme, and the full publication of the results of CQC inspection was awaited. DCS reflected on a recent walkaround he and RW undertook to the maternity unit, describing it as calm, and was pleased by the joint working with Yeovil in planning the additional work. EJ had undertaken two board safety walkarounds in the last month and was always pleased by how positive the maternity team are and how supported everyone reported feeling. This had also been relayed to her by Yeovil staff, and patients whose care had transferred from Yeovil. EJ drew to the Board's attention the growing demand for caesarean sections, both	

Baker, Abi
06/10/2025 12:40:16

	planned and emergency, the recruitment of a new anaesthetist consultant, and encouraged colleagues to visit the unit. MBr extended his thanks to leaders and colleagues in the maternity team for their continued work. The meeting heard that work was ongoing with Yeovil hospital and Somerset NHSFT around next steps for their maternity service and what that meant for DCH. The two trusts were working closely together in this regard and the position would be reassessed in August and aligned communications in September. MBr acknowledge that this might cause a level of uncertainty for Yeovil colleagues and that the trust needed to work to give the as much certainty as possible for staff and families affected. Further detail would be provided to the next Board meeting. CY left the meeting. MBI sought further assurance around the impact of the reduced early pregnancy assessment clinic (EPAC) service in July and August. JoH outlined that the reduced capacity related to staffing and that alternative options to the service were provided whilst the service was not available. There was a discussion around risk number 2183 relating to the impact on the obstetric workforce arising from the Yeovil maternity closure. JoH advised there was mutual aid from Yeovil to support this. AT further noted recruitment exercises to improve workforce stability.	
	Resolved: that the Maternity Safety Report be received for assurance.	
BoD25/118	Joint Food and Drink Strategy	
	JoH presented the first joint food and drink strategy of DCH and DHC, outlining plans for nutrition and hydration for patients and staff. Annual delivery plans would help the trusts to deliver all the aspirations to improve the nutritional value and quality of food and drink at the trusts, recognising the importance of nutrition and hydration in recovery and health. A joint nutrition and hydration steering group was proposed to support this work. FW suggested that consideration be given to explicitly detail the income generation that can be gained from food and drink and the links to social value. JoH would consider including this, although it might be better suited in the enabling plan. The board approved the strategy.	
	Resolved: that the Joint Food and Drink Strategy be received for approval.	
BoD25/119	Safeguarding Adults and Children Annual Report	
Baker, Abi 06/10/2025 12:40:16	JoH outlined that the report had been discussed at Quality Committee and Quality Governance Group prior to today. The annual report was a mandated requirement detailing safeguarding activity at the trust, and also detailed mental health act compliance, deprivation of liberty, and learning disability service activity. Good progress had been made in training and education and there were plans to jointly deliver, with DHC, level three safeguarding training.	

	The increasing level of work with DHC in a number of spheres was noted and commended. EJ suggested that it would be beneficial to have a development session on the safeguarding responsibilities of board members. The board discussed training compliance; it was known that some staff had difficulty doing the training due to workload, but executives were aware of the situation and was considered regularly through People and Culture Committee in Common. Work was taking place nationally and locally about what training was essential and added value.	JeH
	Resolved: that the Safeguarding Adults and Children Annual Report be received for assurance.	
BoD25/120	Infection Prevention and Management Annual Report	
	JoH outlined that: • The Infection Prevention and Management team over the last year had performed well over the last year with some of the lowest rates of some infections for the last three to five years. • There was a national and regional increase in Clostridium Difficile cases. • A good level of grip and control on infection prevention and management in the trust • Thanks were extended to the emergency department team who are often the first to identify risk at the front door and to estates colleagues who supported the work of the IPM team.	
	Resolved: that the Infection Prevention and Management Annual Report be received for assurance.	
BoD25/121	Finance and Performance Committee Assurance Report	
	DU a summary of the meeting held in July. Of note he highlighted: • Good discussions about a number of challenging issues in DCH and in the federation • Board Assurance Framework, including an increase in the score of SR5 Estates, as previously discussed • Receipt of the Financial Recovery Review paper which detailed the mechanisms in place and a proposal to improve financial recovery in the short, medium and long term. This would be discussed in detail in the confidential part of the Board meeting. • The level of risk for both Trusts in the scale of the cost improvement programme (CIP) • The compressed timelines for the development of the winter plans • Update on the Somerset hyper-acute stroke unit (HASU) tender exercise which had resulted in an unexpected reduction in cost • Approval of the radiology service transfer and national cost collection report EJ asked whether there had been any adverse impact on patients with dementia or elderly care patients given the changes on the Mary Anning ward. JoH advised that there was not any evidence of any impacts, and a	

Baker.Abi
06/10/2025 12:40:16

	quality impact assessment had been undertaken to mitigate any risks identified.	
	Resolved: that the Finance and Performance Committee Assurance Report be received for assurance.	
BoD25/122	Balanced Scorecard	
Baker, Abi 06/10/2025 12:40:16	AT outlined that the draft performance assessment framework (PAF) had been received, and the detail was being reviewed by the trust. The PAF required a smaller set of measures, and most were already included in the balanced scorecard; some additional measures would be retained where these were contractual or operational requirements. In relation to the balanced scorecard AT highlighted an increase in both elective and non-elective demand, but performance remaining strong. Weekly meetings were taking place with regional colleagues regarding performance and, positively, it had been agreed that the trust could be stood down in relation to urgent and emergency care (UEC) standards. The trust continued to monitor waiting list size, which continued to grow, particularly in cancer referrals. It was noted that the trust had raised that the waiting list would grow given that the trust was being asked to do less whilst demand increased. SP reflected on learning from a recent NHS Confederation meeting he attended regarding productivity and waiting list validation. AT confirmed that productivity measures demonstrated that the trust performed strongly in this regard, being the second most productive in the south west region. Validation work had been paused whilst the team supported with ophthalmology work, but this would now be stepped up again with monthly validation of 12 week waits. She further noted work to centralise the follow up waiting list (FOWL) and the induction of a referral assessment service utilising a digital service to productivity and efficiency further. An update on the work with clinical teams on the use of digital service to improve efficiencies would be returned to Finance and Performance Committee in Common in September. EJ reflected that the content of the balanced scorecard allowed Board members to consider whether the organisation was safe and welcomed the PAF which would allow focus on the right areas. She noted that it would be useful to have oversight of any significant staffing gaps and whether this was causing safety concerns. MBr requested that this be considered by NP and reported to People and Culture Committee in Common for a proposal on how to look at this systematically with triangulation to other committees. In relation to the productivity work, MBr noted that expectations were going to change and that this needed to be linked to the medium-term financial planning process. The waiting list size should also be strategically linked to this exercise to understand the waiting list position in 12 to 18 months' time. If the waiting list continued to increase other performance metrics would be able to be sustained at their current levels. Diagnostic waits also needed to be included in the next balanced scorecard.	NP

	MBr further asked Finance and Performance Committee in Common to make a statement about the trust's funded beds, how many unfunded beds were in use, and the expectations for future months. DCS reflected that it would be useful for the medium-term financial plan to be linked to activity and requested the CH provide a brief overview, approximately two pages, introducing the process for the Board and all the elements that needed to be considered. FW asked how the trust was funded for beds. MBr noted that the answer was complex, but that there was a difference between the number of beds funded and the number of beds that could be run if every escalation space was utilised. Whilst beds could be run with escalation arrangements there were implications for staffing and quality and therefore the financial and performance positions. The trust needed to understand clearly the cost of escalation beds and have timely discussions with the commissioner to outline the position being faced. EJ added that it would be useful to consider the above in terms of length of stay, and existing versus planned headroom. Responding to DCS, CH reflected on the changes in payment systems in the NHS, moving away from block contracts to payment by results and activity. It would therefore be even more important to focus on productivity to ensure that the trust was utilising all its assets appropriately. He further added that the medium-term financial plan would inform planning for the next three to five years. Planning work had started, and data was being populated, but formal guidance had not yet been issued. Finance and Performance Committee in Common would continue to oversee this process and would provide assurance to Board. There was nothing to note in relation to people or quality that had not already been discussed.	AT/CH CH
	Resolved: that the Balanced Scorecard be received for assurance.	
BoD25/123	Finance Report	
	CY returned to the meeting. CH provided context of the trust's submitted plan for the year, with a planned deficit of £9.8m, with a CIP of £29.1m (8.7% of turnover). The CIP was not scheduled equally across the year but was back weighted to the second half of the year, to allow for plans to be fully identified and implemented over the year. CH outlined the trust's financial position at month three, the end of quarter one: - Financial position broadly in line with the plan of a £2.3m deficit in month and a year-to-date deficit of £7.7m Key drivers of the position to date were: - CIP delivery of £2.7m against a plan of £3m in month three - Positively, agency spend £400,000 lower than planned, with further work to improve this with medical agency an area of key focus	

Baker.Abi
06/10/2025 12:40:16

Baker, Abi 06/10/2025 12:40:16	• Robust plans in place re WTE reduction of substantive staff, monitored through vacancy control panel process. • Increase in bank spend above planned levels, totalling £1m overspent year-to-date, in order to ensure safe and quality services. The drivers of this overspend were being investigated to ensure there were no gaps in control and to provide a full articulation of the reason for the spend • Costs associated with the closure of Yeovil maternity unit were being accurately tracked, with an agreement in principle regarding how the trust would be paid for additional activity With regards to the remainder of the year • £24.5m CIP had been planned, developed, or was in development, leaving an unidentified gap of £4.5m. Work continued to explore opportunities to bridge that gap. • £9m of the identified CIP related to WTE reduction target of 232 WTE. A further £11.6m was linked to the shared services programme. • A financial recovery board had been set up to offer robust weekly monitoring of WTE and financial targets for the year, allowing the trust to adjust and be agile to meet the targets. • A strong cash balance of £24.6m, due in part to the timing of payments, and the cash injection at the end of 2024/25 from the ICB. • Daily cash monitoring was in place. If the trust continued to spend on its current trajectory there was a risk of falling below acceptable cash levels by the end of Q3. This would continue to be monitored. There was no national cash borrowing process for any NHS organisations this year. Work was ongoing to get a principled agreement about cash borrowing within the system. • Capital was slightly ahead of plan. This was positive noting the challenging capital programme and the results of the six-facet survey. MBr reflected on the highly challenging financial environment and did not want colleagues to lose sensitivity to that challenge. For the trust to deliver the financial plan would be extremely difficult. Teams across the trust were engaged in the plan, with a strong focus on quality impact assessments, but the plan was nonetheless very challenging. The Board needed to remain focussed on the risks associated with the plan, including in relation to WTE reduction plans; 100 had been identified to date compared to the plan of 232. CH was in active discussion with the system about the £4.5m gap in CIP and how that might be managed in year. FW highlighted that the WTE reduction an impact on financial delivery would be an area of focus at September's People and Culture Committee in Common meeting. She noted that this was a difficult position as teams had worked had on recruitment and now needed to make WTE reductions. She questioned whether the required service transformation could keep pace with the WTE reduction and wondered if this was a driver of the increase in bank spend. SP reflected on the profit and loss reported, which appeared to be a truncated version of the report previously provided. CH would update the	

	report to include those additional areas were presented to Finance and Performance Committee in Common.	
	Resolved: that the Finance Report be received for assurance.	
BoD25/124	Operational Resilience and Capacity (Winter) Plan (incl. Board Assurance Statement)	
	AT outlined that due to the compressed timescales to produce the plan, a draft version of the plan was presented to Finance and Performance Committee in Common whilst the supporting vaccination plan and other elements, including the system plan, were finalised. The version presented today was the comprehensive plan for DCH with key information from the system plan. An assurance statement had been drafted and needed to be submitted by 30th September, which did not fit with the trust's meeting schedule. The intention was to circulate the full plan to Finance and Performance Committee in Common in September for approval. A system winter planning event was scheduled for tomorrow and which would allow for any gaps and mitigations to be understood, with region-wide testing of plans in September. The plan was presented to Board for endorsement and for authority to be delegated to Finance and Performance Committee in Common to approve the final version. Board colleagues should therefore seek any further assurances required. MBr commended the immense level of work to reach this point and highlighted that there was a statement that he was being asked to sign as CEO. The Board approved MBr and DCS to sign the winter plan assurance statement. It was noted that there was no financial support associated with winter planning as had been provided in previous years. The Board discussed the potential for further periods of industrial action, which was a possibility in the coming winter period. Should this happen, the trust would continue with the plan presented, noting that it would not be the first-time handling winter pressures and industrial action. However, it was not known if there would be funding support for industrial cation. The cumulative impact on waiting lists was noted, but teams were well versed in how to manage such action. The Board supported and endorsed the plan and agreed to delegate final approval of the plan to Finance and Performance Committee in Common on 24 September 2025.	
Baker, Abi 06/10/2025 12:40:16	Resolved: that: • the Operational Resilience and Capacity (Winter) Plan (incl. Board Assurance Statement) be endorsed by the Board • authority to approve the final plan be delegated to the 24 September 2025 Finance and Performance Committee in Common meeting • Approval be given to MBr and DCS to sign the assurance statement.	

BoD25/125	People and Culture Committee Assurance Report	
	FW noted that much of the topics discussed today were also discussed in some form in a number of committees, with a golden thread running through the reports. FW highlighted the following key points: • Review of the Board Assurance Framework and Corporate Risk Register, with a review in to the impact of WTE and the link to the delivery of the financial plan would be received by committee in September. The positive handling of maternity staffing with the additional work from Yeovil was noted. An update on digital staffing would also be received in the coming months. • Recommendation to board to approve Medical Appraisal and Revalidation Annual Report for DCH and DHC. • Positive feedback received re the running of the meeting, the maturity of the committee in common arrangement and of papers. Comments received re there being good and productive discussions.	
	Resolved: that the People and Culture Committee Assurance Report be received for assurance.	
BoD25/126	Medical Appraisal and Revalidation Annual Report	
	RW outlined that Lucy Knight (DHC Chief Medical Officer) was the overall Responsible Officer for DCH and DHC, but that RW acted as deputy on site Responsible Officer. It had been a positive year with 81 doctors revalidated, only two deferred and an appraisal rate of 97%. The Board approved the Medical Appraisal and Revalidation Annual Report.	
	Resolved: that the Medical Appraisal and Revalidation Annual Report be approved.	
BoD25/127	Strategy, Transformation and Partnership Committee Assurance Report	
	DCS highlighted the following key points from the July meeting: • The increasing focus on benefits of transformation as opposed to mechanisms alone • A presentation on the frailty service and their quality improvement projects. The activity undertaken had improved care, patient experience, and saved GP and District Nurse time. • Broad alignment of the joint strategy with the 10-year plan, although there were differences in delivery mechanisms; this may need to be an area of focus in future • Macmillan funding for integrated neighbourhood teams (INT) would start to be received from 1st August • Review of the social value plan, green strategy annual report and six-facets survey results • The trusts capacity and ability to accommodate new ways of working was improving. Whilst there was further work to do in this	

Baker, Abi
06/10/2025 12:40:16

	regard, it was well-developed and would support addressing the delivery gap of the 10-year plan.	
	Resolved: that the Strategy, Transformation and Partnership Committee Assurance Report be received for assurance.	
BoD25/128	Audit Committee Assurance Report	
	SP drew the Board's attention to the following key areas, a number of which had already been discussed today: • Increase in risk score for SR5 Estates on the Board Assurance Framework • Receipt of a review of services procured without a purchase order, which did not identify any unusual findings • Further assurance required about the Joint Transformation and Improvement Board (JTIB) meeting as the last three meetings had been cancelled • A new joint head of risk was being appointed with DHC, which would help focus on continuity and uniformity of risk reporting at both trusts • Receipt of the annual tender waiver report, with £2.4m service procured without more than one tender, three of which were over £100,000. The committee was satisfied with the reasons why and this would be further reviewed by KPMG in their end of year value for money audit. • Some amendments to the internal audit workplan • Improved counter fraud reporting from the new provider, SAFE. Handover from TiAA had been completed. Four fraud referrals had been received year-to-date, which was 70% of last year's total. This would continue to be monitored. • Improved freedom of information act compliance, with thanks extended to DHC colleagues for their role in this. ST reflected that the new service from SAFE felt like an improvement compared to the prior provider.	
	Resolved: that the Audit Committee Assurance Report be received for assurance.	
BoD25/129	Charitable Funds Committee Assurance Report	
Baker, Abi 06/10/2025 12:40:16	DU highlighted the following key points: • Receipt of £780,000 legacy donation, which was part of a larger donation totalling £835,000. The latter part of the donation was subject to discussion about when to withdraw from stocks and shares in the Australia market • Change to charitable funds reserve policies, with the target reserve now £273,000 reflecting the increased resources in the team to support the emergency department and critical care unit (ED/CrCU) appeal. • The ED/CrCU was just below the halfway mark with lots of community fundraising ongoing at present. The local sunflower trail was noted as a long-term supporter of the charity with funds from the trail going towards the appeal.	

	The Board discussed charitable funding for the trust, in light of the pressured financial position. DU outlined that the charity was able to support the trust and had recently amended the areas it was able to support and fund. £150,000 had been set aside for those purposes. Additionally, an innovation fund was being introduced which would support new capabilities, such as robotic surgery tools. It was recognised that this was short term support rather than recurrent decisions. DU clarified that of the £835,000 legacy fund, £500,000 had been diverted to the ED/CrCU appeal. JoH added that publicising the work for the trust often increased donations and generated funding. This should be maximised. NJ reflected on the growth of the charity over his tenure at the trust and commended Simon Pearson for his work building the charity up.	
	Resolved: that the Charitable Funds Committee Assurance Report be received for assurance.	
BoD25/130	Mental Health Legislation Committee Assurance Report	
Baker, Abi 06/10/2025 12:40:16	This was the first meeting of the Mental Health Legislation Committee in Common, and the first Mental Health Legislation Committee for DCH it having previously been a DHC specific committee. The committee was also now a sub-committee of the Board in its own right. JeH provided the below highlights: • This was the first committee in common, chaired by Andreas Haimbock-Tichy • There committee was not quorate from a DCH perspective with no DCH specific executives or NEDs present • The meeting was heavily DHC focused as expected, as DHC was a mental health trust and due to the time of year • The DCH mental health legislation dashboard would be reviewed in future meetings and JeH was working with JoH to ensure the right reports were presented from DCH DCS reflected that the terms of reference for the committee indicated DCH membership and so there should have been DCH members present. JeH added that members of the committee were now aware of the need to attend, and the terms of reference had been written such that quoracy did not rely on one single person attending. EJ reflected on the importance of the committee for DCH, with the growing demand from patients with mental health needs. She saw the committee as a huge support from DHC to DCH in the trust's mental health governance and suggested that if the quoracy of a meeting was in question due to NED availability then discussions could take place to find NED backfill at short notice. JeH added that committee memberships broadly would be reviewed in light of NJ leaving and would be shared with colleagues in the coming weeks.	
	Resolved: that the Mental Health Legislation Committee Assurance Report be received for assurance.	

	CONSENT SECTION	
	The following items were taken without discussion. No questions had been previously raised by Board members prior to the meeting.	
BoD25/131	Green Strategy Annual Report	
	Resolved: that the Green Strategy Annual Report be approved.	
BoD25/132	Social Value Action Plan and Progress Report	
	MBI sought further assurance around the reduction in third sector spending. Executives confirmed that the procurement team looked at social value in the round when awarding contracts and that the federation worked strategically with VCSE sector. However, CH confirmed that whilst part of the procurement framework did consider social value, there was not a specific element relating to VCSE due to certain procurement laws and regulations in awarding contracts.	
	Resolved: that the Social Value Action Plan and Progress Report be received for assurance.	
BoD25/133	National Cost Collection Exercise	
	Resolved: that the National Cost Collection Exercise be approved.	
BoD25/134	Questions from the Public	
	The below questions were received in advance of the meeting from MBy. NJ provided brief answers to the questions, which are detailed below. Q1: When will the Trust follow other trusts within the south west with the establishment of Electronic Health Records, is the treatment provided by the Trust uploading and accessible via the NHS App. <i>A: Our procurement for an EHR has commenced. Treatment provided by the Trust is not uploaded to the NHS App.</i> Q2: How may the mature Dorset Intelligence and insight service (DiiS) conceived by our own DCH Respiratory Consultants drive the prevention of health conditions in targeted communities before other conditions or events arise? This being an enabler to lead upon taking prevention into neighbourhoods, a key feature of the DHSC NHS 10-year plan. <i>A: One of our Respiratory Consultants has led in the use of population health data provided by DiiS but did not conceive of it. DiiS data is currently used effectively in many service developments and is integral to the development of neighbourhood services.</i> Q3: After supporting many research projects across academia in Wessex, why isn't the benefits of public con production ,a feature of continuous improvement, helping the introduction of digital services to achieve productivity improvements and improved patient safety .	

Baker,Abi
06/10/2025 12:40:16

Baker, Abi 06/10/2025 12:40:16	<i>A: Co-design and co-production sessions do take place with service users and patients. We would be happy to provide some examples.</i> Q4: Who is the Lead, who are the leaders, the visionaries within the executives team re Digital Transformation to deliver the Trusts ambition to be one of the leading health trusts in the south west and the newly reshaped ICB region ? <i>A: Beverley Bryant was appointed the Joint CDO for all three providers on 1st April - DCH, DHC and UHD - reflecting the importance of a joined-up digital approach across Dorset. Beverley brings significant expertise and experience from her time in provider, and national level roles. Beverley is currently recruiting a senior digital team to drive digital transformation. Although she will lead our efforts, digital transformation is everybody's job and our medical and operational leadership will play a significant role in transforming our ways of working enabled by the new technologies.</i> Q5: What part may the public play in informing, enabling success, innovation and implementation of digital transformation. <i>A: The public has an important role to play in many different ways. A Dorset Digital Strategy is currently in development which will reflect the importance of appropriate and proportionate public involvement.</i> JPL asked how the project management of the medium-term financial plan and the transformation team would manage the synergies and potential overlap, particularly in terms of innovation. MBr reflected on the purpose of the executive led financial recovery board, chaired by himself, which oversaw these elements. DD would be taking leadership of the transformation team with NJ's departure and would ensure that transformation and PMO for financial recovery were appropriately aligned and not duplicating. MBy reflected on and asked about the need to communicate and engage with the public about the changes and transformations being made in order to improve the knowledge and awareness of the public and further noted the importance of the digital agenda. MBr noted the importance of working with governors and having diversity of voices on the Council of Governors to help share the approach to communication. The Trust's strategy talked about empowered citizens and the need to have a partnership arrangement with citizens regarding health and to be mindful of health inequalities within that. The trust was ne part of the NHS system, so clarity about communications from other partners was also important. JM reflected on his role in the NHS as a member of the patient research champion group, his support of the south west medics service, and echoed MBy's view of the importance of engaging with the public to help share some of the burden felt by the NHS to share services and INTs. He asked whether the public could be involved in shaping the activity of the trust in order to deliver on the vision of the 10-year plan. DCS and MBr noted the importance of public engagement, with MBr describing that the trust was committed to coproduction and working with the population it served. NJ added that through the neighbourhood programme consideration was	

	being given to how to develop and coproduce a citizenship approach regarding engaging with the public. LT asked who was being moved in the WTE process. MBr advised that this was a deliberate and planned approach. AT added that natural turnover was being used to reduce WTE and to change the way we work as a consequence. LT further asked how many overseas visitors attended the trust and whether they paid for the services they received. Whilst she did not have specific figures to hand, AT confirmed the trust did follow up with insurers for any foreign nationals presenting to the emergency department. This detail would be provided outside of the meeting.	AT
BoD25/135	Any Other Business	
	Nil raised.	
BoD25/136	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 7th October 2025 in the Training room 1&2, Sentinel House, Poole and via MS Teams .	
BoD25/137	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.	

Baker, Abi
06/10/2025 12:40:16

**Minutes of a meeting of the Part 1 Board of Directors
of Dorset HealthCare University NHS Foundation Trust
held on 13 August 2025 from 10:00, Training Room 1&2 at Sentinel House, Poole
and
via Microsoft Teams**

Present:		
David Clayton-Smith	DCS	Joint Trust Chair (Chair)
Matthew Bryant	MBR	Joint Chief Executive Officer
Frances West	FW	Non-Executive Director Joint
Jenny Horrabin	JeH	Joint Executive Director of Corporate Affairs
Lucy Knight	LK	Chief Medical Officer
Chris Hearn	CH	Joint Chief Finance Officer
Nick Johnson	NJ	Joint Chief Strategy, Transformation and Partnership Officer
Rachel Small	RS	Chief Operating Officer
Eiri Jones	EJ	Non-Executive Director Joint
Dave Underwood	DU	Non-Executive Director Joint (via videoconference)
Dawn Dawson	DD	Joint Chief Nursing Officer
Andreas Haimböck-Tichy	AHT	Non-Executive Director (via videoconference)
Suresh Ariaratnam	SA	Non-Executive Director
Steve Peacock	SP	Non-Executive Director (via videoconference)
In Attendance:		
Mandy Ford	MF	Joint Deputy Director of Corporate Affairs (Minutes)
Jim Bailey	JB	Corporate Governance Manager (via videoconference)
Ryan Setchell	RSe	Corporate Governance Officer (via videoconference)
Catherine Granville	CG	Service Director People & Culture (Deputy Chief People Officer on behalf of Nicola Plumb)
Becky Aldridge	BA	Chief Executive, Dorset Mental Health Forum (via videoconference)
Tim Howard	TH	Governor (via videoconference)
Apologies:		
Nicola Plumb	NP	Joint Chief People Officer
Claire Lehman	CL	Non-Executive Director Joint

BoD25/088	Patient Story	Action
Baker, Abi 06/10/2025 12:40:16	The Board received the patient story via a video link introduced by DD.	
	The patient story related to a patient's experience with the Dermatology service. It centred around the waiting times to access the service from referral, and the lack of information provided, which led to a lack of confidence with the service.	
	Service Lead advised that there are improvements that the team are working on. The dermatology team agreed they could do more about advising patients regarding waiting times if patients are concerned. They are also developing a new website to look at how we provide more information regarding where patients could be directed. We have committed to work with the patient to review the letters, and to have an open partnership with patients, to be open about waiting times and offer support. We agreed to look at the service as a whole and look to give the best services to patient with the resource that we have available. We will	



	pick up the communication issues and look at other areas where we have long waits, to make sure people were supported properly and were kept informed. The patient did reflect that if the patients were seen, or Artificial Intelligence (AI) was used, they may not need to be seen again after the first consultation. If patients were triaged in primary care, the hospital could then concentrate on seeing those patients that needed to be seen. Patient did advise he had been referred to the service again in November 2024 and again had heard nothing since. However, his wife had been referred to dermatology had a different experience and had been seen quickly. FW stated that it resonated with her that patients are going to appointments that they may not necessarily need, because they are worried about how long it will take to get back into the system if they do not. DU added that how we are communicating with patients was causing uncertainty. We needed to think about the process before implementing anything as a technical solution. SP thanked colleagues for sharing a story where we have not got things right, it felt like time mattered for the patient and that SP had reflected on the visible and invisible quality of care. EJ noted that we provide a service, and it is how we support staff to provide good 'customer care' and this was evident in the Dash report, experience is important. It is an area that we should focus on. ACTION: RS to provide an update on waiting lists and the development of correspondence at the next Board.	RS
	Resolved: that the Patient Story be heard and noted.	
BoD25/089	Meeting open	
	The Chair welcomed members to the meeting. DCS highlighted that this was NJ's last Board meeting with DHC as he would be leaving the Trust at the end of the month to become Managing Director at Salisbury NHS Foundation Trust. DCS thanked NJ for his work over the years at DCH, in his many roles, including acting as CEO at Dorset County Hospital NHS Foundation Trust (DHC) for a period.	
BoD25/090	Apologies	
	Apologies were received from Nicola Plumb, Joint Chief People Officer (Catherine Granville in attendance) and Claire Lehman, Joint Non-Executive Director.	
BoD25/091	Conflicts of interest	
	It was confirmed that there were no declarations of interest relating to the items for consideration at the meeting. The register of interest included in the paper was highlighted; EJ noted that she was the Interim Chair of Salisbury NHS Foundation Trust from 1st July	

Baker, Abi
06/10/2025 12:40:16

	2025. FW and SP's, DU's interest also needed to be amended. However it was confirmed that there were no conflicts related to agenda items today.	
BoD25/092	Minutes of the Meeting held on 11 June 2025	
	The minutes of the meeting dated 11 June 2025 were agreed as an accurate record.	
BoD25/093	Matters Arising: Action Log	
	<u>Action 52</u> - noted this action dated back to August 2024. The Digital Strategy will be prepared for November, which will include the fully costed and deliverable plan to the end of March 2026. Regular updates are provided via the Strategy Transformation and Partnership Committee (STP). Proposal to review the action in November when we have the digital strategy to review to ensure it addresses what we are expecting it to address. SP said he was surprised that that action had not been started, and we had to commit to no more delays. AHT added that if the strategy had not yet been started aiming for November would be ambitious. EJ agreed with that comment. MBr advised that part of the reason it had not progressed was due to the senior digital leadership being focussed on the EHR business case. We know what the landscape is, and we have put it against the capital envelope that we have available. Beverley Bryant (BB), Joint Chief Digital Officer, is in the process of putting her senior team in place. NJ confirmed that this had been discussed at STP, and the strategy was in development and had been co-produced across the system. We do know what systems we have and what is in the pipeline. However, the genuine analysis of the risks and opportunities will take time to complete. JeH noted that a report on the strategy had gone to STP in May 2025. FW advised that BB had offered to come and speak to the PCC about the availability of resources, which is demonstrating the more matrix working now in place. ACTION: JeH to circulate the paper on the development of the Digital Strategy that had been presented to the May STP Committee to Board Members. <u>Action 63</u> – not yet due. This has been moved to December as that is when the next FTSU report is scheduled. <u>Action 67</u>- This action related to an internal audit review of system governance. It had been escalated to DCS and MBr to meet with SP to agree required steps. DCS advised that the ICB were currently undergoing a reorganisation. Action to remain open. <u>Action 68</u> – Terms of reference for MHALAC had been circulated – Agreed to be closed	JeH

Baker, Abi
06/10/2025 12:40:16

	Two additional actions had been referred to other Committees, both of which had been completed. Actions to be closed. The Business Calendar had been shared for information. SP added that it was very helpful to see it laid out in that format and suggested asking the Staff Networks to present when a staff story was considered. DD advised that the stories are prepared in advance so this may not come through for a little while. DD noted that there was a broader point around how we increase the time that the Board can spend with those staff network chairs. Noted Staff Network conference coming up, being held in Swanage, on 5 September, which would be a fantastic opportunity for the Board to spend some time with those groups. ACTION: Invite to event to be shared with Board members.	JeH / Jan Wagner
	Resolved: that the action log be received, updates noted, and approval be given for the removal of completed actions.	
BoD25/094	Chair's Comments	
	The board received a verbal update which included the following highlights: • The Trust was compliant with the Fit and Proper person test (FPPT) submissions which have all been completed. • NED appraisals are nearly all completed. • Visits to services including: • Children's Hospice, Julia's House • Herm ward with the Bournemouth Symphony Orchestra • Several Quality Walkarounds • Working with the system partners. There has been a considerable focus on finances across the system. • Working with local authority colleagues in Bournemouth Christchurch and Poole and Dorset County Council.	
	Resolved: that the Chair's Update be received for information.	
BoD25/095	CEO Report	
	MBr took the report as read but highlighted the following issues: • The 10-year plan has been published and is significant for the Board. There is a focus on out of hospital care and integration, so there is a high degree of alignment between our own strategy and the plan. • Focus on neighbourhood care, with invitations to bid to be neighbourhood health pilots. Two bids had been submitted, one for BCP and one for Dorset County local authority areas. • Public finances remain constrained and there will be challenges with the technological revolution of health care and how it is delivered with more use of AI. The national agenda will develop as it moves from the plan into delivery. • Penny Dash report detailed the approach to quality within the NHS, and we welcome that focus. • At a national level, we are anticipating industrial action. The impact for DHC is lower than the impact at DCH and UHD, but it does have impact	

Baker, Abi
06/10/2025 12:40:16

	locally across the three providers. MBr passed on his thanks to all involved in the planning for that period. • ICB cluster arrangements are being described. This will be significant for us and the way we are working in Dorset. We will be working across Dorset, Somerset, and Wiltshire. This will require us to reflect on our partnerships with our providers, and it is important that we reach out to the provider organisations within that cluster. • EHR has received Cabinet Office approval and the case for Community and Mental Health Services is progressing too. • CQC remain active and visiting our services. A second positive report was received for Glendinning. • Update provided on the proposal to create an NHS Shared service (Estate and facilities, procurement, and sterile services), recognising the strength of feeling around this. There remain concerns about terms and conditions, and NHS pension, which we have been clear from the start will be retained for staff and any new staff joining the organisation. It is very much a wholly owned NHS company. Following a formal dispute being lodged by Unison, work had been paused from July to the start of August. A process for hearing that dispute has been agreed. It is hoped this will take place by the first week in September. This work and engagement were now recommencing. MBr reiterated that this was still a proposal at this stage, and it will need to come back to a future Board to move from a proposal. FW noted that EHR was primarily a project that delivered funding for Somerset and Dorset County, this position had since changed, and FW asked for clarification. NJ advised that the business case for Somerset and the acute trusts within Dorset was approved by the Cabinet Office. Dorset Healthcare was moved out of scope of that original business case because of funding restraints. The original case has now commenced the procurement phase. In parallel there was an opportunity to secure additional funding for Dorset HealthCare of £10m, so we have developed a business case for that which is now with the national teams for approval. The intention is as and when we secure that approval it is to dovetail Dorset HealthCare back into the procurement process.	
	Resolved: that the CEO's Update be received for information.	
BoD25/096	Board Assurance Framework (BAF)	
Baker, Abi 06/10/2025 12:40:16	JeH provided an update on the BAF and reported that all Committees had reviewed their BAF, with the full BAF being presented at Audit Committee. There were no changes reported to the highest scoring risks which were SR3 Workforce, SR6 Finance, and SR9 Digital, which is consistent with the discussions throughout Committees and Board. There are 10 overdue actions across the 10 risks, 5 of which relate to SR9 and SR10 Cybersecurity. SP commented that the BAF was well received and that committees were finding it easier to work with and there is greater connectivity. The next stage would be to complete the risk appetite survey, which has gone out.	

	It was noted that there would be a Board workshop on this in September. SP also noted the number of overdue actions and that we need to maintain focus, particularly if some are repeatedly overdue. There are significant overlaps between workforce, finance, quality and digital, so at some point it would be good to spend some time looking at those interdependencies. JeH explained that the actions had increased from 5 to 10 outstanding, as the SR9 risks had been discussed at Finance and Performance Committee (FPC) and a decision was taken to move the actions to behind schedule rather than to plan where dates had been amended, which moved us from 5 to 10 actions outstanding. DU advised that under FPC and STP there had also been discussions about SR9 and SR10. DU felt that the mitigated score of 9 did not reflect the infrastructure. DU asked that SR10 be reviewed at the Q2 review to ascertain whether the mitigated score was as good as stated. EJ provided assurance that the Committees she sat on did consider where else the risks would impact. In terms of SR7 Collaboration, EJ asked if we should be more reflective of the changes within NHSE and the ICB as they move to cluster arrangements alongside Somerset and noted that we would be a key player in terms of community and mental health services. We must focus our ability to influence within the system space and focus on what is being commissioned. It was also noted that there would be movement in the BAF the following quarter. FW added that the network of interdependence between Committees has become apparent, and they are informing workstreams. FW gave the example of People and Culture Committee (PCC) where there were undertaking a review of the Whole Time Equivalent reduction, which is linked to the financial plan. MBr noted that we are getting to a place where the BAF is an important strategic document that helps to guide and focus Committee discussions, and that is real progress from a year ago. It was noted that after the Board Workshop on Risk Appetite, it may be beneficial to ask Lead Executives to look at their assigned risks and consider if we are in the right place and whether we have anything missing. AHT queried the digital risks and asked if it would be better to have one place where this had oversight. JeH confirmed that this was STP but that there would be cross over to FPC, particularly where financial values in terms of the strategic piece were being agreed. AHT felt that this should be prominent on the agenda, as the focus had been on transformation.	
	Resolved: that the Board Assurance Framework be received for information.	
BOD25/097	Corporate Risk Register	
	DD advised that the data in the report was extracted on 26 July 2025 and reminded the Board that register was dynamic, live, and reviewed daily, so there would have been movement since the report was produced.	

Baker, Abi 06/10/2025 12:40:16	At time the data was extracted, there were 11 risks that were scoring 15 or above, which were detailed within the report. One risk in relation to hydrotherapy provision had increased, and there were three risks where the score had reduced. DD noted that there had been significant work within DHC around overdue risks and thanked executive colleagues for supporting this work within their committees. As at time of the Board, only 4 risks remained overdue, and some had recently been updated. DD updated on changes within the risk function: • Currently in procurement stages for the new risk management system or software. We currently have a different system in each organisation, and we want to move to the same one across Dorset. This should assist with how we manage and oversee risks across the Federation. • We are in the process of recruiting a joint Head of Risk so we can bring the same reports and use the same reporting mechanisms. • An audit will be undertaken on some of the risks that have been on the system for an extended period. That is being undertaken across both organisations, and a report will be provided in due course. SP said it was encouraging to see the move to improve consistency across both trusts, which would help the Audit Committees moving forward. It would be helpful to the Board to understand the strategic oversight that the executive and others input into the risk. At the moment all Committees see is a lengthy list of different risks, and there are some themes coming through. We should understand those themes and trends over time. For example, there was a theme in IT, a theme around maintenance, and a general staffing theme. The more we can start to explain and talk about themes rather than individual risks, it will assist us in having strategic conversations. DD advised that those discussions happen within the individual committees, but we need to be more explicit within the report to Board around the conversations. SP agreed that would be helpful for the Audit Committee as they are trying to give assurance around the risk management framework and the oversight, so getting that visibility would be good. CH advised that in terms of the Estates risk we were currently undertaking a 6-facet survey to understand the critical infrastructure risk across the estate, which will be fed into the risks when we receive the report. EJ reflected that at DCH Board, the Board heard a patient's story in relation to hydrotherapy, and we have an increased risk at DHC where there has been a commissioning decision to pause the service for the people under the care of DHC. EJ suggested we could use the patient stories and the risks to guide system discussions. EJ added that the ICB have established a new Quality and Commissioning Group, where she will be representing the Trust and advised that she will write to the Chair of the Group to ask about Equality Impact Assessments (EIAs) and request that they are included within the Committee structure using the hydrotherapy as an example. It was acknowledged that this was outside of the normal escalation, but it is an ideal opportunity with a NED	

	Committee being established to review quality and commissioning decisions that it would be an appropriate action, noting the long-term adverse impact this could have on patients, it is significant. DCS agreed that commissioning should be collaborative. RS informed the Board that this decision was made by the ICB under personalised commissioning, which is a different issue to the provision of hydrotherapy in general. RS advised she had escalated this to her counterpart at the ICB around the Quality Impact Assessment (QIA) on changes for Continuing Health Care (CHC) commissioning, which includes the impact on learning disability patients. MBr summarised that it had been a helpful conversation, and we needed to, in terms of governance, do the right this for our population, to ensure the risk is recognised in the right place and the system is the place that can take the action.	
	Resolved: that the Corporate Risk Register be received for information.	
BoD25/098	Quality Committee Assurance Report	
	EJ presented the assurance report and highlighted: General: • 10- year plan had two key implications for the Committee with an increased focus on the patient's voice and enhanced transparency an openness around quality metrics, including league tables • Penny Dash report. DHC: • Reflected on the BAF and the Corporate Risk Register, noting movements and actions taken. • LK was now the senior responsible officer for Integrated Neighbourhood teams (INTs) at DHC. • Discussions around a restraint on Children and Young People (CYP) • Intermediate care had undergone an external peer review noting an over reliance on bank medical staff. It was noted that the clinical governance arrangements in the service were good, and lessons will be shared wider across other services. • Strong assurance around regulatory compliance • Some challenges in arranging quality walkarounds • Approval of the Joint Nutrition Strategy.	
	Resolved: that the Quality Committee Assurance Report be received for assurance.	
BoD25/099	Joint Food and Drink Strategy	
	DD advised the strategy had been via QC and DCH Board. It had been developed to meet national standards. A wide range of engagement had taken place in its development. A request from DCH Board was that we considered explicitly detailing the income generation that can be gained from food and drink and the links to social value, and sustainability.	

	JeH noted that we were required to have a named lead, which would be DD. AHT queried if we had a baseline we are working from to demonstrate the impact the strategy has had. DD responded that we have annual PLACE surveys undertaken in addition to the staff survey. We have baseline data for each organisation that we would be looking to improve. CG noted that the staff side representatives had raised concerns about Shared Services, as this was one of the services that would move over. CG asked how we would ensure that the strategy was maintained within the Shared Services organisation. CH responded that there is joint leadership across both organisations, who were consistently reviewing how the catering provision is delivered for staff and patients. This has already been factored into discussions. If the proposal progresses around the shared services company, it enables us to deliver this strategy, and we are confident that food, nutrition, and hydration are fundamental to well-being, so it is something we must provide well to our patients and to our staff. We would like to see what opportunities there are for hotel services to really improve. We have not scored well in this area on the Mental Health National survey. Board approved the strategy.	
	Resolved: that the Joint Food and Drink Strategy be received for Approval.	
BoD25/100	Safeguarding Adults and Children Annual Report	
	DD presented the Annual Report. and noted that it provides assurance that we are achieving all our statutory requirements to safeguard and protect child and adults at risk of harm. This has been considered via the required governance routes before being presented to Board. EJ confirmed this had been via QC and that it was important that staff had the time to undertake and complete the training. SP asked if the Board needed sight of the annual child death report. LK advised that it comes through as part of the Learning from Deaths Report and added that she was working to improve the quality and the content of the information that comes alongside the child deaths, as often we are just given numbers. SP agreed it would be good to show the learning.	
	Resolved: that the Safeguarding Adults and Children Annual Report be received for Assurance.	
BoD25/101	Infection Prevention and Control Annual Report.	
	DD presented the mandated annual report.	

	EJ noted the importance of the mandatory training and how we manage and learn from IPC incidents. CG asked if we were seeing an improvement year on year. DD replied we were but not in all areas. We had a theme of E coli infections, which were often related to indwelling catheters where people got UTIs. There is a piece of work ongoing to look at this. Part of this would be making sure people drink well, which would tie in with the nutrition and hydration strategy and having a drinks menu to offer patients. DU raised a question about the introduction of tiered training and asked what the timeline was for that. DD agreed to respond directly to DU. ACTION: DD to respond to DU around the timeline for tiered training	DD
	Resolved: that the Infection Prevention and Control Annual report be received for Assurance.	
BoD25/102	Finance and Performance Committee Assurance Report	
	DU presented the report and highlighted: • The Committee received a presentation on the financial recovery review report. The report was well received and commended by the Committee; however, they recognise that there is a significant risk in delivery of our financial plans across both Trusts. Whilst the plans are robust, they are incredibly demanding. • The Committee was pleased to hear about the improvements made in the early intervention and psychosis service, and the out of area placement reductions. • The Committee received the winter plan for the first time; these had previously been reviewed at a more tactical level. He acknowledged the work that had gone into producing this within a short timeframe due to compressed timelines. • Corporate risk register was reviewed and noted the work that needs to continue to ensure updates and mitigations are timely to ensure the appropriate management of risks identified at a strategic level. • Performance framework has been published and is being reviewed by both Trusts to make sure we have the appropriate performance assessments in place and consider how that is reported through to Board to ensure we meet the needs of the new framework. • Health and safety compliance report was received, with no areas of concern raised. • The Committee approved the radiological service transfer and agreement to increase the updated cost plan in regard to the Nuffield Road site. This was because we did not have full access to the site prior to procurement and we have since discovered several significant works that need to be undertaken. EJ asked if the increase would have an impact on any savings made by relocating. CH advised that, through our governance processes, we have been able to reallocate some funding via capital and external funding,	

Baker.Abi
06/10/2025 12:40:16

	there is a slight increase in the payback period, but medium to longer term there will be savings.	
	Resolved: that the Finance and Performance Committee Assurance Report be received for assurance.	
BoD25/103	Integrated Corporate Dashboard	
	CH introduced the report which encompassed quality and operational performance for the first quarter of the year. DD highlighted the following from a quality perspective: • 95.4% compliance with Pressure T, which is the pressure ulcer assessment. This is the ninth month that we have been over the thresholds, which is something to celebrate. • Seclusion in adults has been below the mean for seven months, and supine restraints, occlusion, and rapid tranquilisation for under 18s have also remained below thresholds for the last few months. • Nothing of concern to highlight. CG highlighted the following from a people perspective: • Mandatory training compliance is slightly up at 93.5%. • Patient safety compliance is up to 95.9%. • Oliver McGowan part 1 training is at 96.4%. • Estates and Faculties compliance is at 76.8% which is also positive as generally this is always a bit lower. • Internal review of mandatory training was taking place, but we were awaiting the national framework of mandatory training provision, noting how much staff time is taken up completing mandatory training, some of which may not be relevant to their role. • Soft launch of new appraisal process in August, with the full launch happening in September. Current figures are sitting at 85.2% overall. Estates and Facilities are at 61.4% which is positive. • Turnover is static, and vacancies ate slightly up. Sickness rates were also static for the third month. EJ asked if we had to wait for the national mandatory framework review before we did anything locally. CG advised that the national review was coming, which will rationalise some of the content around what is mandatory training and what is statutory training. We have been encouraged to look at this locally and look at what we think is relevant mandatory training for job roles. For example, de-escalation training is delivered to all staff, even support staff, and is that really required. IPC may be another example, do staff that work from home or are always in an office need that training. EJ added that the 85% appraisal rate, meant that 15% were not receiving one, and what was the appetite for improvement in this area. CG responded that we always aim for 95%, but we have to account for people that may be on long term sick, or maternity leave that will not have had an appraisal. We are not outliers in this area, and we are still above the national average.	

Baker, Abi
06/10/2025 12:40:16

	MBr added that we are also having an ongoing look at the quality of the appraisal conversation to ensure that it is meaningful, and asked that PCC look at the issue of the threshold, as if we are saying that 95% for appraisals in the threshold, but we are coming in at 85%, whether we should be worried. We would expect the figures to be higher for the doctors and nurses as it is part of their registration and revalidation processes, so it was queried as to whether the numbers were skewed due to that. ACTION: PCC to consider appraisal thresholds. RS presented the performance data and highlighted: • Discussion at previous Board around the recording of ethnicity data, this has improved and is at 91.7%. There was a dataflow issue, and we were under reporting. There is still further work to do in this area. • Plan to have zero out of area placements by the end of August. We are currently down to two. • The community mental health indicator, which has been an important metric over the previous year around the access or being transformation, is no longer measured nationally. We will not be contractually held to that, but we are still working to improve our access. • CYP is the area of most national attention, and we are not where we would like to be in this area. We have had the business case approved for investment, but we are now working through a mobilisation plan. • Maintained good performance of virtual wards. • No 52-week breaches within the community waiting lists. We do not have the same lens that the acute services do, because they do not operate on referrals. We do have quite a varied picture across the community provision around waiting times. We have not had a clear sense of the demand capacity modelling to inform the commissioning. We are picking this up throughout commissioning contractor services with the ICB. We are concerned about the growing waits across both community services, and some of our associated bed services. FPC were asked to consider the metrics that should be reported to Board around the community services waiting times. ACTION: Discussion at FPC regarding information to be provided to Board around community Service waits. JeH noted the good progress around the recording of ethnicity data and queried whether the national threshold was 100% which felt impossible to achieve. RS agreed to check.	NP/FW
	Resolved: that the Integrated Corporate Dashboard be received for assurance.	RS/DU
BoD25/104	Finance Report	

Baker, Abi 06/10/2025 12:40:16	CH presented the report and the position as at month 3 (end of quarter 1). CH reminded the Board that from a plan perspective, the Trust has a surplus value of £9.8 m based on an efficiency target of about 8.7%, which equated to £38.5m efficiency, which was significant. FPC had received a detailed analysis of the independent review performed by David Moon and Mark Mansfield around that plan. This would be discussed further in Part 2. At the time the plan was signed off, we did not have a fully identified efficiency programme, recognising the scale of the timeframe associated with that and so a sizeable proportion of the efficiency was based within the second half of the year. In terms of performance in the first quarter: • Year to date, there is a deficit of £1.44 m, which is broadly in line with the plan. • Agency use has reduced, however, expenditure on temporary staffing increased by £323k. It is an area that is being reviewed. • Financial Recovery Board has been established. • Out of Area placements - we are seeing a good trajectory in terms of reduction. We have 10 block booked beds, which enables us to ensure we have value for money. At the end of quarter 1, we had seven patients in non blocked beds. RS reported that stood at 2 as at today. We are continuing to see a downward trend over time, which is positive. • Efficiency delivery is slightly ahead of plan at this point in the year. We need to maintain focus in this area to ensure that those areas where we have identified efficiencies can be fully implemented. • Areas where we have unidentified efficiencies continue to be explored. • There is currently in the region on £9.6m risk to that overall efficiency that is largely linked to the transformational element of the plan. We need to determine how we mitigate this. • £4.2m is linked to the NHS Shared Services, so if that is not delivered within year, we will need to find that additional amount from elsewhere. • We are currently slightly ahead with the cash position. • We are slightly behind plan from the capital perspective; however, it is likely that we will catch up with this throughout the course of the year. • Some key elements of expenditure in the year are investing capital in the maintenance back log and digital. • We are in receipt of a significant amount of external funding primarily around our new hospitals programme, and some related to environmental sustainability and we are looking at solar panel installation where appropriate across the estate. • We are also in receipt of funding associated with the critical infrastructure risk, and we were successful in bidding for elements of that funding. SP asked about the agency spend and whether we needed to review the controls in place, and the £9.8m risks around the transformational activity,	

Baker, Abi 06/10/2025 12:40:16	and whether we needed to undertake some scenario modelling about what that looks like, noting that some elements were outside of our control. FW added that PCC have the WTE review, linked to the financial plan, going to the September meeting, and looking at how they dovetail in with transformation, and the speed at which that happens, that could then impact on the temporary staffing spend. AHT questioned our confidence in the recovery plan and what outcome we are expecting. CH responded that that we are seeing a positive trend in terms of agency spend. There was a huge focus on agency spend and we have seen that decline and we are demonstrating value for money in that space. We are seeing an increase in bank expenditure, which is a cost-effective way of filling gaps as generally they are on agenda for change conditions. This is a key area of focus through the internal Financial Recovery Board to ensure that we have the relevant controls in place, and that we are only using bank to ensure quality and safety. We are currently seeing a high use of bank within Estates and Facilities. Medical agency has always been an area of challenge, and we have plans in place on how we address this. LK advised that we do not use bank staff in medical staffing, it is resolved by recruitment. We have an international medical recruitment programme underway and on track. We are expected to be fully recruited within the next 12 months. At the same time, we are implementing a reduction in the rates that we pay on agency locums, and we are fully committed to that. We have improved our year end forecast by around £600k for medical overspend. LK is intending to further reduce this over the next few months. MBr referred to some more up to date information reviewed that morning that detailed agency spend between months 1 and 4 as £265k less than those 4 months in the previous financial year. Medical, was around £85k higher than we were for the same period in the previous year, but if the run rate is reviewed, this is coming down, which reflects the actions LK had described. CH addressed FW's comments and advised that we need to look at spend in totality. What we have seen is a significant focus on agency which has lowered. There is now a focus on substantive staff, and we have a very robust vacancy review panel to facilitate this. Third element is bank expenditure, which we are seeing increase. We have ensured that we have the relevant controls in place, but ultimately the fundamental part is ensuring that we have the right staffing levels in place at any time to deliver a safe service. CH responded to AHT's question about the sustainability of the savings from the out of area placements. From a financial perspective, the reduction of out of area placements is a positive. We had forecast the year end position with a level of out of area usage above our block contract. We are now getting below this, which gives us room in case we do need to use additional beds. This will not deteriorate the Trust forecast position, however in terms of the wider question as to whether this could be	

	sustained, there is always a risk that we have to place someone out of area due to bed flow. We will see some fluctuations at various points. We have 10 additional out of area beds, block booked, that are constantly in use. Once we get to zero usage, we will need to sustain that position. We will have a large degree of capacity coming online through the new hospital programme over the next few years, which will give us a longer-term sustainability perspective. Reducing out of area usage has more than just a financial implication, it also impacts on patients and their families. In regard to the £9.8m risk, there will be a more detailed conversation in Part 2, but ultimately that figure has been validated by the independent review, in terms of what they perceive to be an unidentified risk. Therefore, this is a material risk for delivery this year. On the 8.7% CIP we have effectively allocated 5% within services' budgets recognising this would be the third year of that level of target. We are committed to achieving that in year. That leaves a residual 3.7% that needs to be delivered by transformation across the system. Conversations with the system are taking place. SP queried whether this should be a topic that goes through FPC to get through the detail, and whether there should be triangulation of hotspots where agency/bank use is high. DD advised this already takes place, and she was well sited on the areas of high usage and the rationale for this use. There is a safer staffing group that meets monthly that has representatives from the Nursing and Quality Team, the People Directorate, and the operational directorates so that information can be triangulated. The safer staffing reports come up via the quality governance routes, where the heat maps are reviewed.	
	Resolved: that the Finance Report be received for Assurance.	
BoD25/105	Seasonal Surge (Winter) Plan	
Baker, Abi 06/10/2025 12:40:16	RS presented the winter plan, which is our tactical plan. We have mapped that against the new Urgent and Emergency care (UEC) guidance which details the 'must do' areas for community mental health trusts around winter planning and then detailed some other areas we would expect to consider as part of surge planning. Within the pack, RS had also included the Standard Operating Procedures (SOPs) because there are somethings that are routine and repeat throughout the winter, which are not tactical, but they have been provided so the Board has full sight, noting this was more information that the Board required. This will be refined moving forward. This is a new process for DHC, and it is also significant earlier than usual. It was noted that there is no additional funding for winter surge planning this year which in itself does not necessarily increase the risk of the winter plan as in previous years as a community Trust we have struggled to utilise available funds because of the nature of the workforce that we employ and difficulties getting short term workforce for surge periods.	

	The plan had been via FPC and QC already to look at the resilience and equality issues and no issues were raised. The only thing to note is the requirement around staff vaccinations, based on response rate last year. We are putting in place additional measures to do all we can to increase vaccination uptake this year, recognising the role that plays. DU commented that he was impressed by what had been achieved in three weeks to produce the plans and noted that the issue of no additional funding being available would be more of a significant issue for acute services. MBr asked whether the papers included the Chair and CEO declaration. They did not and RS advised that these need to be submitted post Board. The QIA and EQIA needed to go via Panel to agree, and there was a request to share this with Board members as DCS and MBr would be signing on behalf of the Board. RS advised that we had complied the best we could at this stage, and identified the gaps, but that the template included some standards that are acute only. JeH explained that we will have a parallel process. At DCH we did receive the Board Assurance Template, which was delegated down to FPC to review due to timings and deadlines at the end of September, when we do not have a Board. We will circulate it to Board members for any comments, and we will take the final version through FPC in the same way. ACTION: Declarations (QIA, EQIA) related to Seasonal (Winter) Surge Plans to be circulated to the Board members.	JeH
	Resolved: that the Seasonal Surge (Winter) Plan be received for Approval.	
BoD25/106	People and Culture Committee Assurance Report	
	FW presented the report and highlighted: • The Committee was established and up and running well as a CiC. • People Plan is in place, and we have the delivery framework with accountable timeframes sat behind that. • Review of the assigned BAF risks • Deep dive of the WTE reduction is coming to September meeting. • resourcing and the implication around the people agenda. • Committee discussed the WTE reduction v bank usage implications. • Apprenticeship update for DHC was provided and was a well-received document and linked in with the social value work. It is a good mechanism for delivery in terms of developing people's careers and putting good markers out into the community.	
	Resolved: that the People and Culture Committee Assurance Report be received for assurance.	
BoD25/107	Medical Appraisal and Revalidation Annual Report	

	LK reported that 93.3% of DHC doctors had an appraisal, where appraisals did not take place rationale was provided. There are no doctors that are not engaging with the appraisal process which is a positive. We have adequate appraisal capacity and all actions recommended during the Responsible Officer visit last year have been completed. There were several 'should do's' and all of those had been completed. These actions see the two appraisal and revalidation offices (DCH and DHC) coming together to begin to align training and then approaches, and all the policies and processes. JeH advised that there were two elements that the Board were required to approve. The first was the annual report, and the second was a statement of compliance that must go to NHSE that was not included in the papers that went to PCC or within the Board pack, so the Board can only receive it for assurance today. The document will need to go to September PCC and then October Board to complete the process to approve the statement. We will clarify if the statement can be completed by the Responsible Officer (RO) on behalf of the Board, or if it needs to have Board sign off. CG added that a Responsible Officer Advisory Group (ROAG) had been established, and the appraisal programme had been validated via that route, and it was working well. This is chaired by LK, with DCH, and it meets monthly. There is also a more informal Fitness to Practice meeting monthly, where any concerns or complaint that have come up in relation to the doctors are discussed. That is also working well. SP asked if there were any forward programmes for the committees where this could be documented to ensure it was not missed, and to make sure that all external compliance issues were factored in. SP also asked if there was a threshold for doctors' appraisal as with the other appraisals, and what happened with agency or locum doctors. LK responded that the agency would be responsible for that element and that there are regular contacts made with the agency RO's. EJ noted that the template was late coming out from the Centre which is why it was not with the papers. JeH confirmed it was in Committee plans but an appendix had been omitted from the DHC report.	
	Resolved: that the Medical Appraisal and Revalidation Annual Report received for approval.	
BoD25/108	Strategy, Transformation, and Partnership Committee Assurance Report	
Baker, Abi 06/10/2025 12:40:16	DCS presented the following highlights from the report: • Presentation around the Frailty Service, which demonstrated the Trust strategy in action. The project had improved patient experience and had resulted in a number of patients being able to remain at home, avoiding hospital admission, and saving GP and	

	district nursing time. Learning is being captured so that it can be shared with other services. • Reviewed the BAF, the risk register, and digital risks. • Review of the 10-year plan against the Trust joint strategy, which aligned well. • Funding for the INTs had started coming in from the beginning of August. • Social Value Plan was discussed, and it was noted this had been discussed at DCH Board, and it was felt that there was more that we could do. • Green Strategy annual report was received, and it was noted that there were some impressive figures coming out from the reduction in CO2. • 6 Facet survey for DCH was received and discussed. EJ noted that support for the elderly frail was one of the Trust objectives and queried whether a half day Board Development session, like the CYP one, could be considered. As a result of the project, we are seeing a reduction in hospital admissions and demand on GPs and queried whether this project could be aligned to the Future Care outcomes. SP asked for some clarity around the £9.8m transformation piece as we were stating that there were no changes to the risk. It felt to SP like CH was articulating that there was a broader transformation risk, and asked whether these were the same, different or a connected thing. CH confirmed that this was £9.6m and the mitigation of this would be discussed in Part 2. £9.6m is a risk in terms of our financial plan, and that number was identified before the external review, which validated that. Planned surplus is £9.8m, and the risk associated to that is £9.6m.	
	Resolved: that the Strategy, Transformation and Partnership Committee Assurance Report be received for assurance.	
BoD25/109	Audit Committee Assurance Report	
	SP presented the report and highlighted the following areas: • Presentation received from the executive to bring forward the Equity, Equality and Quality Impact Assessment (EEQIA) internal audit and postpone the Research and Development audit. Committee were supportive of this. • Increased activity coming through around imposter fraud, in terms of volume of activity, volume of events being investigated and the number of people involved. Audit Committee requested that the visibility of the investigations are made available to the Quality Committee and the People and Culture Committee. • Some challenging FOI requests were being received, and not all targets were being met. A request was made to the Executive team to provide support to the FOI team so that they can try to comply with the more complex cases. DD advised the Board that we would never be in a situation where a ward would be staffed with 100% agency staff, as that would be a red flag. It was noted that in terms of the identity fraud activity, this was still subject	

Baker, Abi
06/10/2025 12:40:16

	to a live police investigation. QC will be provided with an update on the process of checking staff. SP requested support from DCS and MBr to ensure that the outstanding actions relating to an ICB audit were updated and closed. This has remained open for some time.	
	Resolved: that the Audit Committee Assurance Report be received for assurance.	
BoD25/110	Mental Health Legislation Committee Assurance Report	
	AHT highlighted the following areas: • First Committee in Common which was challenging, there were no representatives from DCH in attendance, and the meeting was not quorate. • Positive CQC report for Glendinning. This was the second consecutive positive report for that service, and the service should be commended. • Annual Mental Health Legislation report was received. Committee noted that the use of the Act continues to decline. It is unclear whether this is a positive, or if this is a result of how the police are working differently. The team are undertaking some more work to try and understand this. There are some indicators that identify that we are triaging people before they are assessed under the Act, which may also account for lower numbers. • Committee wanted to reassure themselves of the quality of the Mental Health Panel members, and the hearings. Jehl advised that a debrief had taken place, looking at what did work and what we would do differently moving forward. Membership and quoracy will be reviewed and we will be writing out to those staff to ensure that we have a clear process for people to provide apologies for meetings, so it is consistent, and we know in advance if we are quorate or not. DCS noted that it is a relevant Committee to DCH as well, so we need to ensure representation.	
	Resolved: that the Mental Health Legislation Committee Assurance Report be received for assurance.	
BoD25/111	Consent Section	
Baker, Abi 06/10/2025 12:40:16	• Annual Health and Safety (including fire and water) Compliance Report (Assurance) RS noted the award detailed within the report. Report accepted for assurance • Green Strategy Annual Report (Approval) Report accepted for approval. • National Cost Collection Exercise (Approval) Report accepted for approval.	

	Resolved: Consent section received for assurance and approval.	
BoD25/112	Questions from the Public	
	No questions, but Becky Aldridge fed back that it was an interesting meeting and that the level of discussion was good, and like the way the meeting opened with a challenging patient story. There was a thread through the whole meeting around the opportunities for people to have a voice and be more at the centre of their care and design of the NHS in line with the 10-year plan.	
BoD25/113	Any Other Business	
	Nil	
BoD25/114	Date and Time of Next Meeting	
	The next meeting of the Board of Directors will take place on Tuesday 7 October 2025, at Sentinel House.	

Signed by Chair **Date**

Baker, Abi
06/10/2025 12:40:16

BoDiC Action Tracker, Part 1 - 2025/26

Topic	Minute Reference & Name	Date of Meeting	Action	Lead	Deadline	Response	Status
EJ Declaration of Interest (DCH)	BoD25/109 / Conflicts of Interest	12.08.2025	EJ conflicts of declaration on interest to be updated to include her role as Interim Chair of Salisbury NHS Foundation Trust.	AB	07.10.2025	Complete. Register updated and published	Complete
Review of score for SR7: Collaboration (DCH)	BoD25/114 / Board Assurance Framework	12.08.2025	Risk score for SR7: Collaboration to be reviewed, noting the introduction of clustering arrangements in the ICB and the trust's ability to influence in this space as a small district general hospital	MBr	09.12.2025	JeH to review as part of Q2 update	Open - Not yet due
Safeguarding Board Development Session (DCH)	BoD25/119 / Safeguarding Adults and Children Annual Report	12.08.2025	A Board Development Session on the safeguarding responsibilities of Board members to be considered	JeH / DD	07.10.2025	Board Briefing sessions have previously been held during 2025. We will schedule additional 'drop in' sessions during the remainder of 2025	Open - Update provided
Medium-term financial plan overview (DCH)	BoD25/122 / Balanced Scorecard	12.08.2025	CH to provide a brief overview introducing the medium-term financial plan process for the Board and to include all elements that needed to be considered	CH	07.10.2025	Updates provided via regular NED calls and through Finance report on agenda and additional briefing session 26 Sept 25	Complete
Overseas visitors to the trust (DCH)	BoD25/134 / Questions from the Public	12.08.2025	Detail regarding the number of overseas visitors attending the trust and outstanding bills to be provided	AT	07.10.2025	The Trust has seen 101 overseas visitors since the beginning of the calendar year, with a total invoiced to patients of £27,423 of which £9,371 had been paid. The Trust has recently been working with NHSE to claim income from those attending ED with GHIC/EHIC cards, of which we expect £25,947 via the NHSE portal. Additionally, the below income has been paid to the Trust by overseas patients each financial year: 2024/25 year to date: £20,902 2023/24: £71,940 2022/23: £43,164 Recommend close	Complete
Technology Roadmap (DHC)		aug-24	The Board requested the technology roadmap is presented at the board in October Update action June 2025 Board - Interim workplan outlining 'technology debt' with an inventory of outdated technology or anything that is due to expire in the next 18 months - a snapshot review would be undertaken to enable the assessment of any short-term risk to go to the next STP committee meeting (July 25) and the subsequent board meeting (August 25).	CH	October-2024 March-25 June-2025 09/12/2025	October 2024 - In progress. Digital strategy work commenced. Board agreed to change the due date to March 25 in line with the Digital Strategy March 2025 - Technology Roadmap to be brought through STP CiC (Date to be determined) April 2025: Planned to be brought to June Board meeting following an update to the STP Committee in Common. Beverly Bryant (chief digital officer) to be invited to June Board to support the conversation. Due date revised to June 2025. June 2025: NJ in discussion with BB regarding the technology roadmap and to discuss the requirement further with AH-T August 2025: The Digital Strategy will be prepared for November 2025, with a fully costed and deliverable plan to be completed by March 2026. We are also creating a Dorset-wide target operating model for digital. Regular updates have been presented to the STP Committee, including a detailed report on the development of the strategy in May 2025. This identified that a key chapter of the strategy will focus on infrastructure. Our work on technology debt has not yet commenced and will be a significant piece of work and will form part of the plans identified in the strategy. It is proposed that this action is reviewed in November for closure when the strategy is received. October 2025: Report on Digital Strategy development reported to STP May 25 shared with all Board Members (see below). As agreed - on agenda for Nov 25 STP Committee and Dec 25 Board.	Open - Update provided
Representation of information (DHC)	BoD24/023 / Freedom to speak up report	des-24	NP to review the content of table 5 and re-present in a different way.	NP	August-2025 December 2025	August 2025: Marked forward to December, when FTSU review is next scheduled to be presented at Board	Open - Not yet due
Request for the Chair's Assistance (DHC)	BoD25/068 / Audit Committee Assurance Report	11.06.2025	SPe to brief DCS and Matthew Bryant to assist with closing the action regarding the system governance report.	SPe/DCS/MB	13/08/2025 07/10/2025	August 2025: Meeting set for Thursday 18th September at 14:30 October 2025: MBr has met with SP and letter sent to ICB Chair	Complete
Dermatology waiting list (DHC)	BoD25/088 / Patient Story	13.08.2025	RS to provide an update on waiting lists and the development of correspondence at the next Board.	RS	07.10.2025	4 collated actions identified: 1. Comments from Mr L incorporated, 2. webpage info changed, 3. Skin Analytics being led by ICB, 4. Work underway around WL communication. Waiting List reporting is separate action referred to FPC - BoD25/103 / Integrated Corporate Dashboard (below)	Complete
Digital Strategy Paper (DHC)	BoD25/093 / Matters Arising: Action Log	13.08.2025	JeH to circulate the paper around digital strategy that was presented to STP, to the board members	JeH	07.10.2025	Complete - paper circulated	Complete

Staff Network Conference (DHC)	BoD25/093 / Matters Arising: Action Log	13.08.2025	JeH to share the invite to the event with Board members	JeH	07.10.2025	Complete - invitation shared	Complete	
Tiered Training (DHC)	BoD25/101 / Infection Prevention and Control Annual Report	13.08.2025	DD to respond to DU around the timeline for tiered training	DD	07.10.2025	Tier 3 training is scheduled within the workplan for Q3. DD emailed DU on 13th August to confirm this.	Complete	
Impact Assessments (DHC)	BoD25/105 / Seasonal Surge (Winter) Plan	13.08.2025	Declarations (QIA, EQIA) to be circulated to the Board members	JeH	07.10.2025	Winter Plan Assurance Statements considered by FPC Sept 25. Recommend close	Complete	
Actions to other Committees								
Topic	Minute Reference & Name	Date of Meeting	Action	Lead	Deadline	Response	Status	Committee referred to
Ridgeway Ward Redesign (DCH)	BoD24/100 / CEO Update	09.10.2024	An investment review of the ridgeway ward redesign to be returned to Board.	CH	12/08/2025 ~~07/10/2025~~ 25/11/2025	The review of ridgeway ward would be returned to Board once it has been reported to Finance and Performance Committee. August update Deferred to the September Finance and Performance Committee in Common meeting. October update Deferred to November FPCIC	Open - Update provided	FPC
Capital program for end of life / out of date equipment (DCH)	BoD25/115 / Corporate Risk Register	12.08.2025	CH to provide the board with further detail about the extent of the capital funds shortfall for replacing end of life equipment over the next 18 months and the next two to three years, and to identify areas where newer equipment would offer an enhanced service that was now expected. To be reviewed by FPCCIC, with cross referrals as needed to QCIC	CH	26.11.2025	Not yet due	Open - Not yet due	FPC
Staffing gaps, safety concerns (DCH)	BoD25/122 / Balanced Scorecard	12.08.2025	Overview of any significant staffing gaps and whether this is causing any safety concerns to be returned to People and Culture Committee in Common, with a proposal on how to look at this systematically with triangulation to other committees.	NP	22.09.2025	Reviewed at people and Culture Committee 22 Sept 25 and assurance provided via PCC Assurance Report on agenda	Complete	PC
Funded beds (DCH)	BoD25/122 / Balanced Scorecard	12.08.2025	Finance and Performance Committee in Common to make a statement about the trust's funded beds, how many unfunded beds were in use, and the expectations for future months.	AT/CH	24.09.2025	Considered at Finance and Performance Committee 24 September 2025 - feedback to Board provided via FPC Assurance Report on agenda	Complete	FPC
Appraisals (DHC)	BoD25/103 / Integrated Corporate Dashboard	13.08.2025	PCC to look at appraisal thresholds	NP	October/December 2025	Further work is required in the context of the national framework - there was a discussion at PCC in Sept 25 and a formal proposal will be presented to PCC in November	Open - Update provided	PC
Service Wait Metrics (DHC)	BoD25/103 / Integrated Corporate Dashboard	13.08.2025	Discussion at FPC regarding information to be provided to Board around community Service waits.	RS	09.12.2025	Actions are in train for information to be regularly reported to F&PCiC	Open - Not yet due	FPC

Baker, Abi
06/10/2025 12:40:16

Board of Directors - Workplan 2025/26													
Dorset County Date							08-Apr-25	10-Jun-25	12-Aug-25	07-Oct-25	09-Dec-25	10-Feb-26	
Dorset Healthcare Date							09-Apr-25	11-Jun-25	13-Aug-25	Board in Common from Oct			
Activity (* indicates item can be taken under consent)	Purpose	Comments / questions	DCH	DHC	Joint	Frequency	Apr-25	Jun-25	Aug-25	Oct-25	Dec-25	Feb-26	Executive Owner (Author)
Minutes of the previous meeting	Approval				X	Bi-monthly	X	X	X	X	X	X	Chair
Action Tracker	Review				X	Bi-monthly	X	X	X	X	X	X	Chair
Business Calendar	Review				X	Bi-monthly	X	X	X	X	X	X	Chair
Review of meeting	Review				X	Bi-monthly	X	X	X	X	X	X	Chair
Register of Interests	Information				X	Bi-monthly	X	X	X	X	X	X	Chair
Patient story	Information	joint or trust specific balance TBC	X	X		Alternate meetings	X		X		X		Chief Nursing Officer (DHC - contact MM, DCH - contact JoH, HR)
Staff story	Information	joint or trust specific balance TBC	X	X		Alternate meetings		X		X		X	Chief People Officer
Chair's Comments	Information				X	Bi-monthly	X	X	X	X	X	X	Chair
CEO Report	Information				X	Bi-monthly	X	X	X	X	X	X	Chief Executive Officer (JH, SN)
Board Assurance Framework	Assurance		X	X		Quarterly		X	X		X	X	Director of Corporate Affairs
Corporate Risk Register	Assurance		X	X		Quarterly		X	X		X	X	Chief Nursing Officer
Quality and Safety													
Quality Committee Assurance Report	Assurance				X	Bi-monthly	X	X	X	X	X	X	Quality Committee Chair
Safe Staffing Report (incl.Developing Workforce Safeguards)	Approval		X	X		Bi-annual		X Mid point review			X Annual review		Chief Nursing Officer
Learning from Deaths Report	Approval		X	X		Quarterly	Q3	Q4		Q1	Q2		Chief Medical Officer
Annual Inpatient Survey and Action Plan	Assurance		X	X		Annual					X		Chief Nursing Officer
Maternity Report(s)	Assurance		X			Bi-monthly	X	X	X	X	X	X	Chief Nursing Officer
Quality Walkaround Report	Assurance		X	X		Bi-annual			X			X	Chief Nursing Officer
Clinical Audit Plan	Approval		X	X						X			Chief Medical Officer
Patient Safety Incidence Response Plan (PSIRP)	Approval		X	X		4 yearly (minimum)		June 2029 (latest)					Chief Nursing Officer
Quality Account	Approval	To be taken alongside Annual Report and Accounts	X	X		Annual		X					Chief Nursing Officer
Patient Led Assessment of the Care Environment (PLACE)	Assurance	Date for 2024/25 DCH PLACE assessment TBC	X	X		Annual	2026						Chief Nursing Officer
Health Inequalities Report	Assurance	Deferred from QCIC	X	X		Bi-annual	2026			X	X		Chief Nursing Officer (DCH), Chief Medical Officer (DHC)
Patient Carer Race Equality Framework (PCREF)	Assurance			X		Annual	2026			X			Chief Medical Officer
Complaints Annual Report	Assurance		X	X		Annual				X	X		Chief Nursing Officer
Nutrition Strategy and Annual Report	Assurance		X	X		Annual			X				Chief Nursing Officer
Infection Prevention and Control Annual Report	Assurance		X	X		Annual			X				Chief Nursing Officer
Safeguarding Adults and Children Annual Report	Assurance		X	X		Annual			X				Chief Nursing Officer
Violence & Aggression reduction strategy, action plan, and policy	Approval		X	X		Annual					X		Chief Operating Officer
Finance and Performance													
Finance and Performance Committee Assurance Report	Assurance				X	Bi-monthly	X	X	X	X	X	X	Finance and Performance Committee Chair
Finance Report	Assurance		X	X		Bi-monthly	X	X	X	X	X	X	Chief Finance Officer
Performance Dashboard (DCH - Balanced Scorecard) (DHC - Integrated Corporate Dashboard)	Assurance		X	X		Bi-monthly	X	X	X	X	X	X	Chief Operating Officer
Seasonal Surge (Winter) plan	Approval	National requirement to be presented to August 2025 Boards	X	X		Annual			X	X			Chief Operating Officer
Emergency Preparedness Resilience and Response (EPRR) Statement	Approval		X	X		Annual				X			Chief Operating Officer (DCH Ian Kilroy, DHC Sandra Hodgkyns)
Any financial items requiring Board approval	Approval		X	X		As required							As required
DCH SubCo Ltd. Performance Report*	Information		X			Quarterly	X	X		X	X		Chief Strategy, Transformation & Partnerships Officer
DCH SubCo Ltd. Annual Report and Accounts	Assurance		X			Annual					X		Chief Strategy, Transformation & Partnerships Officer
DCH SubCo Ltd. Terms of Reference*	Approval		X			Annual		X					Chief Strategy, Transformation & Partnerships Officer
Premises Assurance Model	Approval	Deferred until October 2025 Deferred again until Dec 2025	X	X		Annual			X	X	X		Chief Finance Officer (David McLaughlin)
Estates Compliance Report	Assurance				X	Annual		X					Chief Finance Officer
Health and Safety Compliance Report	Assurance		X	X		Annual		X					Chief Finance Officer
People and Culture													
People and Culture Committee Assurance Report	Assurance				X	Bi-monthly	X	X	X	X	X	X	People and Culture Committee Chair
Equality Delivery System	Assurance		X	X		Annual						X	Chief People Officer
Gender Pay Gap Report	Assurance		X	X		Annual	X						Chief People Officer
Freedom to Speak Up and Whistleblowing Report	Assurance		X	X		Bi-annual		X Annual report			X		Chief People Officer
Guardian of Safe Working Report	Assurance		X	X		Quarterly	X	X Annual report		X	X		Chief Medical Officer (DCH - Andy Macklin, DHC - Claire Vick)
GMC National Training Survey Results and Action Plan	Approval	Not yet ready, deferred to Nov PCCIC	X			Annual				X	X		Chief Medical Officer (Paul Murray)
Medical Appraisal and Revalidation Annual Report (and statement of compliance)	Approval		X	X		Annual			X	X DHC compliance statement			Chief Medical Officer (DCH - Catherine Youers, DHC - Catherine L
Staff Survey Report	Approval		X	X		Annual	X						Chief People Officer
Equality, Diversity and Inclusion Annual Report	Approval		X	X		Annual	X						Chief People Officer
Workforce Race Equality Standard (WRES)	Assurance		X	X		Annual				X			Chief People Officer
Workforce Disability Equality Standard (WDES)	Assurance		X	X		Annual				X			Chief People Officer
Strategy, Transformation and Partnership													
Strategy, Transformation and Partnership Committee Assurance Report	Assurance				X	Bi-monthly	X	X	X	X	X	X	Strategy, Transformation and Partnership Committee Chair

Activity (* indicates item can be taken under consent)	Purpose	Comments / questions	DCH	DHC	Joint	Frequency	Apr-25	Jun-25	Aug-25	Oct-25	Dec-25	Feb-26	Executive Owner (Author)
Joint Strategy Implementation Update	Assurance	Deferred pending discussion at STPCIC Oct - Removed from agenda in pre-meet			X	Bi-annual			X	X		X	Chief Strategy, Transformation & Partnerships Officer
Green Strategy Annual Report	Assurance		X	X		Annual			X				Chief Finance Officer
Senior Information Risk Owner Annual Report	Assurance		X	X		Annual		X					Director of Corporate Affairs
Social Value Action Plan and Progress Report	Approval	Joint Social Value Annual Plan for 2026/27 in development. 2025/26 metrics to be reported to Board in April 2026	X	X		Bi-annual	X	X	X			Approval of Joint Social Value action plan	Chief Strategy, Transformation & Partnerships Officer
Audit and Governance													
Audit Committee Assurance Report	Assurance		X	X		Bi-monthly	X	X	X	X	X	X	Audit Committee Chair
Risk Management Strategy Update	Approval	DCH deferred to Dec Audit Committee, pending ongoing work	X	X		Annual			X (DHC)		X (DCH)		Joint Chief Nursing Officer
Risk Appetite Statement Annual Review	Assurance	DCH deferred to Dec Audit Committee, pending ongoing work	X	X		Annual			X (DHC)		X (DCH)		Joint Director of Corporate Affairs
Going Concern Statement	Approval		X	X		Annual	X						Chief Finance Officer
Annual Self-Certification of Licence Conditions	Approval		X	X		Annual		X					Director of Corporate Affairs
Fit and Proper Persons Compliance	Assurance		X	X		Annual			X				Director of Corporate Affairs
Annual Clinical Audit Assurance Report	Assurance		X	X		Annual		X	X	X			Chief Medical Officer
Standing Orders	Approval		X	X		Annual						X	Director of Corporate Affairs
Standing Financial Instructions and Scheme of Delegation	Approval		X	X		Annual						X	Chief Finance Officer
Charitable Funds Consolidation	Approval		X			Annual						X	Chief Finance Officer
Committee Effectiveness evaluation	Assurance				X	Annual	2026	X					Director of Corporate Affairs
Committee Terms of Reference	Approval				X	Annual	2026	X					Director of Corporate Affairs
Committee Annual Reports	Assurance				X	Annual	2026	X					Director of Corporate Affairs
Board effectiveness review	Assurance				X	Annual	2026	X					Director of Corporate Affairs
Constitution Review	Approval				X	3-yearly	Apr-28						Director of Corporate Affairs
Charitable Funds Committee Assurance Report	Assurance		X			Bi-monthly	X	X	X	X	X	X	Charitable Funds Committee Chair
Charitable Funds Annual Report and Accounts	Information		X			Annual				X DHC	X DCH		Chief Finance Officer
Mental Health Legislation													
Mental Health Legislation Committee Assurance Report	Assurance				X	Quarterly		X	X		X	X	Mental Health Legislation Assurance Committee Chair
Mental Health Scheme of Delegation	Approval			X		Annual			X	X			Chief Medical Officer
Approval of Associate Hospital Managers	Approval			X		Annual						X	Chief Medical Officer

Baker Abi
06/10/2025 12:40:16

Report to	DCH and DHC Board of Directors in Common	
Date of Meeting	07 October 2025	
Report Title	Chief Executive Officers Report	
Prepared By	Jonquil Williams, Corporate Business Manager	
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? <i>Delete as required</i>	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	Implications for all strategic risks with specific implications detailed in individual reports	
Financial	No specific implications arising from the report	
Statutory & Regulatory	Update on regulatory requirements and segmentation and ICB clustering	
Equality, Diversity & Inclusion	Update on community events and new changing space at DCH	
Co-production & Partnership	Update on system working	

Executive Summary
This report provides and overview of key national and local developments: • National Maternity Investigation • 10-point resident doctor plan • Model Region Blueprint • ICB Board changes • Dorset Place – Weymouth pioneer neighbourhood programme • National oversight framework and provider capability assessment • Joint Board Development programme with University Hospital Dorset • Vaccination programme • NIHR capital funding – DCH Research • 1 year anniversary of the access to wellbeing hub Boscombe
Recommendation
Members are requested to receive the report for information.

Chief Executive Officer's Report – October 2025

1 National updates

1.1 National Maternity Investigation

In June 2025 a rapid national investigation into NHS maternity and neonatal services was announced Health and Social Care Secretary, Wes Streeting. The investigation will urgently look at a range of services across the entire maternity system, following independent reviews across multiple trusts that have revealed a pattern of similar failings: women's voices ignored, safety concerns overlooked and poor leadership creating toxic cultures. The investigation will be led by Baroness Amos.

The Health and Social Care Secretary and Baroness Amos have agreed the terms of reference of the independent investigation, which will include understanding the lived experiences of families, reviewing the quality and safety of services, identifying the drivers and impact of inequalities, and identifying barriers to making improvements.

In September 2025 the Department of Health and Social care (DHSC) named the 14 NHS trusts who will be part of the rapid national investigation. Somerset NHS Foundation Trust have been named as one of the maternity units under review. Dorset County Hospital continue to support Yeovil District Hospital (YDH), part of Somerset NHS Foundation Trust, during the temporary closure of their maternity unit. [14 NHS trusts the focus of national maternity investigation - GOV.UK](https://www.gov.uk/government/news/14-nhs-trusts-the-focus-of-national-maternity-investigation)

1.2 10-point plan to improve resident doctors' working lives

On 29 August 2025 NHS England issued a letter to all Trusts with a 'Ten Point Plan to improve resident doctors' working lives' [NHS England » 10 Point Plan to improve resident doctors' working lives](https://www.nhs.uk/england/10-point-plan-to-improve-resident-doctors-working-lives). The ten actions are required to be completed by all Trusts over a twelve-week period from 29 August 2025 (so by 21 November 2025).

A summary of the 10 Point Plan is provided below:

1. Trusts should take action to improve the working environment and wellbeing of resident doctors
2. Resident doctors must receive work schedules and rota information in line with the Code of Practice
3. Resident doctors should be able to take annual leave in a fair and equitable way which enables wellbeing
4. All NHS trust boards should appoint 2 named leads: one senior leader responsible for resident doctor issues, and one peer representative who is a resident doctor. Both should report to trust boards.
5. Resident doctors should never experience payroll errors due to rotations
6. No resident doctor will unnecessarily repeat statutory and mandatory training when rotating
7. Resident doctors must be enabled and encouraged to Exception Report to better support doctors working beyond their contracted hours
8. Resident doctors should receive reimbursement of course related expenses as soon as possible
9. We will reduce the impact of rotations upon resident doctors' lives while maintaining service delivery
10. We will minimise the practical impact upon resident doctors of having to move employers when they rotate

Trusts are also expected to develop a Board Assurance Framework to provide oversight of this work and the outcomes should be included in trust annual reports to demonstrate accountability and progress. Trust boards are expected to take clear ownership of local improvements to resident

doctors' working lives by developing and implementing action plans informed by staff feedback and national survey results

The DCH and DHC Chief Medical officers are working with senior clinicians to complete their respective Trust plans and an update was provided to the people and Culture Committee in September 2025 to provide assurance on the arrangements in place and plans to meet the requirements set out by NHS England. Completed plans will be reported through the governance structures in each Trust.

1.3 Model Region Blueprint

The 10-year health plan for England set out the reshaping of the NHS operating model to support its vision. A key part of the plan is the abolition of NHS England (NHSE), merging its functions into the Department of Health and Social Care (DHSC), and redesigning the centre to create a more agile, less bureaucratic NHS.

Following publication of the Model ICB Blueprint in May 2025 [NHS England » Update on the draft Model ICB Blueprint and progress on the future NHS Operating Model](#), the Model Region Blueprint was shared with NHS organisations on 8 September 2025. This begins to explain the role of the seven regions as the 'leadership interface between the centre and local health systems, overseeing strategy, managing performance and coordinating improvement and intervention'.

The Model Region Blueprint restates the core functions of regional teams – which will retain their existing geographical footprints – and emphasises their performance management role, which no longer sits with ICBs, alongside an array of additional responsibilities. It also creates a new regional governance model, with an executive team, chief executive and non-executive chair in each region. The delegation of Section 7A public health functions is being further paused and delayed until at least 2027.

Working with ICBs, the regions will oversee transformation at scale, support service configuration and ensure effective implementation of structures, functions and incentives.

1.3 Building on our progress in the second half of 2025/26

On 16 September I attended an NHS Leadership event where the key focus on the meeting was progress made in the first half of the year with the NHS in a breakeven position by the end of month five. Following the event Jim Mackey, NHSE CEO, wrote to all trusts and ICBs to re-iterate the areas of focus for the rest of the year:

- Maintaining financial discipline
- Delivering our priorities
- Mid-year reviews
- Winter pressures

At DCH and DHC these are areas of focus and strongly link to our agenda today.

<https://www.england.nhs.uk/long-read/building-on-our-progress-in-the-second-half-of-2025-26/>

Aaker, Abi
06/10/2025 12:40:16

2 Dorset Updates

2.1 Dorset County Hospital – CQC review of Maternity Services

The Care Quality Commission (CQC) has upgraded the rating of maternity services at Dorset County Hospital from 'requires improvement' to 'good'.

An inspection in May looked at the progress made on the CQC recommendations from a previous safe and well led inspection. Inspectors recognised that we had made significant improvements in several areas since their last inspection, and we had met the requirements of their recommendations.

Our maternity team has worked incredibly hard to make the improvements required and we are pleased their ongoing efforts have been recognised by inspectors, especially in a climate when maternity services across the country are under such close scrutiny and alongside the additional activity our maternity teams have been providing care for Somerset families following the temporary closure of the maternity unit at Yeovil District Hospital.

2.2 Changes to ICB Board

As part of the ICB 'clustering arrangements previously shared with Board members, Rob Whiteman has been announced as the ICB Chair and Jonathan Higman has been appointed CEO for the new cluster covering Dorset, Somerset, Bath and Northeast Somerset, Swindon and Wiltshire.

At the end of September, Patricia Miller (Dorset ICB CEO) has stepped down from her role and David Freeman (Dorset ICB Chief Medical Officer) is stepping into the interim CEO position until the CEO Cluster positions are announced.

I would like to thank Patricia for the support she has provided our trusts and the Dorset health and care system. Patricia has spent forty years in the NHS and her previous post was chief executive at DCH, so she has made an amazing contribution to Dorset and the NHS and we wish her well in the next chapter.

2.3 Neighbourhood Place pilot – Dorset

I am pleased to report that Dorset Place (local authority area) has been selected as one of the 43 areas chosen to pioneer the national neighbourhood health implementation programme. The first wave of the programme will initially focus on improving services for management of people with multiple conditions and complex needs. Not only is this work aligned to the 10-year plan but is directly aligned to our Joint Strategy. We are putting arrangements in place to ensure that the learning from this can be shared as we develop a similar way of working in the BCP Place.

2.4 National Oversight Framework 2025/26 and Segmentation

The new NHS Oversight Framework 2025/26 describes a consistent and transparent approach to assessing integrated care boards (ICBs) and NHS trusts and foundation trusts, ensuring public accountability for performance and providing a foundation for how NHS England works with systems and providers to support improvement.

The 'segmentation' results and league tables were published in early September, with separate league tables for Acute Trusts, Non-Acute Trusts and Ambulance Trusts.

Belinda
07/10/25 12:40:16

DCH has been placed in Segment 3. This is primarily driven by the 'financial worldwide' whereby Trusts with a financial deficit cannot be placed higher than segment 3. In the league tables the trust is ranked 48 out of 34 acute trusts nationally. [NHS England » Acute trust league table](#)

DHC has been placed in Segment 2 and is ranked 23rd out of 61 trusts in the non-acute trust category. [NHS England » Non-acute hospital trust league table](#)

2.5 Provider Capability Assessment

NHS England have published the Provider Capability Assessment [NHS England » Assessing provider capability: guidance for NHS trust boards](#). The capability self-assessment guidance requires boards to self-assess annually against the six oversight domains set out in [The insightful provider board](#). This closely aligns to our committee structure.

The focus of the assessment is on Boards self-awareness. The first self-assessment is required to be submitted by 22 October 2025 along with supporting evidence, for example the board paper(s). The self-assessment should highlight any areas of concern, the reasons why, and planned or taken actions to address.

A presentation was taken to the Board of Directors development session in September and has been shared with Executive colleagues for completion of their domains by early October for final review and sign off.

As this does not fit with our Board timings for approval we are planning to adopt the process for sign off set out below:

- 14 October 2025 – sign off by Joint Executive Management Team
- W/c 13 October 2025 – Confirm and Challenge meetings with Committee Chairs and Executive Leads relevant to domains and Joint Director of Corporate Affairs (all Domains)
- 22 October 2025 - Extra-ordinary Board to approve submission (deadline 22 October 2025)

2.6 Planning

ICB have published the timeline for this year planning cycle with an ambition have completed the planning cycle by December 2025. The expectation is that the medium term operational and financial planning guidance will be published in October with Draft submissions due mid November and final plan submitted in December and plan assurance and acceptance through January and February 2026. Internal governance routes will be mapped alongside the ICB and regional submissions and the board will be kept informed through committee. Alongside this the Dorset ICB are proposing appointing a strategic partner to help shape the plan for the health care system in Dorset over the next few years, including the path to financial recovery and sustainability. It will be important for these two processes to align effectively.

2.7 Flu Vaccination programme

The annual Flu Vaccination Campaign runs from 1 October 2025 to 31 March 2026. All Trusts have been asked to improve take up by a minimum of 5% as part of DHSC Urgent and Emergency Care Plans. Uptake data will be reported at executive level and there will be scrutiny if uptake targets are not achieved.

A working group has been established to run the programme this year and this is being led by People and Culture and Nursing, Quality and Therapies. Dawn Dawson, Chief Nursing Officer, is the Senior Responsible Officer (SRO) for the programme.

2.8 Thousands of babies protected thanks to Dorset vaccination service

A vaccination service run by teams from University Hospitals Dorset (UHD), Dorset County Hospital (DCH), and Dorset HealthCare (DHC) has celebrated a successful first year providing vaccinations to pregnant patients across Dorset.

'Perinatal' vaccines protect both the parent and baby from serious illnesses like whooping cough, RSV and complications from flu, by transferring antibodies. By coming together as three trusts, the team of midwives have developed a flexible year-round service, offering clinics at multiple locations throughout the county, with almost 7,000 perinatal vaccinations delivered since September 2024.

2.9 DCH launches skills bootcamp

Dorset County Hospital (DCH) is launching a Skills Bootcamp in Health and Social Care for adults in Dorset and Somerset who are interested in working in the healthcare sector.

Skills Bootcamps are flexible, government-funded training courses designed for adults aged 19 and over. They provide individuals with the opportunity to gain valuable new skills and knowledge in specific industries or fields.

DCH has been registered as a training provider for Dorset and Somerset and will provide a four-week programme designed to equip learners with the essential skills, knowledge and behaviours needed for a successful career in the health and social care sector.

The Skills Bootcamp in Health and Social Care replaces DCH's Support Worker Scholarship programme and gives participants the chance to upskill and find out more about a career in health and social care across the sector including hospitals, care homes and other community settings. Participants will gain:

- essential skills required for healthcare support
- practical hands-on learning in clinical settings
- a guaranteed interview with a local health and sector employer at the end of the programme.

2.10 NIHR Capital funding

DCH has been awarded a total of £228,521.92 following a successful NIHR capital bid in 2024 to fund a Heidelberg SPECTRALIS® OCT retinal scanner. The project presents a significant opportunity for collaborative service development in Ophthalmology and Research as well as an invest to save opportunity laying the foundations for a commercial pipeline of trials which it is anticipated will bring in significant income to the Trust.

2.11 DHC 1 year anniversary of Boscombe Access Wellbeing Hub

The Access Wellbeing hub in Boscombe marked its first anniversary this week at a special event attended by MP Tom Hayes. The hub offers free mental health and wellbeing support to anyone aged 18 and over, with no appointment needed, and has welcomed over 600 people in 2,260 visits since opening its doors in September 2024.

Tom Hayes, MP for Bournemouth East, returned to the central Boscombe hub on Monday 15 September, after officially opening the space a year ago. He met with the hub’s team of wellbeing coordinators to hear more about how they support and empower people to live well, working with partners across the community to enable clients to find the right help.

Baker, Abi
06/10/2025 12:40:16

Quality Committee in Common Assurance Report
for the meeting held on Tuesday 23 September 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?	DCH – Yes DHC – No
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	• Non quoracy for DHC for much of the meeting • Useful discussion around policies, particularly those that were overdue and the need to address the long-overdue policies • Receipt of maternity reports, noting an increase in some key metrics as detailed below. Discussion around deaths in the service. • Thanks were extended to Neil Tomlin (Maternity Improvement Advisor) for support to the maternity team during his time at 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) with both Trust’s continuing to focus on equality quality impact assessments (EQIAs) as transformational changes were made and cost improvement programmes implemented. <u>Dorset HealthCare:</u> • Safe staffing levels continued to be monitored with Kimmeridge ward on enhanced surveillance. This and other staffing gaps were reported to Quality Governance Group monthly. • Continued support to Melstock ward which was changing the cohort of patients cared for • Ongoing focus on high intensity pathways for patients with mental health needs. There were sustained pressures on beds and the trust was working hard to minimise out of area placements. <u>Dorset County Hospital:</u> • Receipt of the final CQC inspection report in to maternity services. This was embargoed at the time of the committee meeting, with the outcome to return to committee in due course. • Continued focus on reducing bank and agency usage, within the context of increased demand and acuity and reduced bed base. The quality impact of this context was continuously monitored.

Baker, Abi
06/10/2025 12:40:16

- Clinical colleagues were involved in the development of the Electronic Health Record (EHR)
- Clinical improvement event to take place on Friday, which would involve colleagues from across and outside the Trust, with a focus on improving flow and ensuring patient receive the right care in the right place.
- Launch of a new service for paediatric ophthalmology with University Hospitals Dorset (UHD)

Quality Report (DCH/DHC)

Dorset County Hospital

- Receipt of infection prevention and management metrics/thresholds for the year, with some debate nationally about the calculations used to reach these figures
- Positive progress in relation to tissue viability following focused work
- The southwest was an outlier in mixed sex accommodation breaches, with the trust finding challenged within critical care. A deep dive had been completed and actions identified. However, there were no complaints or concerns raised by patients in this regard.
- Ongoing work to improve duty of candour with further refinements to the application of the policy. Working with DHC re aligning process.
- Review of standards of care of night to be undertaken.

Dorset HealthCare

- One out of area placement reported in June, three in July. All have been fully reviewed.
- One case of seclusion in June, two in July. All managed within the safety parameters of the policy.
- New dashboard live in the Integrated Urgent Care Service (IUCS) which enables real time view of 20-minute call backs.
- Reduction in complaints in August, in line with previous years.
- Mental Health Act visit in July in the adult assessment ward, actions following this are being completed
- A series of actions in relation to Duty of candour are ongoing, following the previous review. Duty of candour increased to 71.1% in August.

Learning from Deaths Report (DCH/DHC)

Dorset County Hospital

- Positively, Summary Hospital Mortality Index (SHMI) was 1.05 which was in the expected range and was predicted that this will continue.
- Previous concerns around fractured neck of femur mortality were data quality issues, but Hospital Mortality Group have requested further review of this through quality improvement work.
- Coding was starting to be a concern again.

Baker, Abi
06/10/2025 12:40:16

Dorset HealthCare

- The report showed an increased focus on learning.
- There had been a drop in data point from May due to a change in denominator, but there was no significant variation in the rates of death across services.
- 53 unexpected deaths and 30 coroner inquests in the quarter, with no regulation 28 noticed received. Learning had been identified including the need for joined up care for patients
- Five child deaths in the quarter, with one underdoing a tier two response. Learning will be included in the Q2 report.

Regulatory Compliance Internal Assurance report (DHC) updating on the compliance, clinical accreditation, and CQC work in the trust. Discussions about how replicable the report was in DCH, given the different way in which CQC liaise with acute compared to mental health trusts.

Quality Impact Assessment Assurance Report (DCH/DHC)

Dorset County Hospital noting the new, iterative process. EQIAs relating to maternity, Mary Anning, winter plan, Heidelberg scanner have been completed.

Dorset HealthCare noting that this is a well-established panel. A number of EQIAs were considered at the last panel meeting as well as system quality impact assessments that affected the trusts. Awareness and training for staff to complete the necessary assessments could be improved.

Patient Carer Race Equality Framework (PCREF) (DHC)

Progress against implementation plan. Seeing tangible progress in operational steps needed to move towards being anti-racist organisation. The need to think about how to influence upwards to make cultural changes was noted. Quality Governance Group agreed to stand up a working group for PCREF implementation. Work was ongoing to promote the PCREF campaign across the trust.

Policies (DCH/DHC), with both trusts noting the awaited new risk management system, which was expected to include a policies module which would align process across the trusts.

Dorset County Hospital

- 10 policies overdue review. Discussion around how the committee can be assured there is no risk to patient care due to long overdue policies. There was recognition that some of the longest overdue policies have been superseded, and good custom and practice continues regardless of policy status.

Dorset HealthCare

- An exercise to cleanse policies had been undertaken with 24 policies now overdue. Ambitions to reduce this to single figures by the end of

Baker, Abi
06/10/2025 12:40:16

the year. The complexity and reliance on the system for some of the longest outstanding policies were noted.

There was an aspiration from committee members that there are no policies overdue beyond 12 months within 6 months from now.

Quality Governance Groups Assurance Reports (DCH/DHC)

Dorset County Hospital noting that

- Many of the topics discussed in Quality Governance Group had been discussed today at committee.
- The importance of Quality Committee in Common minutes as evidence for the maternity incentive scheme (MIS) was highlighted.
- SLG had approved investment in staffing and for environmental issues within the aseptic unit, so that it could be reopened.

Dorset Healthcare:

- An external peer review of IUCS service identified good practice and some areas for learning
- Positive progress on actions following last years PLACE report
- Receipt of an assurance report on record keeping in a CAMHS service

Maternity Reports (DCH)

Maternity and Neonatal Quality and Safety Reports, noting:

- Positive position for smoking key performance indicators, term admissions to neonatal unit, and Saving Babies Lives q1 data.
- One neonatal death and one intrauterine death. Bereavement support offered to family and staff and mortality processes were being followed. The committee discussed the deaths in the service recently. Assurance was given that any immediate actions to address safety concerns were implemented, but that otherwise processes were followed and outcomes of those were used to implement any necessary changes or identify themes. The service continued to be open to learning.
- Increase in third- and fourth-degree tears; this was being reviewed by the safety team.
- Audit of Apgar scores was completed with no particular themes identified. Actions were detailed in the report and numbers continued to improve.
- Update on staffing with Yeovil midwives and maternity support workers.
- Thanks and commendation extended to Neil Tomlin for his work at the end of two years of improvement work in maternity.
- Receipt of the Multiprofessional Training Report for Q1. Work continues to ensure that training compliance is met for MIS.

Annual Inpatient Survey and Action Plan (DCH) noting a number of areas where the trust was on or above the national average, and some areas of focus for improvement, including noise at night.

Governance Structure (Joint) outlining the structure of groups that report in to the committee, and detailing trust leads for statutory or regulatory roles.

Baker, Abi
06/10/2025 12:40:16

	Review of the meeting highlighting the difficulty of time keeping and that whilst we are working to align across the trusts, there may be areas where variation is warranted.
Decisions made at the meeting	Approval of the Learning from Deaths Report
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	Y	DCH – Y DHC – N			
Claire Lehman	Y	Y	Y			
Suresh Ariaratnam	Y	Y	A			
Dawn Dawson	Y	Y	A			
Lucy Knight	Y	Y	Apols for most of meeting. Present for the last 45 minutes			
Eiri Jones	Y	Y	Y			
Stuart Parsons	Y	Y	Y			
Rachel Small	A	Y	A			
Anita Thomas	Y	Y	Y until 1500 A for last hour of meeting			
Rachel Wharton	A	A	Y			

Baker, Abi
06/10/2025 12:40:16

Report to	Board in Common (DCH)	
Date of Meeting	7 th October 2025	
Report Title	Maternity and Neonatal Quality and Safety Report	
Prepared By	Jo Hartley Director of the Midwifery and Neonatal Service	
Approved by Accountable Executive	Dawn Dawson, CNO	
Previously Considered By	Quality Committee in Common 23 rd September 2025	
Action Required	Approval	No
	Assurance	Yes
	Information	No

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? <i>Delete as required</i>	
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 months of July and August (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. - KPIs for smoking cessation are positive with a 0.6% smoking at birth from 6% smoking at booking. CO recorded at time of booking is slightly below expectation - The ATAIN percentage remains below 5% at 4.2% for term admissions to SCBU - There has been one neonatal death in August. This was a baby born at home, unexpectedly very poorly. Every effort was made to resuscitate him but very sadly, it was unsuccessful. This will be reviewed and reported on through the normal processes, including the Coroner, MNSI and CDRM - IUD (intra-uterine death) of baby at 36+5 weeks, under the care of the Fetal Medicine Team. Fetal demise on the day of the scan. Postmortem consent obtained. Ongoing support from Bereavement team with early follow up and debrief planned with Fetal Medicine consultant. Review process through PMRT. - The rate of 3rd and 4th degree tears has increased. This will continue to be reviewed through the MDT process. No themes identified thus far. - The SBL update for quarter one is very positive with 100% achieved in five of the safety standards and 67% in the standard around diabetes. - The audit of babies born with an Apgar 7 or less at 5 minutes has been completed. The percentage continues to improve. No themes emerged. The actions are as follows: Advanced neonatal resuscitators reminded to document Apgar score at 10 minutes and ensure care plan is documented. Completed 01/08/2025

2. Anaesthetic staff emailed for comment on high number of women undergoing spinal who have baby born with low Apgar score to discuss if any change may have affected neonatal outcome. No changes or concerns identified by anaesthetists. Completed 02/09/2025
 3. Formally register and re-audit babies born with an Apgar of 7 or less at five minutes 01 September – 30 November 2025, with report due 31 January 2026
 4. Future audit to include checking if NEWTT2 observations chart in use for babies on the maternity unit who had low Apgar's or who required resuscitation (DCH guideline 2343 v5 NEWTT2 – Observations of Babies on The Postnatal Ward and Transitional Care)
- The audit of consultant obstetrician RCOG roles and responsibilities: attendance audit completed. Overall, 91.3% compliance demonstrated for consultant attending RCOG applicable clinical situations (>80% required). Actions:
 1. Remind staff to clearly document when a consultant has been requested and when they attend; and ensure all clinicians aware of the Teams form for recording consultant attendance
 2. Strengthen blood loss monitoring procedure during PPH in labour rooms and theatre to avoid delay in weighing blood loss, to ensure the consultant is called in a timely manner. Include a reminder that the consultant must be informed when blood loss is 1500mls and ongoing.
 3. Investigate if a Consultant Requested and Consultant Attended Form can be added to BadgerNet electronic record to support improvement in documentation and provide auditable data.
 - The case reported of the IUD of twins at 33 weeks reported in July, will be taken to PMRT in October. The DCH Fetal Medicine Consultant will attend.
 - The number of reported incidents of escalation to divert have reduced. Multiple cases of delayed inductions of labour >24hrs. The homebirth service was suspended multiple times in relation to escalation to divert. Overall, staffing is improving in relation to YDH midwives and MSWs joining DCH. However, sickness continues to be challenging.
 - 4 complaints reported. Themes as follows
 1. Delayed induction of labour without an adequate explanation
 2. Partner unable to stay overnight
 3. Failure to ensure partner (Dad) had skin-to-skin with his baby
 4. Poor postnatal care including catheter not emptied, patient not assisted with personal hygiene, bells not answered quickly, bedding not changed. Staff unable to provide feeding support due to being called away to answer bells etc.
 5. Feeling “forgotten about” immediately after the birth
 6. Administration of an injection
 7. Provision of a clear explanation about a plan of care following a change in the risks associated with the pregnancy
 8. Communication around consent for a forceps birth – ensuring the patient was able to understand and provide informed consent
 - No incidents of opening a second theatre in an emergency
 - Risk register
 - 2180**, moderate (12) – lack of psychological support in SCBU
 - 1881**, moderate (9) - The service is now compliant with BAPM guidance as well as the soon-to-be-published RCPCH Facing the Future Standards for paediatric cover.
 - 2159**, moderate (8) – lack of patient and governance confidentiality in SCBU
 - 2183**, moderate (12) – increase in obstetric workforce to two SHOs on labour ward
 - 1825** moderate (8) – neonatal ventilators delivered and training ongoing
 - 1980** moderate (8) – no progress on EPAC business case. There is the possibility of a relatively small amount of mutual aid from YDH

Baker-1361
06/10/2025

1689, moderate (9) – second theatre – business case awaiting a decision. No incidents of needing a second theatre in an emergency

876, high (20) – maternity staffing. Recruitment agreed for newly qualified midwives, starting October 2025. Midwives starting to transfer from YDH to work at DCH on secondments. 2 wte additional band 6 midwives recruited for fixed term 12 months. Agency now used regularly and ward staffing increased to 8 plus the coordinator. However, the manager oncall frequently called in to bolster numbers and incentives used regularly.

- There were no neonatal transfers.
- Training data remains good. Safeguarding training remains below the required percentage so an action plan will be taken to the Trust Safeguarding Committee
- Minutes from the joint Safety Champions and QUAD August 2025
- The workforce data show a continuing increase in percentages of midwives and MSWs off sick. Recruitment underway for MSWs. Ongoing reliance on oncall and midwives working extra shifts. Agency now being used regularly.
- Actions from staff engagement meeting included. Outstanding actions are
 - i) Training for bank staff in the use of BadgerNet
 - ii) Lack of essential equipment
 - iii) Ongoing concerns about the significant training requirements for maternity support workers moving from bd2 to bd3

Recommendation

Members are requested to:

- **Receive the report for assurance.**

Baker, Abi
06/10/2025 12:40:16

Maternity & Neonatal Quality and Safety report

July and Aug (reporting in Sept) 2025

Submitted by Jo Hartley, Director of Midwifery & Neonatal Services

Executive sponsor: Dawn Dawson CNO



Baker, Abi
06/10/2025 12:40:16

Executive Summary

This report sets out the quality and safety activity covering the months of July and August (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.

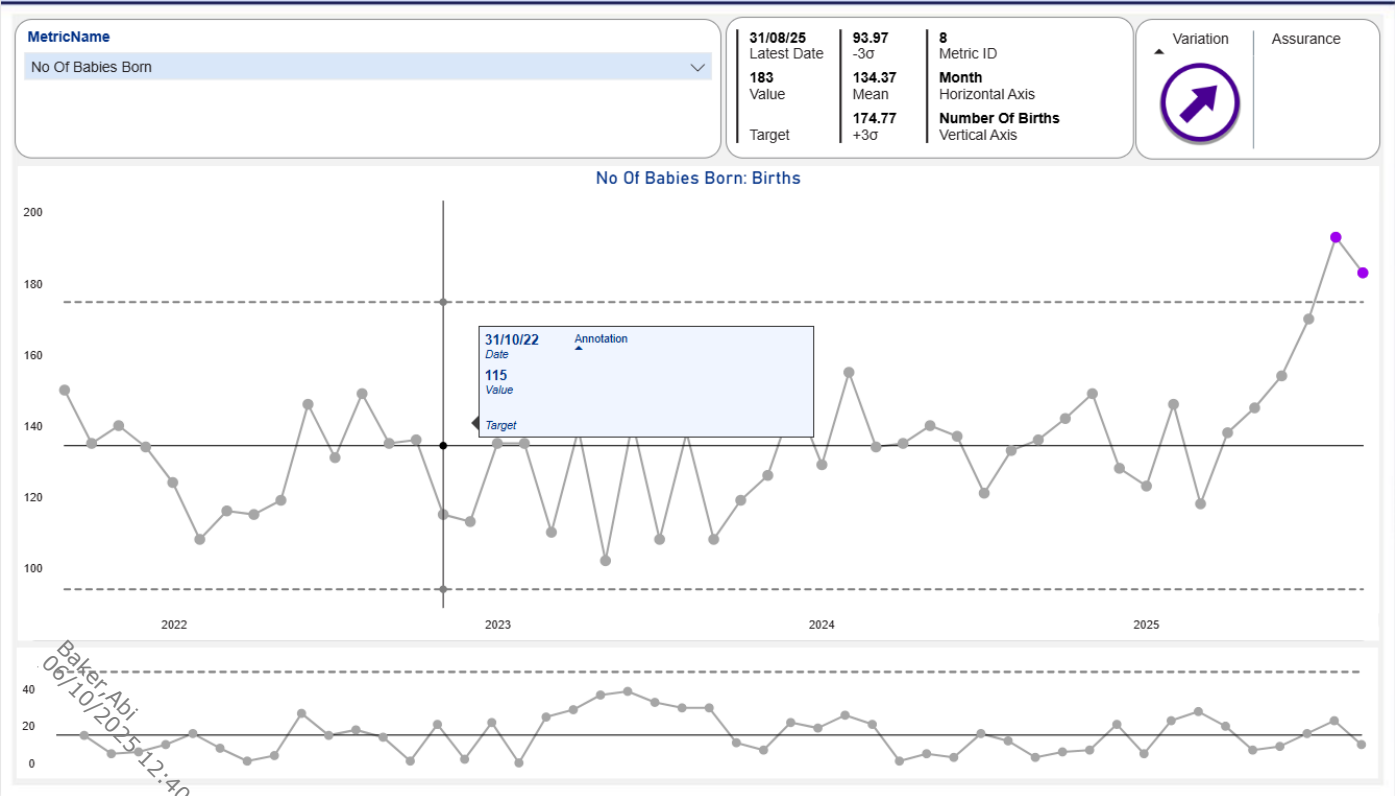
- KPIs for smoking cessation are positive with a 0.6% smoking at birth from 6% smoking at booking. CO recorded at time of booking is slightly below expectation
- The ATAIN percentage remains below 5% at 4.2% for term admissions to SCBU
- There has been one neonatal death in August. This was a baby born at home, unexpectedly very poorly. Every effort was made to resuscitate him but very sadly, it was unsuccessful. This will be reviewed and reported on through the normal processes, including the Coroner, MNSI and CDRM
- IUD (intra-uterine death) of baby at 36+5 weeks, under the care of the Fetal Medicine Team. Fetal demise on the day of the scan. Postmortem consent obtained. Ongoing support from Bereavement team with early follow up and debrief planned with Fetal Medicine consultant. Review process through PMRT.
- The rate of 3rd and 4th degree tears has increased. This will continue to be reviewed through the MDT process. No themes identified thus far.
- The SBL update for quarter one is very positive with 100% achieved in five of the safety standards and 67% in the standard around diabetes.
- The audit of babies born with an Apgar 7 or less at 5 minutes has been completed. The percentage continues to improve. No themes emerged. The actions are as follows:
 1. Advanced neonatal resuscitators reminded to document Apgar score at 10 minutes and ensure care plan is documented. Completed 01/08/2025
 2. Anaesthetic staff emailed for comment on high number of women undergoing spinal who have baby born with low Apgar score to discuss if any change may have affected neonatal outcome. No changes or concerns identified by anaesthetists. Completed 02/09/2025
 3. Formally register and re-audit babies born with an Apgar of 7 or less at five minutes 01 September – 30 November 2025, with report due 31 January 2026
 4. Future audit to include checking if NEWTT2 observations chart in use for babies on the maternity unit who had low Apgar's or who required resuscitation (DCH guideline 2343 v5 NEWTT2 – Observations of Babies on The Postnatal Ward and Transitional Care)
- The audit of consultant obstetrician RCOG roles and responsibilities: attendance audit completed. Overall, 91.3% compliance demonstrated for consultant attending RCOG applicable clinical situations. Actions:
 1. Remind staff to clearly document when a consultant has been requested and when they attend; and ensure all clinicians aware of the Teams form for recording consultant attendance
 2. Strengthen blood loss monitoring procedure during PPH in labour rooms and theatre to avoid delay in weighing blood loss, to ensure the consultant is called in a timely manner. Include a reminder that the consultant must be informed when blood loss is 1500mls and ongoing.
 3. Investigate if a Consultant Requested and Consultant Attended Form can be added to BadgerNet electronic record to support improvement in documentation and provide auditable data.
- The case reported of the IUD of twins at 33 weeks reported in July, will be taken to PMRT in October. The DCH Fetal Medicine Consultant will attend.
- The number of reported incidents of escalation to divert have reduced. Multiple cases of delayed inductions of labour >24hrs. The homebirth service was suspended multiple times in relation to escalation to divert. Overall, staffing is improving in relation to YDH midwives and MSWs joining DCH. However, sickness continues to be challenging.
- 4 complaints reported. Themes as follows
 1. Delayed induction of labour without an adequate explanation
 2. Partner unable to stay overnight

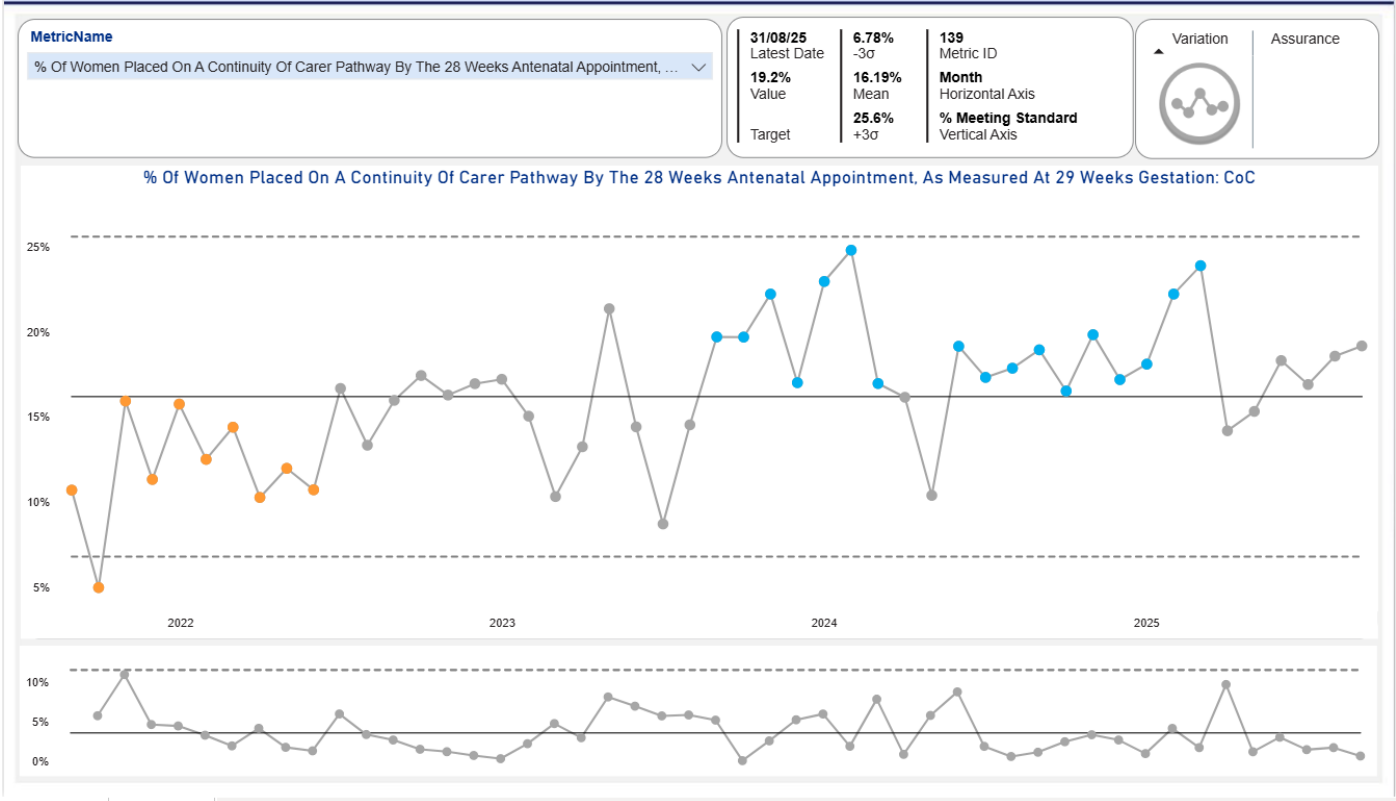
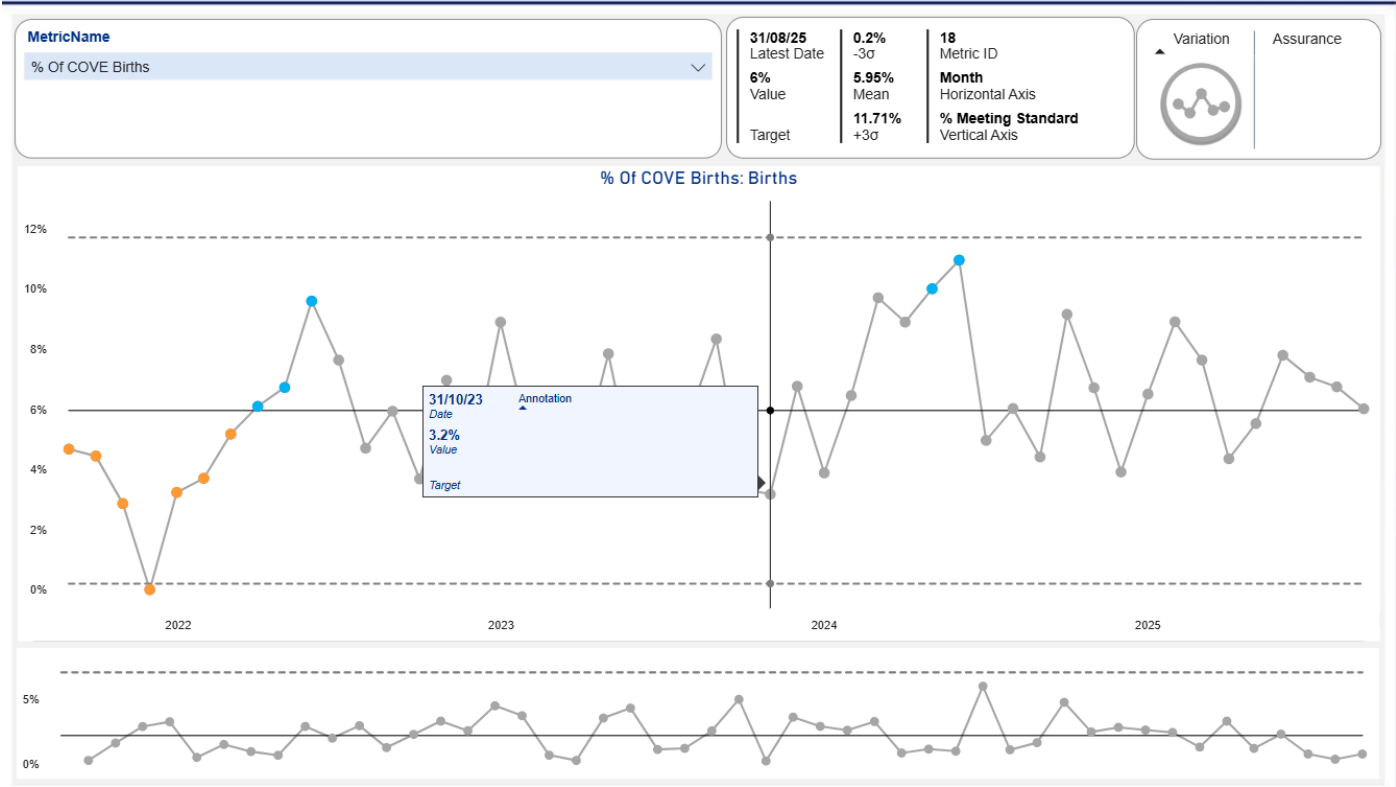
3. Failure to ensure partner (Dad) had skin-to-skin with his baby
 4. Poor postnatal care including catheter not emptied, patient not assisted with personal hygiene, bells not answered quickly, bedding not changed. Staff unable to provide feeding support due to being called away to answer bells etc.
 5. Feeling “forgotten about” immediately after the birth
 6. Administration of an injection
 7. Provision of a clear explanation about a plan of care following a change in the risks associated with the pregnancy
 8. Communication around consent for a forceps birth – ensuring the patient was able to understand and provide informed consent
- No incidents of opening a second theatre in an emergency
 - Risk register
 - 2180**, moderate (12) – lack of psychological support in SCBU
 - 1881**, moderate (9) - The service is now compliant with BAPM guidance as well as the soon-to-be published RCPCH Facing the Future Standards for paediatric cover.
 - 2159**, moderate (8) – lack of patient and governance confidentiality in SCBU
 - 2183**, moderate (12) – increase in obstetric workforce to two SHOs on labour ward
 - 1825** moderate (8) – neonatal ventilators delivered and training ongoing
 - 1980** moderate (8) – no progress on EPAC business case. There is the possibility of a relatively small amount of mutual aid from YDH
 - 1689**, moderate (9) – second theatre – business case awaiting a decision. No incidents of needing a second theatre in an emergency
 - 876**, high (20) – maternity staffing. Recruitment agreed for newly qualified midwives, starting October 2025. Midwives starting to transfer from YDH to work at DCH on secondments. 2 wte additional band 6 midwives recruited for fixed term 12 months. Agency now used regularly and ward staffing increased to 8 plus the coordinator. However, the manager oncall frequently called in to bolster numbers and incentives used regularly.
 - There were no neonatal transfers.
 - Training data remains good. Safeguarding training remains below the required percentage so an action plan will be taken to the Trust Safeguarding Committee
 - Minutes from the joint Safety Champions and QUAD August 2025
 - The workforce data show a continuing increase in percentages of midwives and MSWs off sick. Recruitment underway for MSWs. Ongoing reliance on oncall and midwives working extra shifts. Agency now being used regularly.
 - Actions from staff engagement meeting included. Outstanding actions are
 - i) Training for bank staff in the use of BadgerNet
 - ii) Lack of essential equipment
 - iii) Ongoing concerns about the significant training requirements for maternity support workers moving from bd2 to bd3

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

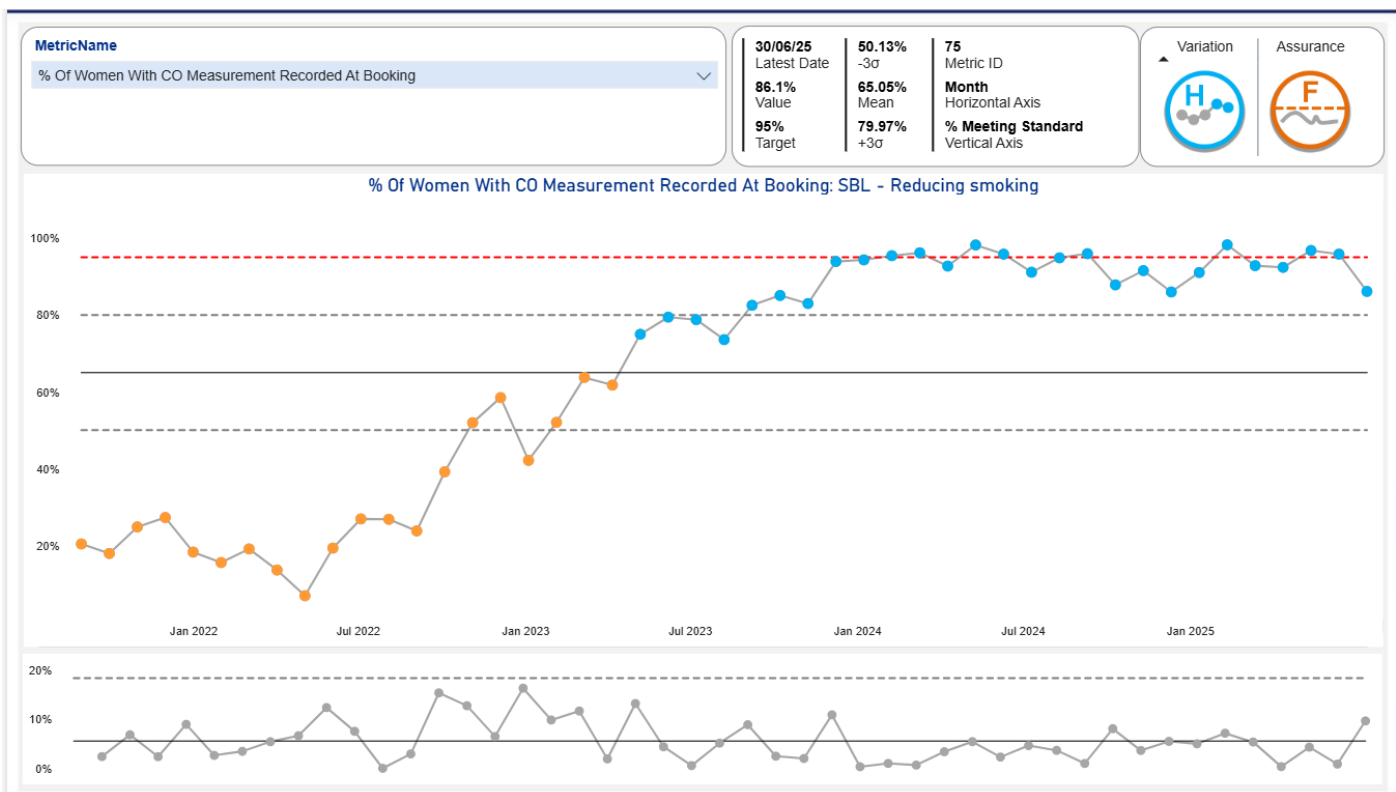
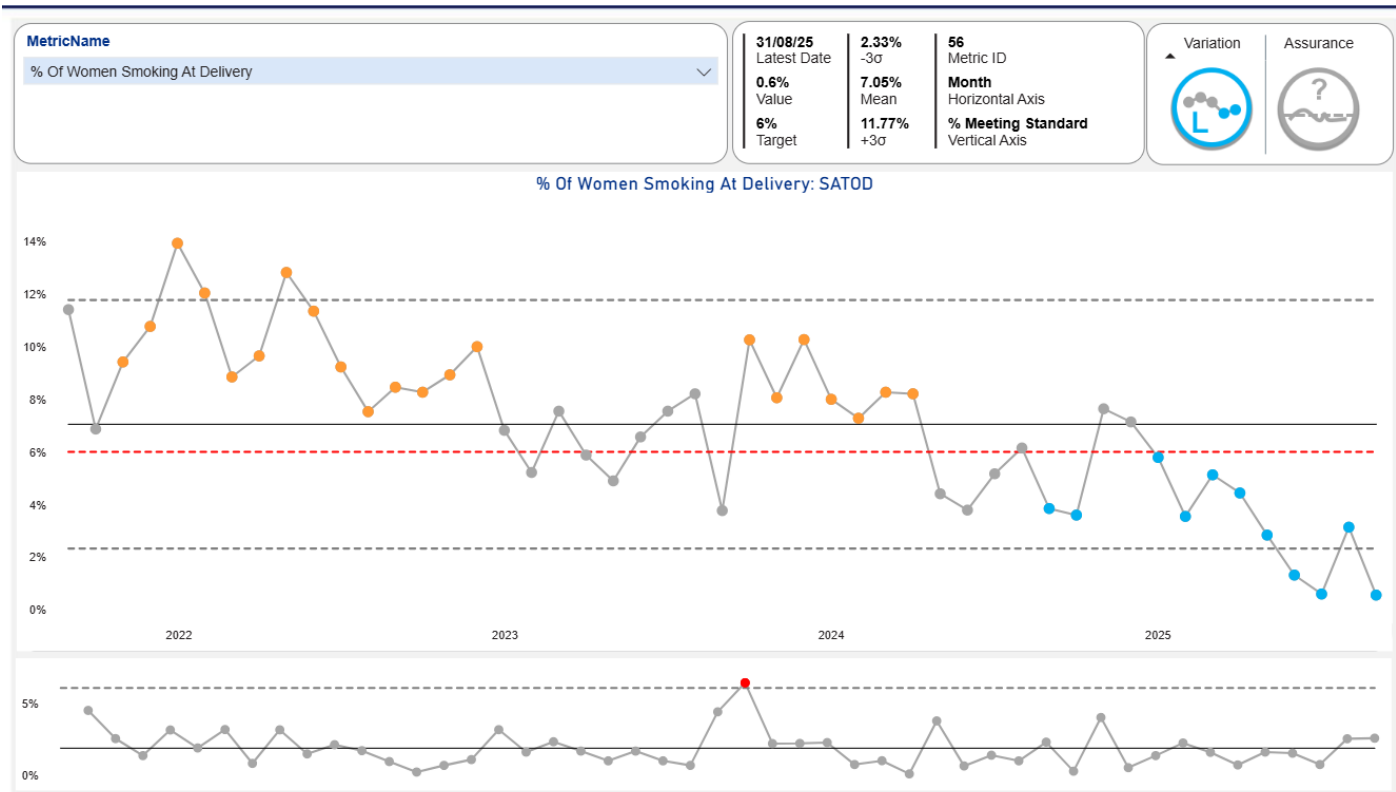
Metric	Target	Current position
Number of women delivered		183 in August
% babies born by elective caesarean	NTI	23.5%
% babies born by emergency caesarean	NTI	20.8%
% of births in the midwife-led unit (The Cove)	NTI	6%
% of women on a continuity of care pathway by 28 weeks	NTI	19.2%
% women smoking at time of delivery	< 6%	0.6% ↓ (6.3% at booking)
% CO recorded at booking	> 95%	90.6% ↓

% CO record at 36 weeks	> 95%	84.3% ↓
Number of stillbirths		1
Number of neonatal deaths		1 in Aug
% babies >37 weeks admitted to SCBU	< 5%	4.2% ↓
Rates per 1000 of PPH >1500mls (current 3 months)	< 30	49.2 ↑
Rates per 1000 of 3 rd /4 th degree tears (current 3 months)	< 25	32.7 ↑
% live births <37 weeks gestation	< 6%	7.2% ↑
Hypoxic Ischemic Encephalopathy incidents		Nil
% of babies with 1 st feed breast milk	NTI	74.9% ↓
% of babies with fetal growth restriction <3 rd centile, born after 37 weeks and 6 days	nil	nil
Rates per thousand of singleton babies born with an apgar score <7 at 5 minutes (rolling 3 months)	National average score 14	15.8 ↓ (improvement)
Number of neonatal admissions	26	

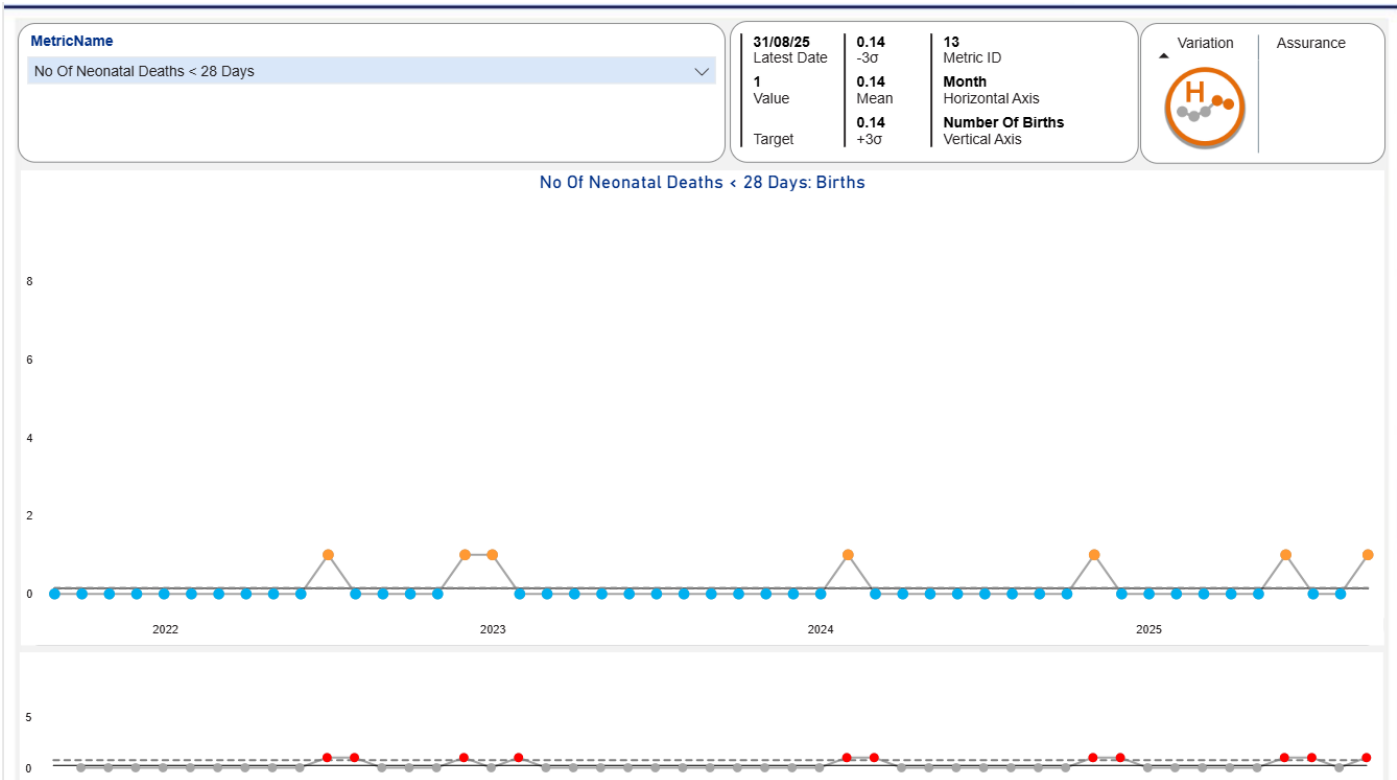
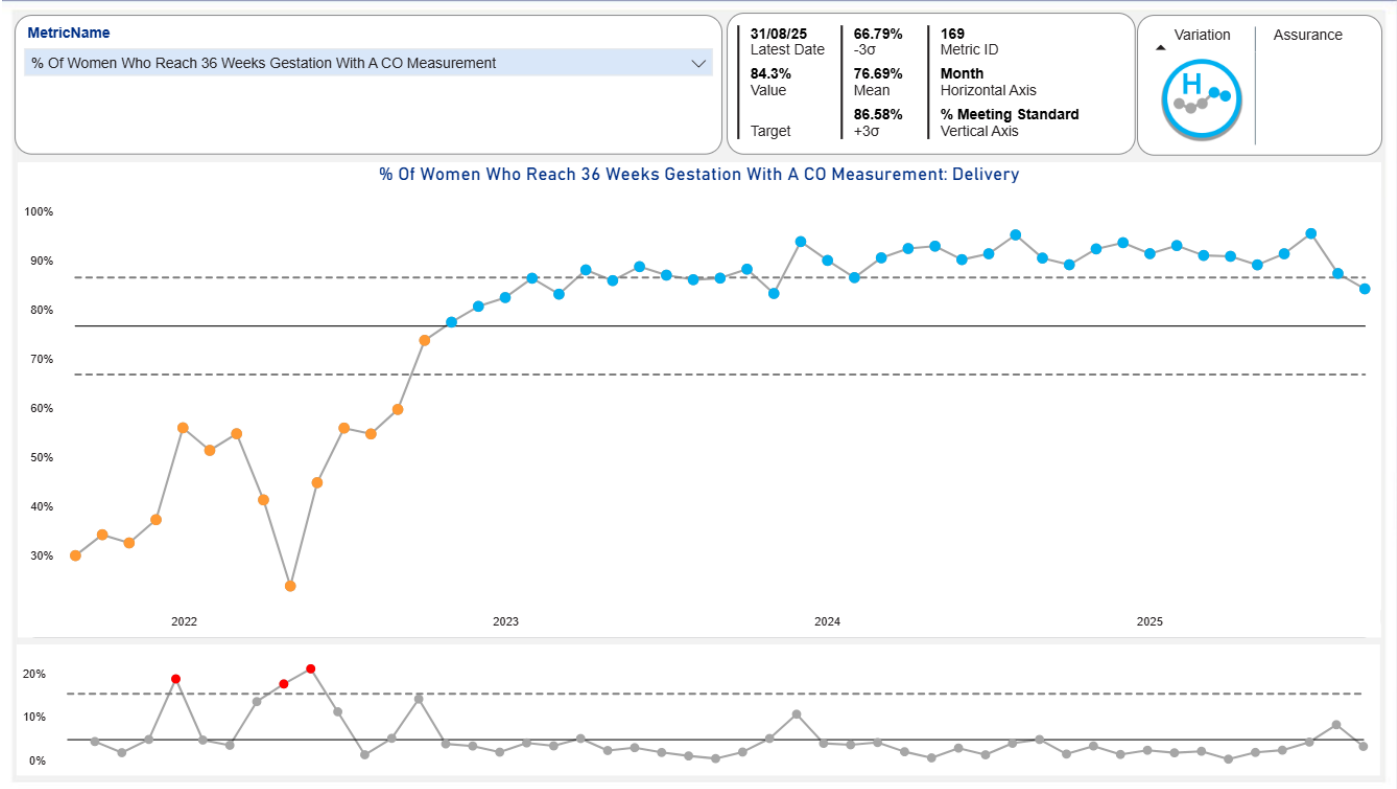




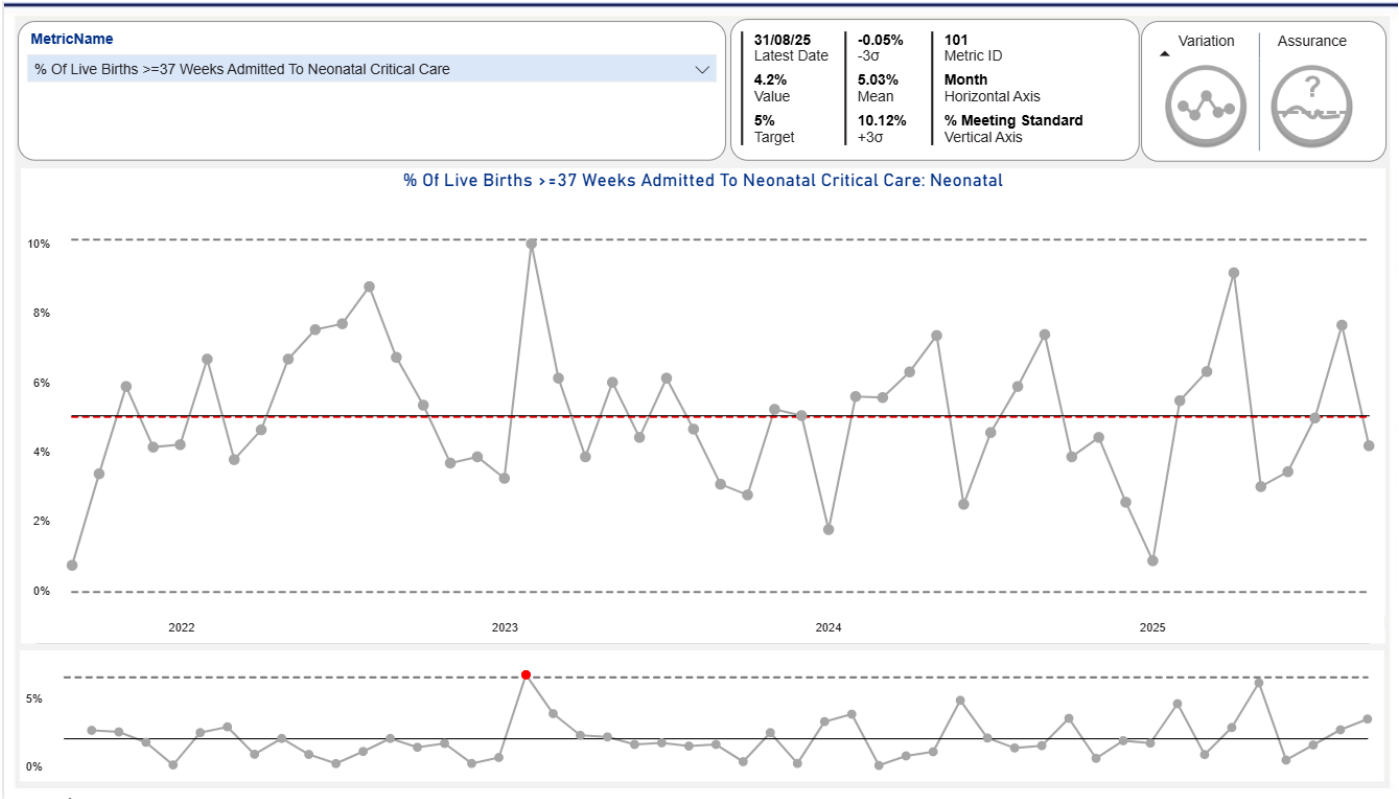
Baker, Abi
06/10/2025 12:40:16



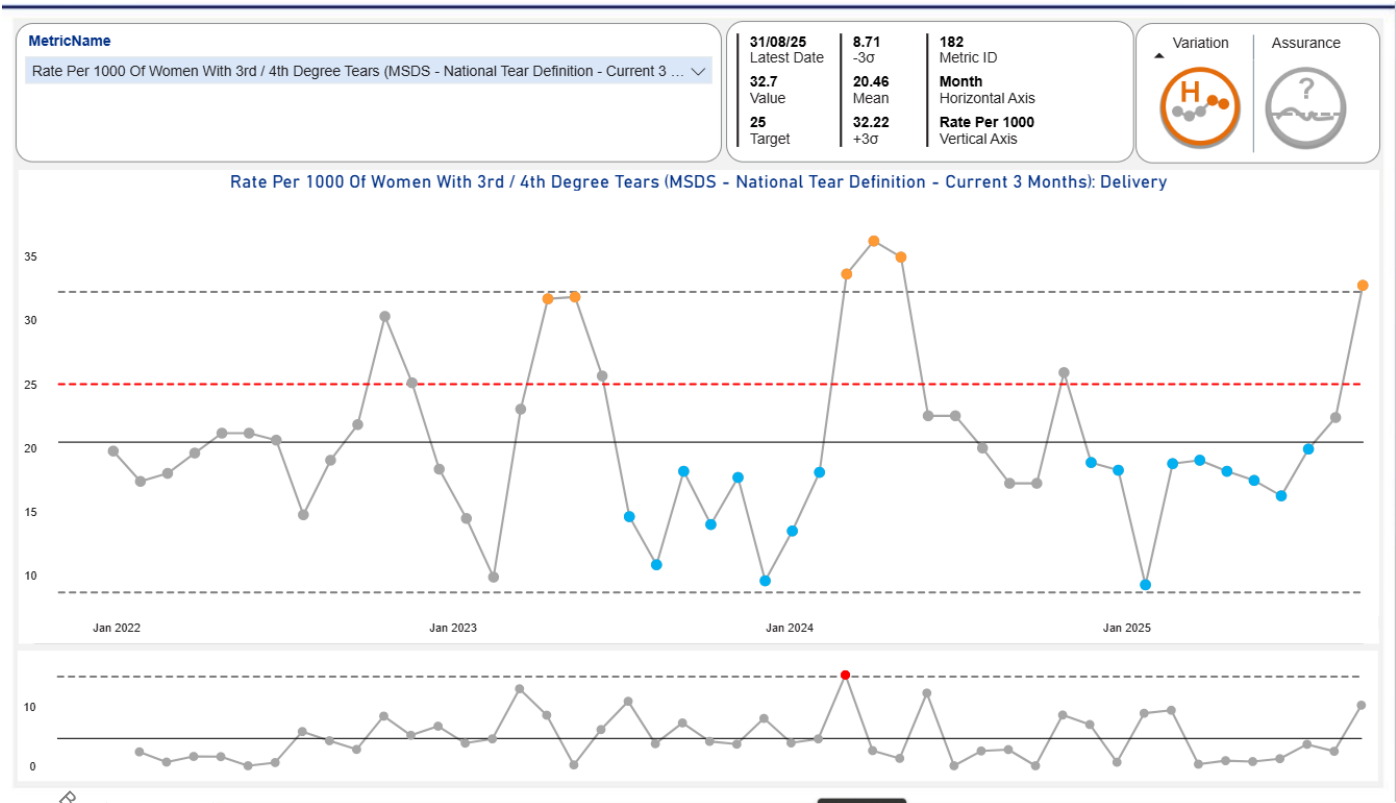
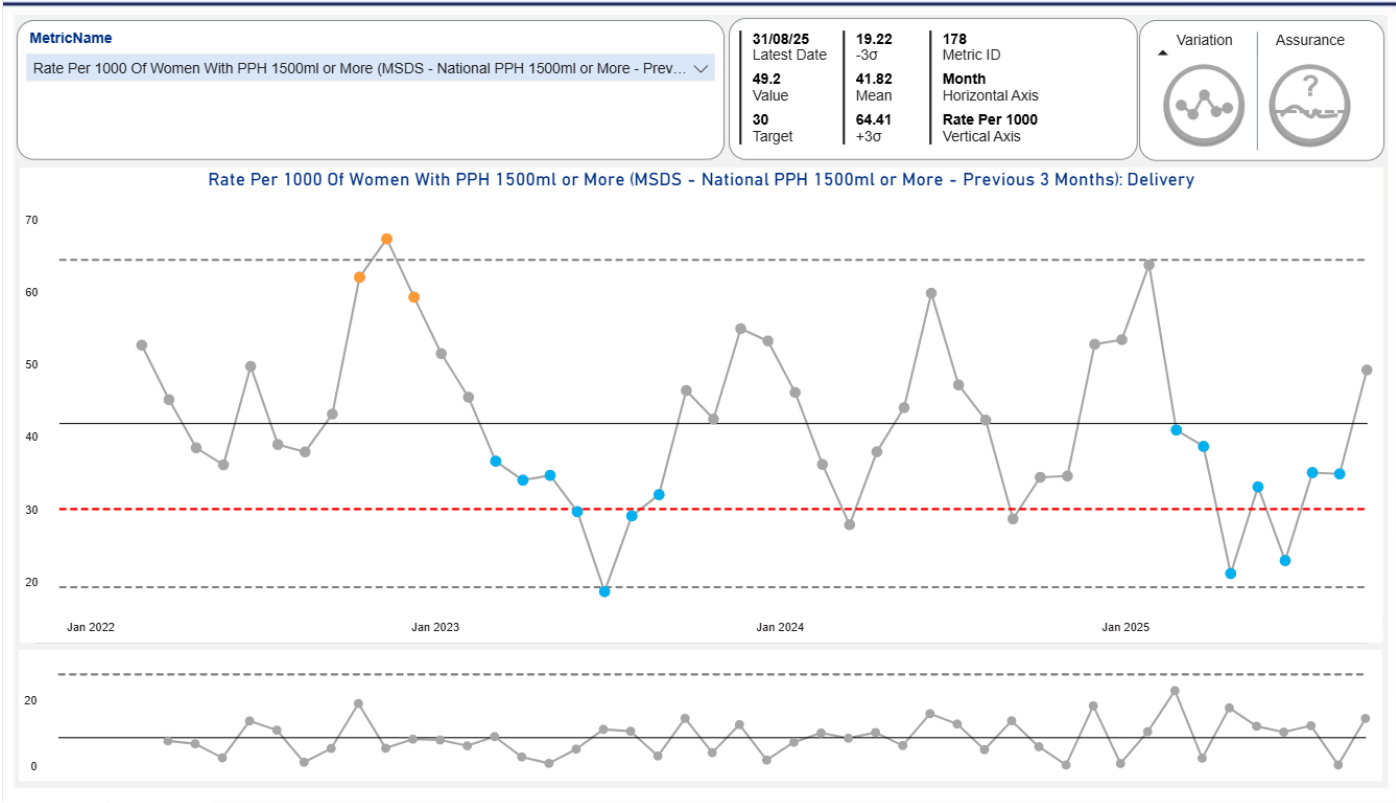
Baker, Abi
06/10/2025 12:40:16



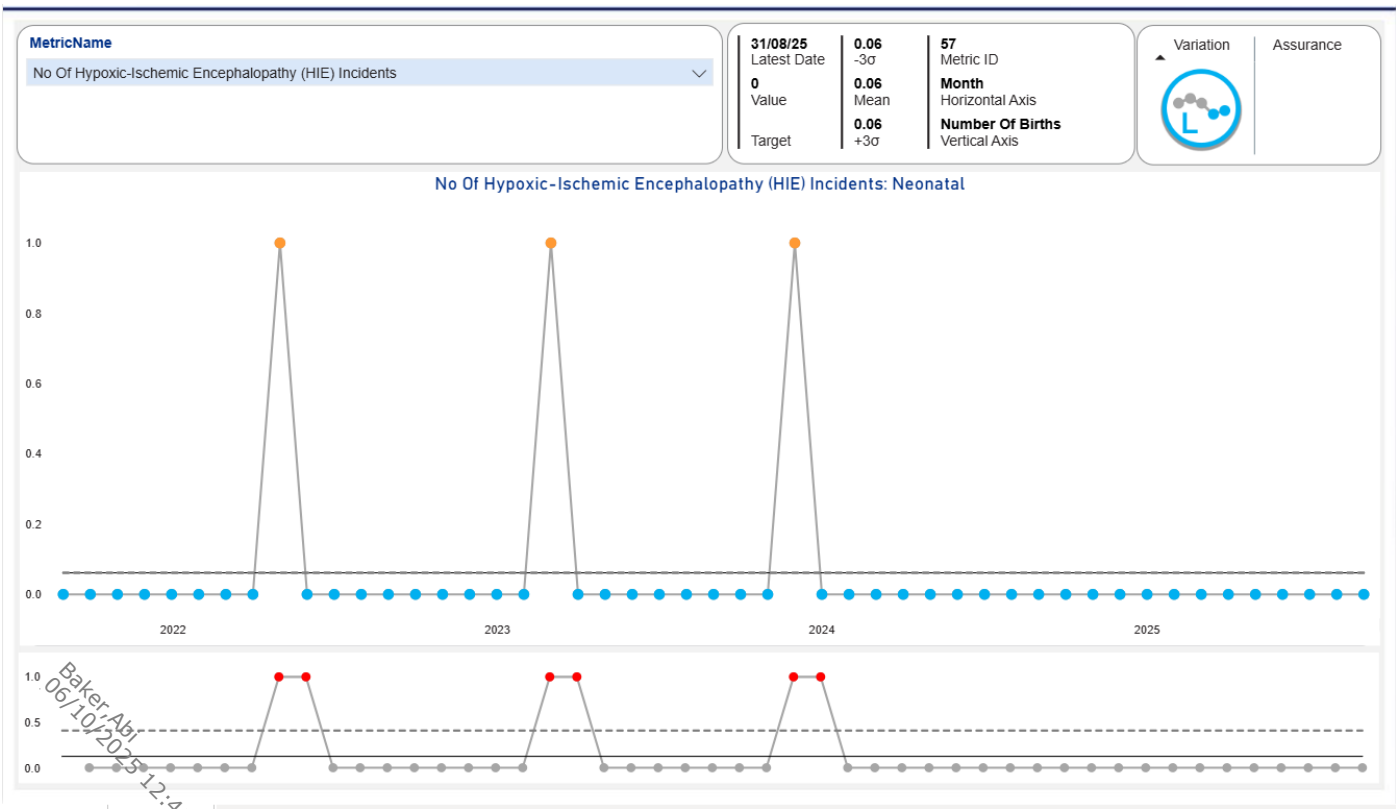
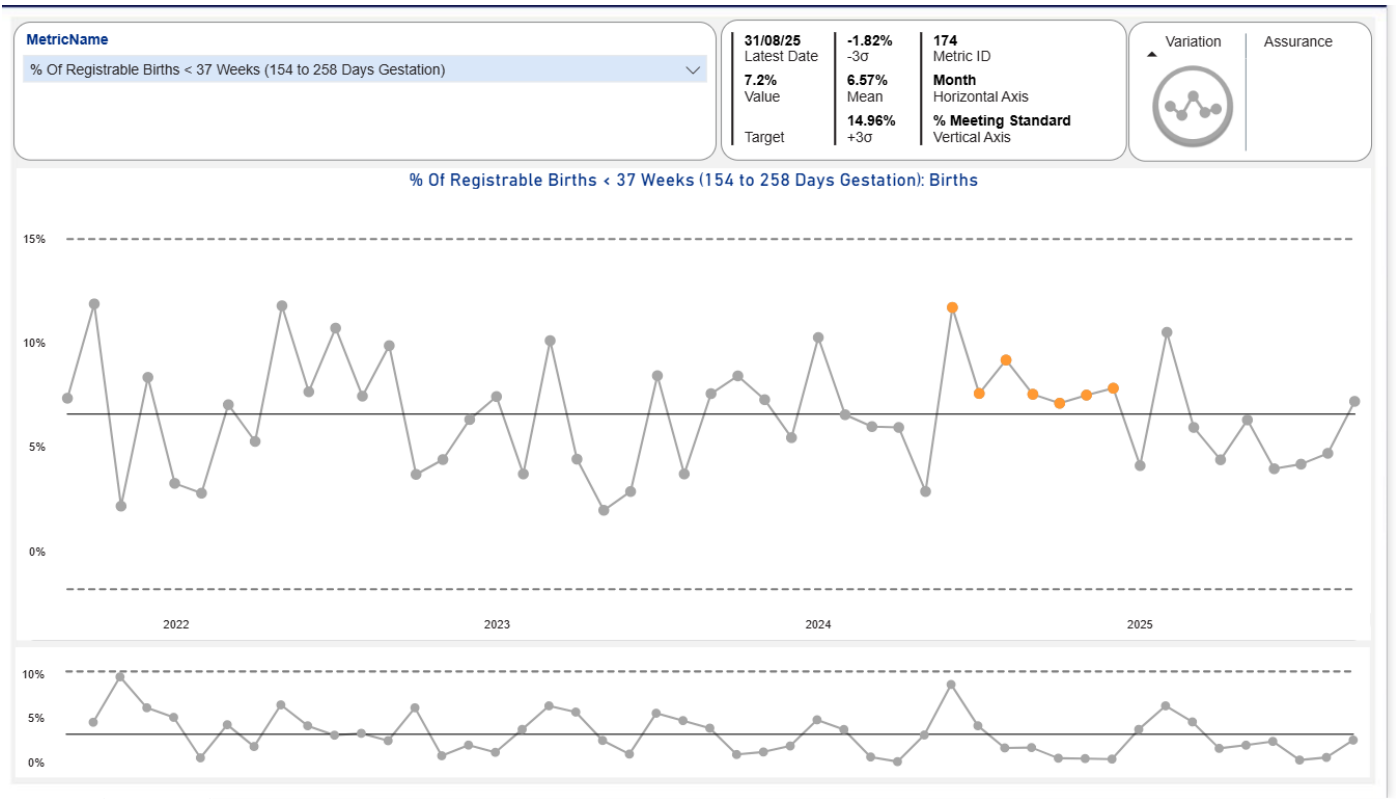
Baker, Abi
06/10/2025 12:40:16

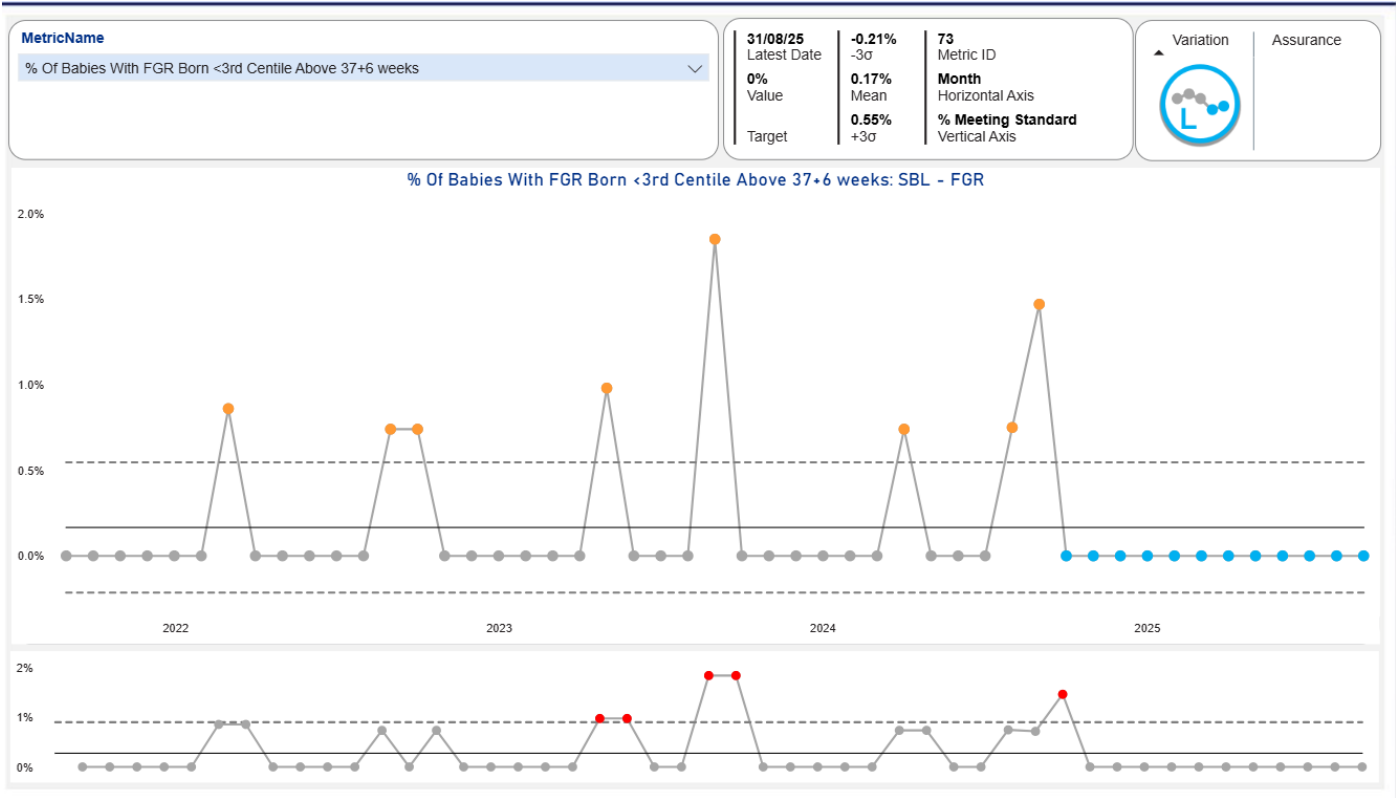
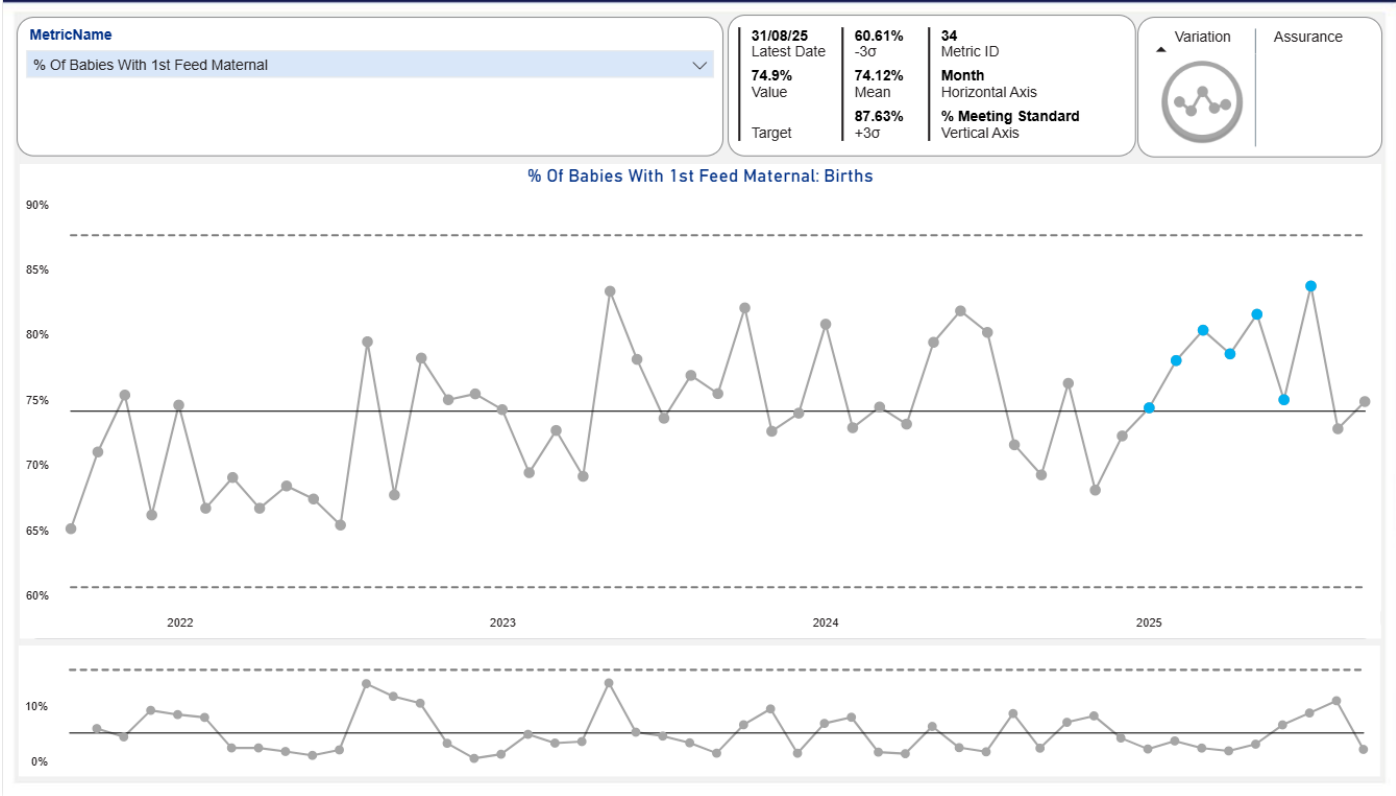


Baker,Abi
06/10/2025 12:40:16

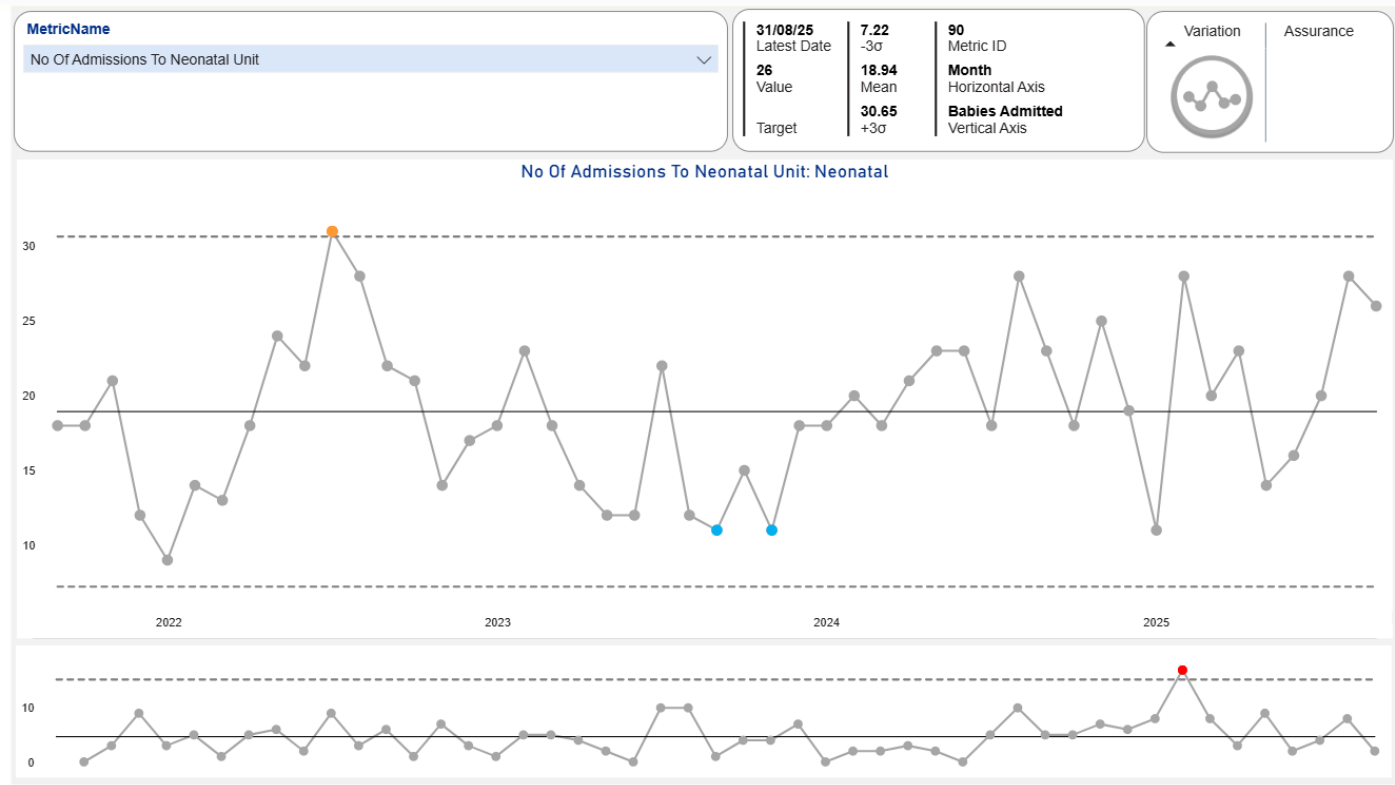
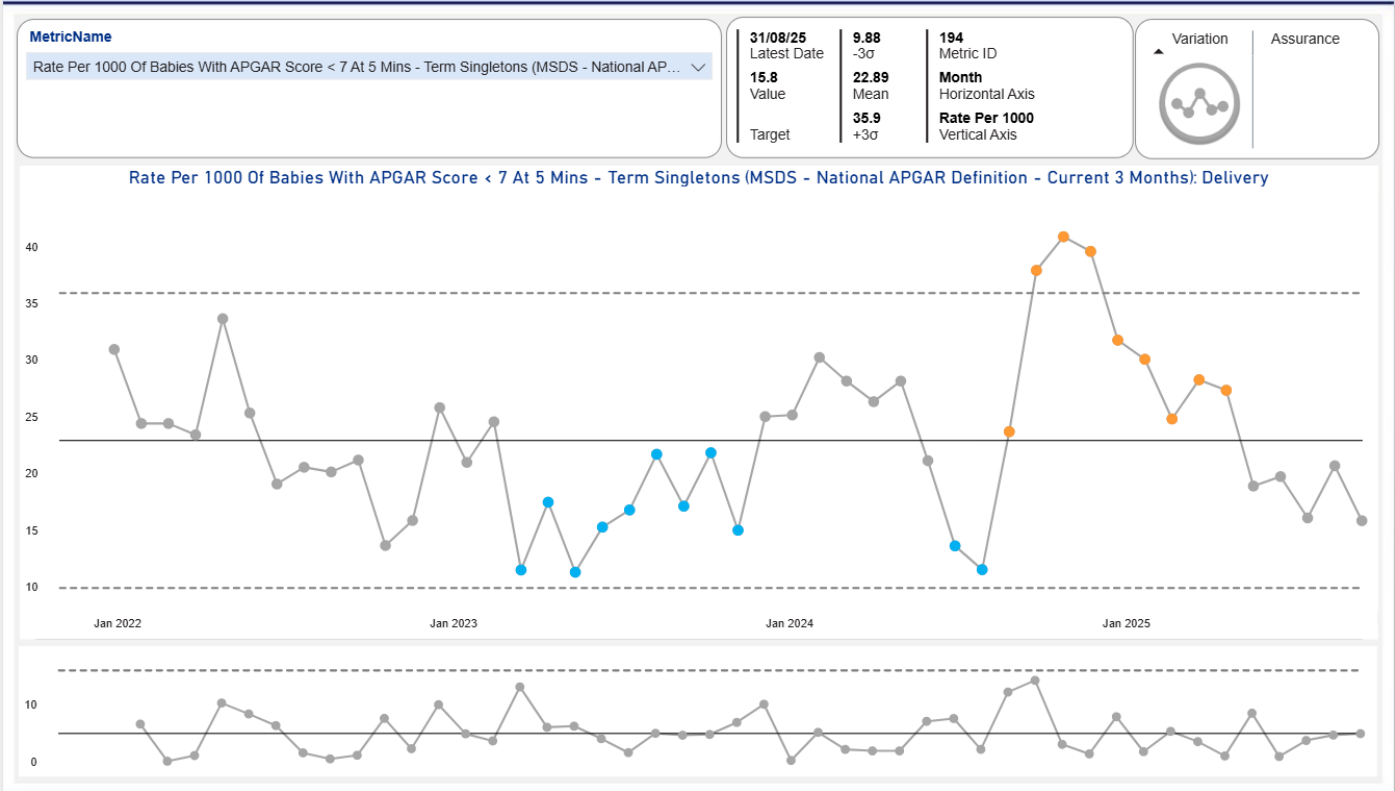


Baker, Abi
06/10/2025 12:40:16





Baker, Abi
06/10/2025 12:40:16



Baker, Abigail
06/10/2025 12:45:15

Total Number of Incidents submitted for July and August 2025

maternity & neonatal
181

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

Red flag	Descriptor	Incidents for July and August
RF1	Escalation to divert of maternity services & poor staffing numbers, including medical staffing and SCBU	8 incidents of escalation to divert relating to cot capacity in SCBU or maternity acuity and poor staffing
RF2	Missed medication	0
RF3	Delay in providing or reviewing an epidural in labour	0
RF5	Full examination not carried out when presenting in labour	0
RF6	Delay of ≥ 2 hours between admission for induction of labour & starting process	24 for IOL delayed, some >24hrs. one for LSCS delayed >24hrs
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	Homebirth service suspended multiple times in relation to escalation to OPEL 3 or 4
RF10	Delay of time critical activity	0

In-utero transfers – UHD is default level 2 NICU for DCH pregnancy <32 weeks	
29/40 threatened labour	transferred to UHD. Discharged home still pregnant
27+6/40 PET	transferred to UHD. Discharged home still pregnant
34+4 placenta praevia	Transferred to UHD because SCBU closed (cot capacity)

Baker, Abi
06/10/2025 12:40:16

harm	incident	Action
Fatal DCH109284	Planned homebirth attended by midwives. Term baby born in poor condition, heartbeat detected. Resuscitation commenced and 999 call made. Ambulance crew attended and contact with HEMS. Decision to withdraw resuscitation attempts made by MDT during transfer to hospital.	Case to be overseen by the Coroner with CDRM, PMRT and MNSI. Family being supported by Bereavement Team
Moderate DCH106403 Update	Baby readmitted to postnatal ward from home on day 2. Baby collapsed on the ward and was urgently admitted to SCBU and transferred out to NICU in Southampton. Sadly, baby died a short time later. Currently this remains as moderate until the external reviews have completed. This grading in no way detracts from the very sad outcome	MNSI nearly completed their interviews – final one next week. Family receiving support from the SFT Maternity & Neonatal Independent Senior Advocate Preliminary PMRT & CDRM has graded the case as a B for antenatal care and a B from the birth of baby until the death. However, this is not a conclusive meeting as that will occur after the MNSI report is published, as well as the PM and coroner's decision
Initially assessed as no harm but now regraded as moderate DCH107239 Update	Two day old baby taken to the postnatal ward via ambulance for low blood sugar and poor tone. Admitted to SCBU and transfer to tertiary centre. Baby now at home.	Baby is currently well and will be followed-up in baby clinic Work stream with SWAST focused on admission pathways for neonates
Moderate DCH107133 Update	Baby admitted to SCBU for low oxygen saturations. Maternal medication indicated regular neonatal observations. These were not carried out on the postnatal ward overnight. Checked at approximately 8hrs of age and required escalation. Baby now at home.	Baby is currently well and has been regraded to low harm . Email to staff regarding observations on babies using the NEWTT observation chart and O2 saturations

Opening a second theatre in an emergency – non reported

3rd & 4th degree tears July and August

Ethnicity	Grade of tear	Mode of birth	Hands on	OASI	Position of woman	Baby's weight	Blood loss	Referral made
White British	3a	In water	off		kneeling	3588g	350mls	yes
White British	3a	forceps	on		lithotomy	4282g	515mls	yes
Indian	3a	normal	on		Semi prone	3930g	480mls	yes
White British	4	normal	off		Not recorded	4530g	400mls	yes
White British	3a	normal	on		Not recorded	3600g	770mls	yes
White British	3a	normal	poised		Not recorded	4000g	300mls	yes

White British	3a	forceps	off		lithotomy	3526g	1402mls	yes

SBL update quarter one

Saving Babies' Lives (Version 3.2) Board Report

Trust	Dorset County Hospital
Date of report	21/08/2025
Review period	Quarter 1, 2025/26
ICB accountable officer	Pam O'Shea (Interim ICB Chief Nursing Office)
Trust accountable officer	Dr Rachel Wharton (Chief Medical Officer)
LMNS peer assessor name(s)	Vicky Garner (LMNS Lead Midwife)

Executive summary:

- This is the first quarterly review since the launch SBLv3.2, with its updated interventions and evidence requirements.
- 100% compliance achieved in Elements 1 (Smoking in Pregnancy) and 5 (Preterm Birth) for the first time.
- Q2 2025/26 priorities to demonstrate sufficient progress with SBLv3.2 implementation:
 - Further improving compliance with uterine artery doppler assessment (intervention 2.7) now process embedded
 - Establishing and evidencing improvement meetings for Element 5
 - Evidencing additional requirements in Element 6 to reflect SBLv3.2 changes

		Q1	Q2	Q3	Q4
% of interventions fully implemented (LMNS Validated)	Element 1 Smoking in pregnancy:	100%			
	Element 2 Fetal growth restriction:	100%			
	Element 3 Reduced fetal movements:	100%			
	Element 4 Fetal monitoring in labour:	100%			
	Element 5 Preterm birth:	100%			
	Element 6 Diabetes:	67%			
	Total implementation (all elements):	97%			



Dorset Local Maternity and Neonatal System



Agreed Improvement Activity and Shared Learning

Element 1	- First-time achievement of 100% compliance in this element. 7 of 9 stretch audit targets met or exceeded. - Process indicator 1e (CO verified quit at 4 weeks) target raised to 55% from Q2, aiming for stretch ambition of 60% by Q3 2025/26.
Element 2	- Compliance with uterine artery doppler assessment (intervention 2.7) sustained above 50% target. With process now embedded, a new target will be set in Q2, aiming for ≥80% by end of Q3 2025/26. - Exception reports for outcome indicator 2d (<3rd birthweight centile born after 38 weeks) and process indicator 2b (antenatal detection of small for gestational age babies) provide assurance of processes and outcomes with no associated harm.
Element 3	- Next working day ultrasound compliance (intervention 3.2, process indicator 3b) sustained; current focus is improving compliance for patients attending at weekends. - Intervention 3.2 learning to be shared at LMNS safety meeting, September 2025.
Element 4	100% compliance with Element 4 sustained over last two quarters. - Perinatal mortality review tool reporting shows no associated risks of harm identified.
Element 5	- No singleton preterm births during Q1 2025/26, limiting the relevance of several Element 5 audit metrics. Whilst this is positive, caution is advised in interpreting this data. Compliance over the last 12 months offers a more reliable picture of performance and priorities. - A priority for Q2 is establishing improvement meetings and providing evidence of ongoing audit and quality improvement to meet the new requirements of SBLv3.2. - Minimum SBLv3.2 target for process indicator 5d (optimal cord clamping) is now set at 70%
Element 6	100% compliance with new audit for type 1 diabetic patients being offered Hybrid Closed Loop System (intervention 6.2) to be celebrated. - Following changes to SBLv3.2, guideline updates and Trust Board confirmation that HCL specific roles are in place are required to achieve full compliance.

Risk Register

ID	Title	Risk Statement	Open	Risk	responsibility
2180	Lack of psychological support service for neonatal service	Lack of funding for specialist psychological professional, to support parents, in line with staffing recommendations for the Neonatal Units. Discrepancy in care across the region, as some units have psychological support in place (level 2 and 3 around us). When infants step down in care and move to DCH this support is nonexistent.	25/06/2025, Débora Pascoal-Horta, Neonatal Matron, quarterly review	Moderate 12	Service specific

Baker, Abi
06/10/2025 12:40:16

2159	Patient and governance confidentiality	Layout of neonatal unit results in daily breaches of confidentiality. Notes trolley in corridor. Phone conversations in the middle of the ward. Multidisciplinary conversations with external agencies in the middle of the ward. Inability of staff to leave the area for private conversations. No private area for storage of iPads, notes and computers where staff can document without being observed. Complaints received from parents, detailing how they could hear and observe confidential information. Observational analysis done for a period of 3 days, that showed numerous breaches of information governance and patient confidentiality events every hour. Mitigation: Covers created for patient observations clipboards. Staff reminded about confidentiality and the need to move to a different area for private conversations, when possible. Staff asked to datix when they witness incidents related to confidentiality. Daily observation and reminder by Matron and Governance Lead to the Team about open folders and iPads and logging out PCs after use. Update Proposal made to Space Utilisation Group accepted. However, it was decided that this project should merge with existing project for offices across the Trust. Unsure at present when this can be actioned.	09/05/2025, Débora Pascoal-Horta, Neonatal Matron, quarterly review	Moderate 8	Division
2183	YDH closure impact on obstetric workforce	Update obstetric cover is poised to improve with new doctors starting next month. This will provide an extra SHO for labour ward, alongside the established gynae middle-grade and obstetric middle-grade for daytime hours. The acuity is notably higher on labour ward and the attendance at DAU has increased.	30/06/2025, James Male, Service Manager. Quarterly review	moderate 12	division
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 funding. 1.8wte included in the maternity business case related to the DCH funding required for the advice line	07/04/2025, Jo Hartley, DoMN Services, quarterly review	moderate 12	Division

Baker, Abi
06/10/2025 12:40:16

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 progress in relation to the business case to fund staffing cover required for five day opening. YDH confirmed they have some capacity to assist – meeting arranged to discuss	20/09/2024, Jo Hartley, DoMN Services, quarterly review	Moderate 9	Division
1881	Neonatal Nursing & Medical Staffing	Update Business case approved and CoE actioned, increasing the establishment for the unit and allowing recruitment in the next few weeks. RNs with QIS also joined the bank and are now doing regular shifts on the unit, reducing drastically the use of agency. Risk still present but reduced. YDH neonatal nurse also working all her hours at DCH. Recruitment ongoing. Consultation with some staff to change band 3 to band 6 nurse on nights - allowing for 3 RNs and therefore a supernumerary lead nurse The service is now compliant with BAPM guidance as well as the soon-to-be-published RCPCH Facing the Future standards for paediatric cover. The additional doctors to support an independent tier 2 rota have meant a more robust/resilient level of compliance. Tier 1 Rotas should have a minimum of 8 whole-time equivalent (WTE) staff who may additionally cover paediatrics if this does not reduce safety and quality of care delivery. There should be a resident Tier 1 practitioner dedicated to the neonatal service during weekday day-time hours and an immediately available resident Tier 1 practitioner 24/7." Tier 2 Shared rota with paediatrics comprising a minimum of 8 WTE staff. Tiers 1 and/or 2 may be able to be covered by appropriately skilled nursing staff" Tier 3 "A minimum of 7 WTE consultants on the on-call rota with a minimum of 1 consultant with a designated lead interest in neonatology.	01/05/2024 Débora Pascoal-Horta, Neonatal Matron, quarterly review	Moderate 9	Division

Baker Abi
06/10/2025 12:40:16

1825	3 x neonatal ventilator SLE 5000 out of service	Update New ventilators now on the unit and comprehensive training package for all staff in place. Anticipated timeframe for full use of new equipment is mid August to ensure all staff confident with use.	26/02/2024, Debora Pascoal-Horta, neonatal matron, quarterly 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 Continued LTS makes the maternity digital service extremely fragile and it is likely the one midwife providing cover will be moving to a new job, leaving no dedicated digital cover for maternity. Significant impact on troubleshooting, training, onboarding new staff, data cleansing (directly related to MIS). A request has been submitted to recruit an interim lead for the service. This has now been regraded to high risk	14/01/2025, Jo Hartley, DOMN, quarterly	high 15	division
1689	Opening a second theatre in an emergency & the elective pathway	Update There have been several successful trials of use of an additional theatre and these went well. Business case submitted to support an elective pathway being considered in relation to increased YDH activity. A second theatre wasn't required in July and August for an emergency cases	29/06/2023 managed by Jo Hartley DoM, quarterly review	moderate 9	division
876	Maternity Staffing	Update whilst incidents of escalation to OPEL 3 and 4 continue to occur regularly and IOLs and LSCSs are regularly delayed, there has been progress in relation to recruitment. 6.4wte NQM appointed for 12 months fixed term. 2 wte additional band 6 midwives recruited for fixed term 12 months. Agency now used regularly and ward staffing increased to 8 plus the coordinator. However, the manager on call frequently called in to bolster numbers and incentives used regularly. There isn't enough	21/09/2021 Managed by Jo Hartley, Director of Midwifery, monthly reviews	High 20	Division

		coordinators to ensure a 24/7 oncall for homebirths and senior cover. Sickness in the senior team often has to be covered by matrons. Given the challenges with ensuring a coordinator is available for every shift, the significant reliance on agency and the frequency of rotas not being fully staffed, the risk remains high	

Complaints and birth debrief feedback for maternity and SCBU

Total informal and formal

Month	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
total	1	1	1	3	2	2	2	4	0	1	4	1

Themes
Delayed induction of labour without an adequate explanation
Partner unable to stay overnight
Failure to ensure partner (Dad) had skin-to-skin with his baby
Poor postnatal care including catheter not emptied, patient not assisted with personal hygiene, bells not answered quickly, bedding not changed. Staff unable to provide feeding support doe to being called away to answer bells etc.
Feeling “forgotten about” immediately after the birth
Administration of an injection
Provision of a clear explanation about a plan of care following a change in the risks associated with the pregnancy
Communication around consent for a forceps birth – ensuring the patient was able to understand and provide informed consent

Theme	Key Insights from birth debriefs Quarter 1 2025
Communication	Clear, empathetic communication is essential. Miscommunication or dismissive comments caused distress in several cases. Reviewing notes together was consistently helpful.
Pain Management	Pain was often underestimated or poorly managed, especially during IOL or rapid labours. Emotional context (e.g., hearing others in pain) also influenced perception.
Continuity of Care	Disruptions in handovers, delays in medical review, and inconsistent documentation were common concerns. Positive experiences were linked to consistent, calm care.
Clinical Care	Common clinical themes included IOL, PET, GBS, shoulder dystocia, and emergency LSCS. Rapid labours and evolving plans or care influenced outcomes.

Emotional Support	Debriefing was universally valued. It helped parents process trauma, understand decisions, and plan for future births. Partner involvement and mental health support were also key.

Audit data – Apgar of 7 or less, after 5 minutes for singleton birth

In July 2025 it was noted via the Business Intelligence SPC charts that Dorset County Hospital (DCH) had a sustained higher-than-average number of babies born with an Apgar score of 7 or less at 5 minutes over a period of eight months from July 2024 – March 2025. Despite the rate decreasing from March 2025, the records of all babies born between 01 June 2024 – 31 May 2025 with an Apgar of 7 or less were examined to assess if there were any identifiable themes to improve neonatal outcome. Total number of births in date range: 1608 Number of babies born with Apgar 7 or less at 5 minutes: 88 Percentage of all births with Apgar 7 or less at 5 minutes: 5.4% Discussion The majority of babies with an Apgar of 7 or under at five minutes were those born 38+0 to 39+6 weeks (58%). Just under a third of pregnancies had no antenatal risk factors, with the next highest risk groups being large for gestational age, hypertension, reduced fetal movements and diabetes. The highest intrapartum risk factor was concern shown for the foetus during electronic fetal monitoring (CTG) with 37% babies in this group, followed by 29% who had no intrapartum risk factors, the use of oxytocin 19% and the presence of meconium 18%. It is recognised that a baby may have none, one or more intrapartum risk factors. The majority of babies (77%) were born in maternity theatre – 39 requiring an emergency caesarean section and 21 for elective caesarean section. In 39 cases the mother had a spinal anaesthetic and in 16 cases a general anaesthetic was administered, with two women receiving a spinal prior to GA. A further 10 women had an epidural in theatre for either a caesarean section or instrumental birth and three women had a spontaneous vaginal birth in theatre with Entonox only. During 45 of the births in theatre an advanced neonatal resuscitator was requested to attend the birth and was documented as present in all but three cases where it is not documented if they were present. In just over half of all cases, an advanced neonatal resuscitator was required for the birth and was in fact present at 70% of births overall. The disparity between requested and present may reflect the labour ward coordinator being present at the birth and who is a trained advanced neonatal resuscitator. The majority of babies (89%) required respiratory support via Positive End Expiratory Pressure (PEEP) with just under half of these also requiring inflation and/or ventilation breaths. Five babies did not require any respiratory support and for one baby it was not documented. In just over half the births, an Apgar was not recorded at 10 minutes of age. On examining documentation in the records, it was noted that in the majority of these cases the baby’s condition had improved at ten minutes and the baby was back with the mother. Cord gases were taken at 75 (85%) of the births, as recommended by NICE Intrapartum guidance. Of these, 62 babies (70%) blood gas result were within normal range. Key Findings <table> <tr> <td>Born in maternity theatre</td><td>77%</td></tr> <tr> <td>Spinal anaesthetic</td><td>45%</td></tr> </table>		Born in maternity theatre	77%	Spinal anaesthetic	45%
Born in maternity theatre	77%				
Spinal anaesthetic	45%				

Advanced Neonatal Resuscitator present	70%
Apgar documented at 10 mins	54%
Cord gases taken	86%
Admitted to SCBU	33%
Documented on-going care plan	89%

Themes

No themes identified

Actions

Advanced neonatal resuscitators reminded to document Apgar score at 10 minutes and ensure care plan is documented. **Completed 01/08/2025**

Anaesthetic staff emailed for comment on high number of women undergoing spinal who have baby born with low Apgar score to discuss if any change may have affected neonatal outcome. No changes or concerns identified by anaesthetists. **Completed 02/09/2025**

Formally register and re-audit babies born with an Apgar of 7 or less at five minutes 01 September – 30 November 2025, with report due 31 January 2026

Future audit to include checking if NEWTT2 observations chart in use for babies on the maternity unit who had low Apgar's or who required resuscitation (DCH guideline 2343 v5 NEWTT2 – Observations of Babies on The Postnatal Ward and Transitional Care)

Audit data – Consultant Obstetrician RCOG Roles & Responsibilities: Attendance Audit

Baker, Abi
06/10/2025 12:40:16

Background

This RCOG define the clinical scenarios and situations when consultants should be informed and when they should attend in person. In situations where the consultant is to be informed, this should include a full discussion regarding the patient's care and any concomitant clinical activity. Where individual units or doctors choose to deviate from these standards, there must be a clearly documented justification for doing so.

Aim

Demonstrating compliance with 80% of applicable RCOG situations when a consultant must attend is a requirement for Maternity Incentives Scheme year 7 Safety Action 4.

Discussion

One incident concerned a consultant not attending evening ward round. This was escalated at the time to the Maternity Manager On Call and followed up appropriately; the consultant did then attend. At the time of the reported non-attendance for evening ward round it is noted there had been a recent change to the time of ward rounds.

There were 13 cases of Postpartum Haemorrhage (PPH) over 2000mls and ongoing, ten of which were attended by a consultant. Of the three cases not attended, in two cases the consultant was notified when the blood loss was 1500mls but not explicitly asked to attend as it was thought the blood loss was settling. In the one remaining PPH case, the consultant was not informed or asked to attend.

During the data collection period it was noted the QR/Teams Form was completed for a total of five cases when the consultant was requested.

RCOG situations where a consultant must attend

Clinical Situation	Number of Cases	Attended	Percentage
Acuity, unit closure, 2 nd theatre	1	1	100%
Any return to theatre	1	1	100%
Team debrief requested	0	0	n/a
If requested to do so	30	29	93.5%
Early warning score or sepsis screenig tool suggests HDU/ITU care likely	0	0	n/a
Placenta praevia	1	1	100%
CS birth BMI >50	0	0	n/a
CS birth <28/40	0	0	n/a
Premature twins <30/40	0	0	n/a
4th degree perineal tear	1	1	100%
Unexpected intrapartum stillbirth	0	0	n/a
Eclampsia	0	0	n/a
Maternal collapse	1	1	100%
PPH>2000mls and ongoing	13	10	77%

The findings over the three-month period covered by this audit demonstrate a 91.3% compliance with the RCOG Consultant Roles and Responsibilities criteria which meets the 80% and over requirement for Maternity Incentive Scheme Year 7 Safety Action 4.

Recommendations:

- 1. Remind staff to clearly document when a Consultant has been requested and when they attend; include that Consultants, Registrars and Coordinators can complete the Teams Form.
- 2. Strengthen blood loss monitoring procedure during PPH in labour rooms and theatre to avoid delay in weighing blood loss, to ensure the Consultant is called in a timely manner. Include a reminder that Consultant must be informed when blood loss is 1500mls ongoing.
- 3. Investigate if a Consultant Requested and Consultant Attended Form can be added to BadgerNet electronic record to support improvement in documentation and provide auditable data.

Neonatal transfer out data for July and August

Gestation	Weight	Reason	Transferred to
Nothing to report			

Neonatal exceptions (babies that should have been born at a maternity unit with a level 2 or 3 neonatal service or babies remaining in SCBU past 44 weeks gestation)

Baby born 17/05/2025	29+4 weeks, 1230g	Now 45+1/40 corrected gestational age. Remains on low flow oxygen for chronic lung disease associated with prematurity

Babyloss data for July and August

Baker, Abi
06/10/2025 12:40:16

Intrauterine death	Neonatal death	Late neonatal death
D799719. IUD of baby at 36+5 weeks, known probable T21 and cardiac anomaly, under care of Fetal Medicine Team. Fetal demise on day of scan. Postmortem consent. Ongoing support from Bereavement team with early follow up and debrief planned with Fetal Medicine consultant D839226, IUD of baby at 20+6 weeks, detected at anomaly scan. Postmortem consent. Debrief and feedback with results at DCH. Ongoing bereavement support by YDH. D593418 IUD of baby at 21+1 weeks, following an attendance for reduced fetal movements. No post-mortem, but genetics and placental histology results will be fed back via the consultant follow up. Ongoing support with bereavement team	D593418 Neonatal death of baby at 40+5 weeks. Unexpected and cause of death yet unknown. A post-mortem is being carried out by the Coroner's office, MNSI and PMRT reviews will be undertaken. Ongoing support by bereavement team.	

Baker, Abi
06/10/2025 12:40:16

Perinatal Training Compliance

Rolling 12-month period ending July 2025

Key	
≥90% compliance	
<90% compliance	

MIS Year 7 Reportable Training	Staff Group	Compliance (%)
SA6 SBLv3 Element 1.8	Carbon Monoxide Monitoring Midwives and MSWs giving Antenatal Care	92%
SA6 SBLv3 Element 1.9	Very Brief Advice all staff (midwives, obstetricians and MSWs)	91%
SA6 SBLv3 Element 2.11	Practical SFH assessment (obstetricians and midwives)	91%
Fetal Monitoring and Surveillance in the AN and Intrapartum period	Obstetric Consultants	60%
	Obstetric doctors (Registrars)	100%
	Midwives	92%
PROMPT	Obstetric consultants	100%
	Obstetric Registrars	100%
	Doctors on obstetric SHO rota	83%
	Midwives	97%
	MSWs	97%
	Obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors	92%
	All other obstetric anaesthetic doctors contributing to the obstetric rota	90%
Neonatal Basic Life support (NBLS) Yearly	Paediatric consultants	100%
	Paediatric registrars	100%
	Neonatal nurses	94%
	MSWs and HCAs who require this training as per local policy	100%
	ANNP	100%
	Midwives	93%
RCUK NLS Certification	Senior midwives and homebirth midwives	100%
	Paediatric Consultants	100%
	Paediatric Registrars	100%
	Neonatal Nurses	100%

Trust Mandated Training	Staff Group	Compliance (%)
Adult Basic Life Support	Obstetric Consultants	70%
	Obstetric Registrars	100%
	Drs on Obstetric SHO rota	100%

Safeguarding training Level 3	Midwives	86%
	MSWs	97%
	Midwives	80%
	MSWs	39%

Safety Walkabout with CNO and DoN



Integrity | Respect | Teamwork | Excellence

NHS
Dorset County Hospital
NHS Foundation Trust

Safety Champions Action Board

Safety Walkarounds

27. 08. 2025 Jo Howarth + Dawn Dawson

- Quality walkround - unit very busy today and in OPEL 3.
- Discussed impact of clinical need on other workstreams
- No immediate safety concerns raised with us today.
- 4 deliveries whilst on the unit today.
- Visited SCBU as part of the Walkaround today. No immediate concerns raised.
- Positive impact of improved anaesthetic rota.

Safety Champion Meetings

27. 8. 25.

Issues identified : Storage of Cots + equipment : Picker Survey Actions + opportunities to work with MHD on areas for improvement.

Importance of Perinatal M+Ms + MDT attendance

Staffing + future plans.

Positive feedback from GMC President Dr. Survey

Positive feedback from Fi NLS training at Y.D.H

BB One Show Tonight @ 7pm!



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

Perinatal Quad and Safety Champion Meeting August 2025

Perinatal Joint Quad & Safety Champion Meeting

Minutes of the Meeting of 27th August 2025
Microsoft Teams meeting

- Present:
- Aglaia Salvari (AS) – Anaesthetic Consultant & Safety Champion
 - Elizabeth Passells (EP) – Maternity Governance Lead & Deputy Safety Champion
 - Jo Howarth (JH) – Director of Nursing
 - Hannah Eastwood (HE) – MNVP Representative
 - Claire McFarland – Family Services Business Manager & QUAD representative
 - Claire Hollingsworth – (CH) Paediatric Consultant, Neonatal Lead, Neonatal safety Champion & QUAD
 - Srabani Mukherjee – Obstetric Consultant & QUAD

Chair: Jo Hartley – Director of Midwifery and Neonatal Services

1.1 Apologies – to note:

Jenny Townsend Anaesthetic Consultant & Safety Champion.

Lindsey Burningham, Head of Midwifery & Neonatal Services and QUAD

Nichola Coliandris, Maternity Matron

Actions from previous meeting:

1. AS shared her concerns about the impact of 3 caesareans booked for several days this week, plus emergencies requiring prioritisation. One day, an elective gynae case was cancelled to fit in a 5th elective caesarean – due to being cancelled twice already. The requirement for a second theatre for elective work is now really pressing, with daily delays for women booked to have caesareans or inductions of labour. Nichola Coliandris has written an options appraisal and business case. Currently awaiting feedback and costings from the Division. **ACTION:** AS is going to meet with NC. **Update:** The second theatre project continues with support from the COO and Board.
2. JoH raised concerns about second theatre standard operating procedure and the provision of a surgical first assistant out of hours if both cases occurred simultaneously. Reviewed with the divisional director and agreed the Surgical SHO will be asked to attend to assist in theatre. Clarity around this aspect to be strengthened in the SOP. **ACTION:** LB to update the guidance about this specific issue in the form of a Critical Incident Response Card to be circulated to the CSM team and the Surgical speciality team. **Update:** action card has been produced. Awaiting feedback from Surgical team
3. Risk Register Update: Update the risk register to include the new risks associated with the Yeovil service changes. **ACTION** completed
4. Operational Meeting Setup: Set up an operational meeting involving the team to discuss the next steps and workstreams related to the Yeovil service changes. **ACTION** completed
5. Escalation Policy Review: Review and update the escalation policy to include external landscape considerations and coordination with other hospitals. **ACTION** delayed due to sick leave
6. Medication Shortage Escalation: Email the chief pharmacist to address the ongoing shortage of Clexane and ensure adequate stock for the ward. **ACTION** completed
7. Staff Engagement Session: Organise a staff engagement session to provide updates on the Yeovil service changes and address staff concerns. **ACTION** completed

Meeting summary

Band 3 MSW role changes Raised through the FtSU Guardian by an MSW – concerns about the impact of the band 3 job description and new skills required, on the team. Significant disquiet reported. **ACTION:** continue with staff engagement sessions with DoM or HoM. Ensure support continues for training (JoH)

Discussion around workforce gaps. SCBU has been very busy and has closed due to cot capacity. Maternity continues to see an increase in activity due to YDH closure. Agency staff now used regularly in maternity. Business cases currently being finalised and submitted in relation to BR Plus recommendations and the YDH activity

Lack of substantive doctors noted. Locums relied upon in the middle grade rota. Consultant rota also requires support – locum agreed (doctor who has worked at DCH previously). Successful recruitment should see improvement in October

QI project linked to Safety Action 3 - this is the early onset sepsis scoring for all babies shortly after birth, before transfer to the postnatal ward. This commenced in March 2025 and is to reduce the use of unnecessary antibiotics and identify babies at risk. Current compliance was 80% in June. A significant programme of teaching was provided including a video, questionnaire and 1:1 teaching.

The second theatre programme for elective LSCSs is progressing with support from the Board

Update provided about SBL – currently 100% compliant with 5 out of the 6 safety standards. The diabetic safety standard is at 80% with an action plan to address the outstanding action linked to guidelines. **ACTION** LB to liaise with Diabetic Team for an update

Postnatal leadership – to improve postnatal care, the postnatal team will be increased to provide a specialist postnatal lead on every shift – expressions of interest invited (cost neutral). This links with the PSIRP priority. Extra dinamaps and neonatal sats monitors also required **ACTION** NC to purchase new equipment as required and ensure SCD is updated about what is required.

Anaesthetic update – tier 3 cover for maternity progressing well. High risk anaesthetic clinic needs a room on the maternity unit as recently had to use The Bereavement Suite. **ACTION** JoH to identify a room for their use

Consultant attendance audit – three months audit of consultant attendance in compliance with the RCOG guidance about when a consultant should attend. All relevant clinical scenarios were reviewed. There were two cases of note.

- i) Consultant requested to attend for PPH. LW consultant busy in gynae theatre. Second consultant not available due to sickness. LW consultant was able to attend after 14 minutes. Outcome was good
- ii) Consultant did not attend for evening ward round on a Friday. The registrar informed the coordinator the consultant wasn't required. Escalated to the manager oncall. Consultant attended **ACTION** – NC to discuss with coordinators why the Teams form isn't completed in relation to capturing this information

Action plan from CQC Patient Survey – three areas of focus – information about IOL and informed consent, breastfeeding support (sometimes too much, sometimes too little), postnatal care. **ACTION** JoH, HE, LP – joint work with UHD around IOL information and support. Postnatal work continues. Breastfeeding support to include feedback from service users

M&M postponed – poor medical staffing has resulted in M&M being postponed as there is no-one available to present the obstetric case, and very few available to attend. Currently only 5 registrars working (should be 8) and absences in the consultant body. General agreement this was a significant concern if it continued. **ACTION** SM to review availability of obstetric doctors to present and to discuss with consultants that they present cases.

Neonatal consultants & other neonatal update – no longer resident now that middle grade posts have increased. Tier one doctors all to be NLS trained and to be encouraged to attend any resuscitation events on labour ward. Whilst admission numbers of babies to SCBU hasn't increased, the length of stay has significantly increased and this has impacted cot availability.

Neonatal nursing workforce - We discussed the proposed changes to nursing work force with additional band 6 post on nights offset by a reduction of band 3 posts to allow a supernumerary shift co-ordinator on nights/weekends. There is a consultation process which is due to start – as it involves a change to current workforce arrangements. There was a business case presented to the board which agreed an extra wte band 6 nurse. Jo Howarth confirmed RN recruitment can begin alongside the consultation. **ACTION** Ensure the risk is updated to reflect recent progress.

Consultation to change the workforce establishment. Recruitment for increasing bd 5&6 nurses JoH, Jodie Crabb, HR

Recent neonatal death – an update provided about the recent neonatal death of a baby following a low risk labour and birth. MNSI, PMRT, CDOP and the coroner involved. The family are being supported by the bereavement team and the staff are being support and have attended a TRiM session with good feedback. Reporting will follow the process and will report into Quality Committee, Board and the LMNS

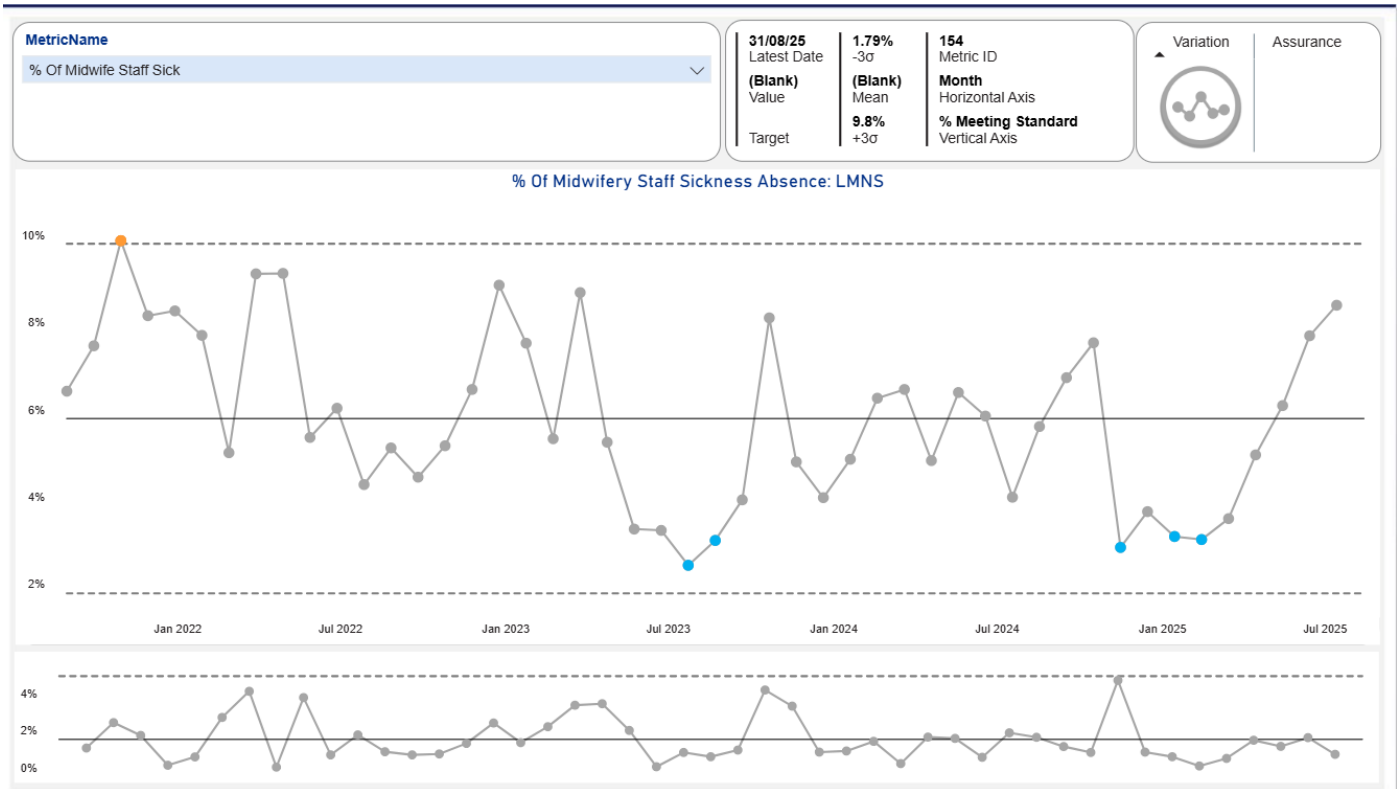
Intermittent auscultation – discussed the challenges of listening to the FH after every contraction in the 2nd stage for 60 seconds (this could be almost continuous). An audit has commenced into second stage intermittent auscultation. Acknowledged that two midwives present at a home birth earlier than usual would improve documentation. Also, DCH will be involved in trialling a new system for intermittent auscultation escalation with Health Innovation Wessex – NC leading on this for DCH

Paediatric doctor or ANNP joining the obstetric handover in the morning and evening. **ACTION** CH will explore the possibility of this

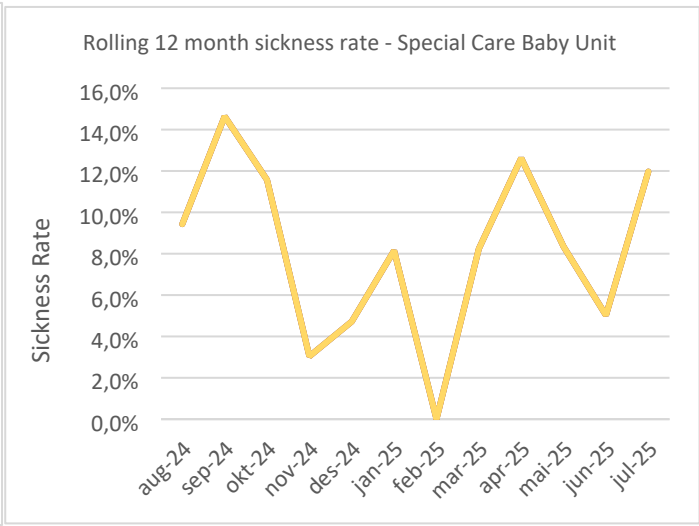
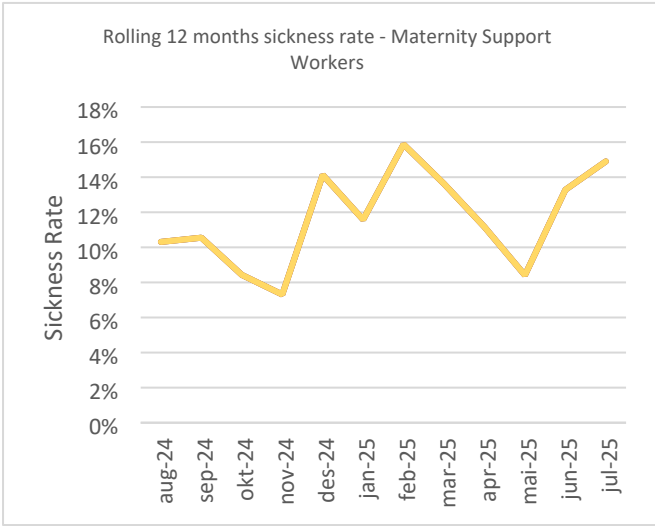
Increased obstetric staffing on LW – there will be 2 SHOs rostered for LW and DAU

Next meeting - 24th September 2025

Workforce data



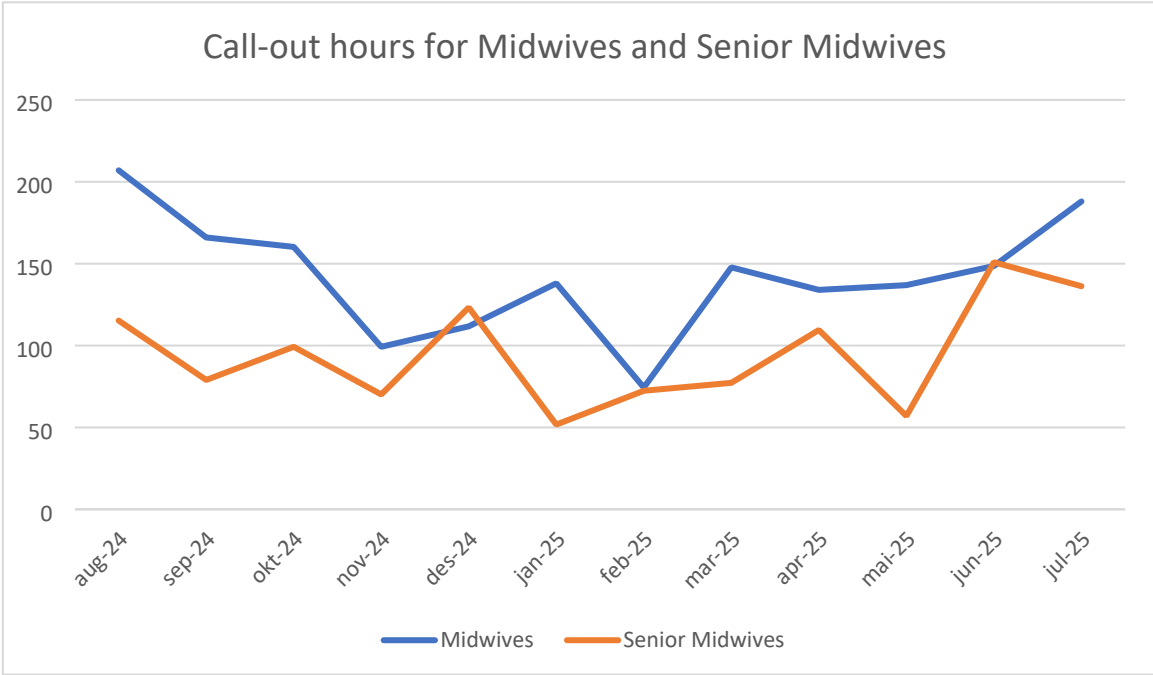
Baker.Abi
06/10/2025 12:40:16



July Call-Out Hours

Midwife call-out for the unit – **188 hours.**

Senior Midwives call-out – **136.25 hours**



Bank and Excess hours

	Maternity Unit/ DAU	MSW's / DAU	SCBU
Bank	344.25 hrs / 138 hrs	340.75hrs/20hrs	544.5
Excess/Overtime	552 hours	69.5 hours	82.02

Shifts not covered by substantive or bank staff

Maternity Unit – based on 6 midwives per shift		Special Care Baby Unit	
Day Shift	16.6%	Band 5/6	0 shifts not covered
Night Shift	9.1%	Band 3	2 shift not covered
Total	10.6%		
Maternity Support Workers			
Day Shift	23%		
Night Shift	12.9%		
Total	19.8%		

Actions from staff engagement sessions

Meeting dates for 2025: 3rd March
 31st March
 13th May
 30th May
 8th July
 4th September

All meeting are recorded and accessed by staff who haven't been able to attend the primary meeting

Staff feedback	Action	Owner	Timescale	Outcome & Evidence	Complete Y/N
Concerns about not enough midwives or MSWs allocated to work on shift	Increase staffing on shift temporarily (using YDH staff) and substantively with a business case	Jo H	Sep 2025	Staffing on the ward has increased to 8 midwives plus a coordinator and 3 MSW on nights in response to YDH increased activity. Currently, business cases are being considered to increase staffing substantively. Agency midwives and nurses now used regularly. 7 bank midwives employed, 6.4wte NQM employed for 12 months.	yes
Concerns about general bank staff and some agency staff unable to use BadgerNet	Provide BadgerNet training to regular bank and agency staff and maintain the bank/agency pool to a small number who are familiar with BN	Jo H	Nov 2025	Unable to provide BN training currently as there is LTS in the maternity digital team	no
Concern about lack of breaks	Ensure staff have breaks during their shift – discuss with coordinators and monitor success	Jo H and matrons		There is a sustained focus on ensuring staff have a break when working. On the postnatal ward, these are booked at the start of the shift. Coordinators understand the importance of ensuring breaks are protected. Specialist	yes

				midwives and managers available to cover for breaks for 1:1 care	
Concern about lack of equipment impeding care particularly dinamaps and O2 saturation monitors	Identify areas of equipment shortage and order accordingly. Where possible, borrow from YDH if appropriate	NC	Nov 2025	O2 sats monitors ordered. Enquiry with medical electronics as to ordering more dinamaps.	ongoing
Frustrating that out of area women arrive on the maternity unit, stating they have a guaranteed a single room postnatally	Communication to UHD, YDH that women birthing at DCH are never guaranteed a dingle room after birth	JoH	Aug 2025	completed	yes
Not enough icons to request shifts, due to the changes in banding	Selina to discuss with e-roster team to have the current band 2 shift made available for request by the now band 3's	SW	July 2025	Request made and will be actioned from the next off duty (02/06/2024)	yes
Rostering a NIPE midwife on every shift	Review the possibility of this in relation to midwives who are qualified to provide this	NC, PW, JoH	Sep 2025	Currently, there are not enough midwives qualified in NIPE to roster them separately (and honour flexible working arrangements etc.) However, more midwives are gaining this qualification, leading to a more effective cover. In the future, it may be possible to factor this in to rostering but this will not be in the near future	Yes because no further action is possible currently
Pool room for IOL	Management team to review the use of water for IOLs	JoH matrons	Aug 2025	This has been reviewed and the conclusion is that any induction of labour must be risk assessed in relation to the woman's unique set of circumstances, including why she is being induced (as this will often be a risk in and of itself). This assessment would inform any decisions to use water for labour or birth.	yes
Concerns about the significant requirements moving from a band 2 MSW to a band 3 MSW	Requirements to be reviewed by the senior management team and practice development leads.	JoH, matrons, SD, CW	Nov 2025	This is an ongoing discussion with several workstreams being considered, within the context of the Core Competency Framework	no

	Consideration for specialist roles for MSWs – antenatal and postnatal				

Next meeting September 12th 2025

Baker, Abi
06/10/2025 12:40:16

Report to	Board of Directors, Part 1 (DCH Board)	
Date of Meeting	07 October 2025	
Report Title	Learning from Deaths Q1 2025/26	
Prepared By	Dr Adam Nicholls	
Approved by Accountable Executive	Dr Rachel Wharton, Chief Medical Officer	
Previously Considered By	Hospital Mortality Group 17.09.25 Quality Governance Group 09.09.25 Quality Committee in Common 23.09.25	
Action Required	Approval	Y
	Assurance	-
	Information	-

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? <i>Delete as required</i>	
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	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	No implication	
Co-production & Partnership	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 April 2024 – March 2025 is 1.04. • Work has started across Dorset to align Learning from Deaths reports but this work is uncertain because of changes to the ICS structure. • Coding remains a significant risk for our SHMI. Recent approved changes in coding run the risk of adversely impacting our SHMI • SJR completion in Division A has improved • Concerns around ICNARC data have been resolved and relate to a data interpretation error • HMG have requested further information around quality improvement for fractured neck of femurs and in surgical clerking which will be reported in subsequent LfD reports.

Baker
06/10/2025 12:40:16

Recommendation

Members are requested to:

- **Approve** the report.

Baker, Abi
06/10/2025 12:40:16

CONTENTS

- 1.0 DIVISIONAL LEARNING FROM DEATHS REPORTS
- 2.0 NATIONAL MORTALITY METRICS AND CODING ISSUES
- 3.0 OTHER NATIONAL AUDITS/INDICATORS OF CARE
- 4.0 QUALITY IMPROVEMENT ARISING FROM SJRs & HMG
- 5.0 MORBIDITY and MORTALITY MEETINGS
- 6.0 LEARNING FROM CORONER'S INQUESTS
- 7.0 LEARNING FROM CLAIMS
- 8.0 SUMMARY

Baker, Abi
06/10/2025 12:40:16

1.0 DIVISIONAL LEARNING FROM DEATHS REPORTS

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

1.1 Family Services and Surgical Division Report - Quarter 1 2025/26 Report

Structured Judgement Review Results:

The Family Services & Surgery Division had 48 deaths in quarter 1, of which 41 that require SJR's to be completed. Within quarter 1 55 SJR's have been completed from this quarter and previous months.

Outstanding SJR's:

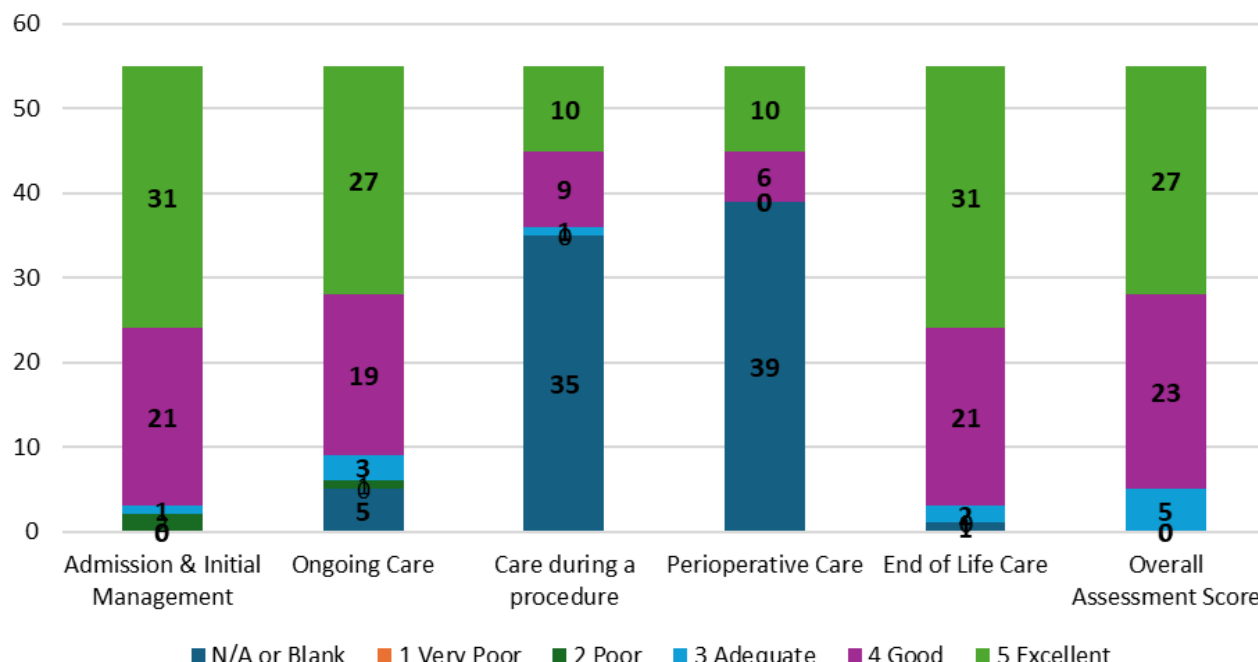
The Division have completed a number of SJR's from previous quarters. The backlog of outstanding SJR's (over 2 months) for the Division as at 30/07/2025 is 1:

May
1 (notes still at Boscombe)

Feedback from SJR's Completed in Quarter 1:

Phase Score	Admission & Initial Management	Ongoing Care	Care during a procedure	Perioperative Care	End of Life Care	Overall Assessment Score
N/A or Blank	0	5	35	39	1	0
1 Very Poor	0	0	0	0	0	0
2 Poor	2	1	0	0	0	0
3 Adequate	1	3	1	0	2	5
4 Good	21	19	9	6	21	23
5 Excellent	31	27	10	10	31	27

Baker,Abi
06/10/2025 12:40:16



Overall Quality of Patient Record:

Blank	Score 1 Very poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
0	0	0	7	22	26

- Good documentation of initial clerking in ED and post arrest care. No documentation of first UHS follow-up. Limited notes for afternoon of 14/01 and O/N whilst on CCU, however good ITU/CCOT documentation during their involvement.
- Excellent Documentation throughout patients hospital stay and good clerking.
- Excellent documentation throughout. Excellent surgical clerking.
- Medical clerking poor- lack of completion/ detail/ assessment in places. Otherwise documentation both medical and nursing was excellent throughout.
- Good medical and urology documentation. Missing ED Clerking ?not done. Legible writing throughout.

Avoidability of Death Judgement Score:

Score 1 Definitely avoidable	Score 2 Strong evidence of avoidability	Score 3 Probably avoidable (more than 50:50)	Score 4 Possibly avoidable but not very likely (less than 50:50)	Score 5 Slight evidence of avoidability	Score 6 Definitely not avoidable
0	0	1	1	8	44

*One SJR unscored as unable to make a judgement as no documentation around place or time of death.

Action Required:

Following completion of the 55 SJR's, 6 were highlighted as requiring actions.

Further learning via:

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

Other actions:

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

- 1 was for review and discussion at Specialty M&M/Clinical Governance meetings and presentation at HMG – both completed.
- 1 was for communication with the GP to identify any learning.

SJR's 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.

Areas of good practice and area for improvement are discussed and reviewed at HMG.

1.2 Division of Urgent & Integrated Care – Quarter 1 Report 2025 / 26

In quarter 1 there were 243 deaths, 34 SJR's were requested from these deaths, and 42 SJR's were completed during this period (completed SJR's not necessarily from this quarter).

	Q1			Q2			Q3			Q4			Q1		
	Ap r	Ma y	Ju n	Ju l	Au g	Se p	Oc t	No v	De c	Ja n – 25	Fe b	Ma r	Ap r	Ma y	Ju n
Deaths	48	59	65	53	52	45	75	105	82	62	61	66	72	81	90
Deaths requiring SJR'S from Month	9	14	12	15	8	15	6	22	26	20	12	7	13	14	7
*Completed SJR'S	6	4	0	1	10	9	1	9	2	0	0	0	13	19	10

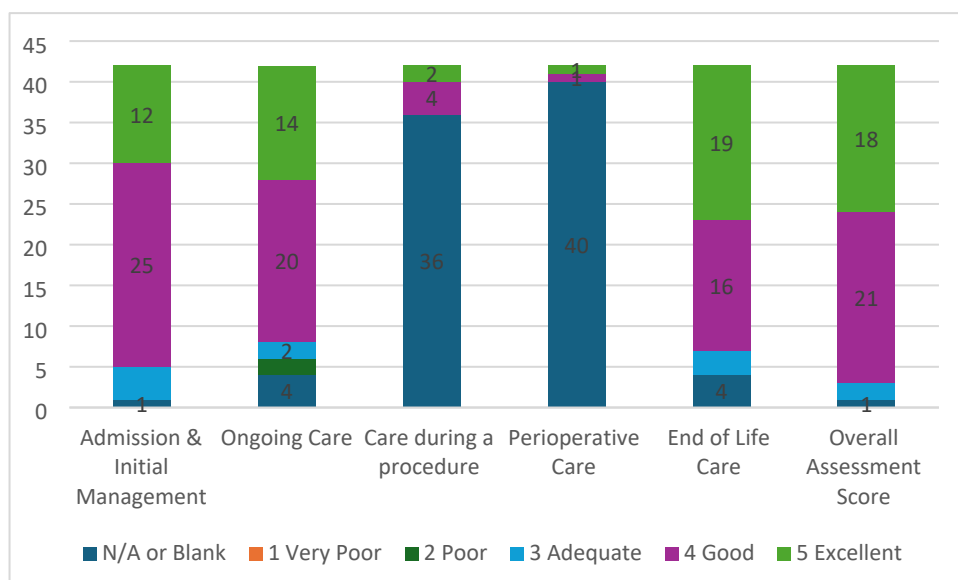
* Completed SJR'S not necessarily from that month's deaths

Outstanding SJRs for the Division as at 20/08/2025 is **9** reviews:

Sept	October	November	December	Jan	Feb	Mar	Apr	May	Jun
26	10	12	14	20	12	7	7	2	0

Phase score from 42 completed SJR's in Q1 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	4	36	40	4	1
1 Very Poor	0	0	0	0	0	0
2 Poor	0	2	0	0	0	0
3 Adequate	4	2	0	0	3	2
4 Good	25	20	4	1	16	21
5 Excellent	12	14	2	1	19	18



Overall Quality of Patient Record:

Blank	Score 1 Very poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
7	0	0	4	23	8

- Clear and concise throughout
- Good, clear plans and documentation
- Difficult to review notes as they were mixed up.
- Not filled in any order but all documentation is present.

Avoidability of Death Judgement Score:

Score 1 Definitely avoidable	Score 2 Strong evidence of avoidability	Score 3 Probably avoidable (more than 50:50)	Score 4 Possibly avoidable but not very likely (less than 50:50)	Score 5 Slight evidence of avoidability	Score 6 Definitely not avoidable
0	0	0	1	0	41

Action Required:

Following completion of the 42 SJR's, 1 required further action which was to share the learning via appropriate governance channels.

SJR Key themes from Areas of Good Practice:

- Good involvement of patient and/or family
- Thorough assessment
- Prompt consultant review and investigation
- Second opinion sought where appropriate

SJR Key theme of Areas for Improvement:

- Flow from ED to inpatient bed
- Length of stay in ED

- Length of time to verify death
- Poor weekend review
- No EOL pathway

Baker, Abi
06/10/2025 12:40:16

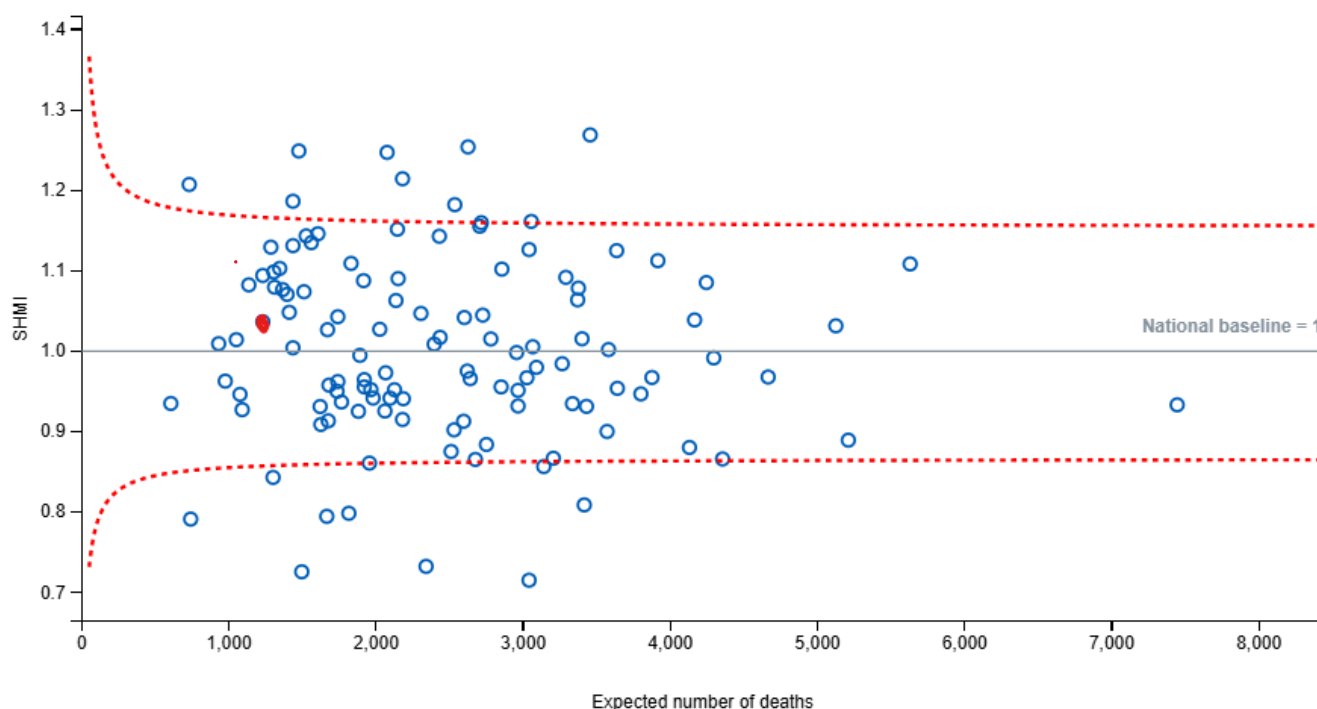
2.0 NATIONAL MORTALITY METRICS AND CODING

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).

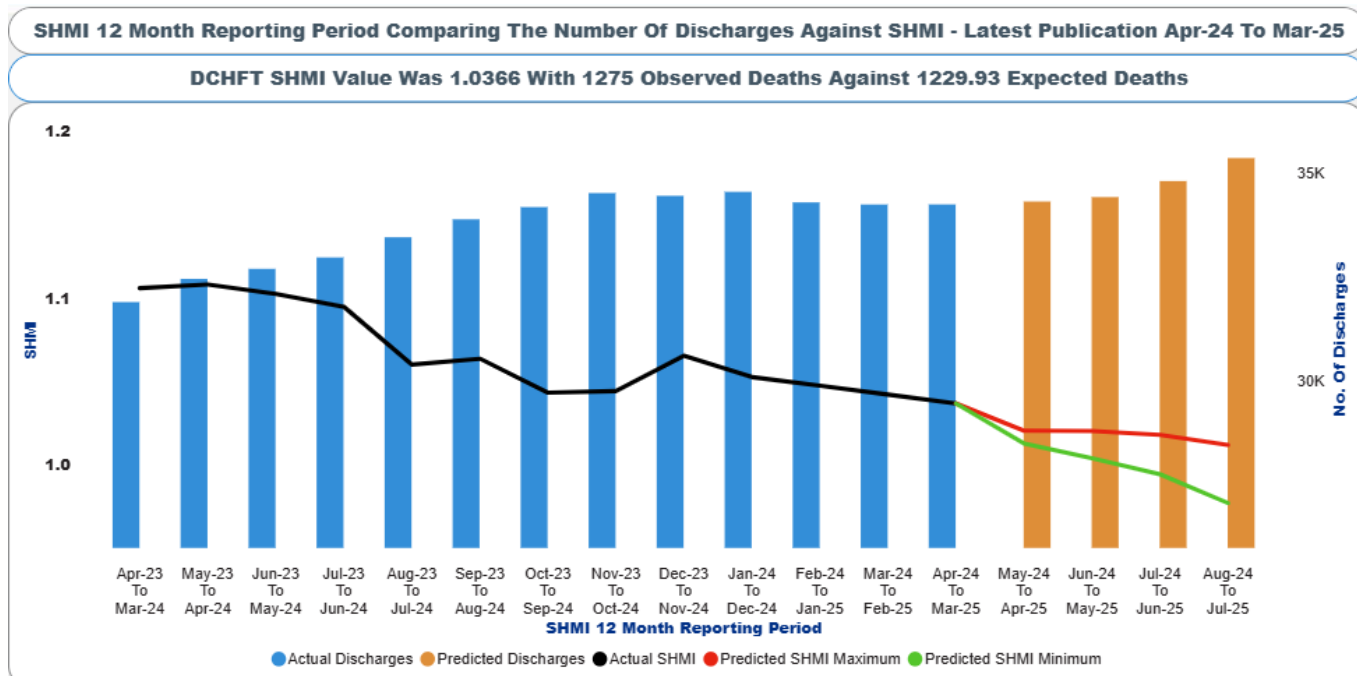
The latest SHMI publication for funnel plots from NHS England is for the period April 2024-March 2025. The trust's SHMI value is 1.04 which is as expected.

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.

Baker, Abi
06/10/2025 12:40:16



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 5.8 for non-elective admissions. This remains below the national average of 6.1, but is an improvement on the previous quarter. This is not impacting our SHMI at present, but needs to be closely monitored. DCHFT mean depth of coding for elective admissions remains further below the England Average at 5.2 (compared to 6.4).

The coding team have had two changes agreed which may impact SHMI, and need to be monitored. The team intend to use a greater use of agency coders because of the high vacancy rate. Secondly the team will be coding more episodes from the electronic records. Mitigations are in place to ensure that patients who died in hospital or within 30 days of admission will continue to be coded from the full patient record.

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.

Baker, Abi
06/10/2025 12:40:16



3.0 OTHER NATIONAL AUDITS/INDICATORS OF CARE

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

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

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

3.1 NCAA Cardiac Arrest data

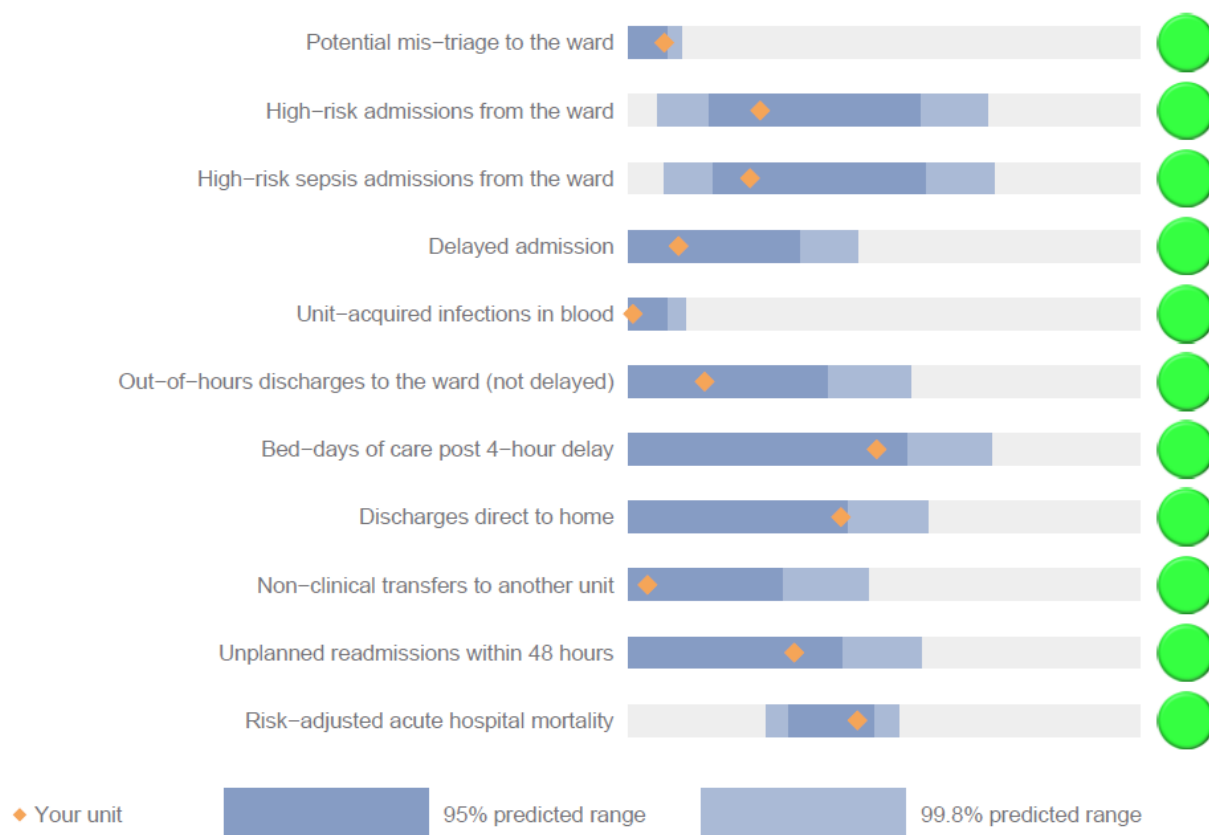
The NCAA data is reported in 6 monthly periods with the next data release covering 1/10/24-31/03/25. There are no updates on the latest data at the time this report was written. This data is discussed at the resuscitation committee.

Baker, Abi
06/10/2025 12:40:16

3.2 ICNARC Intensive Care survival data for dates 1 April 24 – 31 Mar 2025

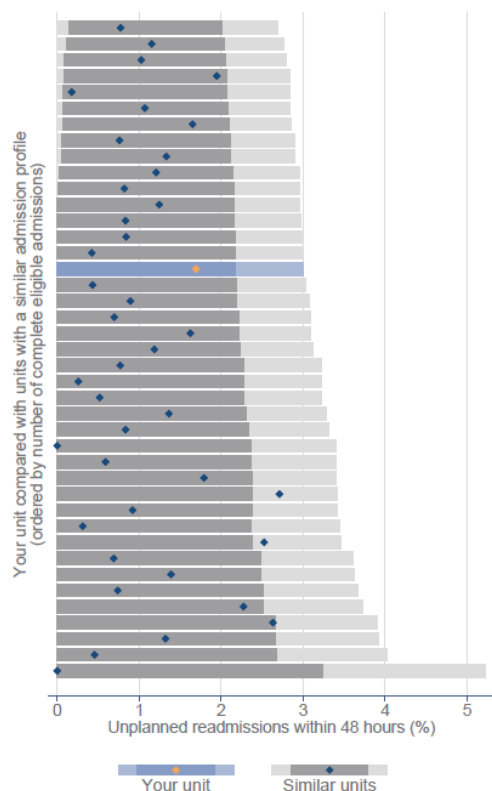
All of the indicators are green. The last quarter showed an amber for mis-triage to the ward, but the data has been re-run excluding patients whose pathway included admission from ED to the cardiac catheter lab, and then to ITU – this has seen this issue resolved.

Quality indicator dashboard

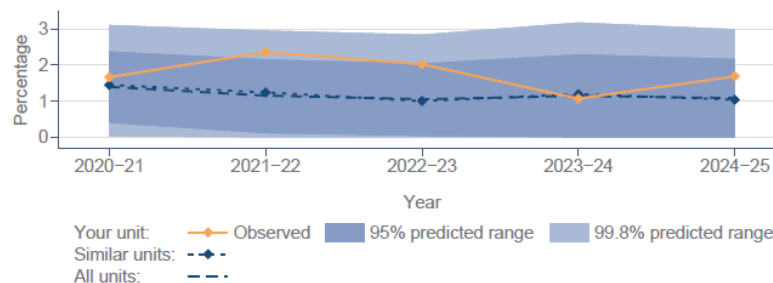


Unplanned readmissions to the unit were at the expected level, having been amber in quarter 3:

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, 2.9)	(0.0, 4.5)	●
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)	1.1	(0.0, 2.9)	(0.0, 4.7)	▲
Quarter 4	107	107 (100.0)	1 (0.9)	1.0	(0.0, 2.8)	(0.0, 4.6)	●
Full year	473	473 (100.0)	8 (1.7)	1.1	(0.0, 2.2)	(0.0, 3.0)	●



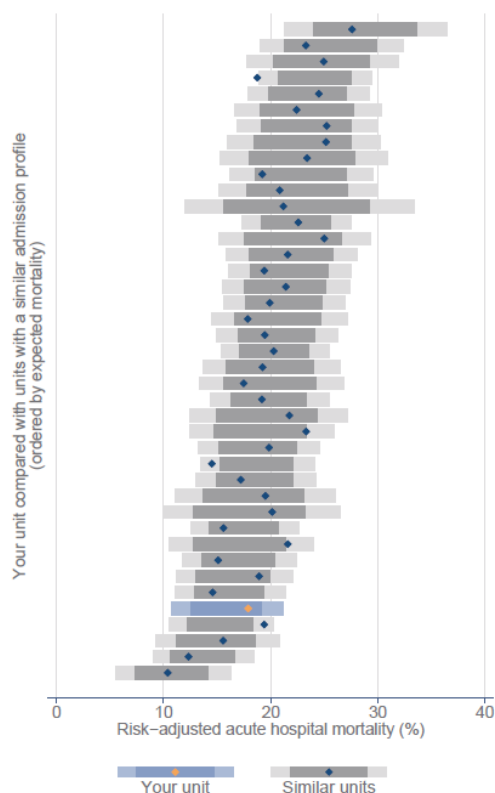
Definition

- 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

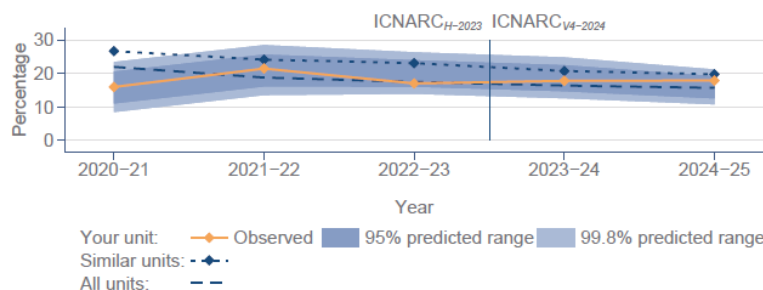
Mortality is within the expected range:

Baker, Abi
06/10/2025 12:40:16

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)	15.5	(10.0, 20.8)	(7.2, 24.3)	●
Quarter 2	172	172 (100.0)	30 (17.4)	14.4	(9.1, 19.6)	(6.5, 23.0)	●
Quarter 3	170	170 (100.0)	37 (21.8)	18.7	(12.7, 24.5)	(9.7, 28.2)	●
Quarter 4	156	152 (97.4)	23 (15.1)	14.8	(9.1, 20.4)	(6.3, 24.1)	●
Full year	669	665 (99.4)	119 (17.9)	15.9	(12.6, 19.2)	(10.8, 21.2)	●



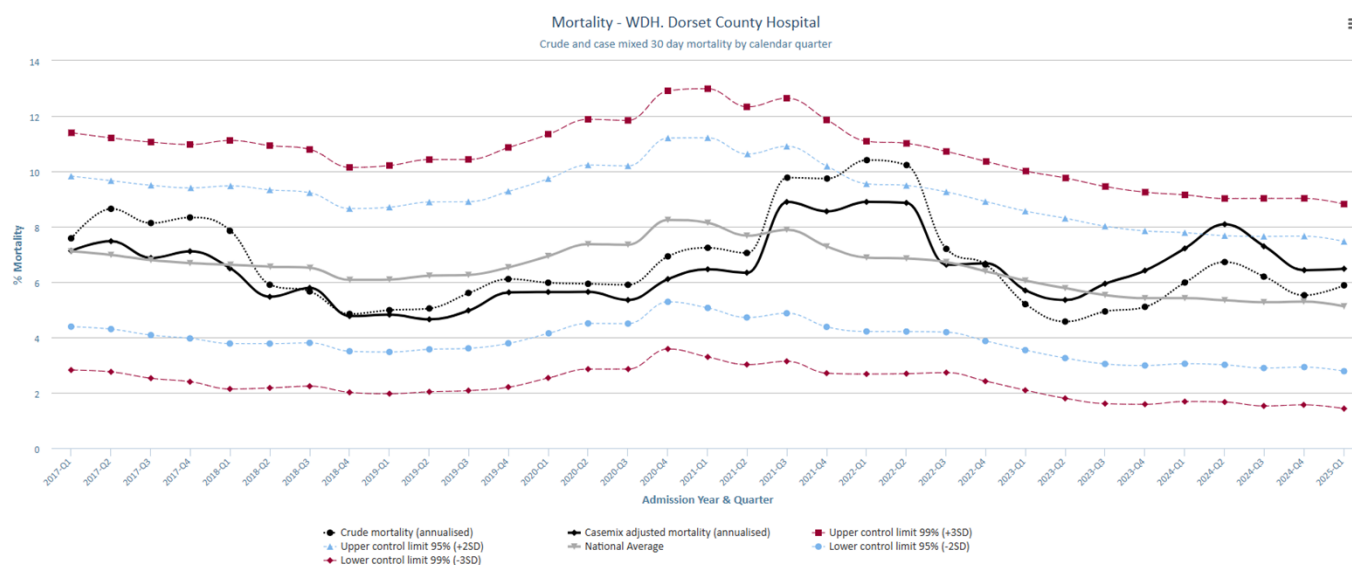
Definition	
• Eligible:	All critical care unit admissions, excluding readmissions, patients dead on admission and those admitted to facilitate organ donation
• Complete:	The number and percentage of eligible admissions with sufficient data to calculate an ICNARC _{V4-2024} model risk prediction and complete 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 _{V4-2024} 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

3.3 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, and although it was improving has now plateaued. This information has been shared with the orthopaedic team so that we can work to further improve our data. Future reports will be updated with any quality improvement in hip fractures.

Our filtered SHMI data for hip fractures show that we are within the expected control limits.

Baker, Abi
06/10/2025 12:40:16



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.

This has been reported in previous mortality reports but has been taken out of this report as it does not directly pertain to mortality. There is a lot of data within the readmissions PowerBI report and a decision will be made as to how best to report and monitor this going forwards.

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 1.

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.healthinnwest.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 1. There has been one early neonatal death reported by a tertiary center pertaining to a woman who birthed at DCH and received her antenatal care in YDH. This case was reported during Quarter 1 2025. This case has been referred to MNSI (Maternity & Newborn Safety Investigations) by DCH, but the tertiary centre will lead on the PMRT review as baby died there. DCH will be involved in all review processes.

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:

- Decisions to transfer patients – are these impacted by a lack of beds in receiving trusts, and does this impact the care a patient receives?
- Quality of surgical clerking in division B has been a persistent issue raised in SJRs despite quality improvement initiatives – division B has been asked to review this and to report back through HMG.
- There is an improved process for care and communication with seniors to monitor complications after primary PCI in cardiology.

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.

6.0 LEARNING FROM CORONER'S INQUESTS Q1

DCH has been notified of **17** new Coroner's inquests being opened in the period 01 April 2025 – 30 June 2025. We have seen a huge increase in the complexity of the cases.

2 preventing future deaths were issued by the Dorset coroner in to 4 organisations.

Regulation 28 given during an inquest that we attended (May 25):

1 x Regulation 28 pertaining to evidence being provided by the Prison Service staff during a jury inquest that they never received training about diabetes and there is a lack of understanding, and national guidance for Prison Service staff relating to the symptoms of a hypo glycaemic or hyper glycaemic attack, which can be fatal. Regulation 28 given to Secretary of State for Health and Social Care, and Director General Chief Executive Officer of His Majesty's Prison and Probation Service (HMPPS).

19 inquests were held during Quarter 1. **16** inquests were heard as Documentary hearings, not requiring DCH attendance. **2** required a clinician to attend court in person (**1** of these being held with a Jury). **1** remote. **0** inquests were held hybrid (some clinicians attending remotely, whilst others attended in person).

6 pre-Inquest review hearings were held.

We currently have **59** 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.

Clinical Leads have been attending inquests to ensure there is some resilience within the Risk Team. Jodie Crabb, Sonia Gamblen, Dr Rachel Wharton, Adam Nicholls, Audrey Ryan and Laura Foot have all now attended at least one inquest each.

Learning Identified: Seek better communication with prison to ensure admission avoidance and appropriate discharge.

7.0 LEARNING FROM CLAIMS Q1

Legal claims are facilitated by NHS Resolution, who also produce a scorecard of each Trust's claims pattern and costs. We are currently awaiting the new scorecard, which is due to be released by the end of September.

Claims pattern Quarter 1 FY 25/26.

New potential claims	13 clinical negligence, 0_employee
Disclosed patient records	34 (20 disclosure for claims inc updated records, 14 disclosures to the coroner)
Formal claims	12 clinical negligence, 0 employee claim
Settled claims	3 clinical negligence, 1 employee claims (Relating to pressure ulcers, injury wrist from falling door magnet which fell while employee was exiting to the room, in hospital fall resulting in fractured hip and pressure ulcers, phototherapy burn)
Closed - no damages	6 clinical negligence, 4 employee claims

8.0 SUMMARY

The latest SHMI publication from NHS England is for 12 month period ending March 2025. 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.

SJR completion rates have improved in Division A.

Mortality in Hip Fractures has been above the national average for some time, although was improving. A request has been made to the team to clarify what improvement work is ongoing in this area.

There has been a persistent theme of poor surgical clerking in SJRs in division B which has been looked into before. HMG have requested an update on this work and this will be reported in future reports

Baker,Abi
06/10/2025 12:40:16

Report to	Board of Directors, Part 1 (DHC Board)	
Date of Meeting	7 October 2025	
Report Title	Learning from Deaths Report – Quarter 1	
Prepared By	Ellie Lindop, Deputy Director of Nursing, Therapies and Quality Contributions for this report received from: Summa Cameron, Incident Information Co-ordinator Amelia Atkin, Learning and Review Strategic Lead Debbie Straw, Patient Safety Specialist Jane Rickett, Specialist End of Life Nurse Practitioner Carol Brand, Specialist End of Life Nurse Practitioner Karen Tancock, Dorset CLDT Senior Clinical Lead Clare Travis Punter, Safeguarding Children's Lead	
Approved by Accountable Executive	Lucy Knight Chief Medical Officer	
Previously Considered By	Mortality Governance Group, 10 September 2025 Quality Committee in Common, 23 September 2025	
Action Required	Approval	Yes
	Assurance	No
	Information	No

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? <i>Delete as required</i>	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 Quality and Safety	
Financial	Nil	
Statutory & Regulatory	National Quality Board Framework (2017) and Patient Safety Incident Response Framework (2022)	
Equality, Diversity & Inclusion	No implications	
Co-production & Partnership	No implications	

Executive Summary
The following report provides the Trust Quarter 1 update relating to compliance with the National Quality Board Framework (2017) and the Patient Safety Incident Response Framework (2022). In summary: • A total of 53 unexpected deaths were reported (of which 15 were inpatient deaths). • A total of 30 inquests were heard by the Coroner in relation to the Trust, with no Regulation 28 notices received. However thematic learning has been identified for consideration. • One PSII was concluded with areas of both positive learning and recommendations for improvement. • Three child deaths were reported, of which one was identified for a wider investigation. An update is anticipated to be available in quarter 2. • A total of 11 Learning and Disability deaths were reviewed under the LeDeR process. One was an unexpected death.

- In total, 30 expected deaths were reported, of which 29 were in the Integrated Community Services (ICS).

The committee are asked to receive this report as assurance of the processes that are undertaken in relation to the management of learning from deaths and compliance with the reporting requirements associated with the National Quality Board Framework (2017), aligned with Patient Safety Incident Response Framework (PSIRF) methodology. Presented in this report are areas of learning for the Trust, and in some cases the wider Dorset system for discussion, consideration and identification of any further opportunities for improvement.

Colleagues are asked to consider areas of good practice highlighted for wider sharing and consideration, in addition to areas which require further improvement.

Recommendation

Receive the report for **approval**.

Baker, Abi
06/10/2025 12:40:16



Healthier lives



Empowered citizens



Thriving communities

Learning from Deaths Report (Quarter 1 2025-26)

1.0 INTRODUCTION

- 1.1 This report provides a quarterly overview of patients who have died whilst under Dorset Healthcare Trust as a primary provider of care (as per the National Quality Board (NQB) framework, 2017).
- 1.2 Where the Trust is not a main provider, there is consideration on identification of the patient/ service users' death, if it would be appropriate to undertake a full learning review process as a Trust, collaborate with the main provider of care and provide insight into the care/ services provided or whether there is no identified need to review further after initial discussion and consideration (as per the NQB framework) unless further information is identified that does require a review. Predominantly, service users of Mental health services are more likely to require a review especially if their death is confirmed as a likely consequence of their mental health diagnosis.
- 1.3 Following a review of process and criteria (as reported in the last report for quarter 4 2024-2025), deaths recorded for patients awaiting assessment from Memory Assessment Services are now excluded from routine reporting on unexpected deaths, the GP for this cohort of service users is the primary care provider.
- 1.4 Expected deaths of inpatients continue to be included for oversight in this report, with a focus on the identification of learning (refer to section 9).
- 1.5 To highlight, data within this report is based on the date of death (incident date).

2.0 SUMMARY TRUST REVIEW PROCESS

- 2.1 All inpatients' deaths (expected and unexpected) are reported on the Trust Risk Management System (Ulysses) when identified and a review is undertaken (based on NQB guidance and with the Patient Safety Incident Response Framework (PSIRF) methodology). For deaths of community service users, these are either reported via the service who provided care for consideration, or notification is received from an external source (e.g. the coroner).
- 2.2 There are multiple tools which can be used to support the review and identification of learning from deaths (refer to Appendix 1).
- 2.3 Since the introduction of the PSIRF methodology, the Structured Judgement Review (SJR) tool has not been considered as new PSIRF tools were trialled by the Trust. On further review and consideration, the SJR is now being actively reintroduced where it is

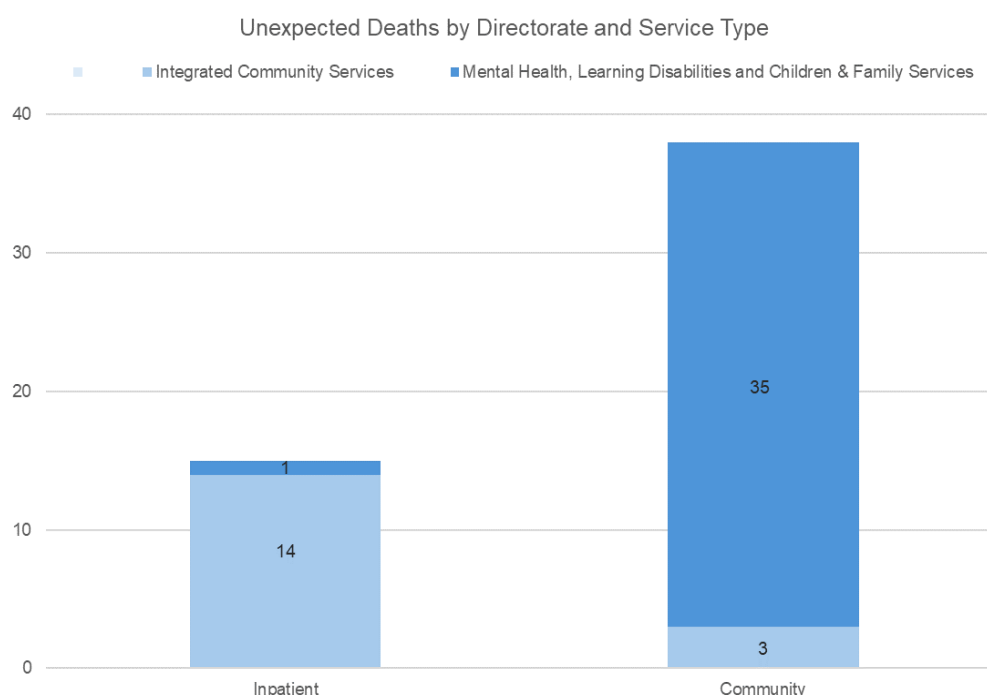
Baker
06/10/2025 12:40:16

identified that this would be an appropriate tool to review a death, whilst continuing to align with the concepts of PSIRF methodology.

3.0 OVERVIEW OF UNEXPECTED DEATHS REPORTED

3.1 In Q1 2025/26, a total of 53 unexpected deaths were recorded on the Trust's incident reporting system. Of these, 38 deaths occurred in community services and 15 were in inpatient services (refer to Figure 1). The majority were reported within the Mental Health, Learning Disabilities, and Children & Family Services directorate (36), with lower numbers reported in Integrated Community Services (17).

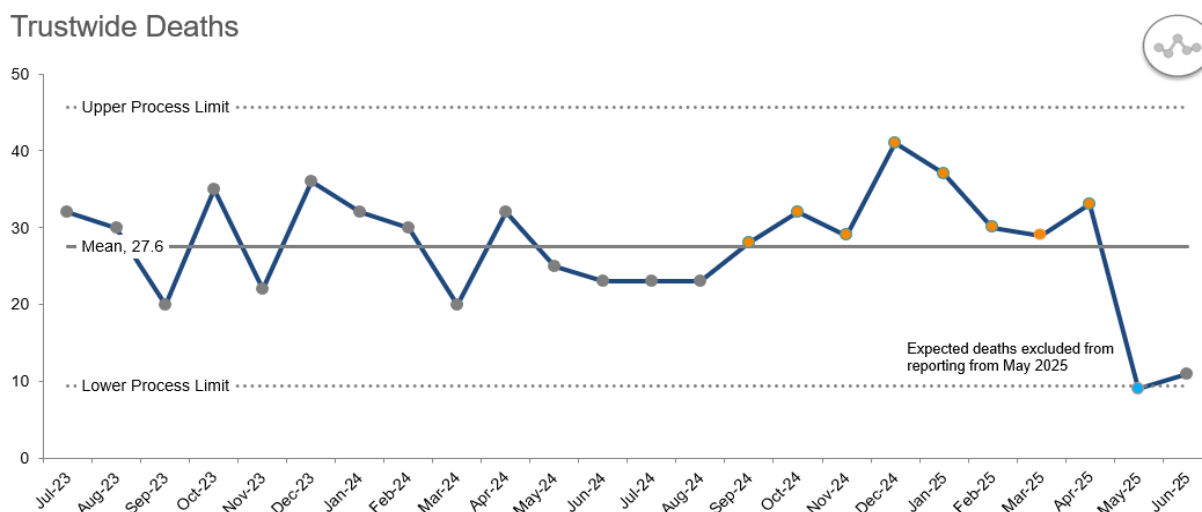
Figure 1 Overview of Deaths by Directorate and Service Type Q1



3.2 The number of deaths reported Trust wide over the last 24 months averaged 27.6 per month (refer to Figure 2). This metric is showing special cause improvement, reporting on the lower process limit (9.4) in May (9), and remained close to the lower process limit in June (11). This significant reduction reflects the change in process for recording deaths,

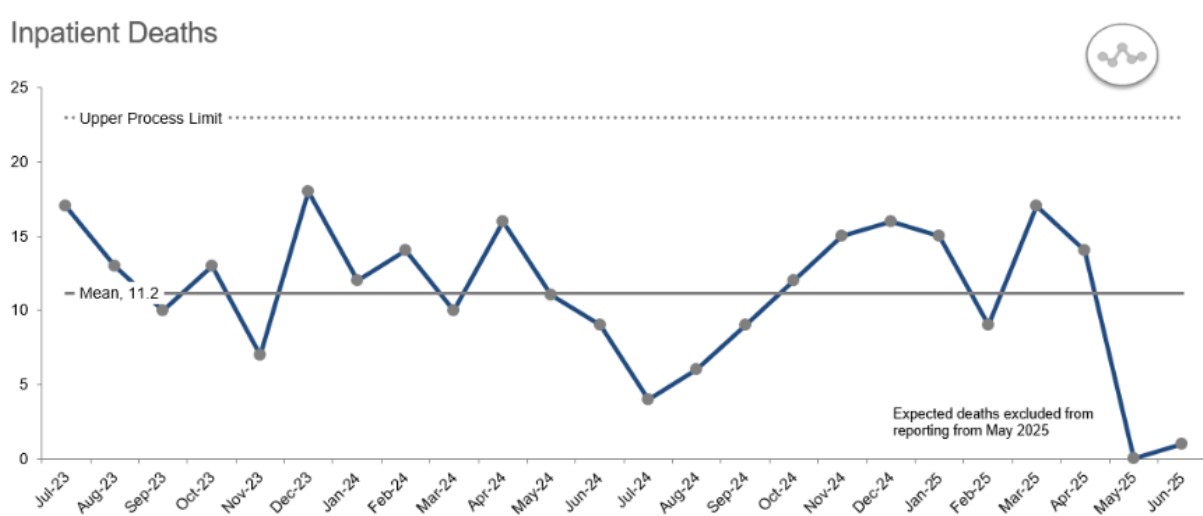
as expected deaths are now excluded from this overview (see Figure 2).

Figure 2 Overview of Deaths Reported July 23 – June 25



3.3 Over the last 24 months, the number of inpatient deaths averaged 11.2 per month Trustwide. In May 2025, the number of reported inpatient deaths dropped to 0, reaching the lower process limit, and remained low in June with just one reported death. This recent sharp decline reflects the change in reporting process as noted above (see Figure 3).

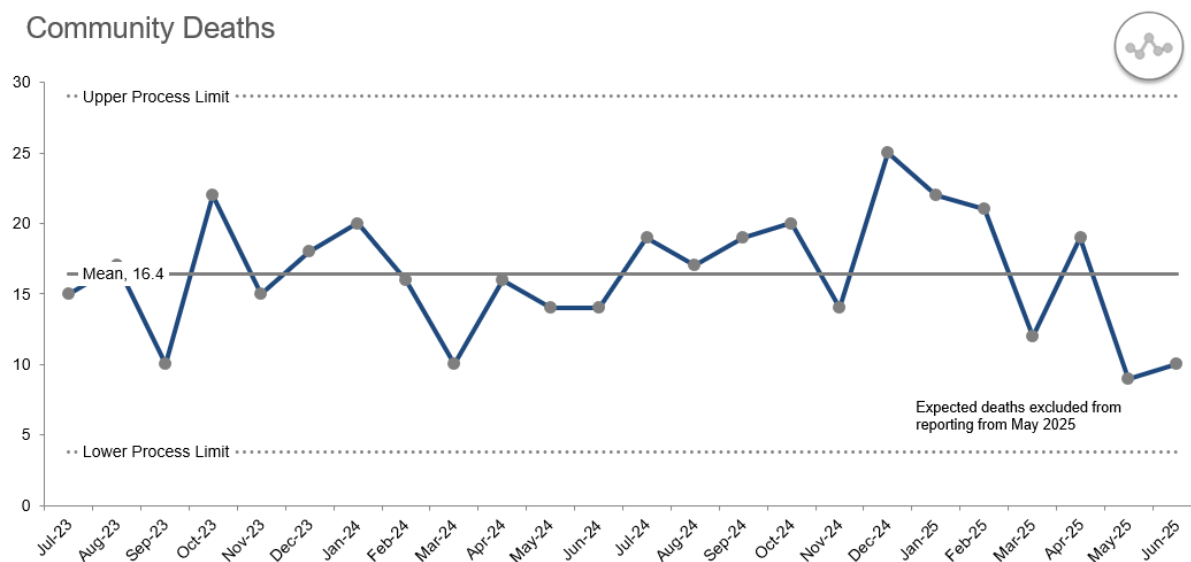
Figure 3 Overview of Inpatient Deaths Reported July 23 – June 25



3.4 Thirty-eight deaths occurred within community services in Q1 2025/26, averaging 16.4 across the last 24 months. This metric is reporting within process limits (3.8-29.0)

indicating natural variation. The decline in reported deaths in May and June 2025 reflects the previously noted change in reporting practice (see Figure 4).

Figure 4 Overview of Community Deaths Reported July 23 – June 25



4.0 PREVENTION OF FUTURE DEATHS (REGULATION 28) RECEIVED/LEARNING FROM INQUESTS

- 4.1. In Q1 Dorset Health Care did not receive any Regulation 28 reports. However, for one inquest the Coroner had questions around the Multi-Agency Risk Management Meeting (MARM) process that he required answering post inquest. These questions were responded to by the Joint Chief Nursing Officer and detailed the guidance for the Management of a MARM, audits undertaken and guidance on the recording of the MARM. The Coroner also raised concerns around the use of acronyms in reports and assurance was given that a glossary would be added to future reports.
- 4.2. In summary in Q1, there were:
- A total of 30 inquests.
 - There were three Pre-Inquest Review Hearings.
 - No additional learning was identified from the concluded inquests as the recommendations and learning had already been identified following Patient Safety Reviews.

Baker, Abi
06/10/2025 12:40:16

- 4.3. Of the 30 inquests, 10 had a conclusion of suicide, and four were concluded as drug/alcohol related deaths. For the remainder, refer to the table 2 below.

Table 2

Directorate	Accidental Death	Narrative Conclusion	Natural Causes	Not Indicated	Total
Integrated Community Services	1	2	-	1	4
Mental Health, Learning Disabilities and Children & Family Services	1	2	-	3	6
Not Indicated	1	1	2	2	6
Total	3	5	2	6	16

There were five additional inquests which were documentary (read-only inquest), the outcome has not yet been received.

- 4.4. Recurring Themes from Dorset Inquests are identified as:

Mental Health Care:

Inadequate risk assessments and crisis response.

Lack of coordinated care across agencies and in house services.

Communication Failures:

Poor sharing of patient information between NHS Trusts and emergency services.

Systemic Gaps:

Variability in hospital protocols for record access.

In consideration of the above thematic learning, it is recommended that as a Trust we continue to review our processes and seek to identify if any further action is required to improve this position in consideration of the impact both for the patients and service

Baker, Abi
06/10/2025 12:40:31

users, the Trust and the wider Dorset system.

5.0. PSIRF Learning

- 5.1. Currently the Trust Risk Management System (Ulysses) is unable to extract the data required to provide an overview of the type of response undertaken when a death is reviewed. The new PSIRF module, due to launch in quarter 2, is anticipated to enable effective data extraction to support this overview going forwards which will enhance future reporting and oversight in addition to assurance of the Trust approach to learning from deaths.
- 5.2. On review of learning from a completed PSII's the following learning was identified for the Trust.

Areas of Good Practice

- A high standard of care provision following a return to Dorset with good engagement
- Records were readily available from the previous provider of care.
- There was evidence of consideration of wider holistic needs
- Trust operational policies and guidance was followed by the teams involved in the provision of care and support.

Areas for improvement

- Safeguarding services to work with the Safeguarding Adults Boards to review the use of MARMs and identify both barriers to the process and ways to improve all stakeholder's participation in the process.
- The Trust to ensure that the latest guidance around the MARM process is shared with all operational teams, as well as being available on the intranet
- The Trust to review processes for sharing information regarding the death of patient to ensure all relevant teams are notified.

6.0. CHILD DEATHS

- 6.1. There were five reported child/young people deaths over Q1. Two of these deaths were expected due to miscarriage and prematurity. Three deaths were unexpected deaths, and none have identified learning specific to Dorset HealthCare only at the time of reporting.

Baker, Abi
06/10/2025 12:40:16

- 6.2. One death related to a three-year-old Dorset child who died after being struck by a vehicle having wandered into the road. Previous contacts for the family relating to concerns regarding children acquiring injuries due to inadequate supervision and the S17 Child in Need threshold was agreed.
- 6.3. A six-week-old baby was found unresponsive in her cot by her parents, no concerns were raised regarding child protection and no new learning was identified, however this is a reminder of the importance of continued promotion of “safe Sleep”.
- 6.4. A 14-year-old Dorset young person known to CAMHS was reported missing by parents early in the morning, having been last seen the night before and was then subsequently found having passed away due to suicide. An initial Tier 2 response has been undertaken and outcomes are awaited. Any learning identified will be presented in the Quarter 2 report.

7.0. LEARNING DISABILITY DEATHS (LeDeR)

- 7.1. In Q1, 11 LeDeR reviews were completed for people with a learning disability known to Dorset Healthcare at the time of their passing. The age range of this group was 21-78 years old. Of these, one was unexpected, with the cause confirmed as Sudden Unexplained Death in Epilepsy (SUDEP). None of the eleven NHS Dorset LeDeR reviews identified learning that was additional to the Integrated Care Board’s identified priorities around health inequalities).

7.2. Q1 LeDeR Outcomes

On conclusion of the LeDeR process, both good practice and two areas for wider learning were identified.

Good practice identified included:

- Good communication across agencies.
- Dorset epilepsy service offering appropriate reasonable adjustments around venues for appointments.
- Co-ordinated Support from District nurses and CTLD staff.
- MacMillan Unit facilitating same-day discharge to enable an individual to die at home in accordance with their wishes.
- Availability of End-of-Life plan and Treatment Escalation Plan enabled an individual to remain at home.

Baker, Abi
06/10/2025 12:40:16

- Dorset Adult Integrated Respiratory Service met regularly with day service provider to agree acceptable parameters for oxygen saturation levels. This enabled the individual to continue attending until his passing.

Two points of learning were identified:

- CPR was commenced for one patient despite a DNACPR being in place as the document could not be located. This remains an ongoing system wide issue, particularly with individuals living in their own homes.
- Sudden Unexpected Death in Epilepsy (SUDEP) was identified as the cause of death for one patient. Following this, all nurses within CTLDs have been provided with updated training about SUDEP and the assessing and management of risk for individuals with epilepsy.

As a result of this learning, the Community Team Learning Disability (CTLD) completed a “learning loop” (learning on one page) in relation to the importance of fully involving families in treatment planning and decision making.

8.0. SAFEGUARDING REVIEWS (related to learning from deaths)

- 8.1. There were eight active Safeguarding Adult Reviews (SARs) on going at the end of Q1. Two thematic reviews remain on hold.
- 8.2. The SAR – ‘Peter’ was presented at the SAB in June and will now be published. The following points of learning were noted:
 - The risks from diabetes can be increased by mental health needs, brain injury and self-neglect
 - Forming a therapeutic alliance is essential but does not remove all risks.
 - There is a need for holistic approaches to health and care needs. Addressing medical as well as social needs, such as loneliness and isolation, is essential for comprehensive care.
 - People whose capacity fluctuates in the presence of other risk factors require careful assessment and appropriate application of legal frameworks to ensure their safety and well-being
 - There is a need for clear processes and to streamline and clarify how concerns are raised and managed such as distinguishing between safeguarding concerns and requests for care assessments

Baker, Abi
06/10/2025 12:40:16

- There is a need for interagency collaboration. Improved collaboration and information sharing between healthcare providers, adult social care services, and other agencies are critical for managing complex cases effectively.

- 8.3. There were eight active Domestic Homicide Reviews/ Domestic Abuse Related Death Reviews (DARDR) ongoing in Q1. There were two new referrals during Q4. There have been no publications.
- 8.4. One Serious Case Review (SCR) under the Multi Agency Public Protection Arrangement framework was completed along with all recommended actions. One action plan remains ongoing following the last local review.
- 8.5. There were two ongoing Child Safeguarding Practice Reviews during Q1. One new referral did not meet the threshold for a Child Safeguarding Practice Review (CSPR) and one that had been ongoing has now been referred in for a DARDR.
- 8.6. Several local learning reviews were ongoing throughout Q1, including:
 - A BCP learning review and DARDR for an 18-year-old care leaver who died by suicide continued in Q1. DHC CAMHS have been asked to provide the BCP Partnership with assurances around how work is carried out with young people who are hard to engage, what policies are in place to guide practitioners and how do CAMHS manage continuation of work with young people who temporarily move out of area.
 - A Dorset multi-agency learning review for a 6-month-old baby who died from hypoxic brain injury secondary to drowning. A task and finish group has been set up to consider a number of multi-agency themes, including:
 - working with parents that are neurodiverse,
 - a partnership workforce survey on the neurodiversity including ADHD to inform how to strengthen the learning and development offer in increasing the knowledge and skills,
 - information around safe bathing and accessibility of information and guidance for all including (but not exclusively) those with neurodiversity, learning and other needs.

- 8.7. Learning from an ongoing Dorset CSPR involving a young person who died on the railway line continues. DHC were asked to provide assurances around the use of motivational interviewing and trauma informed practice. A multi-agency audit on extra-familial harm is



also planned for Q2.

- 8.8. The multi-agency and single agency actions from the above reviews are presented to the Trust Safeguarding Group on a bimonthly basis and minutes go to all Directorate Management Groups.

9.0 END OF LIFE CARE (Expected Deaths)

- 9.1 There were 30 expected deaths recorded within inpatient services in Q1 2025/26. Twenty-nine deaths occurred within community hospital wards and one death occurred within an older person's mental health ward; see Table 3.

Table 3

Directorate	Total Deaths	Reviews Outstanding
Integrated Community Services	29	0
Mental Health, Learning Disabilities and Children & Family Services	1	0
Total	30	0

- 9.2 On review of learning, the following was identified during Q1:

Areas of Good Practice Identified

- End of Life Care continues to be maintained to an excellent standard across all wards, with ongoing updates and developments using the principles of Gold Standards Framework (GSF) to support personalised care.
- Staff are confident that the team they work within can prove good end of life care
- Staff are proactive in engaging with specialist services across multiple organisations to support complex symptom control needs where required.

Areas identified for continued improvement

- Improved documentation of conversations regarding nutrition and hydration/ psychological/ social/spiritual support as identified from the recent National Audit for Care End of Life (NACEL) reports.

Baker, Abi
06/10/2025 12:40:16

- Continued education and support for ward teams to continue to improve conversations with patient and families with Advanced Care Planning to reflect patient wishes.
- Increasing staff awareness of the Dorset Care Plan (DCP) where there have been Advance Care Planning conversations by other professionals which supports ongoing discussions around clinical management plans and patient wishes. Any updates to the care plans are then visible to other organisations via the DCR.
- Delayed or failed discharge / transfer plans (as per patient's wishes) due to lack of care and or local beds (hospice or Community Hospital)

10.0 MEDICAL EXAMINER DEVELOPMENTS

No matters to highlight in regard to learning shared by the Medical Examiner in this quarter.

11.0 NEXT STEPS

The reporting content and style will continue to be reviewed and developed to ensure that the Trust is able to evidence and demonstrate learning to provide assurance relating to deaths, as per the National Quality Board Framework (2017) and the Patient Safety Incident Response Framework (PSIRF).

12.0 SUMMARY

- 12.1. In summary, the committee are asked to receive this report as assurance of the processes that are undertaken in relation to the management of learning from deaths and compliance with the reporting requirements associated with the National Quality Board Framework (2017) and aligned with PSIRF methodology. Presented in this report are areas of learning for the Trust and in some cases the wider Dorset system for discussion, consideration and identification of any further opportunities for improvement.
- 12.2. Colleagues are asked to consider areas of good practice highlighted for wider sharing and consideration, in addition to areas which require further improvement.

Author (Overall): Ellie Lindop

Role: Deputy Director of Nursing, Therapies and Quality

Date: 15.08.25

Baker AM
06/10/2025 12:40:16

Appendix 1

Review Process	Description
After Death Analysis (ADA)	Can be used for expected deaths on wards.
Structured Judgement Review (SJR)	A review following a death in hospital to determine whether a more in-depth review is required. More detailed reviews will occur where there are concerns about the care delivery. This may lead to a Patient Safety Review (PSR) or Patient Safety Incident Investigation (PSII) review if there is concern of a systemic nature.
Mortality Reviews	A systemic review of a series of case records using a structured or semi-structured methodology.
National Review Process	Within their own internal governance systems NHS organisations also need to adhere to the 'Learning from Deaths' criteria in the event of a death being more likely than not due to problems in care.
Multi-agency Statutory Review Processes	
Learning Disability Mortality Review (LeDeR)	Reviews funded by NHS England into the health and social care provided to people with learning disabilities and autism with the objective of reducing health inequalities.
Domestic Homicide Reviews - now referred to as Domestic Abuse Related Death Reviews.	Reviews commissioned by Community Safety Partnerships into the death of a person (aged 16 or over) which has, or appears to have resulted from violence, abuse, or neglect.
Safeguarding Adult Reviews	Carried out by Safeguarding Adult Boards for the purposes of learning when an adult(s) with care and support needs dies and abuse and/or neglect is known or suspected to be a factor in the death and there are concerns about the way in which agencies have worked together.
Mental Health Homicide Reviews	Independent investigations commissioned by NHS England into homicides that are committed by patients being treated for mental illness.
Child Death Overview Panel (CDOP)	A multi-disciplinary panel which considers information in relation to child deaths to establish and learning and prevent future deaths.

Baker
06/10/2025 12:40:16

Review Process	Description
Multi-agency Public Protection Arrangements (MAPPA) Serious Case Review	This review establishes whether multi-agency public protection arrangements were effectively applied in the event of a death caused by someone known to be a sexual or violent offender.
Child Safeguarding Practice Reviews	Following notification of an incident (a child dies or is seriously harmed) a rapid review will be conducted by partners. On receipt of information from the rapid review, a decision will be made as to whether a Child Safeguarding Practice Review should be conducted if it is considered that abuse or neglect was a factor.

Baker, Abi
06/10/2025 12:40:16

Report to	Board of Directors, Part 1 (DHC)	
Date of Meeting	7 th October 2025	
Report Title	Dorset Healthcare – Implementing the Patient Carer Race Equality Framework: Bi-annual Update	
Prepared By	Dr Helena Posnett, Consultant in Public Health and Trust Lead for Health Inequalities	
Approved by Accountable Executive	Dr Lucy Knight, Chief Medical Officer (Executive Lead for Health Inequalities)	
Previously Considered By	Quality Committee in Common, 23/09/2025	
Action Required	Approval	N
	Assurance	Y
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? <i>Delete as required</i>	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability		No
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	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 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 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 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.	
Financial	No implication	
Statutory & Regulatory	This report provides an update on Dorset Healthcare's moral duty and contractual requirement to implement the Patient Carer, Race Equality Framework (PCREF) – the NHS' first anti-racism framework by 31 st March 2025	
Equality, Diversity & Inclusion	PCREF speaks to equality, diversity and inclusion, with respect to our workforce <i>and</i> the communities we serve.	
Co-production & Partnership	Co-production and partnership is core to PCREF specifically with racialised and ethnic minority communities in Dorset (those with lived experience, their carers, our staff, and communities); and between organisational functions.	

Baker, Abi
06/10/2025 12:40:16

Executive Summary

The purpose of this paper is to:

- 1) provide an update on progress against the Trust's Patient Carer Race Equality Framework 2025/26 Implementation Plan (the Plan) and assurance that work is progressing in line with our moral duty and contractual expectations, and
- 2) highlight risks and issues currently being managed - in relation to delivering the required cultural transformation to be an anti-racist organisation, Board to Floor

Recommendation

Members are requested to note the update, and receive this report for **assurance**.

Baker, Abi
06/10/2025 12:40:16



Healthier lives



Empowered citizens



Thriving communities

Page 2 of
13

Implementing the Patient Carer Race Equality Framework: Bi-annual Update

1. Purpose of Paper

- 1.1 In Dorset, **almost 1 in 6 people** registered with a GP (~123,000; 15%) identify as belonging to a community minority (an ethnic group other than White British), of which the largest populations are White Other (~59,000) and Asian/British (~28,000).¹ Against a backdrop of persistent inequalities experienced by racialised communities² in the mental health sector, Dorset Healthcare University NHS Foundation Trust (the Trust) has a **moral and contractual duty to implement the Patient Carer Race Equality Framework (PCREF) - NHS England's first anti-racism framework**³.
- 1.2 To embed an anti-racism approach, and in line with the guidance⁴ and contractual requirements, **the Trust's 2025/26 PCREF Implementation Plan (the Plan) went live on 31 March 2025**. This focuses on three core areas:

1. Leadership and governance	- Nominate an executive board lead and establish governance structures, accountability and leadership across the organisation. - Co-develop, implement and review local PCREF plans with racialised communities and your workforce. - Identify priorities for improvement in meeting the specific legislative and regulatory requirements relating to equalities to include in local PCREF plans - Monitor core measures at Trust Board level on a regular basis and publish PCREF plans.
2. National organisational competencies	- Engage with racialised communities to identify and agree core organisational competencies. - Agree on measurable and practical actions to co- develop in local PCREF plans. - Ensure the whole organisation is aware of its responsibilities in implementing local PCREF plans
3. Patient and carer feedback mechanism	- Ensure patient experience data is used, monitored and flowed to national data-sets to enable bench- marking, lesson-sharing and service improvement. - Ensure outcome measures are routinely used and monitored locally, and flowed to national datasets to enable benchmarking, lesson-sharing and improvement of services. - Agree approaches for implementing a 'real time' and transparent feedback loop for racialised and ethnically and culturally diverse communities.

- 1.3 PCREF is mandatory and will become part of CQC inspections. It is a **Trust Quality Priority and EDS2 Domain 1 focus area** (restrictive practice focus) for 2025/26.
- 1.4 Delivery of PCREF will also enable the Trust to meet its requirements in relation to NHS England's statement under section 13SA(1) of the NHS Act 2006 on how NHS bodies should exercise their powers to collect, analyse and publish information related to health inequalities. For further details of PCREF, please see summary in Appendix 1.

¹ DiiS Data, accessed 19/1/25

² Ethnic, racial and cultural communities who are minoritised populations in England, have been racialised ([Centre for Mental Health – Guide to race and ethnicity terminology](#)), and who experience marginalisation.

³ [NHS England » Patient and carer race equality framework](#)

⁴ <https://www.england.nhs.uk/mental-health/advancing-mental-health-equalities/pcref/>

- 1.5 The purpose of this paper is to (i) provide an update on implementation progress and assurance that work is progressing in line with our moral duty and contractual expectations, and (ii) highlight risks and issues currently being managed.

2. Key highlights - progress since 31 March 2025

2.1 Across all areas of the Plan, **action owners have been agreed** and are responsible for more detailed planning and delivery.

2.2 Appendix 2 provides a full status update for the Plan. There has been **key progress in the following areas**:

- Agreement with the Dorset Mental Health Forum for a PCREF co-production workstream to sit within the Wellbeing and Recovery Partnership. An operational planning meeting is scheduled for August.
- Delivery of an Action Learning Set aligned to the Culture of Care Programme and in partnership with Black Thrive Global – to inpatient teams working on Reducing Restrictive Practice, focused on improving cultural awareness (a key organisational competency)
- Collaborative conversations with People and Culture to explore scaling Equality Diversity and Inclusion (EDI) staff champions (developed as a Quality Improvement (QI) project on Chine Ward within the Culture of Care Programme) – to be discussed at the anticipated Joint Culture and Belonging Group
- Work is underway to baseline the quality and completeness of protected characteristics recording in patient records – including a deep dive into ethnicity – to inform future targeted improvement work
- Inclusion of key, related health inequalities indicators, to drive improvement as part of the NHS Dorset Annual Health Inequalities Report 2025 – pending publication.

2.3 The following **opportunities have also arisen**; to be added to the Plan as they develop:

- Initial stakeholder meeting held to explore how best to co-produce an improvement plan with Gypsy Roma Traveller Communities – with agreement for a workshop in Q3 to shape our System response to key guidance: [Tackling Mental Health Inequalities for Gypsy, Roma and Traveller People](#)
- Expression of Interest for the NHS Charities Together Innovation Challenge 2 selected to progress to full proposal submission: to mobilise a peripatetic team to provide meaningful activities and engagement in the community for children and young people who need mental health support, aligned to PCREF.

3. Programme Governance

3.1 Following discussions, the governance route to Board has transferred to Quality Committee in Common. Dr Lucy Knight (Chief Medical Officer and Executive Lead for Health Inequalities) is the Executive Sponsor.

3.2 Bi-annual Trust assurance updates to the Board (such as this) include progress against the Plan, covering the three core areas. Quarterly contractual updates to NHS Dorset are expected to continue. In June, the Trust Lead for Health Inequalities provided an update at the System Health Inequalities Steering Group

3.3 Stakeholders from the National Culture of Care Programme continue to provide active support to the Trust in relation to PCREF. Acknowledging the good work started through the Culture of Care Programme to enable front-line staff to talk about race, inpatient colleagues were invited to share their QI projects at the Southern Region Culture of Care Learning Network in May. The Trust Lead for Health Inequalities was also invited to present the Dorset approach at the national Board Race Equity Training delivered by Black Thrive Global.

3.4 The approach to developing the Plan acknowledges the role played from Board to Floor and across all Directorates to enable the required cultural transformation. The size and scale of the Plan reflects available Trust capacity.

3.5 Risks and issues are described below. Following discussions at Quality Governance Group, a working group is being considered.

Risk	Issue	Mitigation
Failure to deliver required cultural transformation needed to be an anti-racist organisation from Board to Floor	Sub-optimal governance structure for Plan oversight – to enable robust check and challenge, sufficient strategic visibility and prioritisation of any further needed work (or not)	Per Quality Governance Group advice 5/8/25 - to explore working group. Per Quality Committee in Common advice 23/9/25 – to update in 6 months
	Unclear plan for supporting communications re the Trust's anti-racist approach - which includes publishing the Plan per requirements; to "ensure the whole organisation is aware of its responsibilities in implementing local PCREF plans"	Per above
	Lack of project management capacity to coordinate progress updates and facilitate review and refresh of Plan against core competencies in Q4, and Evaluation (per baseline assessment guidance ⁵)	Per above
	Unidentified resource to enable a co-production focus – with patients, carers and communities	Mitigated through new co-production workstream within Wellbeing and Recovery Partnership. Monitor

.....
Dr Helena Posnett, Consultant in Public Health (Trust Lead for Health Inequalities)

29 September 2025

.....

⁵Is the implementation of the PCREF at a local level regularly and independently evaluated with patients, carers, the workforce, voluntary sector organisations and racialised and ethnically and culturally diverse communities and publish the findings?

APPENDICES

APPENDIX 1: Introduction to PCREF

- There is a **recognised and long-standing backdrop of persistent inequalities experienced by racialised communities⁶ in the mental health sector**. People from “Black and Black British groups are four to five times more likely to be detained under the Mental Health Act than their white counterparts, have higher rates of being restrained in inpatient units, and are far more likely to encounter mental health services through the criminal justice system. [People] from other racialised groups have poorer mental health and access to mental healthcare, including increased use of crisis pathways, leading to more negative experiences and outcomes compared to the majority white British groups”⁷.
- Launched in November 2023, the anti-racism approach of PCREF has been coproduced with experts by experience, carers of those with mental health challenges, and PCREF pilot trusts and early adopter sites who have partnered with ethnic led voluntary sector organisations. It describes the **participatory approach to anti-racism** required to improve experiences of care, and is split into three components (please see Figure 1):

Part 1 – Legislative and regulatory obligations (Leadership and governance):

Legislation has been identified that applies to all NHS mental health trusts and mental health providers in fulfilling their statutory duties, and leaders of the Trusts and mental health providers will need to ensure these core pieces of legislation are complied with across their organisation.

Part 2 – National organisational competencies: aligns with the vision in the Independent Review of the Mental Health Act 2018 (MHA). Through a co-production process, six organisational competencies have been identified working with racialised communities, patients and carers. Trusts and mental health providers should work with their communities and patients and carers to assess how they fair against the six organisational competencies (and any more identified as local priorities) and co-develop a plan of action to improve them.

Part 3 – The patient and carers feedback mechanism: which seeks to embed patient and carer voice at the heart of the planning, implementation and learning cycles.

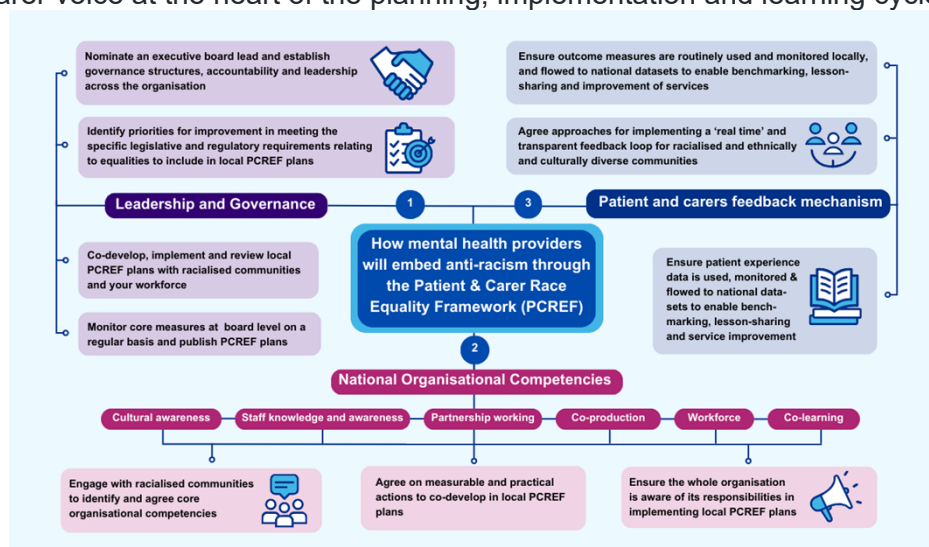


Figure 1: Graphic describing the Patient Care Race Equality Framework

⁶ ethnic, racial and cultural communities who are minoritised populations in England, have been racialised ([Centre for Mental Health - Guide to race and ethnicity terminology](#)), and who experience marginalisation.

⁷ [NHS England » Patient and carer race equality framework](#)

APPENDIX 2: PCREF Implementation Plan 2025/26

Leadership and Regulatory Position		Lead (working with others)	Status 30/7	Comment
1.1 Data Reporting	1.1a Continue to work with System Partners to publish with narrative, in relation to priority health inequalities indicators, as evidence of meeting NHS England's statement under section 13SA(1) of the NHS Act 2006 on how NHS bodies should exercise their powers to collect, analyse and publish information related to health inequalities	Health Inequalities	Complete	Inclusion of key, related health inequalities indicators, to drive improvement as part of the NHS Dorset Annual Health Inequalities Report 2025 – pending publication Guidance for 2025/26 pending
	1.1b Work with System Partners to review opportunities to improve service-level reporting of equity of access-experience-outcomes – with an initial focus on priority areas, co-produced with patients, carers and communities Links to 2.1a, 3.2, 3.3	Business Intelligence	In progress	Pending 1.1, dashboard development planned focusing on DNAs, restrictive practice and detentions under the Mental Health Act
	1.1c Develop and implement an improvement plan in response to the System focus on ethnicity recording through EDS2 Domain 1. Links to 2.1a	Mental Health Directorate	In progress	Work underway to baseline the quality and completeness of protected characteristics recording in patient records – including a deep dive into ethnicity – to inform future targeted improvement work
	1.1d Consider reporting of all deaths in mental health inpatient unit to CQC by protected characteristics (not just those detained under the Mental Health Act)	Nursing, Therapies and Quality	In progress	Tasks agreed and assigned to owner(s); update due 20/8
1.2 Regulatory Obligations	1.2a Review specific recommendations of the Mental Health Act (MHA) Review 2018, key legislation and relevant supplementary documents and guidance; and share key messages with stakeholders to inform further improvements as needed	TBD, pending discussion with National Culture of Care Programme re	On Hold	Response pending from National Culture of Care Programme

		centralisation of task		
	1.2b Work with System Partners to review and implement the System Equality Impact Assessment Tool, and ensure regular reviews of policies and practices are undertaken with an equalities lens.	Nursing, Therapies and Quality	In progress	Tasks agreed and assigned to owner(s); update due 20/8
	1.2c Identify opportunities to improve quality feedback processes, from the perspective of racialised patients, carers and communities and implement including: • Involvement of racialised experts by experience – in reviewing patient safety data already shared with the Board including the inappropriate use of force • Management of complaints • Documentation and management of Advance Choice Directives (treatment preferences) • Management of feedback from culturally appropriate advocacy services • Management of feedback and involvement of racialised carers for example in line with the Triangle of Care. Links to 2.1a, 2.1b	Nursing, Therapies and Quality, with Dorset Mental Health Forum and wider partners including Dorset Race Equality Council, Community Action Network	In progress	Tasks agreed and assigned to owner(s); update due 20/8
	1.2d Baseline review in relation to implementation of the Accessible Information Standard, to enable progress to be made <i>(Per baseline assessment, to include:</i> • <i>Are patients routinely offered information in compliance with NHS England's Accessible Information Standard in regards to patients on their rights, complaints procedures, and advocacy services available to them?)</i>	Nursing, Therapies and Quality	In progress	Tasks agreed and assigned to owner(s); update due 20/8

Baker, Abi
06/10/2025 12:40:16

2. Organisational Competences		Lead (working with others)	Status 30/7	Comment
2.1 Co-production Competency (organisational and service-level)	2.1a Develop and implement a plan to involve racialised patients, carers and communities in relation to implementation of PCREF, from Board to Floor. <i>(Per baseline assessment, to include consideration of:</i> <i>Are racialised and ethnically and culturally diverse community representatives included at Trust board level and inducted/equipped with the skills/training to participate meaningfully in discussions?</i> <i>Is there an independent mechanism i.e. advisory board (where applicable) in place for oversight on the implementation of the PCREF, consisting of local community leaders, patients/carers and voluntary sector organisations?</i> <i>Is there a partnership framework implemented along with good guiding principles on what is an anti-racism and anti-oppressive partnership working?</i> <i>Are community champions identified and supported to inform service development, and to inform communities of early intervention support available</i> <i>Is the impact of partnership working including Trusts working towards equitable relationships, that has mutual benefits and shared decision-making with racialised and ethnically and culturally diverse communities evaluated? This includes monitoring satisfaction levels with partner organisations, patients, carers, and staff</i>	Nursing, Therapies and Quality, with Dorset Mental Health Forum and wider partners for example, Dorset Race Equality Council and Community Action Network	In progress	Agreement with the Dorset Mental Health Forum for a PCREF co-production workstream to sit within the Wellbeing and Recovery Partnership. An operational planning meeting is scheduled for August.

Baker, Abi
06/10/2025 12:40:16

	- Are there service plans and care treatment plans co-produced with racialised and ethnically and culturally diverse communities, faith leaders, ethnic led VCSE partners, which address: 1 - Language translation service needs and or other accessible information?" 2 - Different cultural food requirements? 3 - Different faith requirements, such as access to prayer spaces and spiritual support? 4 - The type of aftercare mental health provisions offered? 5 - Trauma informed practice? - Are research initiatives co-produced with local communities to understand barriers and opportunities in improving race equity in service access, experience, and outcomes?) Links to multiple actions			
	2.1b Establish an active mechanism for involving staff from racialised communities in relation to implementation of PCREF Links to multiple actions	People and Culture, working with the Staff Multicultural Network	In progress	Links established with Staff Multicultural Network and members increasingly involved in activities e.g. in 2.2a
2.2 Improving competencies at Service-level (inpatients settings, reducing restrictive practice)	2.2a Work with the Culture of Care Programme to develop and implement an improvement programme working with and led by inpatient teams through the lens of reducing restrictive practice (RRP). To include at a service-level: - Activities to promote an anti-racist culture and respond to incidents of abuse - Training and Action Learning Sets - Review of related policies and practice - Review of available data Evaluate and share learning with wider settings including community teams Links to 2.1a, 2.1b	PCREF RRP Working Group, with National Culture of Care Programme	In progress	Delivery of an Action Learning Set aligned to the Culture of Care Programme and in partnership with Black Thrive Global – to inpatient teams working on Reducing Restrictive Practice, focused on improving cultural awareness (a key organisational competency) Collaborative conversations with People and Culture to explore scaling EDI

Baker, Abi
06/10/2025 12:40:16

				champions (developed as a QI project on Chine Ward within the Culture of Care Programme) – to be discussed at the anticipated Joint Culture and Belonging Group
2.3 Improving competencies at Organisational-level	2.3a Align workforce related activities already underway and planned to PCREF to enable reporting and acceleration of work. To include leadership and workforce support offers from Culture of Care Programme. <i>(Per baseline assessment, to include consideration of:</i> <i>• Is cultural awareness training commissioned with organisations/representatives that understand racialised and ethnically and culturally diverse communities' experiences?</i> <i>• Are specific development goals relating to inequalities related to race in embedded in staff personal development plans?</i> <i>• Does the Trust co-develop clear policies on addressing racism, whether experience by patients or staff?</i> <i>• Is there a co-developed reciprocal mentoring programme, which focuses on improving understanding of cultural differences?</i> <i>• Are frontline workers aware of and implementing best practice in care for racialised and ethnically and culturally diverse communities, such as the NHS Talking Therapy positive practice guide for 'Black, Asian and minority ethnic' patients?</i>	People and Culture	In Progress	Many actions already underway via Trust's Inclusion and Belonging Action Plan e.g. Cultural competence and awareness covered in Conscious Inclusion Training and now mandatory for all line managers, 3rd cohort of reciprocal mentoring focusing on all underrepresented groups concluded in July (Cohort 1 was race-specific) Gaps identified which would require strategic prioritisation e.g. embedding specific race inequalities focus in staff personal development plans. Queries also raised as to scope of People and Culture to review all recommendations e.g. in relation to clinical guidance for staff – to be explored

Baker, Abi
06/10/2025 12:40:16

Baker, Abi 06/10/2025 12:40:16	- Are there a diverse range of champions acting as specialist advisers representing the racialised and ethnically and culturally diverse communities and supporting the Trust on anti-racism activities? - Are there wellbeing equality indicators developed with ethnically and culturally diverse staff, reported at Trust board level supplementary to the WRES/WDES indicators - Is there a clear plan implemented to improve staff survey outcomes and consider the racial diversity of ethnically and culturally diverse staff including alignment with the regional Mental Health Workforce Equity Fellowship?)			
	2.3b Deliver re-tender of translation services - with involvement of racialised staff, patients, carers and communities Links to 2.1a, 2.1b	People and Culture	In progress	Underway; plan being discussed to incorporate NHS England » Improvement framework: community language translation and interpreting services
	2.3c Review availability of culturally appropriate food available - with involvement of racialised staff, patients, carers and communities – to inform improvements Links to 2.1a, 2.1b	Nursing, Therapies and Quality /Estates	In progress	Tasks agreed and assigned to owner(s); update due 20/8
	2.3d Review how faith requirements are supported such as access to prayer spaces and spiritual support - with involvement of racialised staff, patients, carers and communities – to inform improvements Links to 2.1a, 2.1b	People and Culture	In progress	Tasks agreed and assigned to owner(s); update due 20/8
	2.3e Strengthen collaboration with local authority partners and evidence feedback from culturally appropriate advocacy services to improve service provision - including qualitative and quantitative data sharing	Mental Health Directorate	In progress	Tasks agreed and assigned to owner(s); update due 20/8

3. Patient and Carer Feedback Mechanism		Lead (working with others)	Status 30/7	Comment
3.1 Feedback Tool	Await national guidance <i>(Per baseline assessment, to include consideration of:</i> <i>Is there a suitable and impactful tool to measure the experience of ethnically and culturally diverse patients and carers at a local level? Does this tool evidence how these experiences vary, and how feedback is being taken on board in a transparent way?)</i>	Nursing, Therapies and Quality	On Hold	National guidance awaited
3.2 National Data Returns	See 1.1b, 1.1c <i>(Per baseline assessment, to include consideration of:</i> <i>Are access and outcomes measures routinely flowed into national mental health datasets (i.e. Talking Therapies recovery) in line with national requirements to better understand the impact of mental health services of racialised ethnically and culturally diverse communities accessing/receiving care from Trusts and mental health providers?)</i>	See 1.1b, 1.1c		n/a
3.3 Co-production of relevant measures	See 1.1b, 1.1c <i>(Per baseline assessment, to include consideration of:</i> <i>Have the access, experience and outcomes measures monitored routinely at a Trust and mental health provider board level been agreed/co-produced with racialised and ethnically and culturally diverse experts by experience? This should be alongside the existing nationally recommended outcome and experience tools, as well as the metrics already specified in Part 1. Please refer to Annex C on outcome and experience tools.)</i>			n/a

Baker, Abi
06/10/2025 12:40:16

Report to	Board of Directors, Part 1 (DCH)	
Date of Meeting	7 th October 2025	
Report Title	National Inpatient Survey 2024 Report	
Prepared By	Hannah Robinson – Head of Patient Experience	
Approved by Accountable Executive	Dawn Dawson – Joint Chief Nursing Officer	
Previously Considered By	Quality Governance Group 09.09.25 Patient Experience and Public Engagement Committee 30.07.25 Quality Committee in Common 23.09.25	
Action Required	Approval	N
	Assurance	N
	Information	Y

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? <i>Delete as required</i>	
Care	Yes	
Colleagues		No
Communities		No
Sustainability		No
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 Quality and Safety	
Financial	No implication	
Statutory & Regulatory	Yes	
Equality, Diversity & Inclusion	Yes	
Co-production & Partnership	Yes	

Executive Summary
This report summarises the findings from the NHS Adult Inpatient Survey 2024, undertaken by IQVIA for Dorset County Hospital NHS Foundation Trust between January 2025 and April 2025. A total of 37 Trusts took part in the survey with IQVIA. Note: Update following approval of the attached report: The Adult NIS survey was publicly published on the 9th September 25. Report Headline: More people reporting a better overall hospital experience than last year, but patient satisfaction still far lower than five years ago, https://www.cqc.org.uk/press-release/more-people-reporting-better-overall-hospital-experience-last-year-patient Trust overall experience score 8.3, an increase from 8.1 in 2023, with comparison results ‘about the same’ as other Trusts: https://www.cqc.org.uk/provider/RBD/surveys/109 The full CQC benchmarking report has not been issued at time of publication as the CQC are carrying out checks on locations registered by our provider, (IQVIA). The details provided in the report below will be further discussed through PEPEC with key areas for improvements to be identified and plans put in place: The survey methodology followed exactly the detailed guidelines determined by the Survey Co-ordination Centre for the overall Adult Inpatient Survey programme. The survey required a sample of 1,250 consecutively discharged inpatients, working back from the last day of November 2024, who had a stay of at least one night in hospital. There were a number of categories of patients excluded from the survey e.g. psychiatric patients and maternity patients.

473 completed questionnaires were returned from the sample of 1105 for Dorset County Hospital NHS Foundation Trust. The final response rate for the Trust was 45% (473 usable responses from a usable sample of 1059).

The scores for the Trust are mostly in line with the sector scores and stable year on year. The findings highlight areas for recommendation, but it is noted that the Trust should also celebrate areas where scores are higher than the sector benchmark.

The survey top and bottom five scored questions are displayed below

Top Five		Bottom Five	
Q28. Were you given enough privacy when being examined or treated?	9.49	Q8h. Were you ever prevented from sleeping at night by any of the following? I was not prevented from sleeping	3.65
Q31a. Thinking about your care and treatment, did hospital staff take into account the following individual needs? Language needs (e.g. translation, braille)	9.31	Q41. Thinking about any medicine you were to take at home, were you given any information?	4.54
Q16. During your time in hospital, did you get enough to drink?	9.21	Q2. How did you feel about the length of time you were on the waiting list before your admission to hospital?	5.23
Q47. Overall, did you feel you were treated with respect and dignity while you were in the hospital?	9.14	Q36. To what extent did hospital staff involve your family or carers in discussions about you leaving hospital?	5.69
Q18. Did you have confidence and trust in the doctors treating you?	9.13	Q8a. Were you ever prevented from sleeping at night by any of the following? Noise from other patients	6.17

The results of the National Inpatient Survey 2025 provide some clear areas for us to both celebrate where we are doing well and where there is need to prioritise quality improvement to support a more positive patient experience. It identifies what matters most to our patients and gives us the opportunity to learn and make improvements within our control.

Wider sharing of the survey results and a stakeholder meeting to discuss next steps and a quality improvement plan will form the basis to consider and act on the survey recommendations. Quality improvement projects will be established or linked to ongoing programmes of work. These will be monitored through PEPEC.

Recommendation

Members are requested to:

- Receive the report for **information**

Adult Inpatient Survey 2024

Dorset County Hospital NHS Foundation Trust

Management Report

Produced by IQVIA UK&I Healthcare

© 2025. All rights reserved. IQVIA® is a registered trademark of IQVIA Inc. in the United States, the European Union, and various other countries.



Baker, Abi
06/10/2025 12:10:16

Table of Contents

Introduction	3
Observations and Recommendations	5
Reading the Report	6
Section Scores	10
Top / Bottom 5 Scores	11
Admission to Hospital	12
The Hospital and Ward	19
Doctors	34
Nurses	40
Your Care and Treatment	47
Leaving Hospital	64
Overall	84
Demographic Characteristics	90

Baker, Abi
06/10/2025 12:40:16

Introduction

The Adult Inpatient Survey was undertaken by IQVIA for Dorset County Hospital NHS Foundation Trust between January 2025 and April 2025.

Methodology and Sampling

The methodology follows exactly the detailed guidelines determined by the Survey Co-ordination Centre for the overall Adult Inpatient Survey programme.

The survey required a sample of 1,250 consecutively discharged inpatients, working back from the last day of November 2024, who had a stay of at least one night in hospital. There were a number of categories of patients excluded from the survey e.g. psychiatric patients and maternity patients.

Response Rate

473 completed questionnaires were returned from the sample of 1105 for Dorset County Hospital NHS Foundation Trust . 46 patients were excluded from the sample for the following reasons:

- ♦ Moved / not known at this address 19
- ♦ Ineligible 2
- ♦ Deceased 25

The final response rate for the Trust was 45% (473 usable responses from a usable sample of 1059).

Report Content

This report presents the survey results in a number of different ways. It sets out the full results in the same format as they appear in the questionnaire. It provides an analysis of areas where the organisation is achieving good results, as well as areas where management action is required. It provides benchmarking charts comparing results against similar organisations.

IQVIA has identified a number of conclusions arising from the survey and makes a number of recommendations for action. These are included in the Observations and Recommendations section.

Baker
09/05/2025 12:40:16

Introduction (continued)

Publishing and publicising your results

This is a confidential report from IQVIA to the organisation. The decision about whether or not to publish it – or to publicise contents to staff or patients – is entirely up to each organisation. However, our strong advice, in the spirit of openness and transparency, is that the results should be publicised through all available channels.

Having run the Adult Inpatient Survey in a multitude of NHS organisations over many years, we have found that the most effective organisations report to staff and patients on the outcomes of the survey; and tell staff and patients what they are doing as a result. This significantly improves the credibility of the process. Publicity could include:

- Presentations to the Board on key strategic issues
- Distribution of findings to Clinical Governance teams, and to Divisional and Departmental heads
- Discussions on the results with staff representatives
- Publication of results on the internet
- Display presentations in appropriate locations in the organisation.

Whatever decision is taken locally, there will be a national publication with the key results for each organisation, which will be published in August 2025 (TBC). However, until the Co-ordination Centre publishes the national results on the NHS Inpatient Survey website, there is an embargo on the publication of any 2024 survey results which use the benchmarked analysis included in the feedback reports.

Baker, Abi
06/10/2025 12:40:16

Summary and Recommendations

Summary

The scores for Dorset County Hospital NHS Foundation Trust are mostly in line with the sector scores and stable year on year. Whilst focussing on two or three areas for improvement, the Trust should also celebrate areas where scores are higher than the sector benchmark.

At question level, 2 scores have improved significantly since 2023, whilst 1 score has significantly declined. When compared to the other sector organisations, 8 scores are in the top-20% range. There are 36 scores that are in the intermediate-60% and 5 in the bottom-20%.

Identify areas for improvement by looking at the questions where the scores are at the lower end of the intermediate 60% or in the bottom 20% range. It is also important to consider the scores that are low in their own right, irrespective of their position when benchmarked, and those that have declined over time.

The recommendations below focus on questions where the Trust score falls behind the sector benchmark score.

Recommendations

Admission to hospital	Review possible actions that can be taken to reduce waiting times for patients. Examine the reasons why some patients felt that they were not being admitted when they anticipated. Investigate how patients are being informed and updated regarding waiting times.
Admission to hospital	Review the quality of information that is provided whilst patients are waiting for hospital admission. Ensure this information is clear, concise and accessible to all patients.
Your care & treatment	Examine the reasons for patients feeling that their cultural needs were not taken into consideration. Ensure that staff are taking the time to treat patients with care and with the understanding that each patient is different.
Leaving hospital	Prior to discharge, direct staff to actively enquire if there have been any changes to their home and if the require any additional equipment. Ensure staff document and address such needs when planning their discharge.
The hospital & ward	Address why some patients who brought their own prescribed medication to the ward reported not being able to take it when they needed to. Examine current practices for evaluating and documenting any medication patients bring with them when they are admitted. Ensure patients have enough medication for the duration of their stay and that it is accessible for them to take as prescribed.

Baker, Abi
06/10/2025 12:40:16

Reading the Report

Standardised Data

Used in the **Benchmark Charts and Tables**.

This data provides the Trust with an indication of how scores rank when directly compared with the average scores, whilst suppressing any differences that may be present due to local variation in terms of patient demographic profile. Standardising the data in this way ensures that any comparisons drawn are reliable when determining variations in scores and top and bottom performers.

The process undertaken to standardise the data is based on national methodology used by the CQC to produce the national benchmark reports and should be useful to provide an indication of what a Trust's national results are likely to be. However, please be advised that there will be minor differences between the numbers in this report and a Trust's official national benchmark report as IQVIA only has access to a proportion of the data whilst the national standardisation process will be based on the full dataset available for all Trusts.

Raw Data

Used in the **Compositional Charts**.

This data provides the Trust with an unadjusted view of exactly how patients have responded to the survey. This view of the data is important to ensure the Trust has full visibility of the survey results as a dataset in its own right. Comparisons with the unadjusted survey averages are also provided for information.

Longitudinal Charts - Scored Questions Only

Each scored question for which there is more than one year of data available has a longitudinal chart showing the 2022, 2023 and 2024 scores for the Trust plotted against the equivalent score for all Trusts surveyed by IQVIA.

Compositional Charts - Raw Data - Scored Questions Only

The compositional chart uses data as reported in the Initial Results which have been previously provided. It shows the range of responses to the specified question for the organisation and for all similar organisations in the IQVIA database (survey average). The vertical scale is always 0-100%. These charts exclude any non-specific responses such as don't know / can't remember.

Reading the Report (continued)

Suppression

All scores within the benchmark charts and tables pages are suppressed if fewer than 30 respondents have answered an individual question. When scores are suppressed, no RAG rating is assigned.

Important Note - Scored Questions

For each scored question in the survey, the individual responses are converted into scores on a scale from 0 to 10. A score of 10 represents the best possible response and a score of 0 the worst. The higher the score for each question, the better the trust is performing.

It is not appropriate to score all questions in the questionnaire as not all of the questions assess the Trusts in any way, for example, there may be 'routing questions' designed to filter out respondents to whom following questions do not apply. An example of a routing question is Q1 (Was your most recent overnight hospital stay planned in advance or an emergency?).

13	Did your NHS mental health team treat you with care and compassion?	
1	☐ Yes, always	10
2	☐ Yes, sometimes	5
3	☐ No	0
4	☐ Don't know / can't remember	--

In the above example three of the four responses are scored. The first response is treated as being entirely positive, the second as partially positive and the third as negative. The final option is not scored, and so excluded from any calculation. Such scoring should be taken into account when comparing raw percentages in the compositional charts against overall question level scores.

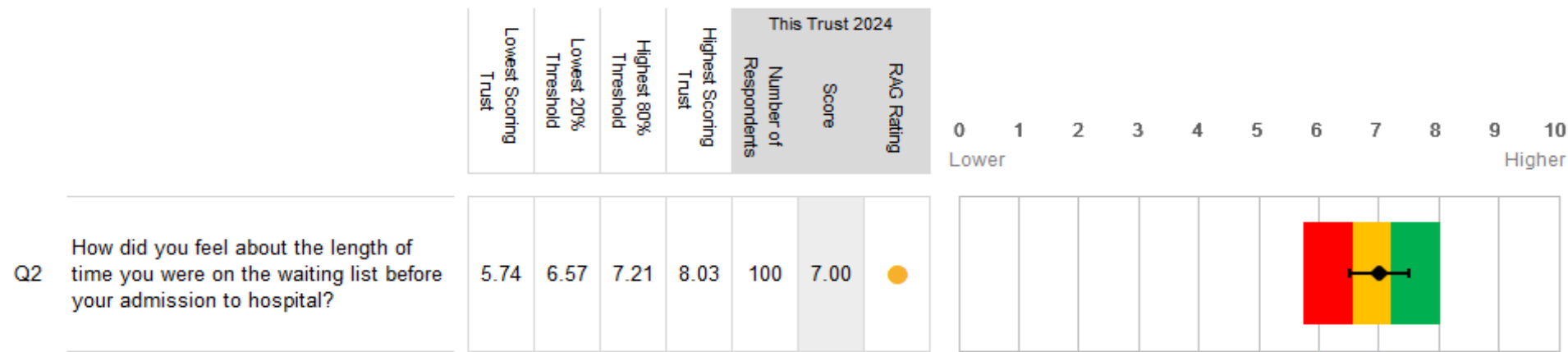
Scores are always based on the positive response to the question, this includes questions where the question wording may be focused on a potentially negative experience.

For full details of the scoring please refer to the Scored Questionnaire which can be accessed here:
<https://nhssurveys.org/wp-content/surveys/02-adults-inpatients/04-analysis-reporting/2024/Scored%20Questionnaire.xlsx>

Reading the Report (continued)

Benchmark Charts and Tables - Scored Questions Only

The benchmark charts (example below) show results for scored questions only.



Each scored question has a data table, detailing the following:

- The first column shows the question number and question text
- The second column shows the lowest score achieved across all Trusts in the IQVIA database
- The third column shows the highest value in the lowest scoring 20% of Trusts (i.e. the threshold or end of the red segment of the chart)
- The fourth column shows the lowest value in the highest scoring 20% of Trusts (i.e. the threshold or start of the green segment on the chart)
- The fifth column displays the highest score achieved across all Trusts in the IQVIA database
- The sixth column shows the base size or number of respondents for the question/Trust
- The seventh column shows the Trust's score for this year (as depicted by the black circle on the chart)
- The final column shows a RAG rating indicator. If a Trust's score falls within the lowest 20% of scores for that question, a red dot will be displayed. If a Trust's score falls within the intermediate 60% of scores for that question, an amber dot will be displayed. If a Trust's score falls within the highest 20% of scores for that question, a green dot will be displayed. If the Trust's score is suppressed, no RAG rating is displayed.

Reading the Report (continued)

Each scored question also has a bar that represents the range of results across all 37 Trusts that took part in the survey with IQVIA. The bar is divided into three segments as follows:

- A red section: the lowest scoring 20% of Trusts
- An amber section: the intermediate 60% of Trusts
- A green section: the highest scoring 20% of Trusts

The black marker represents the score for the Trust. As an example, if the marker is in the green section of the bar, it means that the Trust is among the top 20% of Trusts surveyed by IQVIA for that question. The line on either side of the marker shows the 95% confidence interval (the degree of uncertainty surrounding the Trust's score).

Baker, Abi
06/10/2025 12:40:16

Section Scores

This section of the report summarises the overall score for each survey section. Section scores are based on the average across all scored questions in the section.

Section Name	Trust	All
ADMISSION TO HOSPITAL	6.66	6.80
THE HOSPITAL AND WARD	7.55	7.50
DOCTORS	8.89	8.72
NURSES	8.46	8.35
YOUR CARE AND TREATMENT	8.34	8.17
LEAVING HOSPITAL	7.00	6.93
OVERALL	8.67	8.66

Baker, Abi
06/10/2025 12:40:16

Top & Bottom Five Questions

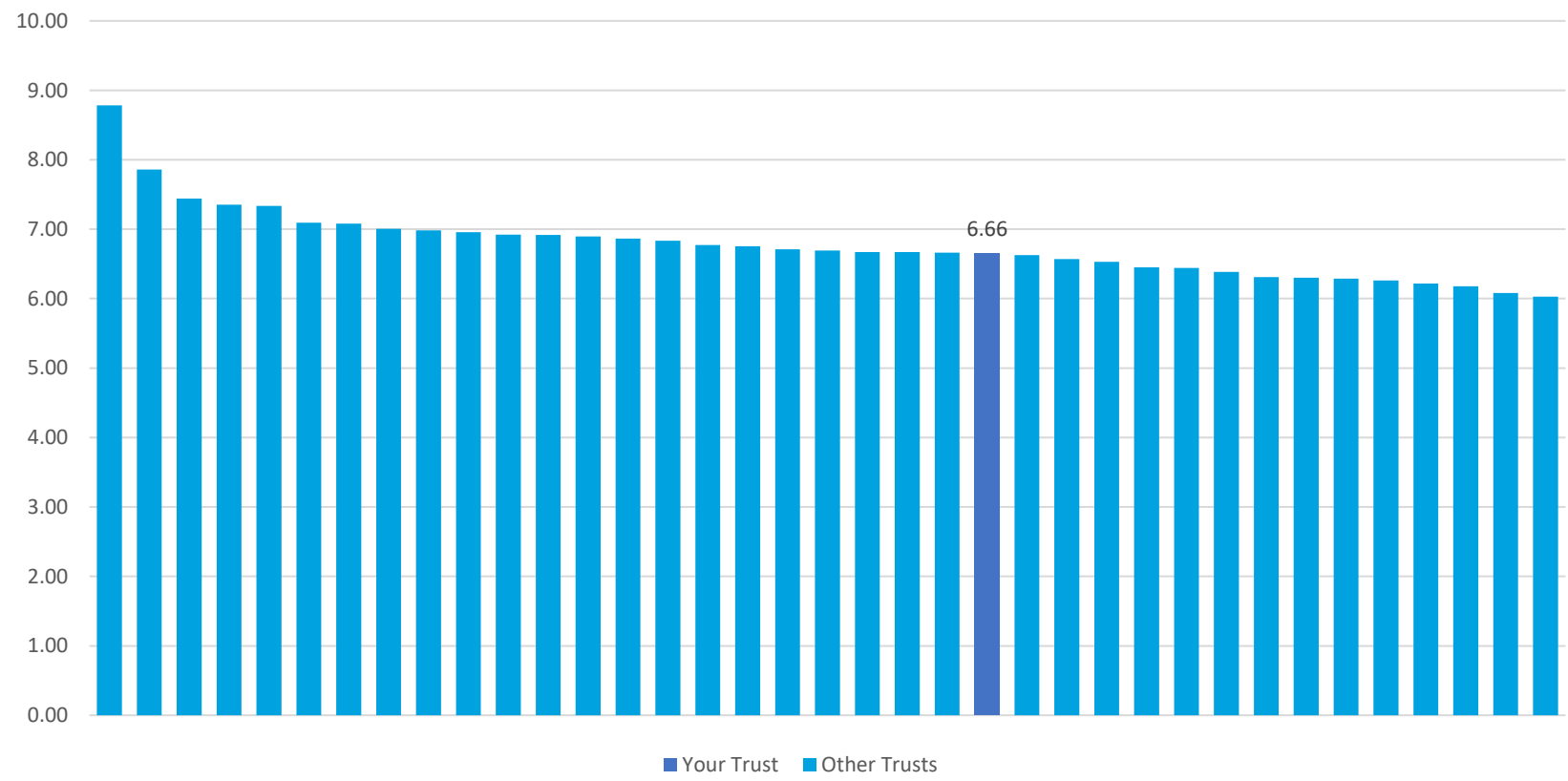
This section of the report summarises your organisation's highest and lowest scoring results for the current year across the entire survey.

Top 5 Questions	Score
Q28. Were you given enough privacy when being examined or treated?	9.49
Q31a. Thinking about your care and treatment, did hospital staff take into account the following individual needs? Language needs (e.g. translation, braille)	9.31
Q16. During your time in hospital, did you get enough to drink?	9.21
Q47. Overall, did you feel you were treated with respect and dignity while you were in the hospital?	9.14
Q18. Did you have confidence and trust in the doctors treating you?	9.13

Bottom 5 Questions	Score
Q8h. Were you ever prevented from sleeping at night by any of the following? I was not prevented from sleeping	3.65
Q41. Thinking about any medicine you were to take at home, were you given any information?	4.54
Q2. How did you feel about the length of time you were on the waiting list before your admission to hospital?	5.23
Q36. To what extent did hospital staff involve your family or carers in discussions about you leaving hospital?	5.69
Q8a. Were you ever prevented from sleeping at night by any of the following? Noise from other patients	6.17

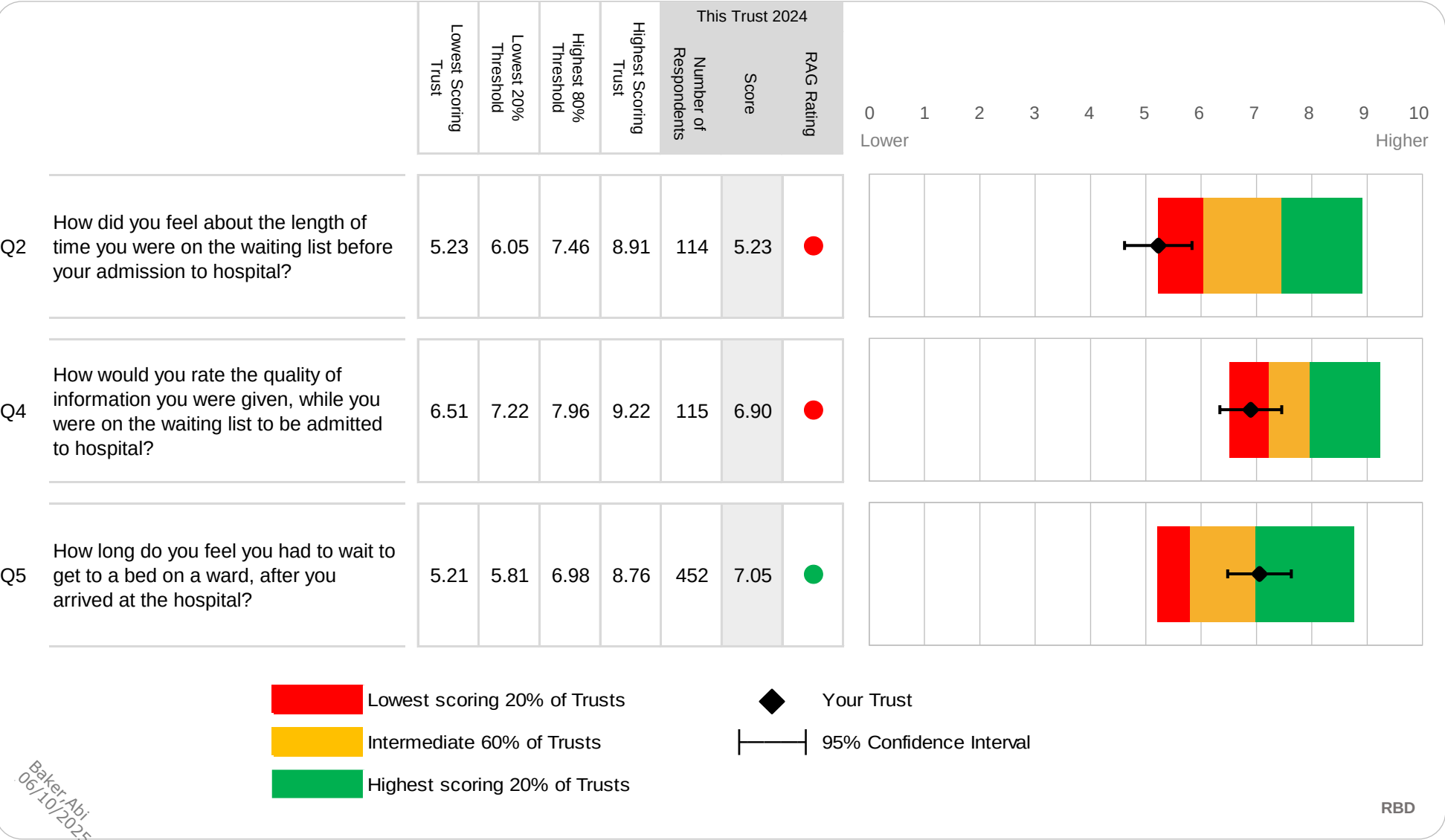
Section A

ADMISSION TO HOSPITAL



Baker, Abi
06/10/2025 12:40:16

ADMISSION TO HOSPITAL - Benchmark Charts and Tables



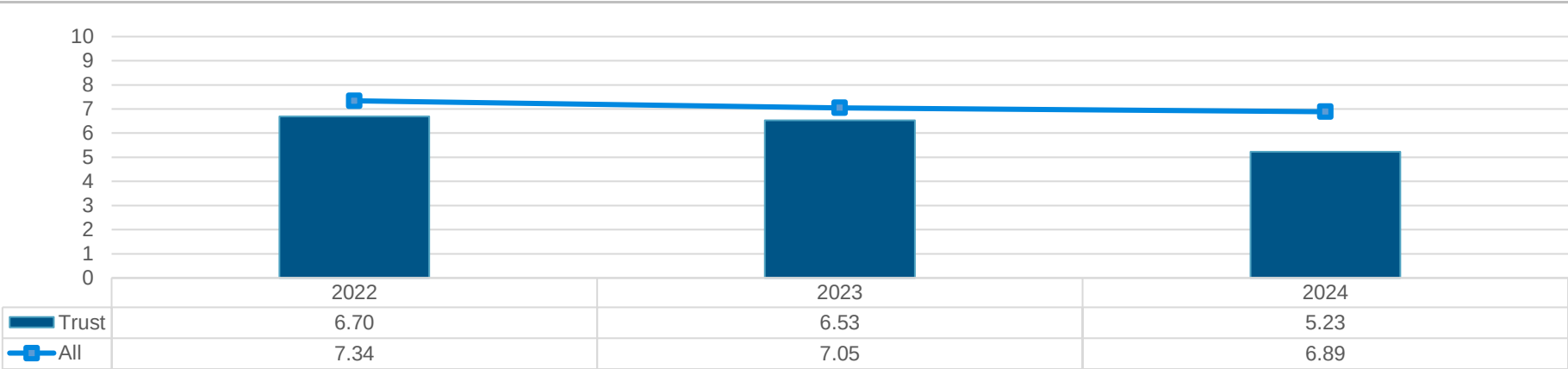
Baker, Abi
06/10/2025 12:40:16

ADMISSION TO HOSPITAL - Benchmark Charts and Tables



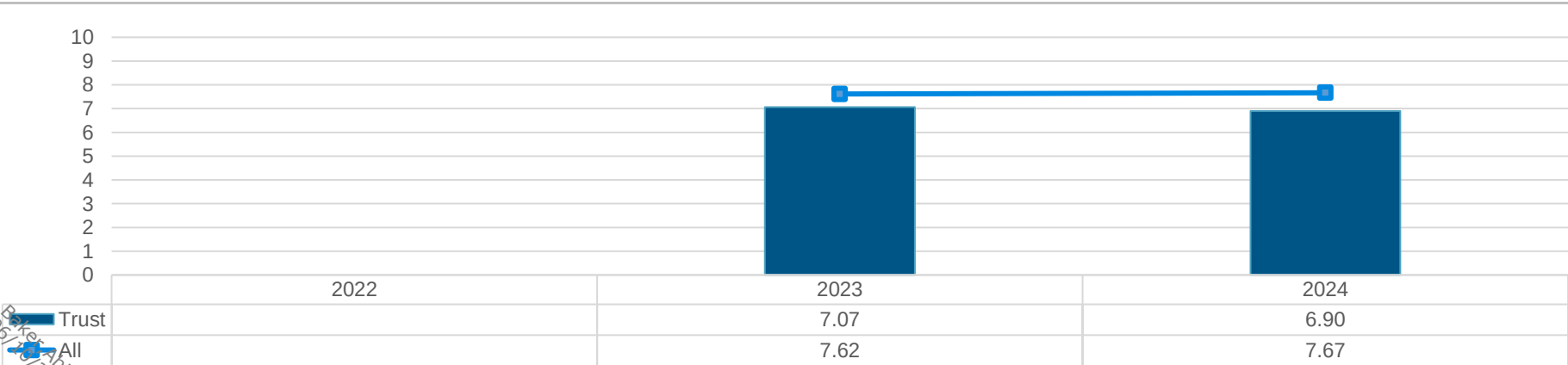
ADMISSION TO HOSPITAL - Longitudinal Charts

Q2. How did you feel about the length of time you were on the waiting list before your admission to hospital?



RBD

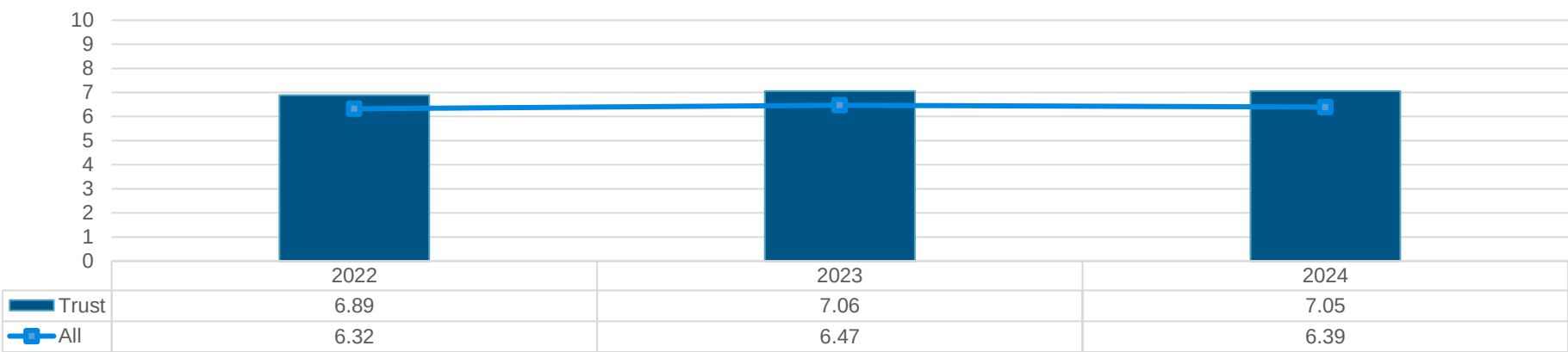
Q4. How would you rate the quality of information you were given, while you were on the waiting list to be admitted to hospital?



RBD

ADMISSION TO HOSPITAL - Longitudinal Charts

Q5. How long do you feel you had to wait to get to a bed on a ward, after you arrived at the hospital?



RBD

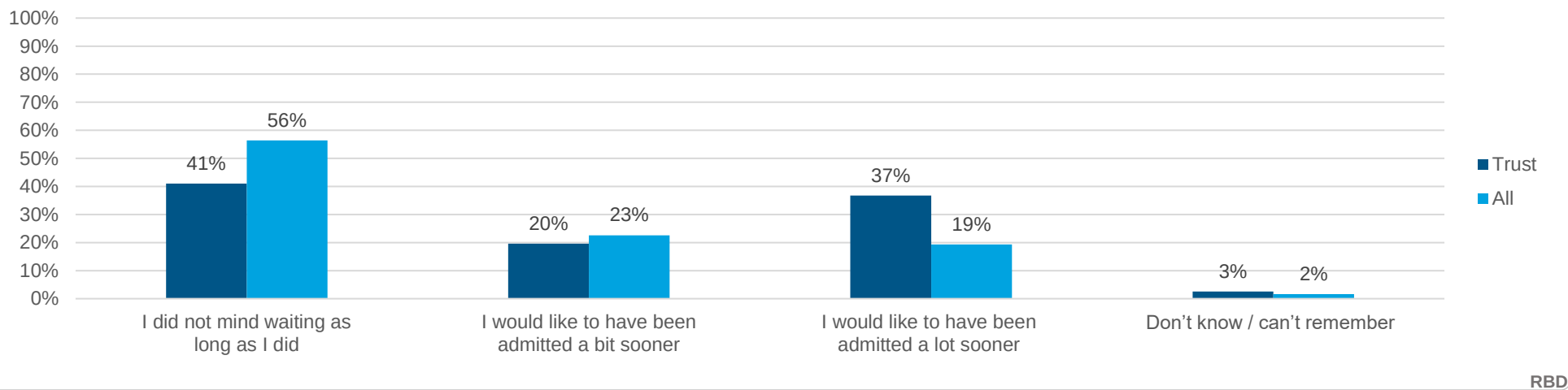
Q7. Thinking about the location(s) selected at Q6, how long did you wait, in total, before you were admitted onto a ward?



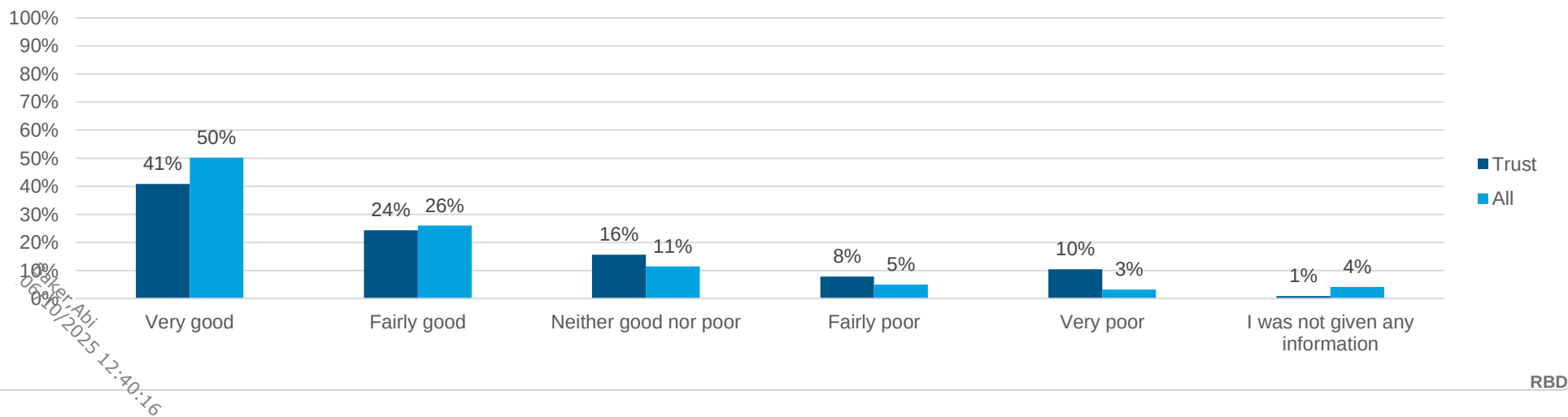
RBD

ADMISSION TO HOSPITAL - Benchmark Charts and Tables

Q2. How did you feel about the length of time you were on the waiting list before your admission to hospital?

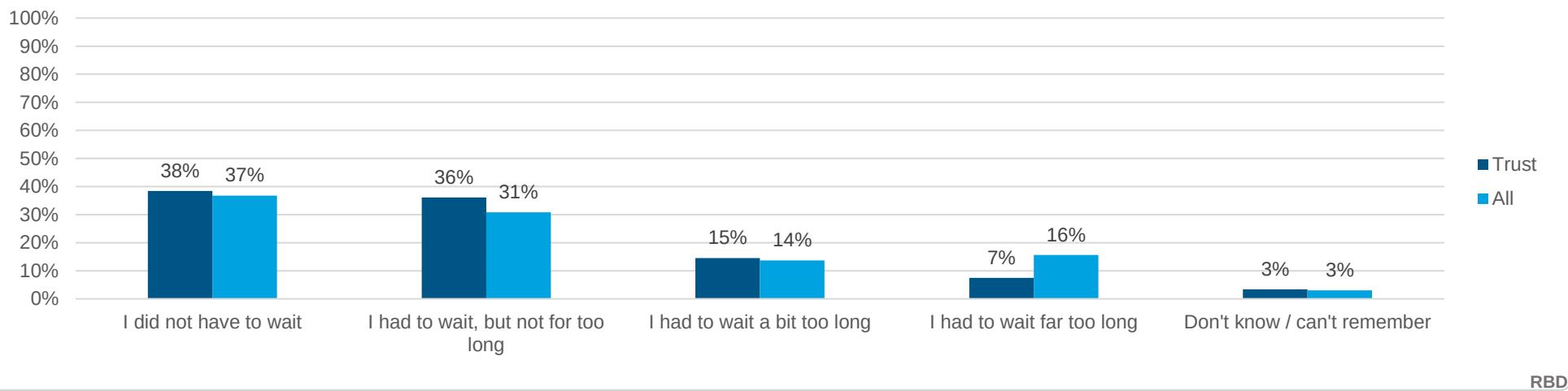


Q4. How would you rate the quality of information you were given, while you were on the waiting list to be admitted to hospital?

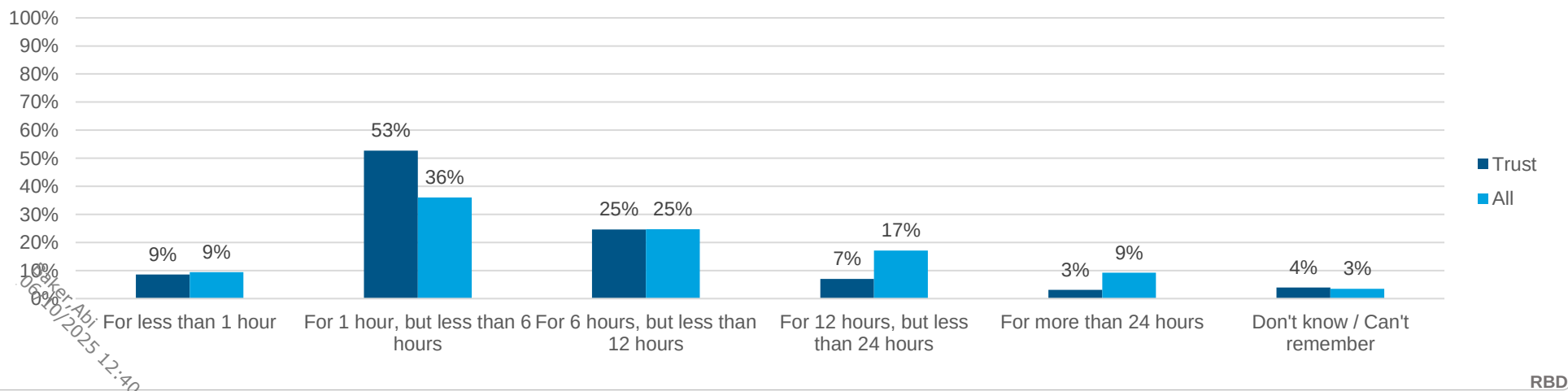


ADMISSION TO HOSPITAL - Benchmark Charts and Tables

Q5. How long do you feel you had to wait to get to a bed on a ward, after you arrived at the hospital?

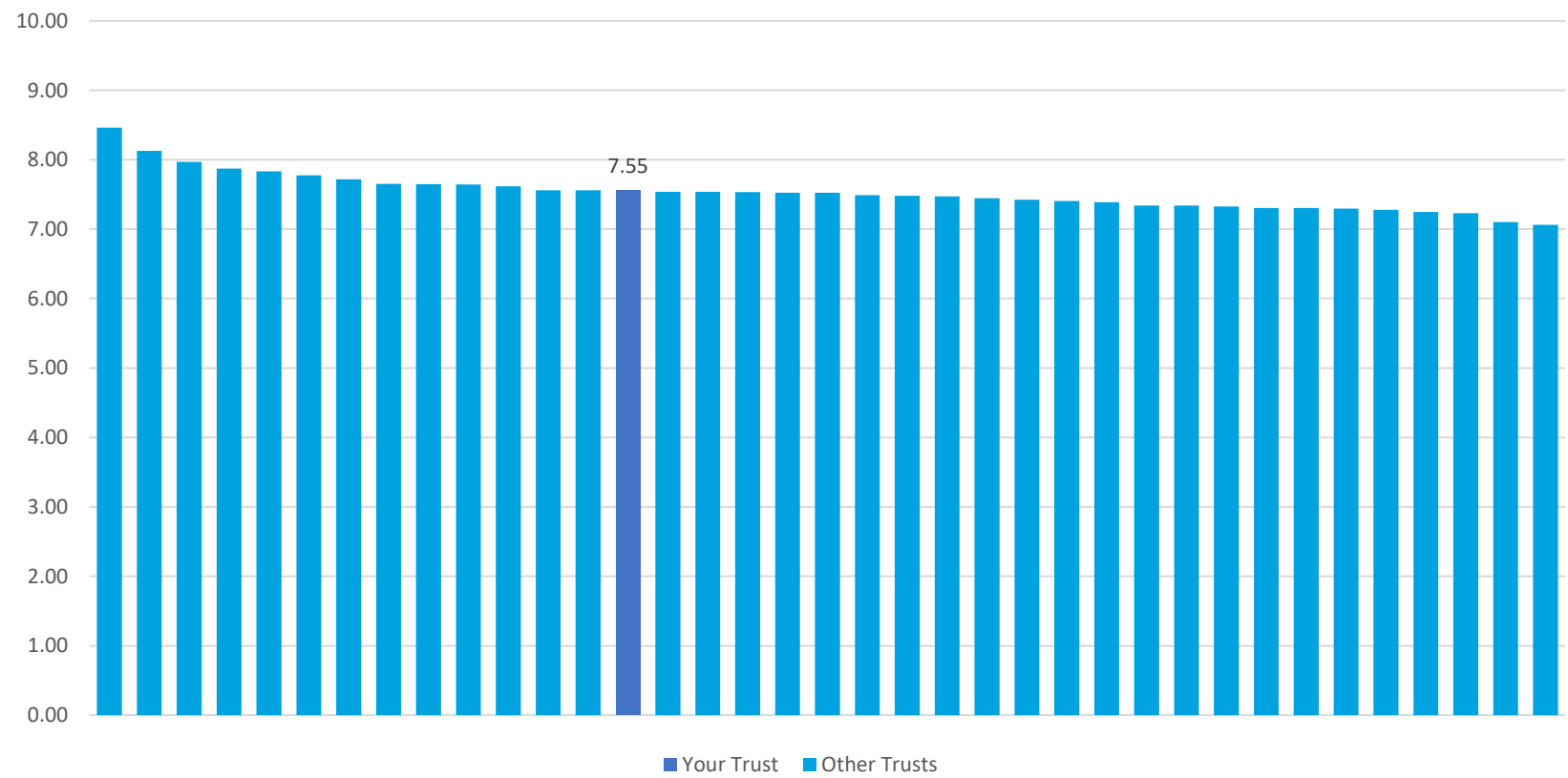


Q7. Thinking about the location(s) selected at Q6, how long did you wait, in total, before you were admitted onto a ward?



Section B

THE HOSPITAL AND WARD



Baker, Abi
06/10/2025 12:40:16

THE HOSPITAL AND WARD - Benchmark Charts and Tables



THE HOSPITAL AND WARD - Benchmark Charts and Tables

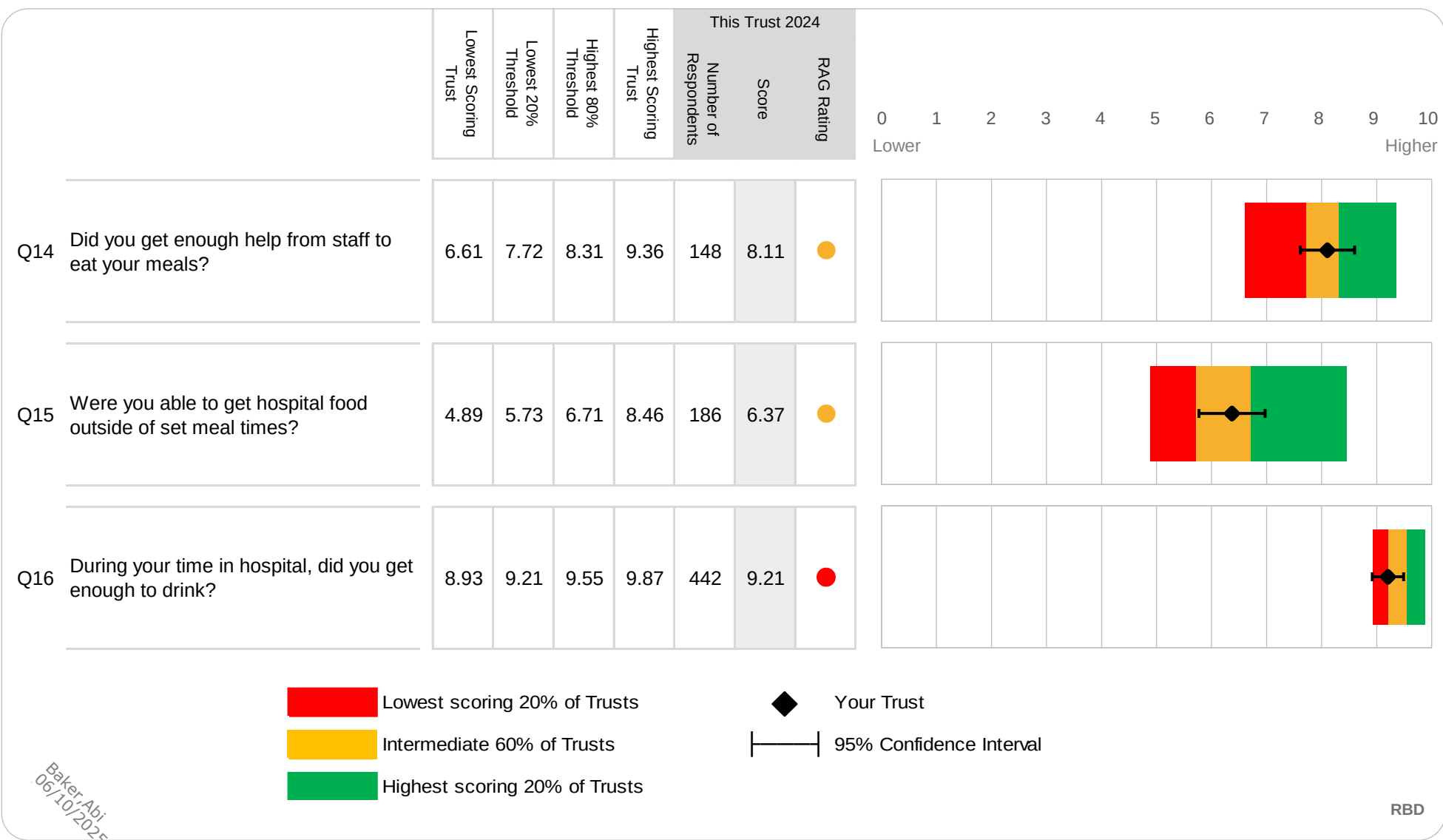


THE HOSPITAL AND WARD - Benchmark Charts and Tables



Baker, Abi
06/10/2025 12:40:16

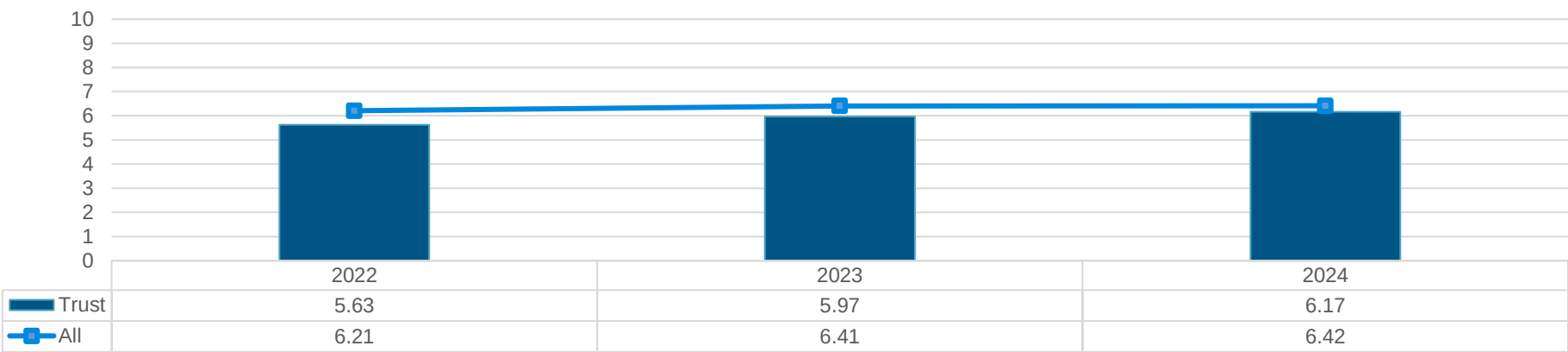
THE HOSPITAL AND WARD - Benchmark Charts and Tables



Baker, Abi
06/10/2025 12:40:16

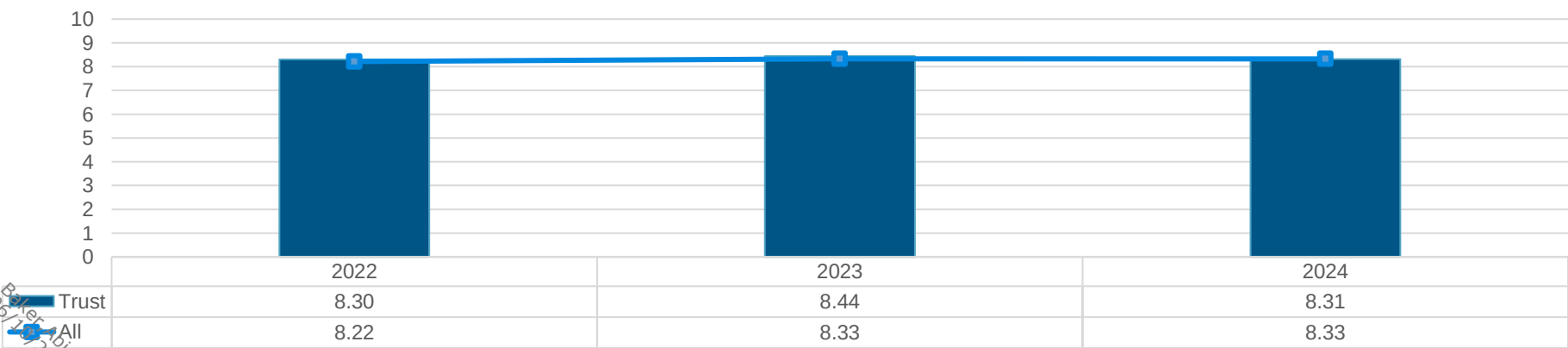
THE HOSPITAL AND WARD - Longitudinal Charts

Q8a. Were you ever prevented from sleeping at night by any of the following?



RBD

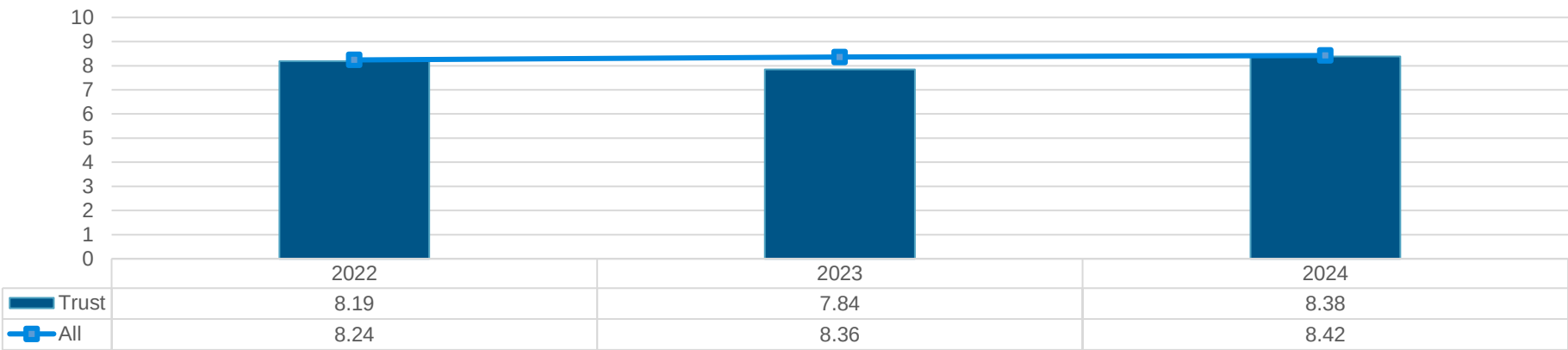
Q8b. Were you ever prevented from sleeping at night by any of the following?



RBD

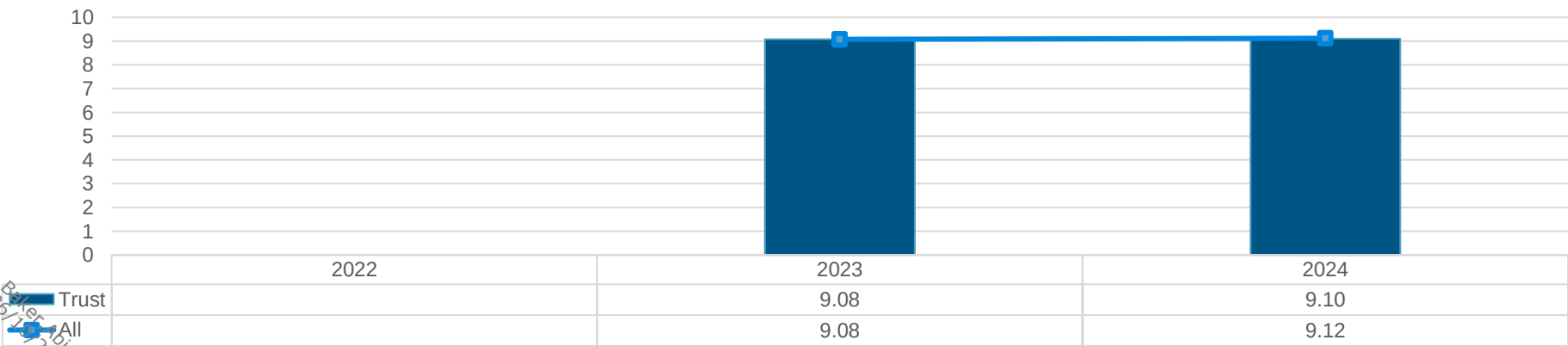
THE HOSPITAL AND WARD - Longitudinal Charts

Q8d. Were you ever prevented from sleeping at night by any of the following?



RBD

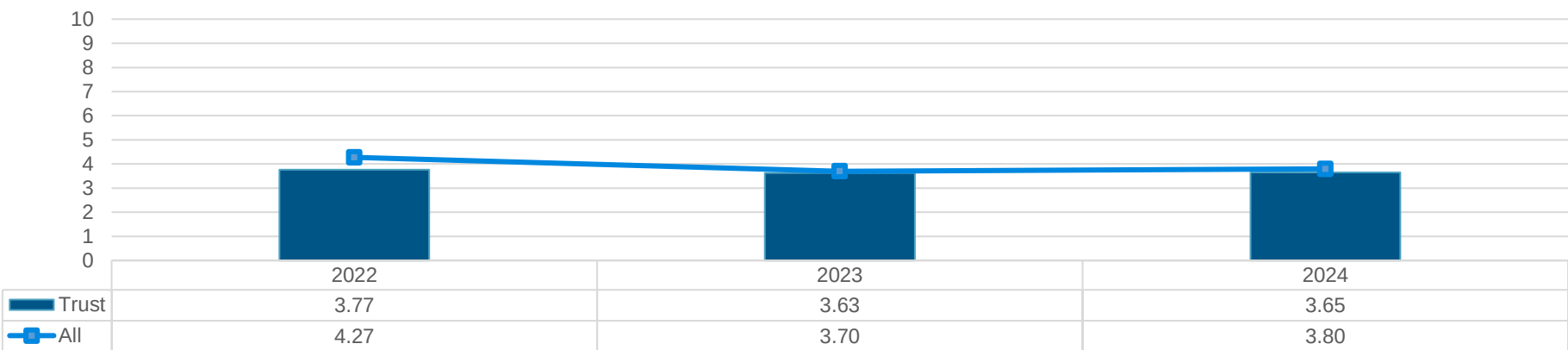
Q8f. Were you ever prevented from sleeping at night by any of the following?



RBD

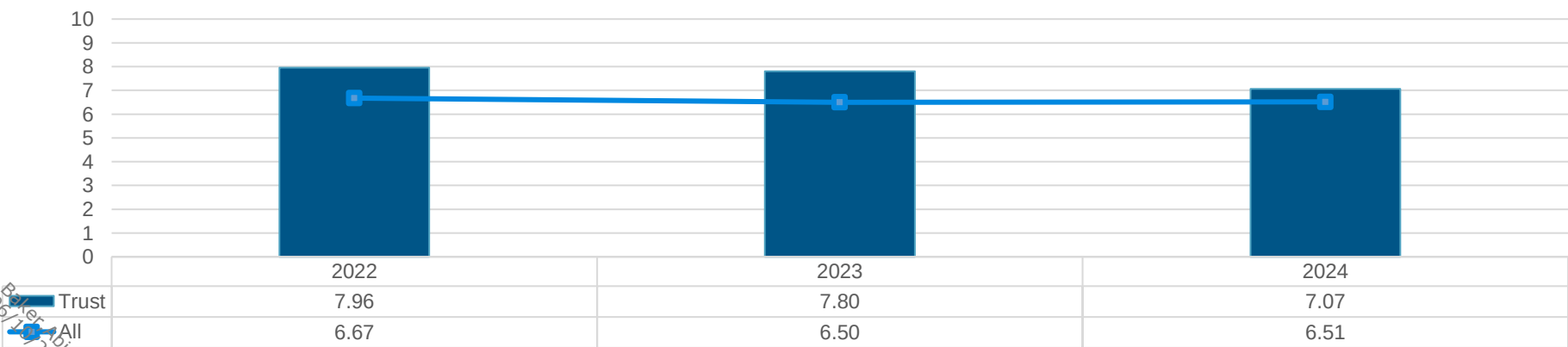
THE HOSPITAL AND WARD - Longitudinal Charts

Q8h. Were you ever prevented from sleeping at night by any of the following?



RBD

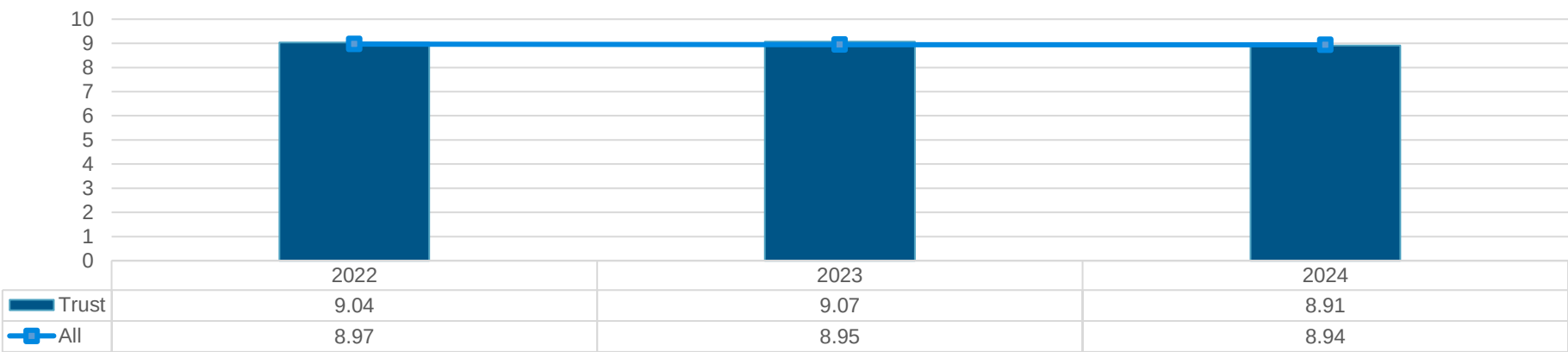
Q10. Did the hospital staff explain the reasons for changing wards during the night in a way you could understand?



RBD

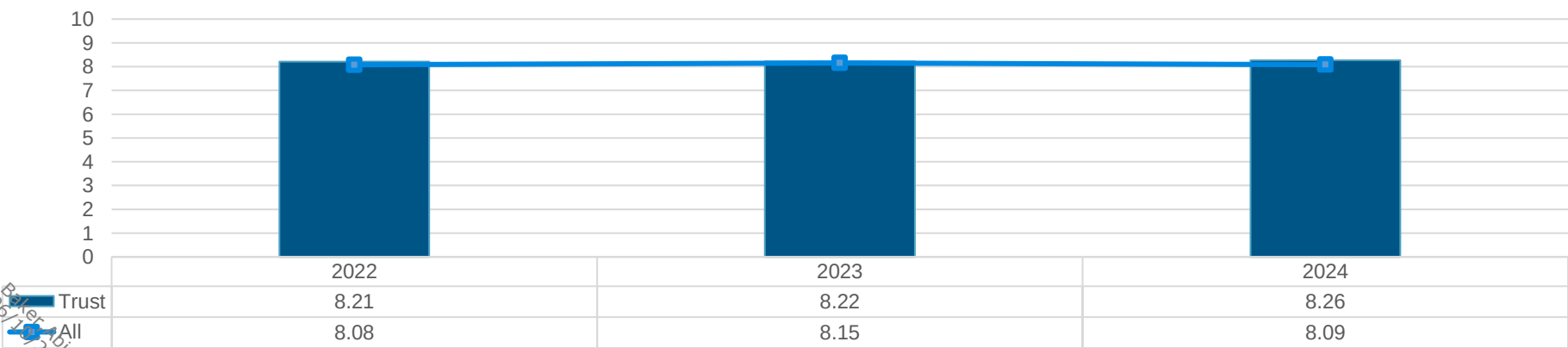
THE HOSPITAL AND WARD - Longitudinal Charts

Q11. How clean was the hospital room or ward that you were in?



RBD

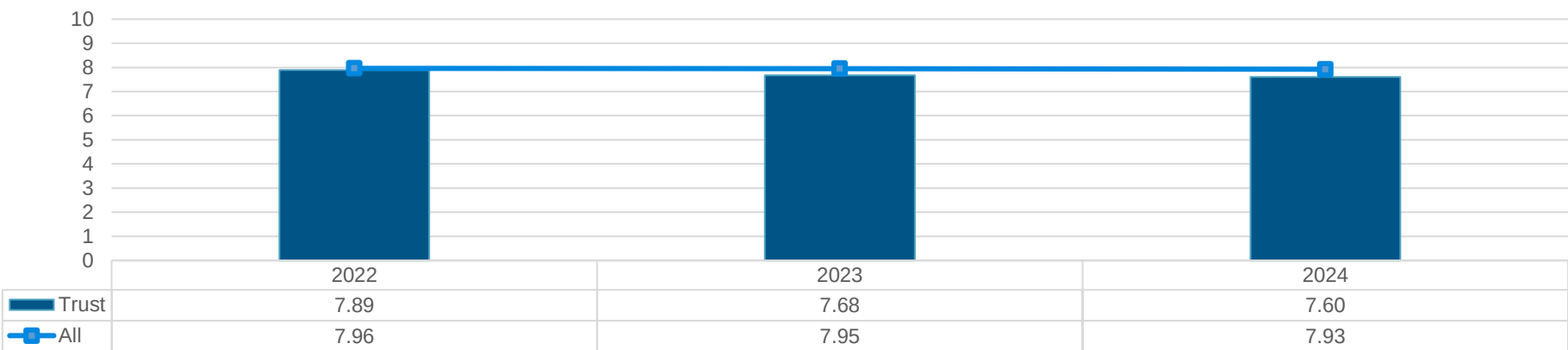
Q12. Did you get enough help from staff to wash or keep yourself clean?



RBD

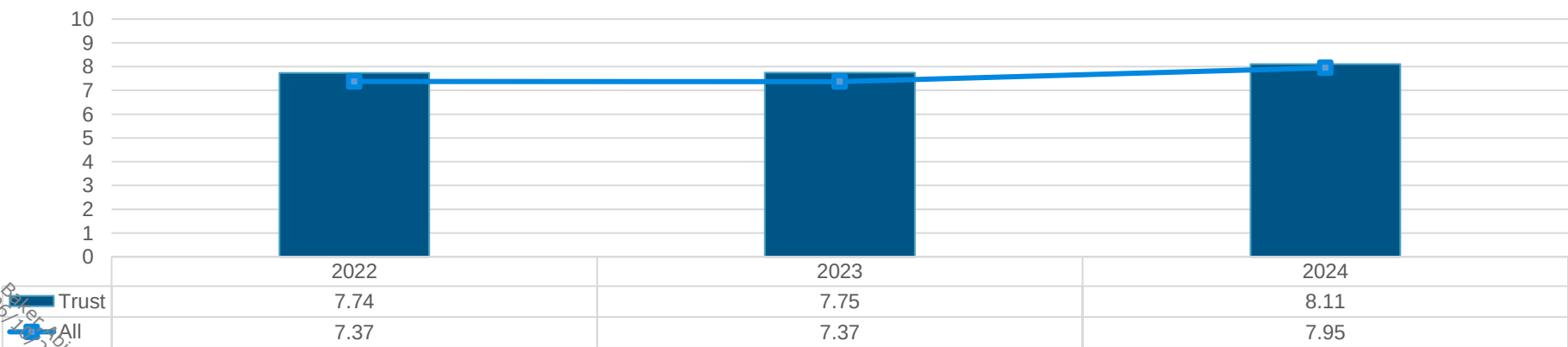
THE HOSPITAL AND WARD - Longitudinal Charts

Q13. If you brought medication with you to hospital, were you able to take it when you needed to?



RBD

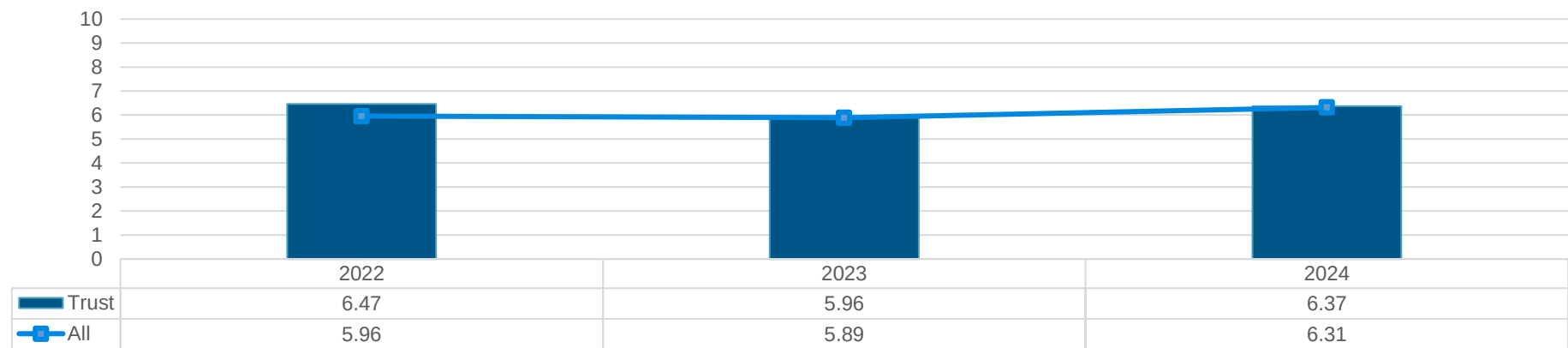
Q14. Did you get enough help from staff to eat your meals?



RBD

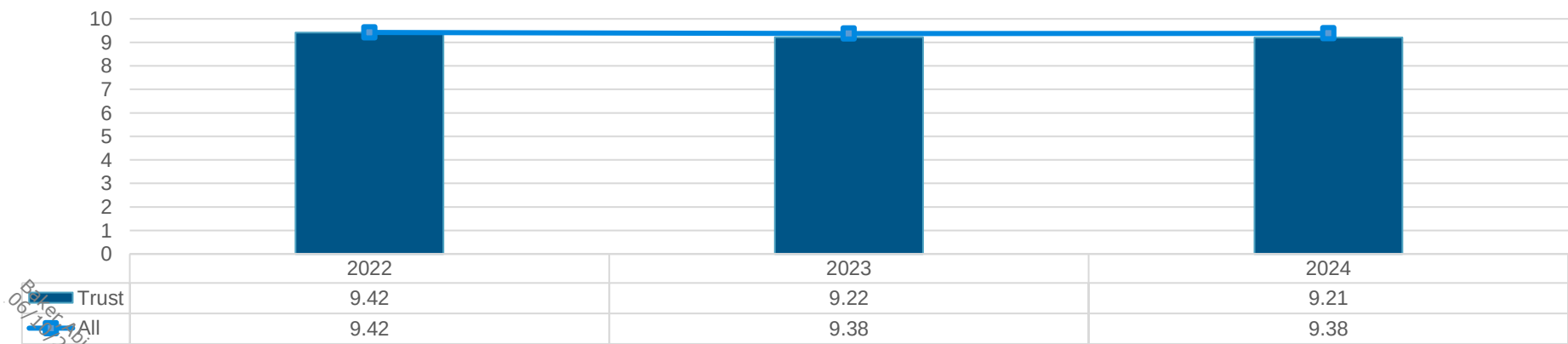
THE HOSPITAL AND WARD - Longitudinal Charts

Q15. Were you able to get hospital food outside of set meal times?



RBD

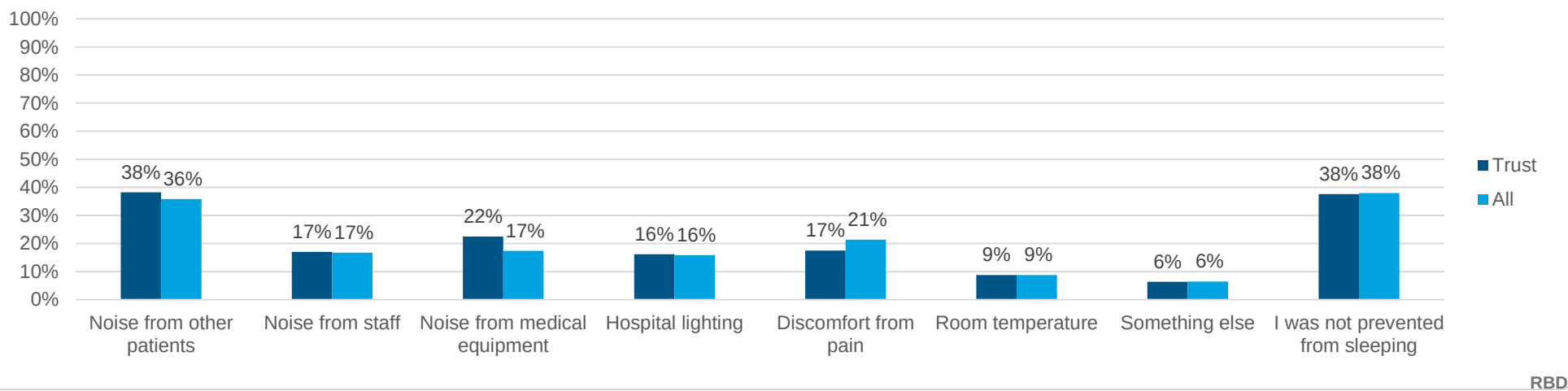
Q16. During your time in hospital, did you get enough to drink?



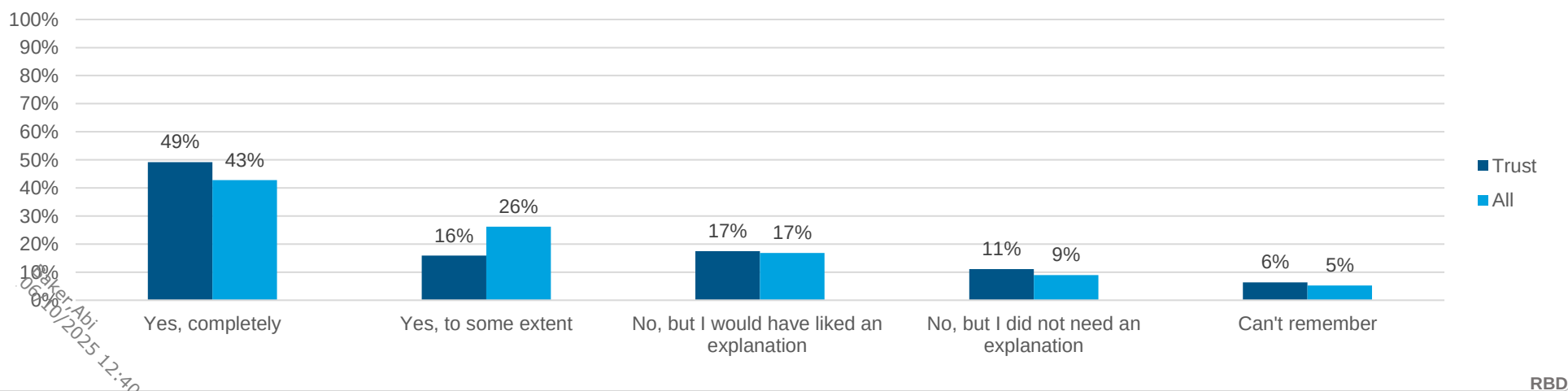
RBD

THE HOSPITAL AND WARD - Benchmark Charts and Tables

Q8. Were you ever prevented from sleeping at night by any of the following?

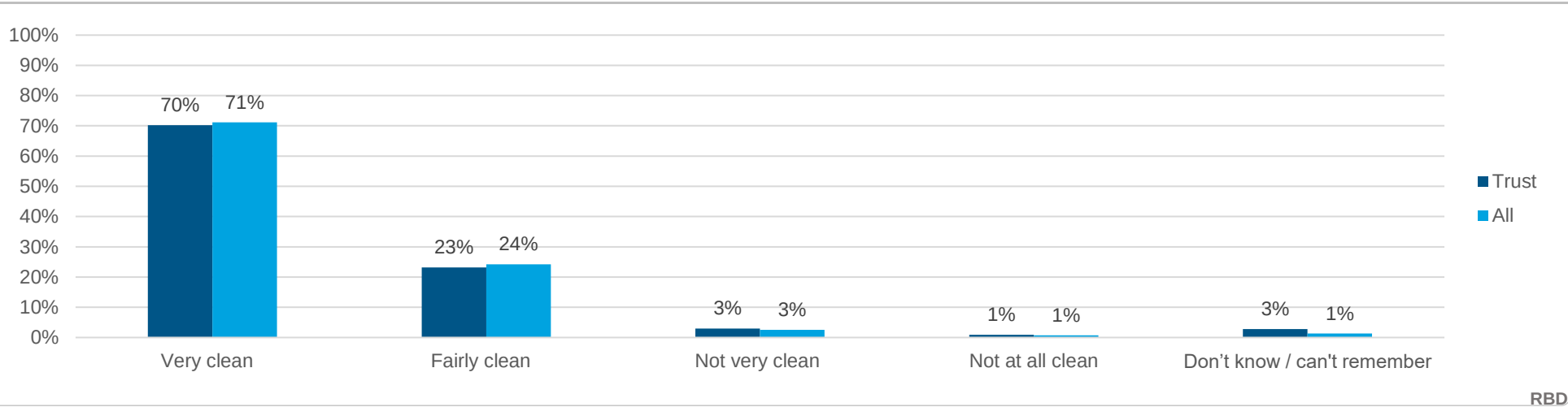


Q10. Did the hospital staff explain the reasons for changing wards during the night in a way you could understand?

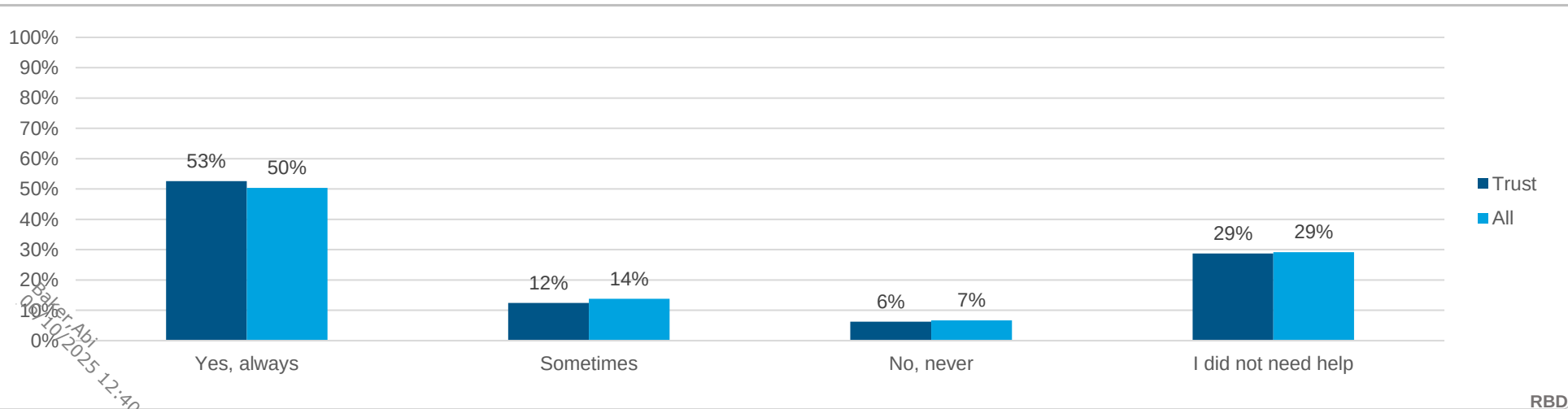


THE HOSPITAL AND WARD - Benchmark Charts and Tables

Q11. How clean was the hospital room or ward that you were in?

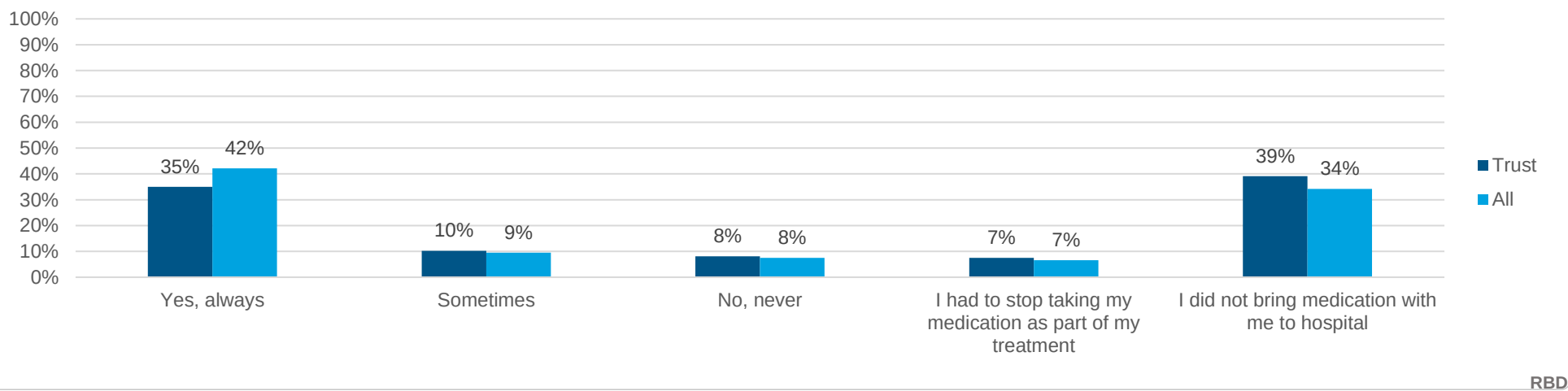


Q12. Did you get enough help from staff to wash or keep yourself clean?

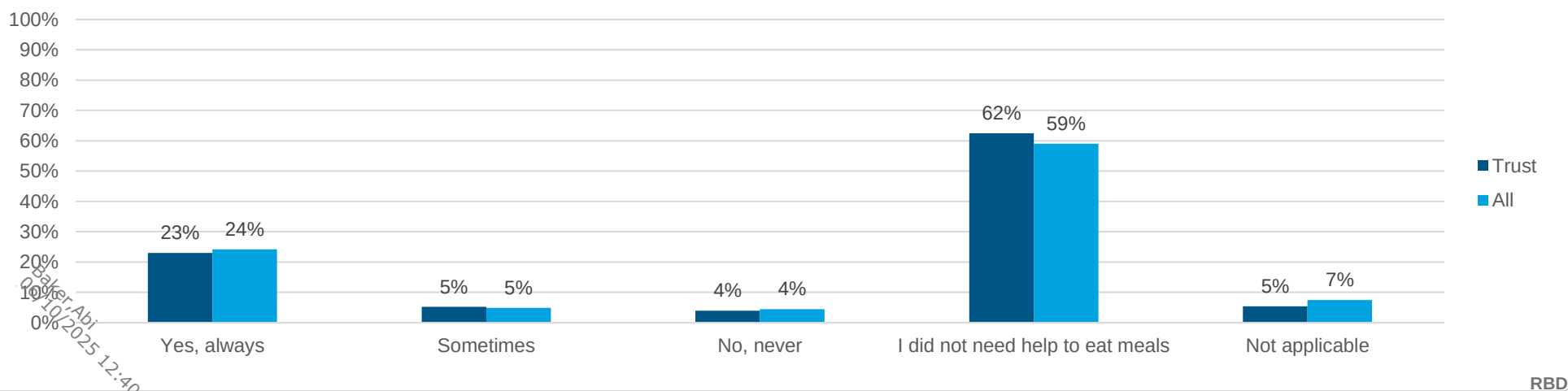


THE HOSPITAL AND WARD - Benchmark Charts and Tables

Q13. If you brought medication with you to hospital, were you able to take it when you needed to?

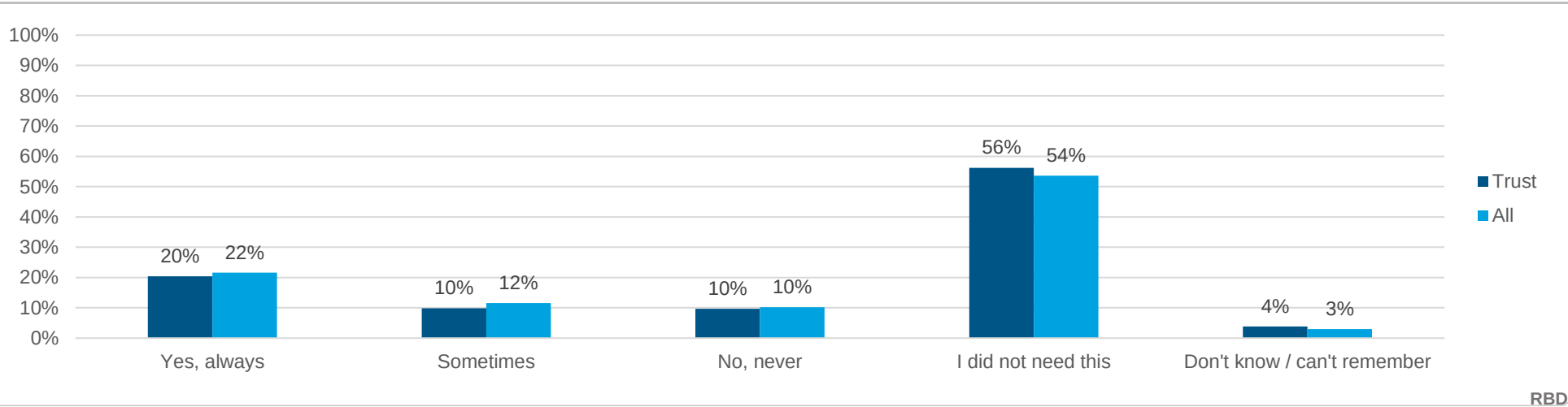


Q14. Did you get enough help from staff to eat your meals?

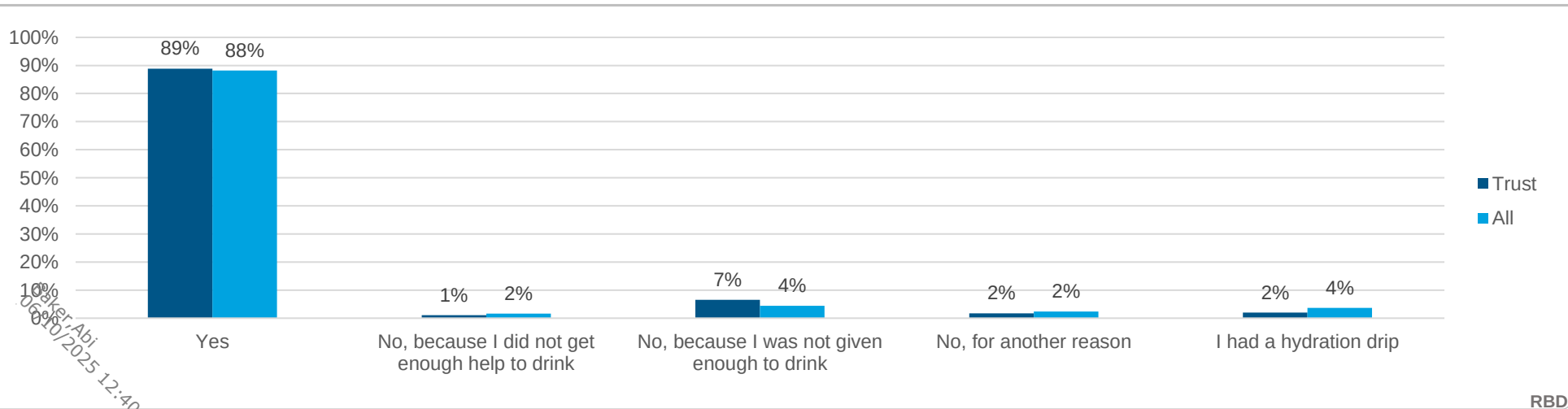


THE HOSPITAL AND WARD - Benchmark Charts and Tables

Q15. Were you able to get hospital food outside of set meal times?

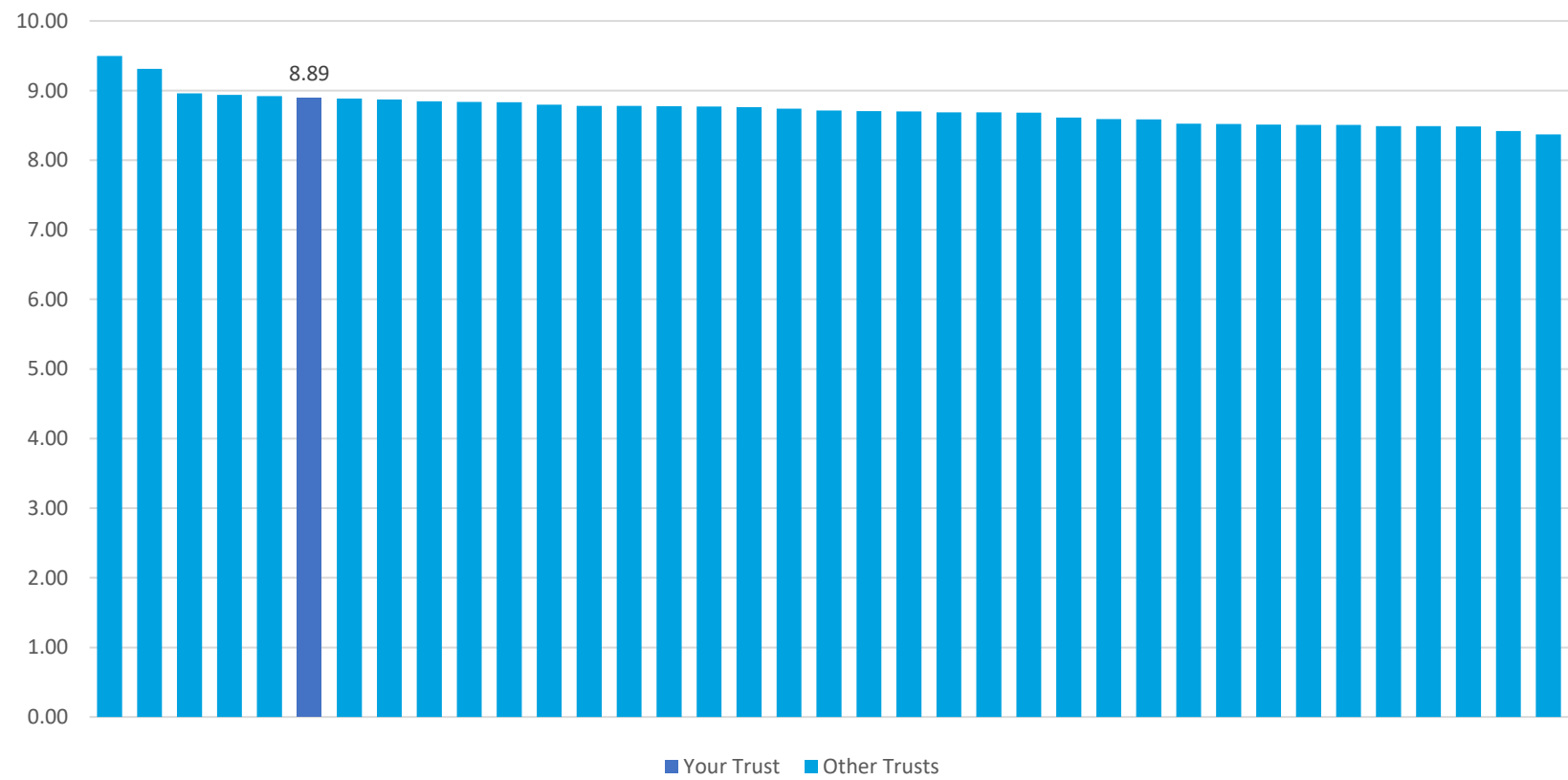


Q16. During your time in hospital, did you get enough to drink?



Section C

DOCTORS



Baker, Abi
06/10/2025 12:40:16

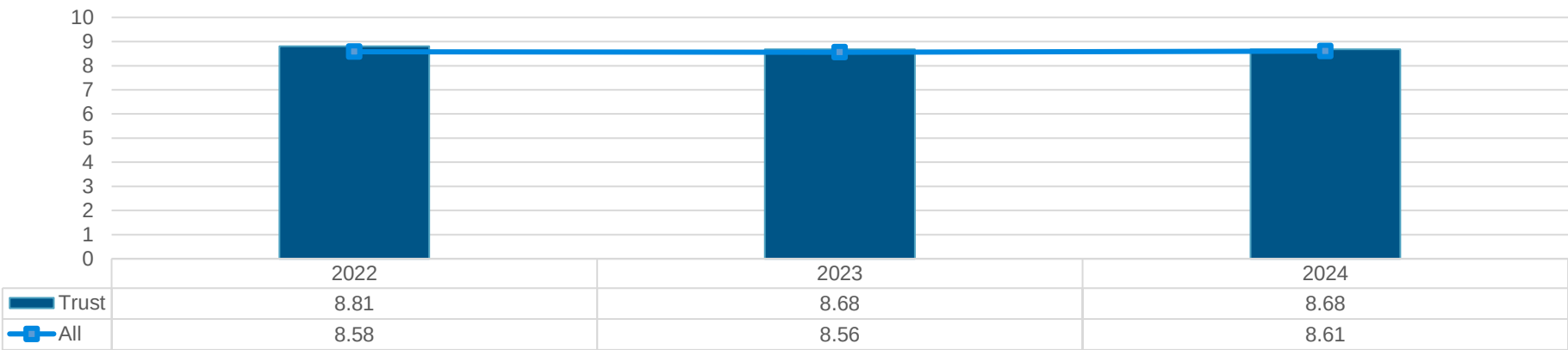
DOCTORS - Benchmark Charts and Tables



Baker, Abi
06/10/2025 12:40:16

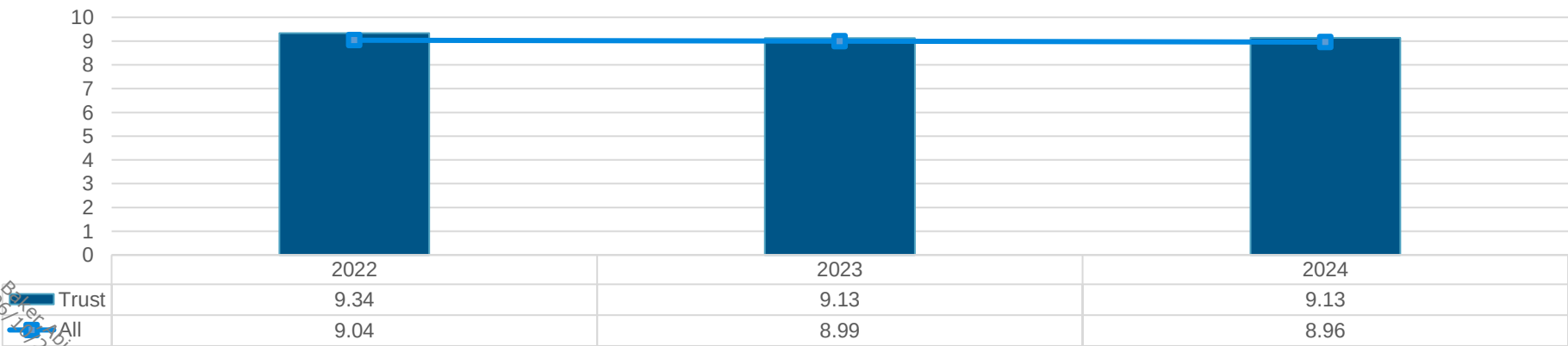
DOCTORS - Longitudinal Charts

Q17. When you asked doctors questions, did you get answers you could understand?



RBD

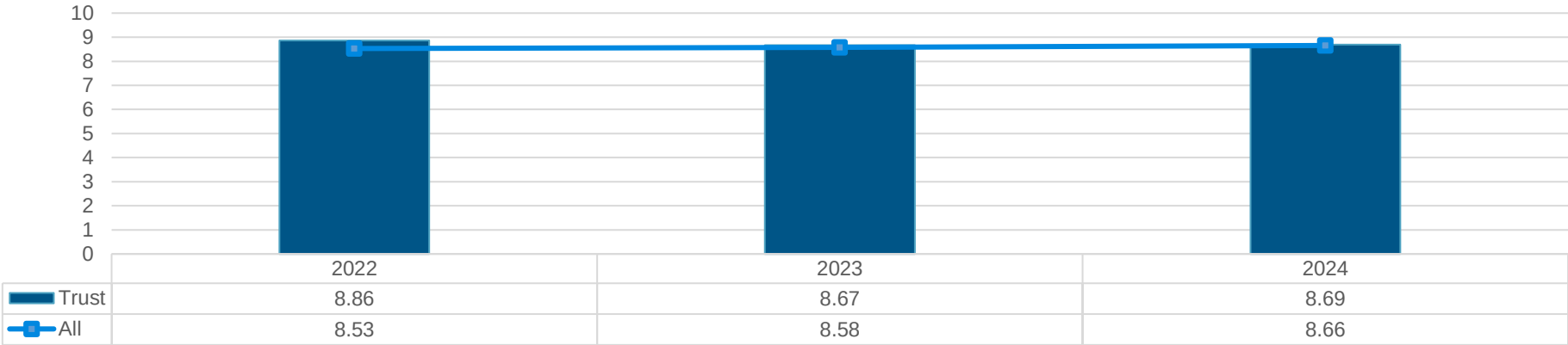
Q18. Did you have confidence and trust in the doctors treating you?



RBD

DOCTORS - Longitudinal Charts

Q19. When doctors spoke about your care in front of you, were you included in the conversation?

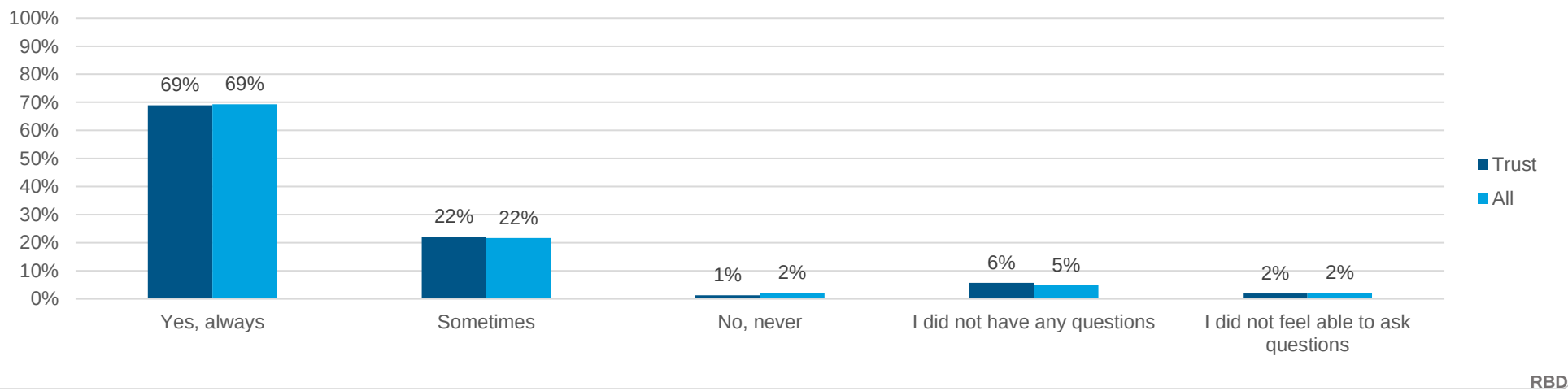


RBD

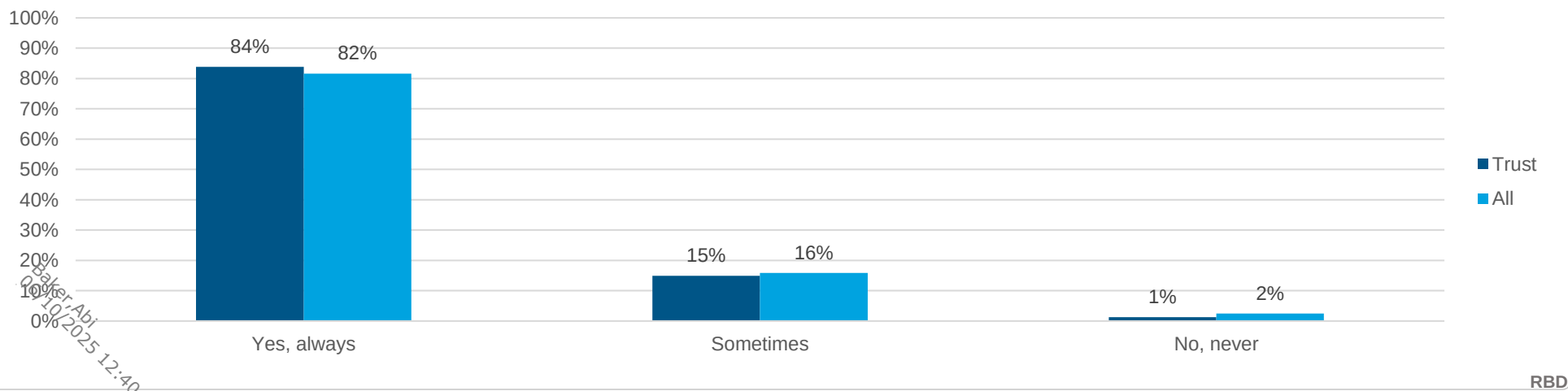
Baker, Abi
06/10/2025 12:40:16

ADMISSION TO HOSPITAL - Benchmark Charts and Tables

Q17. When you asked doctors questions, did you get answers you could understand?

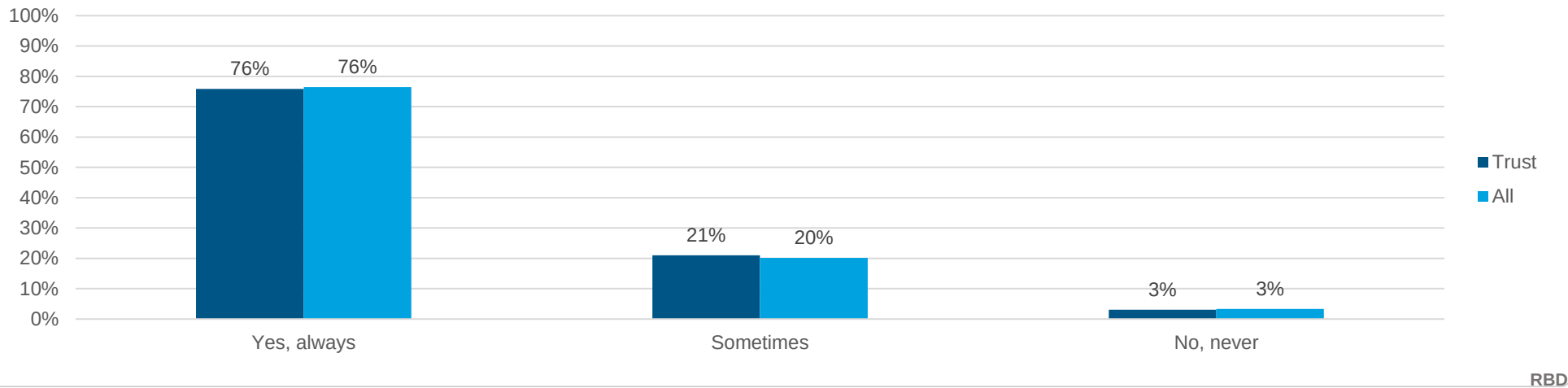


Q18. Did you have confidence and trust in the doctors treating you?



ADMISSION TO HOSPITAL - Benchmark Charts and Tables

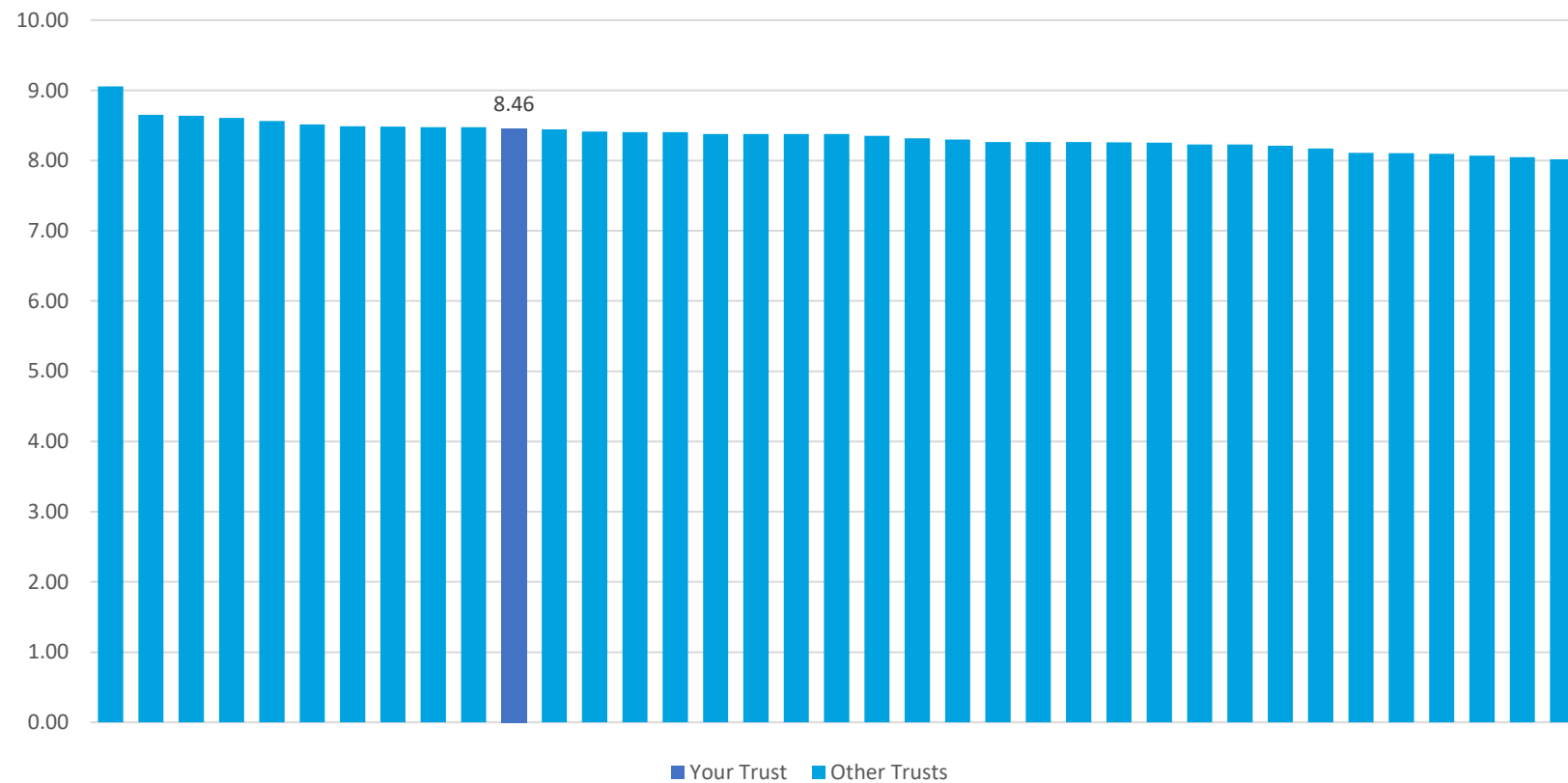
Q19. When doctors spoke about your care in front of you, were you included in the conversation?



Baker, Abi
06/10/2025 12:40:16

Section D

NURSES



Baker Abi
06/10/2025 12:40:16

NURSES - Benchmark Charts and Tables



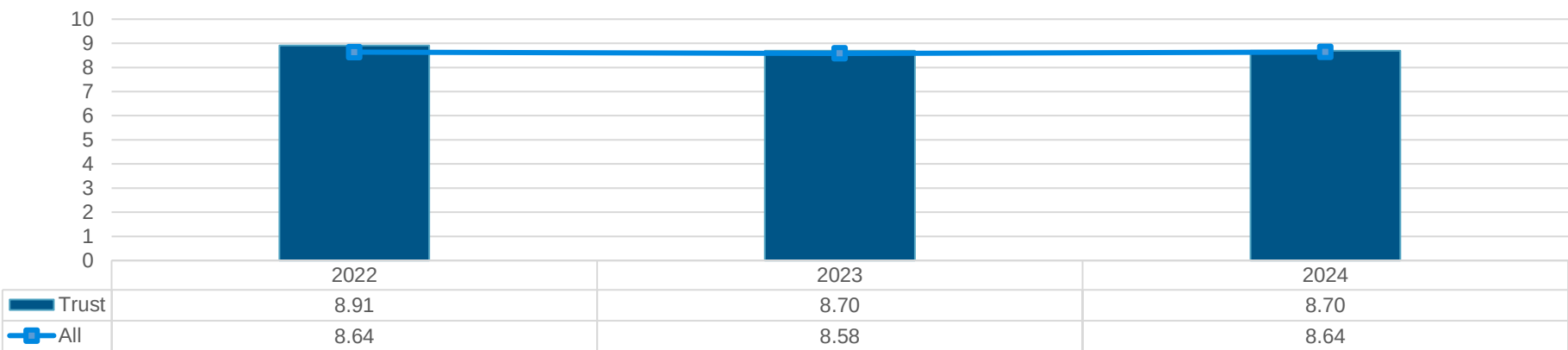
Baker, Abi
06/10/2025 12:40:16

NURSES - Benchmark Charts and Tables



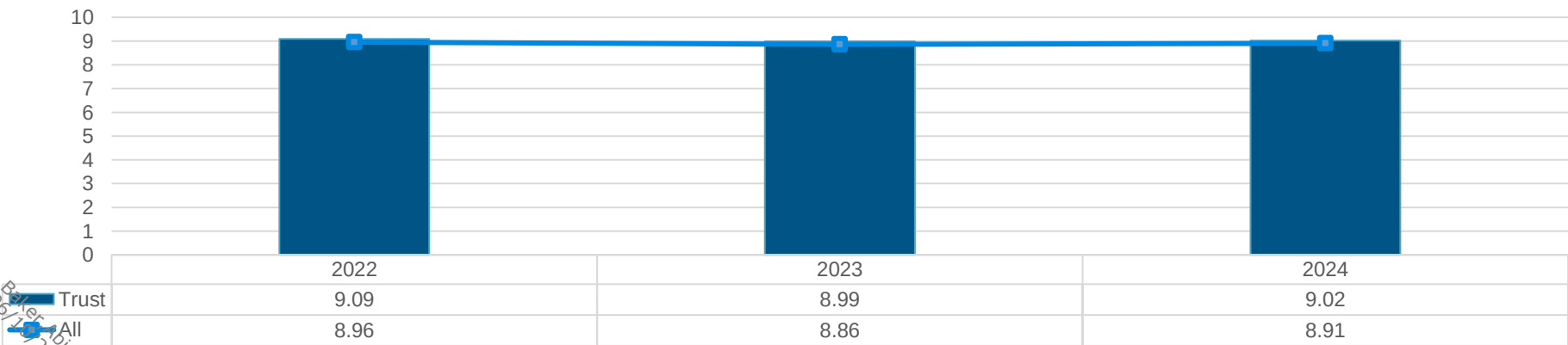
NURSES - Longitudinal Charts

Q20. When you asked nurses questions, did you get answers you could understand?



RBD

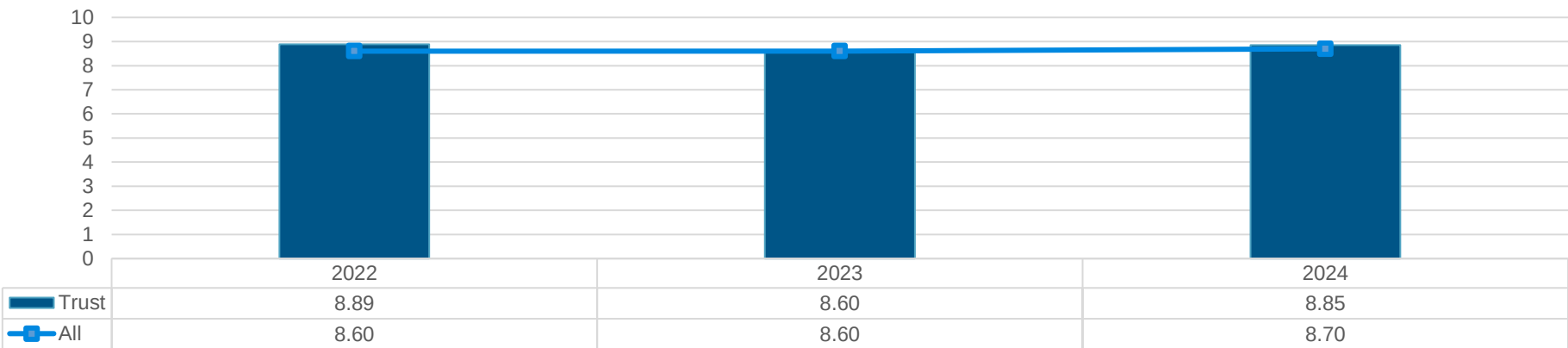
Q21. Did you have confidence and trust in the nurses treating you?



RBD

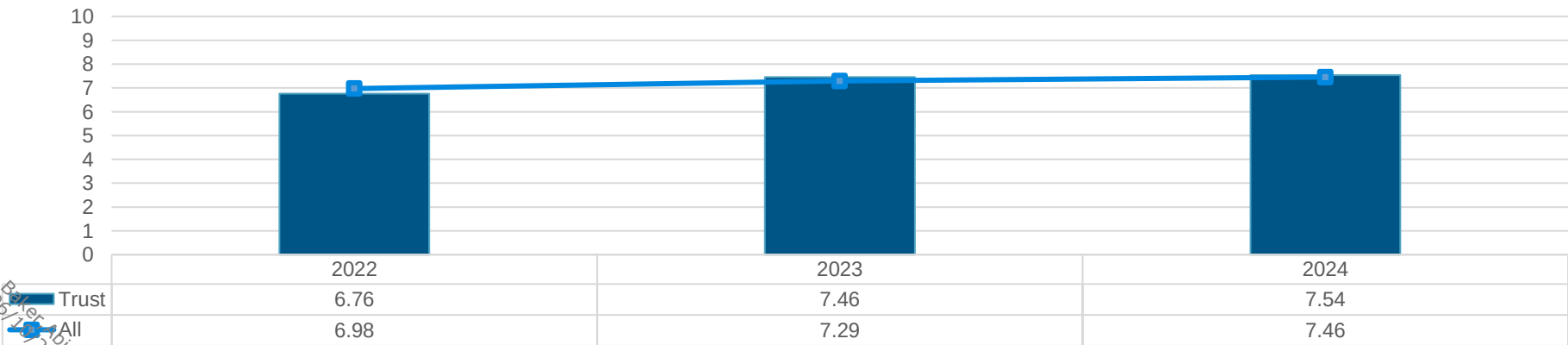
NURSES - Longitudinal Charts

Q22. When nurses spoke about your care in front of you, were you included in the conversation?



RBD

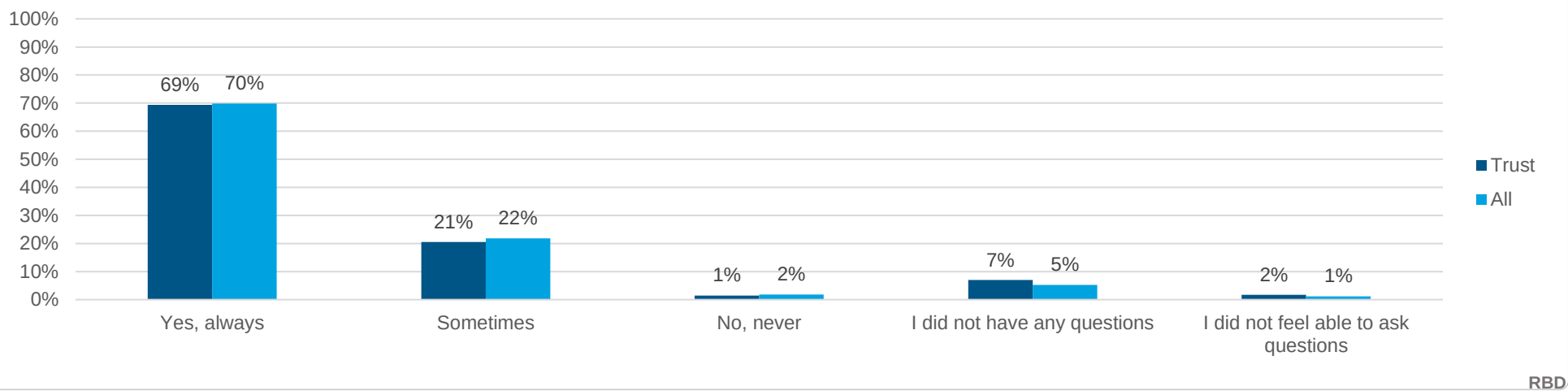
Q23. In your opinion, were there enough nurses on duty to care for you in hospital?



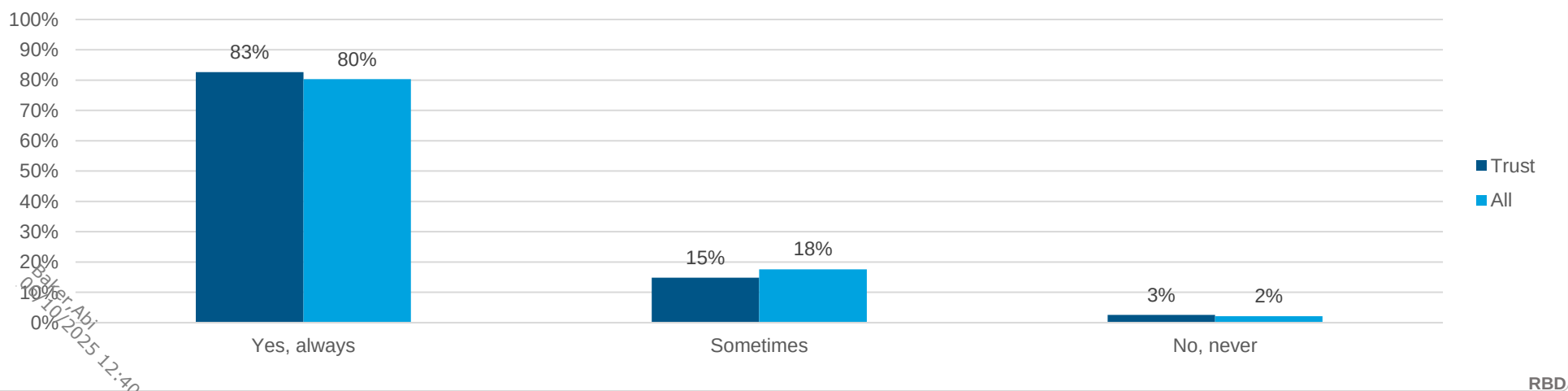
RBD

NURSES - Benchmark Charts and Tables

Q20. When you asked nurses questions, did you get answers you could understand?

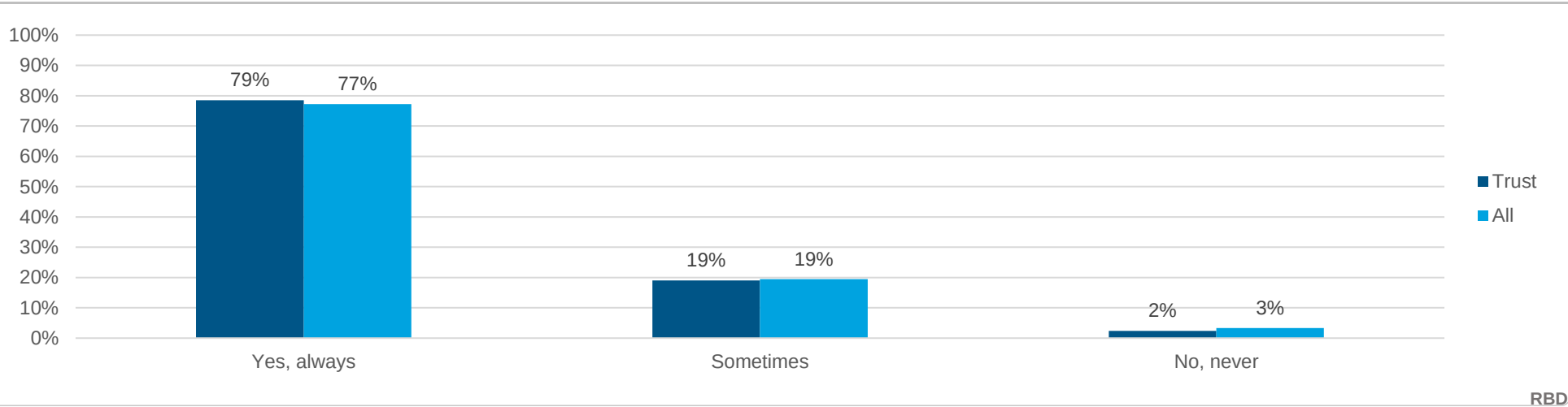


Q21. Did you have confidence and trust in the nurses treating you?

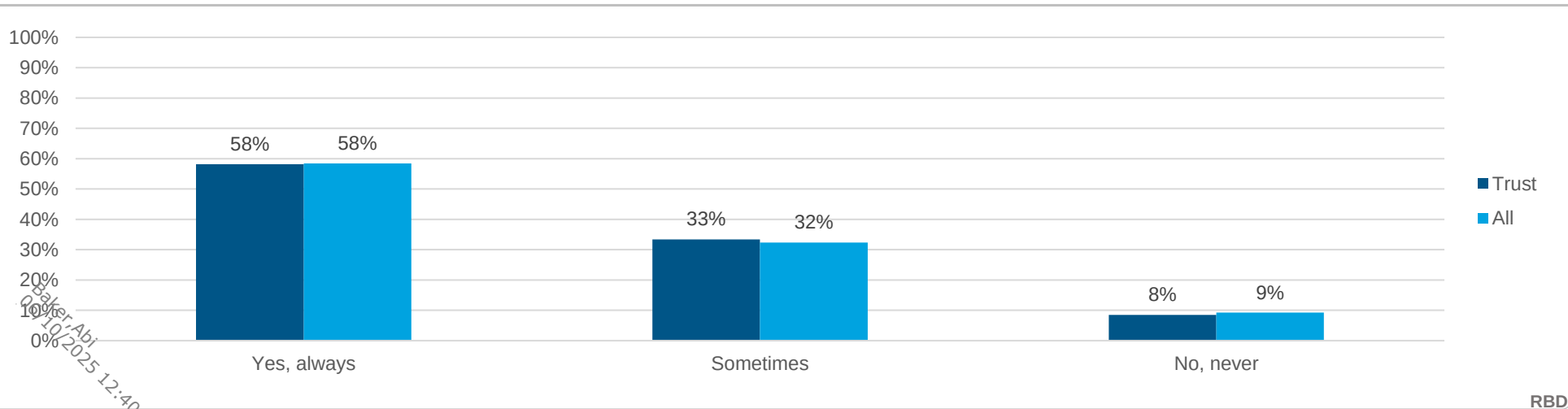


NURSES - Benchmark Charts and Tables

Q22. When nurses spoke about your care in front of you, were you included in the conversation?

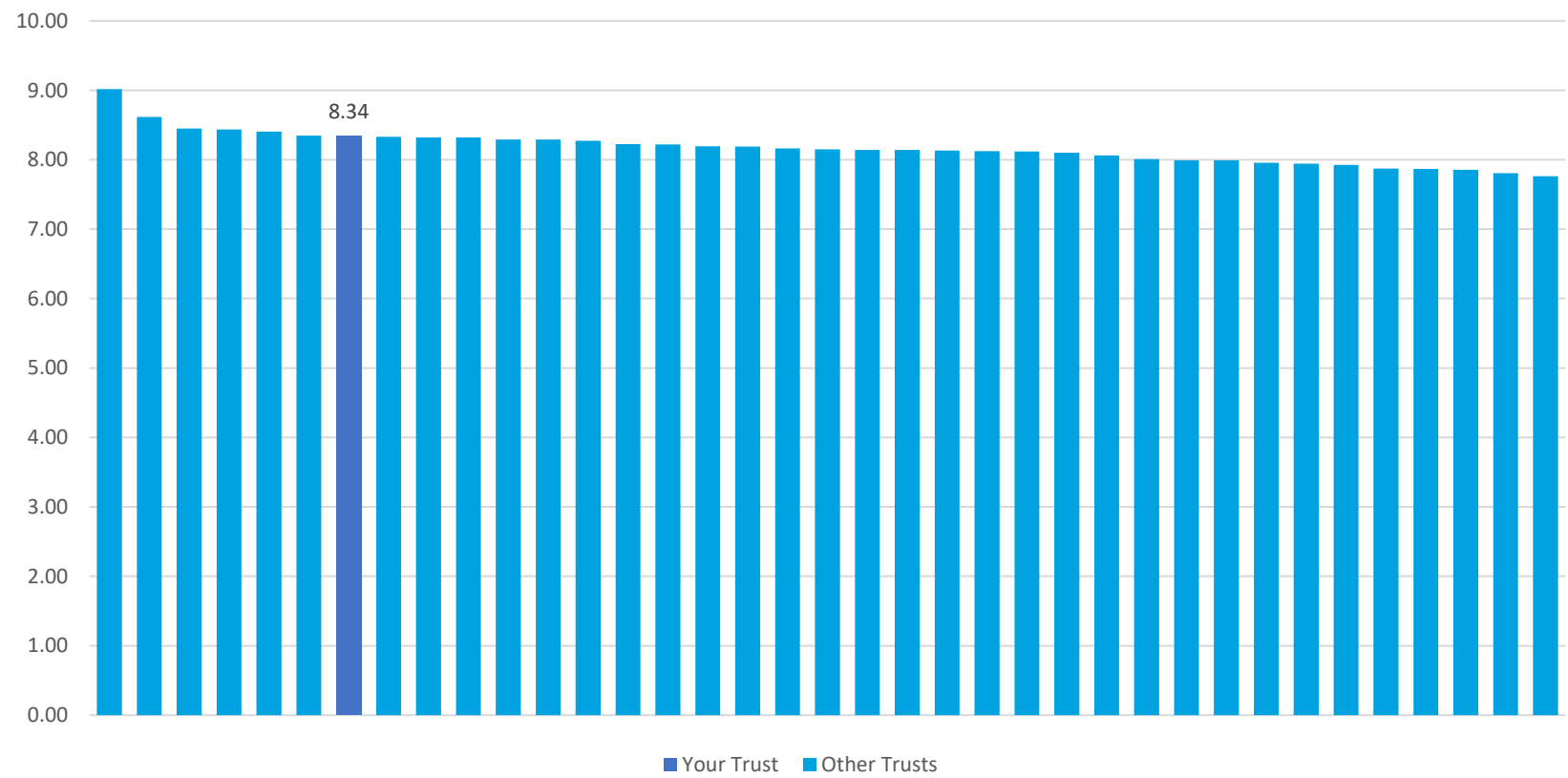


Q23. In your opinion, were there enough nurses on duty to care for you in hospital?



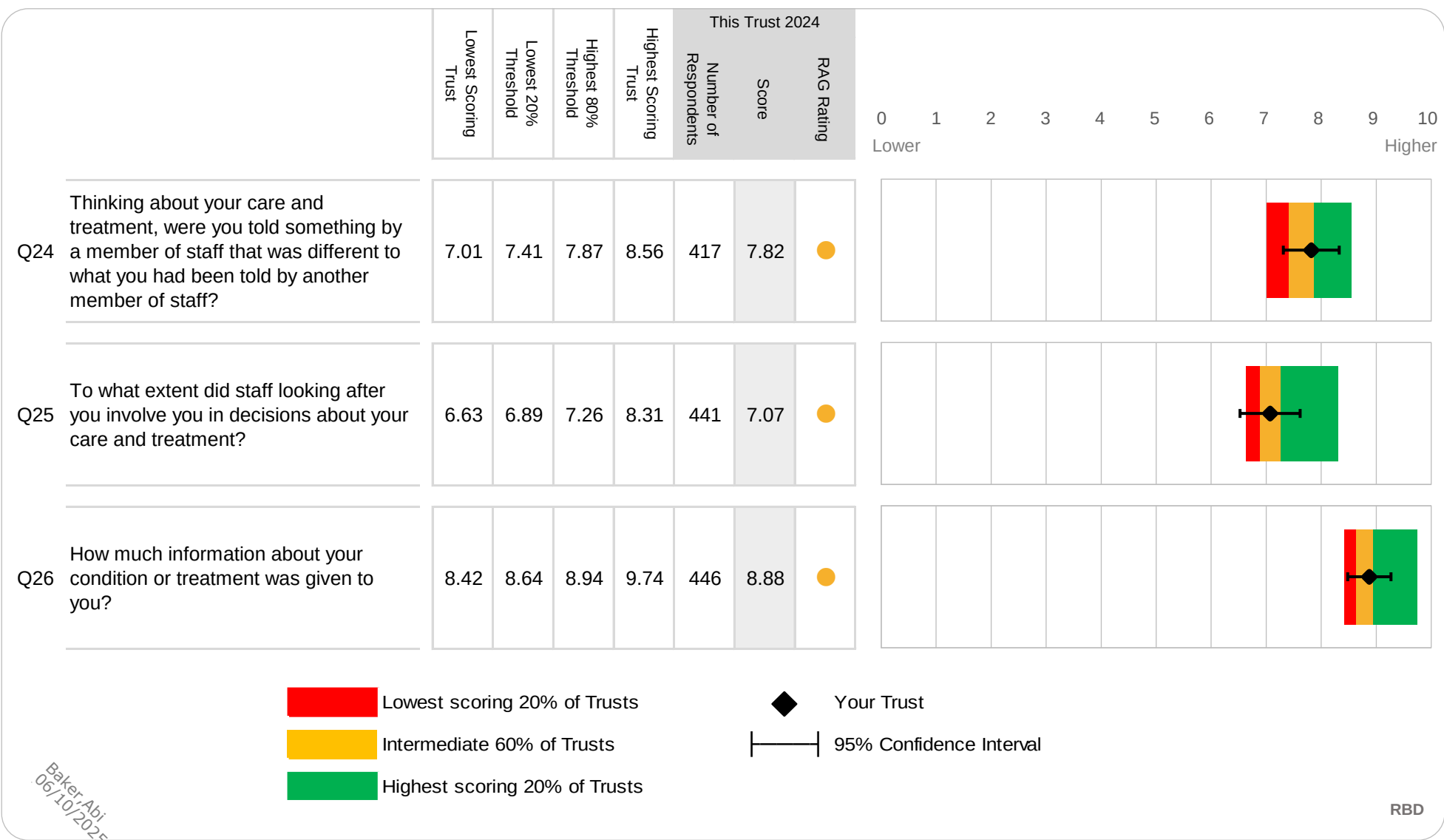
Section E

YOUR CARE AND TREATMENT



Baker, Abi
06/10/2025 12:40:16

YOUR CARE AND TREATMENT - Benchmark Charts and Tables

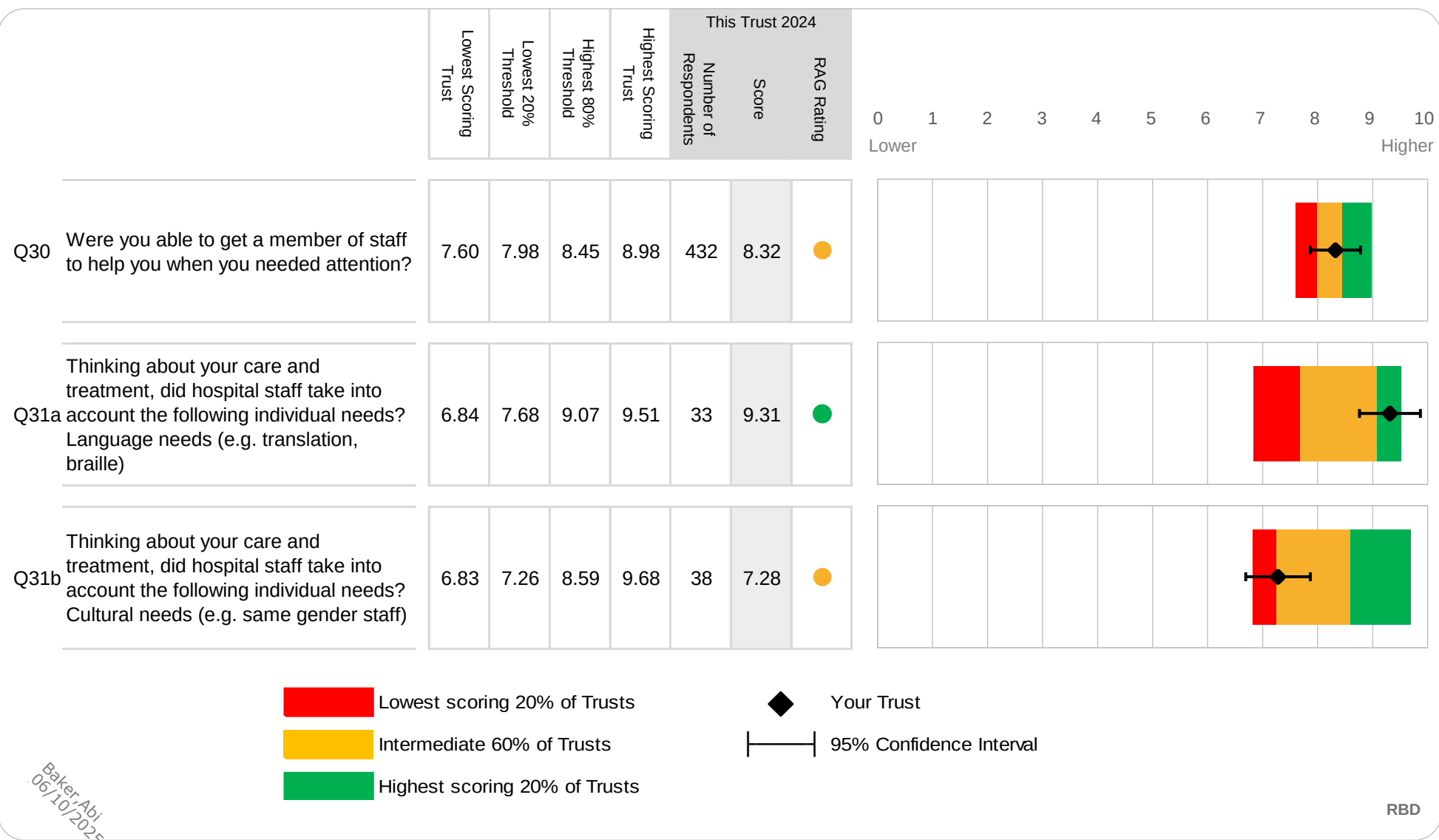


YOUR CARE AND TREATMENT - Benchmark Charts and Tables

Baker, Abi
06/10/2025 12:40:16

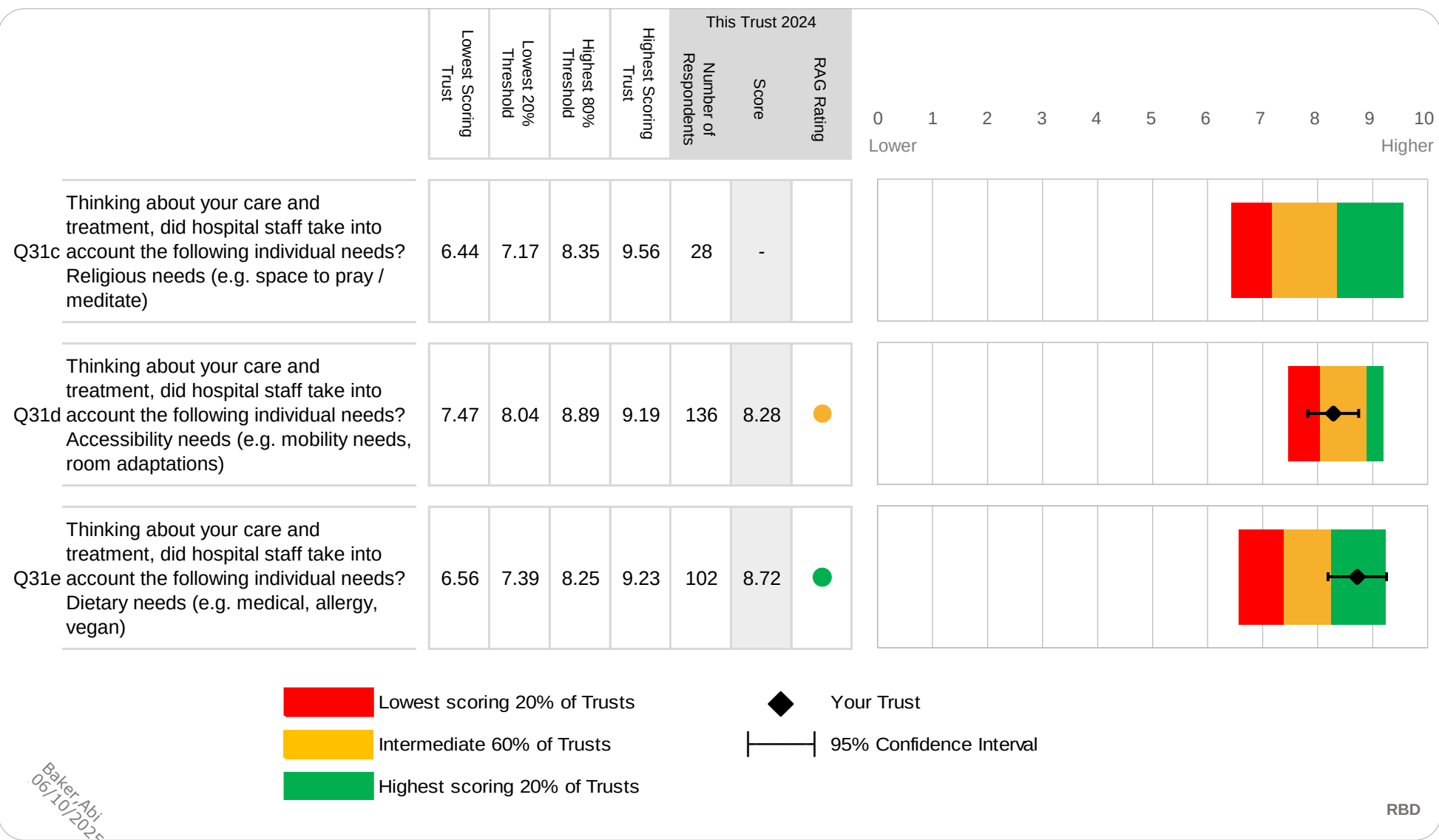
RBD

YOUR CARE AND TREATMENT - Benchmark Charts and Tables



Baker, Abi
06/10/2025 12:40:16

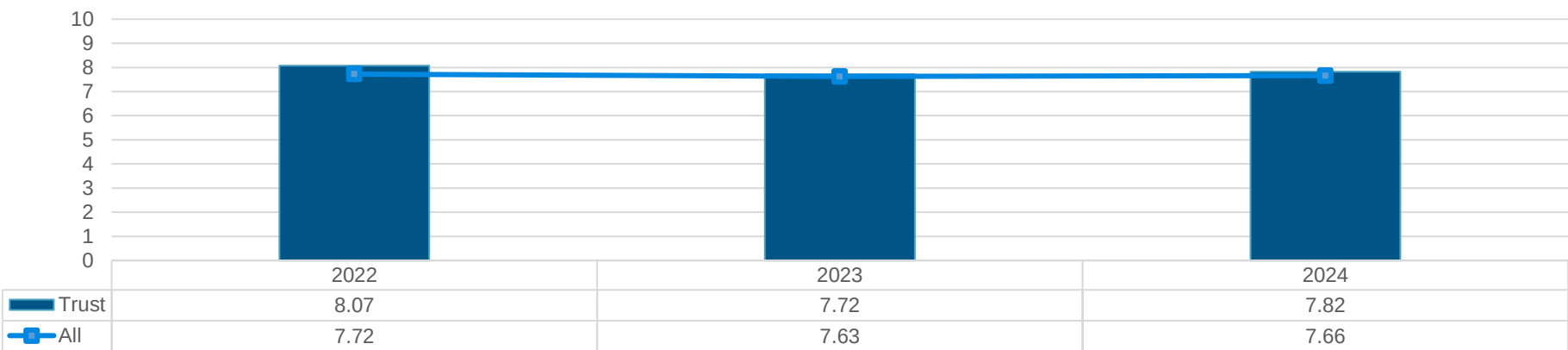
YOUR CARE AND TREATMENT - Benchmark Charts and Tables



Baker, Abi
06/10/2025 12:40:16

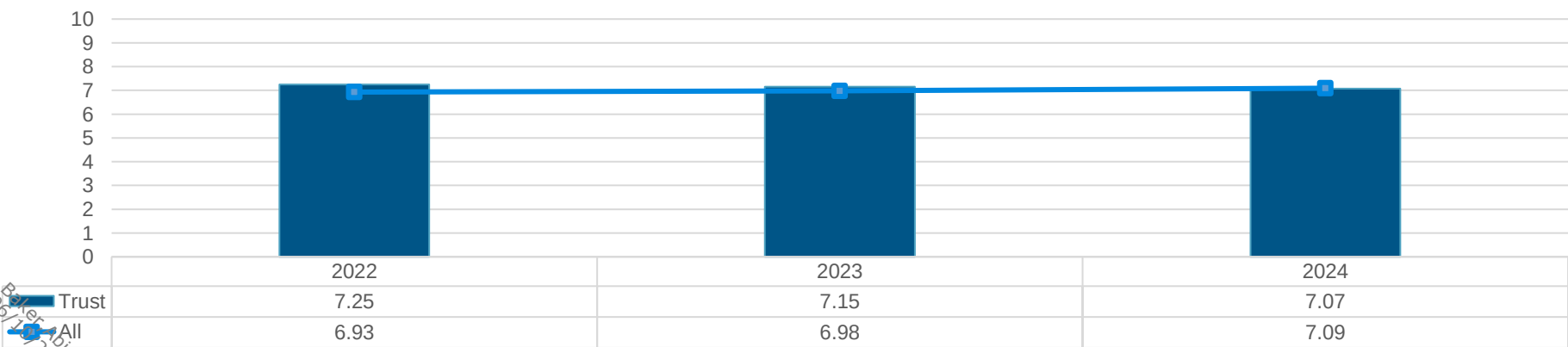
YOUR CARE AND TREATMENT - Longitudinal Charts

Q24. Thinking about your care and treatment, were you told something by a member of staff that was different to what you had been told by another member of staff?



RBD

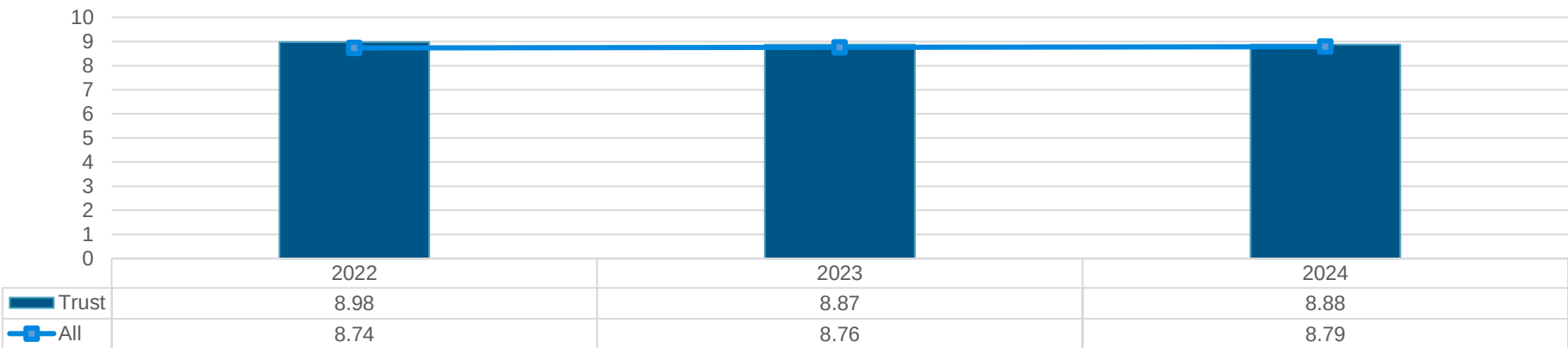
Q25. To what extent did staff looking after you involve you in decisions about your care and treatment?



RBD

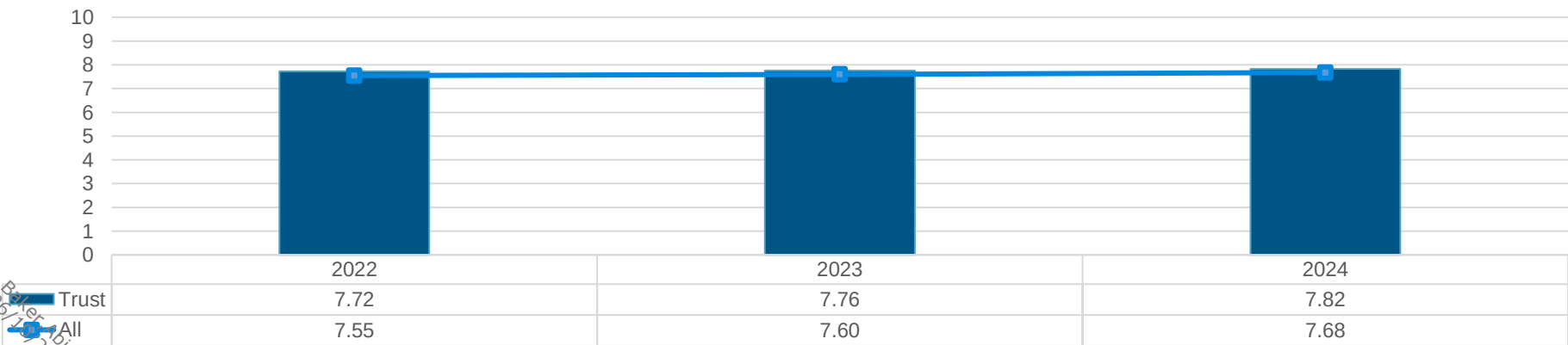
YOUR CARE AND TREATMENT - Longitudinal Charts

Q26. How much information about your condition or treatment was given to you?



RBD

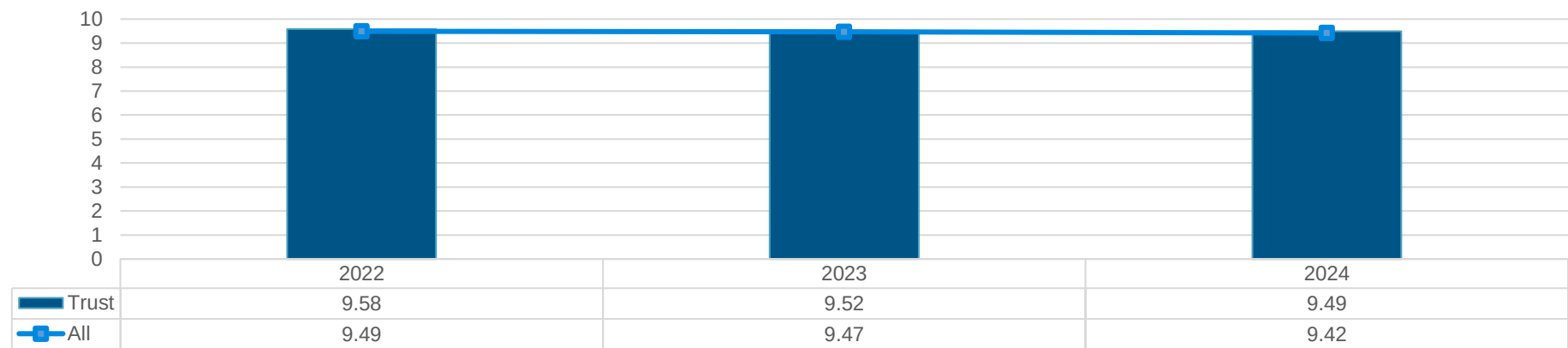
Q27. Did you feel able to talk to members of hospital staff about your worries and fears?



RBD

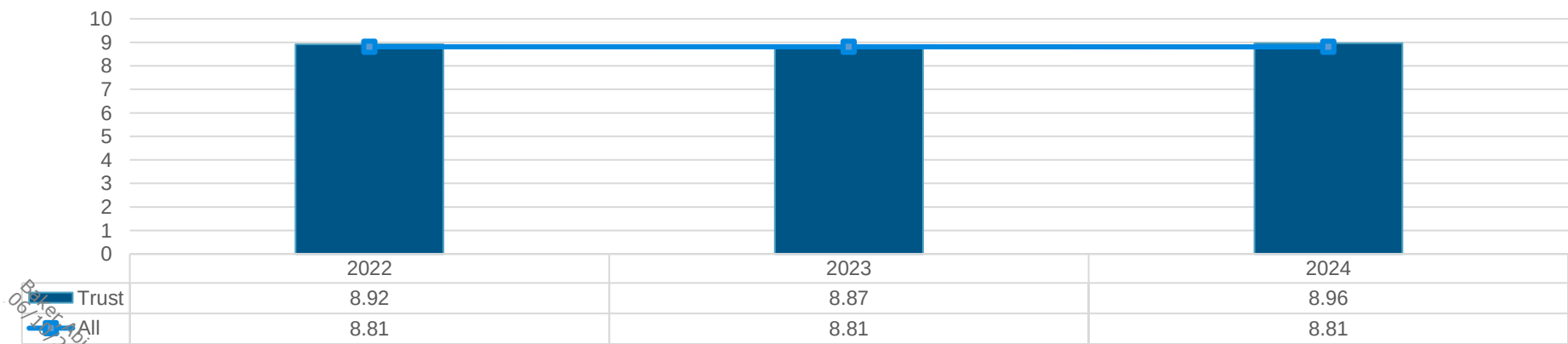
YOUR CARE AND TREATMENT - Longitudinal Charts

Q28. Were you given enough privacy when being examined or treated?



RBD

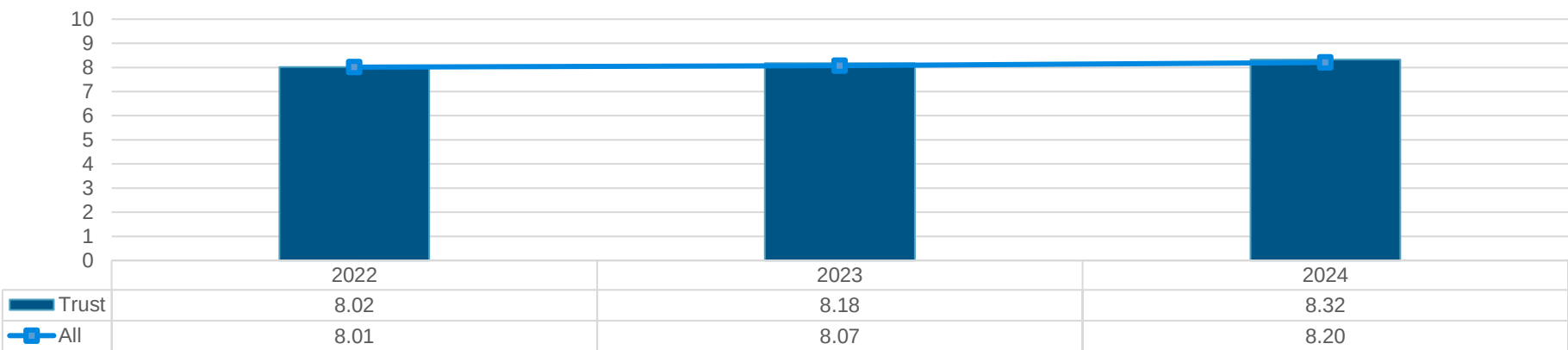
Q29. Do you think the hospital staff did everything they could to help control your pain?



RBD

YOUR CARE AND TREATMENT - Longitudinal Charts

Q30. Were you able to get a member of staff to help you when you needed attention?



RBD

Q31a. Thinking about your care and treatment, did hospital staff take into account the following individual needs? Language needs (e.g. translation, braille)



RBD

YOUR CARE AND TREATMENT - Longitudinal Charts

Q31b. Thinking about your care and treatment, did hospital staff take into account the following individual needs? Cultural needs (e.g. same gender staff)



RBD

Q31c. Thinking about your care and treatment, did hospital staff take into account the following individual needs? Religious needs (e.g. space to pray / meditate)



RBD

YOUR CARE AND TREATMENT - Longitudinal Charts

Q31d. Thinking about your care and treatment, did hospital staff take into account the following individual needs? Accessibility needs (e.g. mobility needs, room adaptations)



RBD

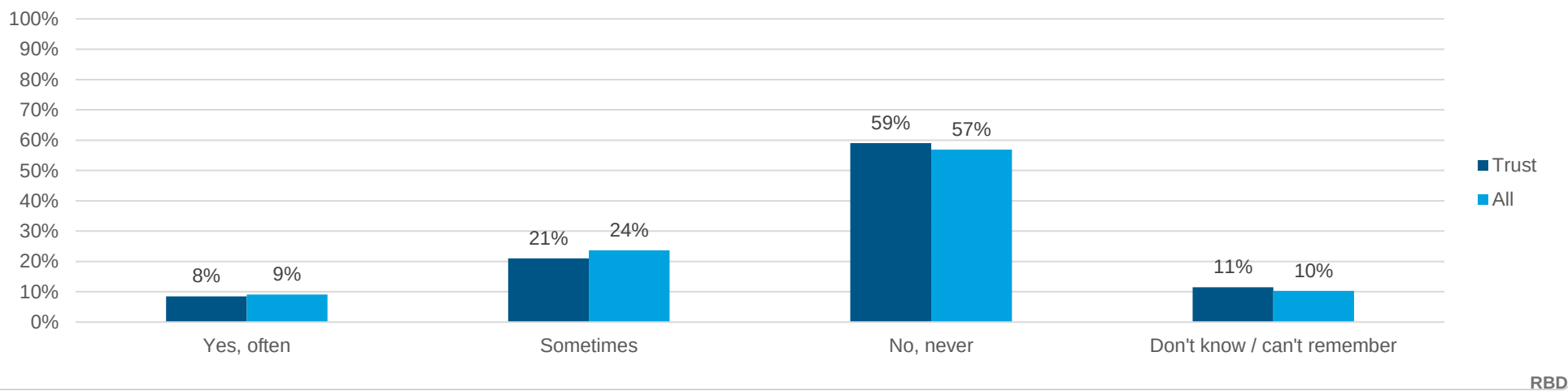
Q31e. Thinking about your care and treatment, did hospital staff take into account the following individual needs? Dietary needs (e.g. medical, allergy, vegan)



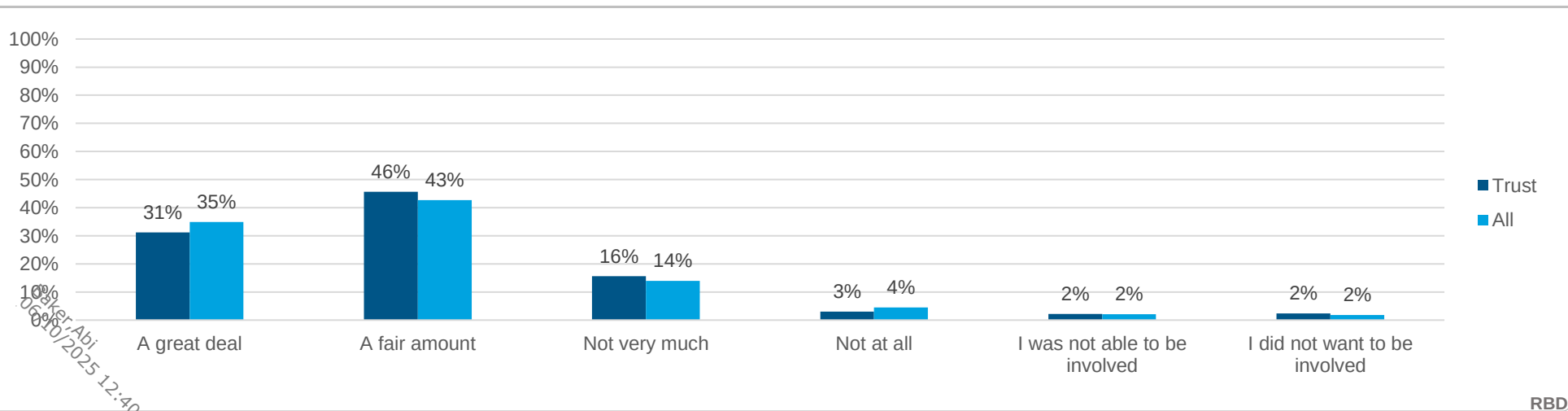
RBD

YOUR CARE AND TREATMENT - Benchmark Charts and Tables

Q24. Thinking about your care and treatment, were you told something by a member of staff that was different to what you had been told by another member of staff?

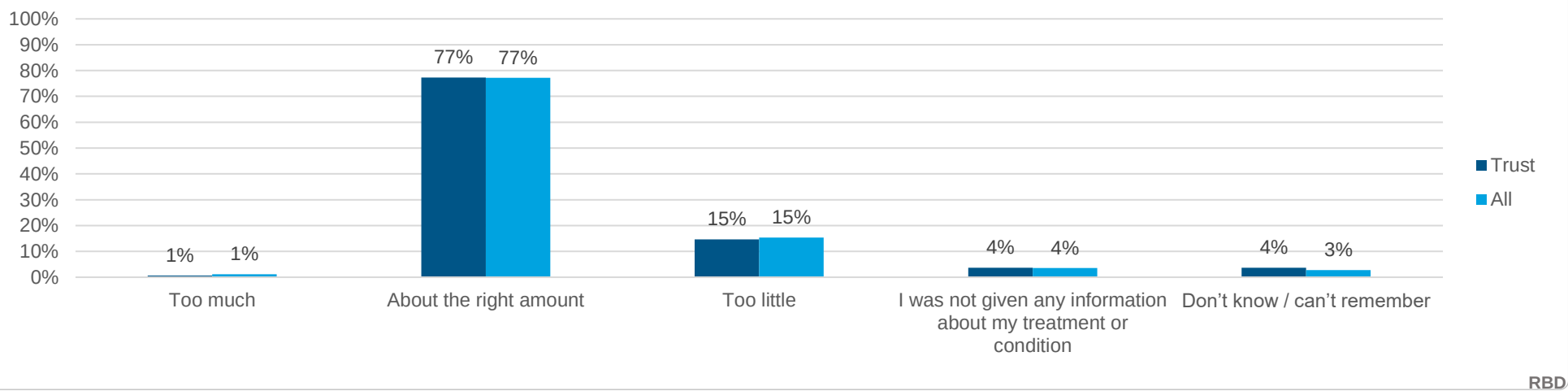


Q25. To what extent did staff looking after you involve you in decisions about your care and treatment?

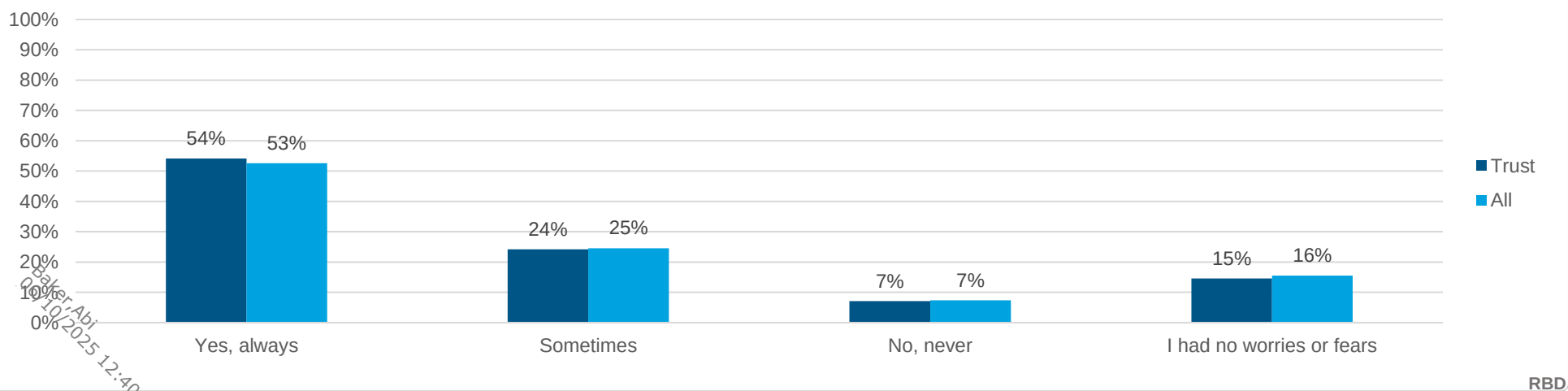


YOUR CARE AND TREATMENT - Benchmark Charts and Tables

Q26. How much information about your condition or treatment was given to you?

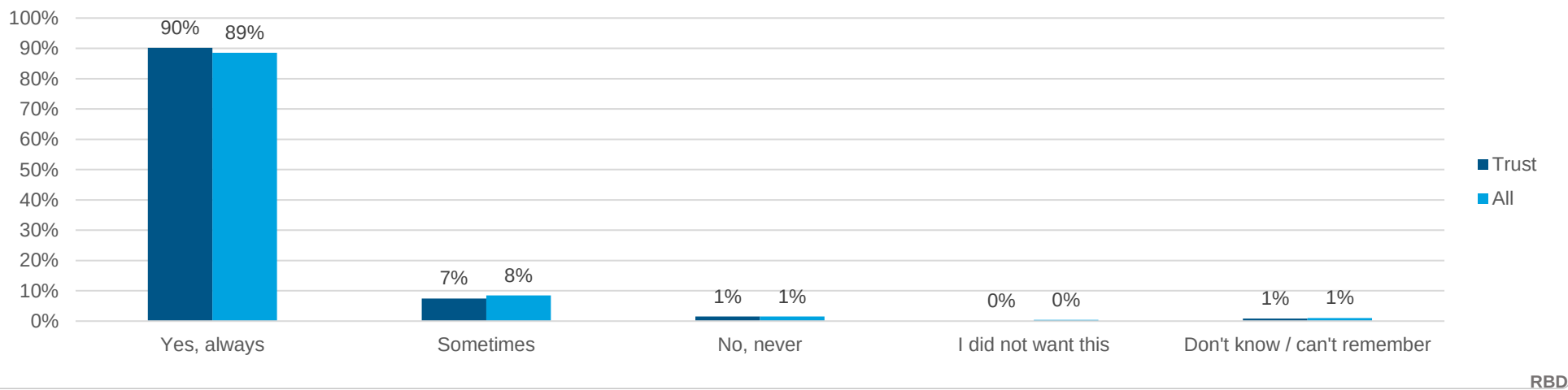


Q27. Did you feel able to talk to members of hospital staff about your worries and fears?

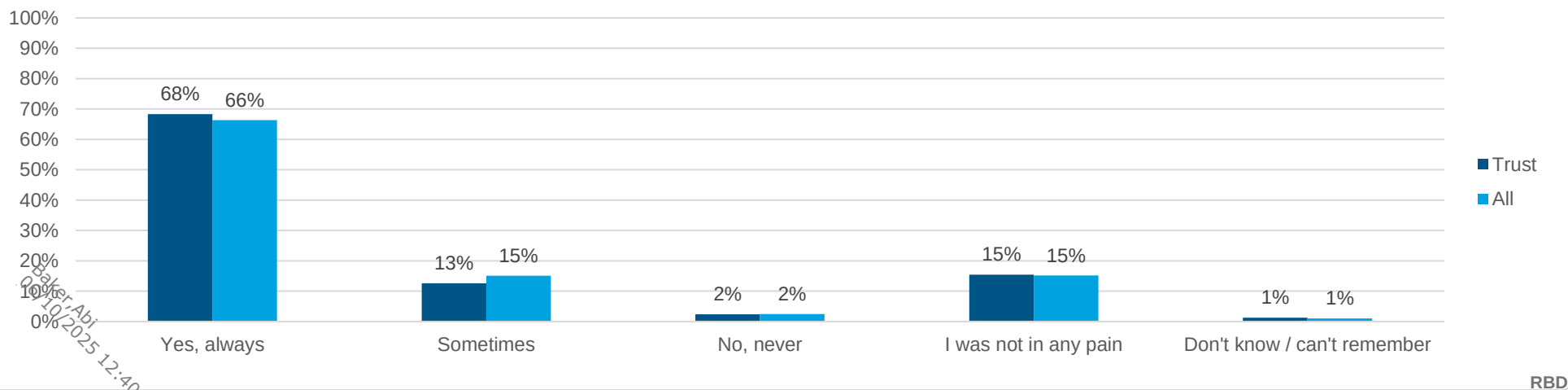


YOUR CARE AND TREATMENT - Benchmark Charts and Tables

Q28. Were you given enough privacy when being examined or treated?

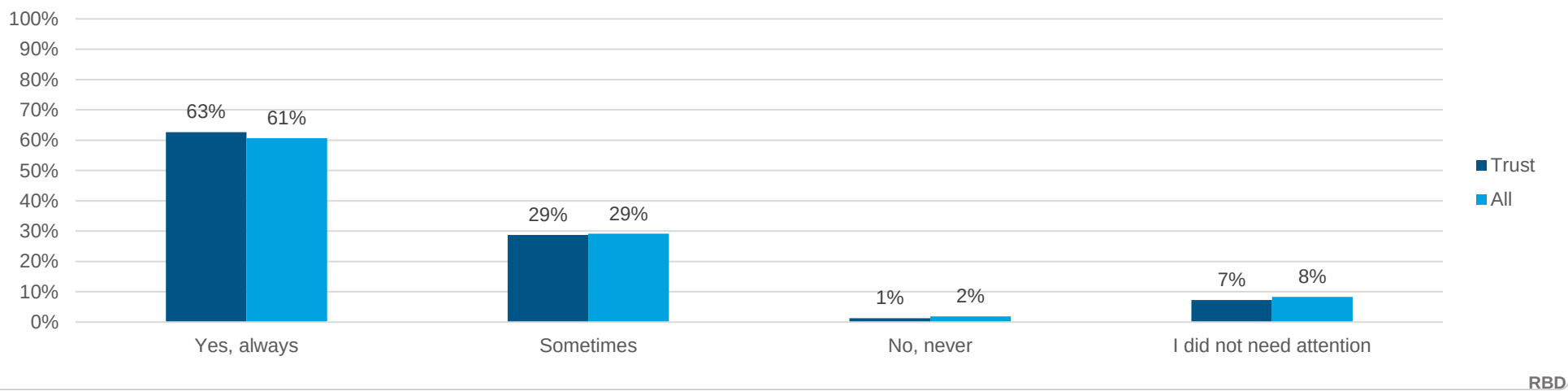


Q29. Do you think the hospital staff did everything they could to help control your pain?

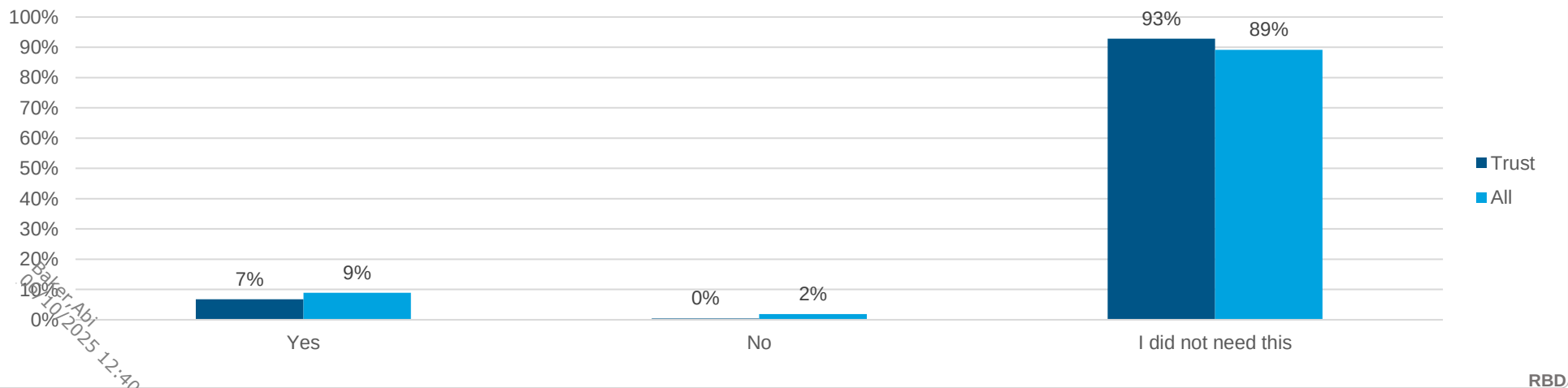


YOUR CARE AND TREATMENT - Benchmark Charts and Tables

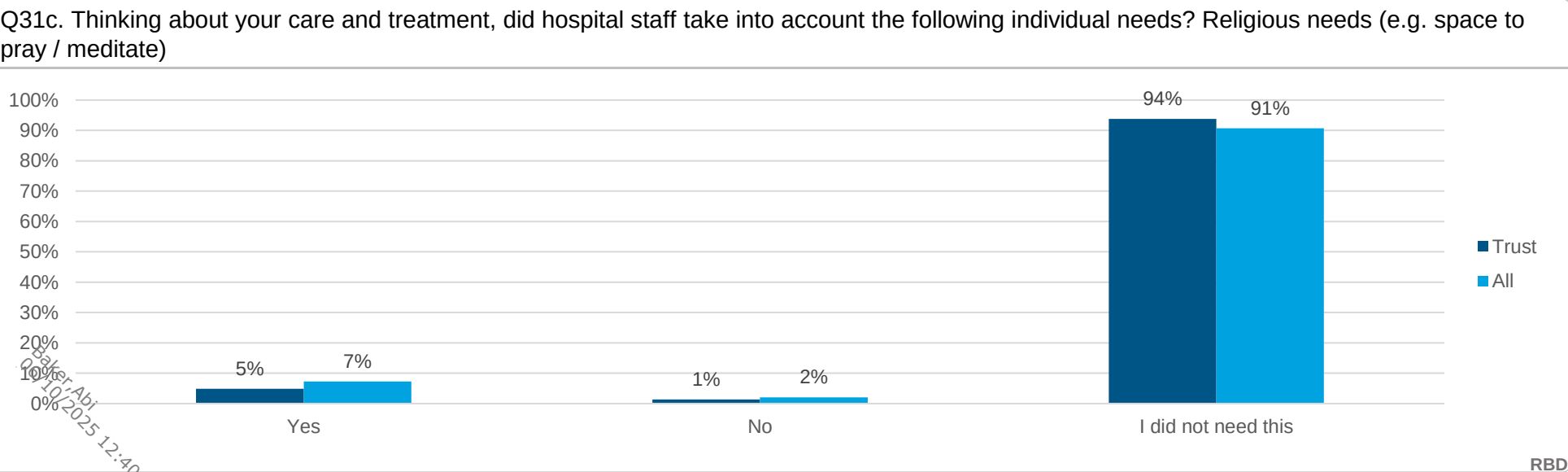
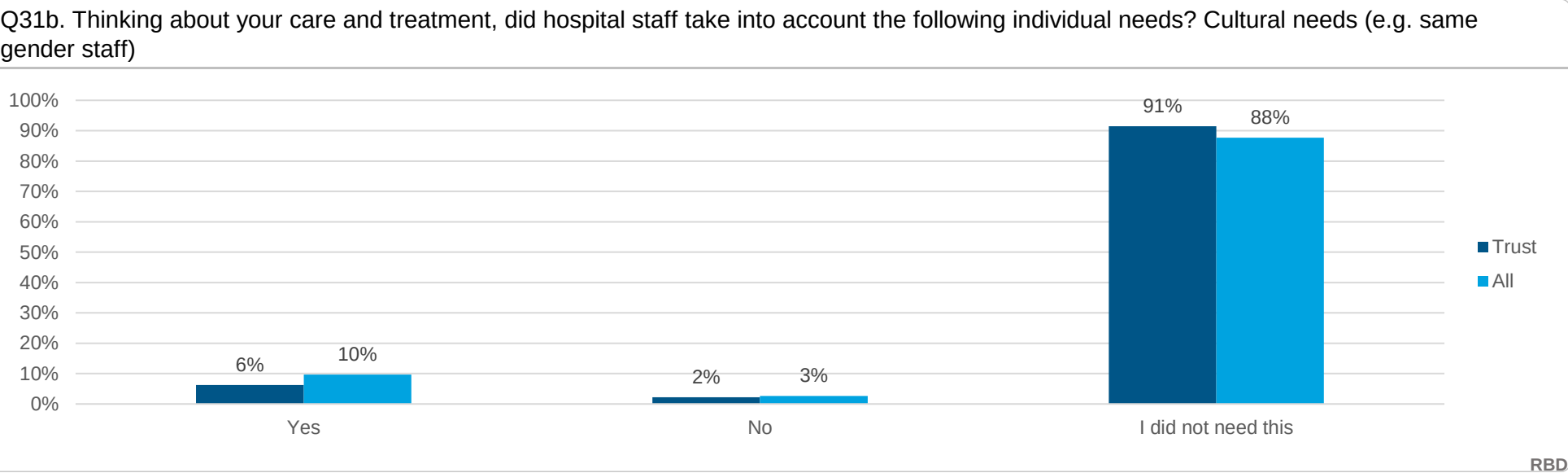
Q30. Were you able to get a member of staff to help you when you needed attention?



Q31a. Thinking about your care and treatment, did hospital staff take into account the following individual needs? Language needs (e.g. translation, braille)

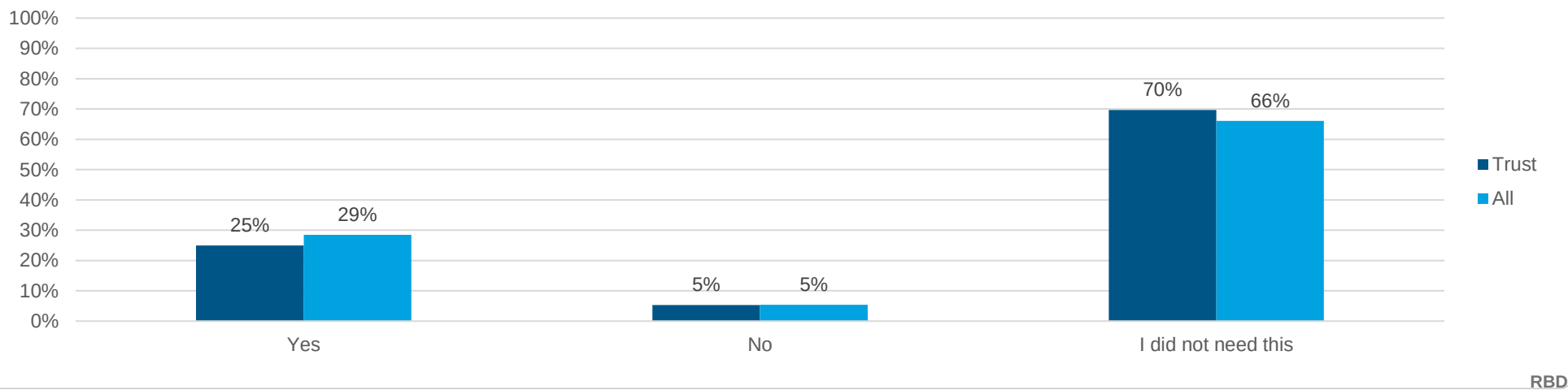


YOUR CARE AND TREATMENT - Benchmark Charts and Tables

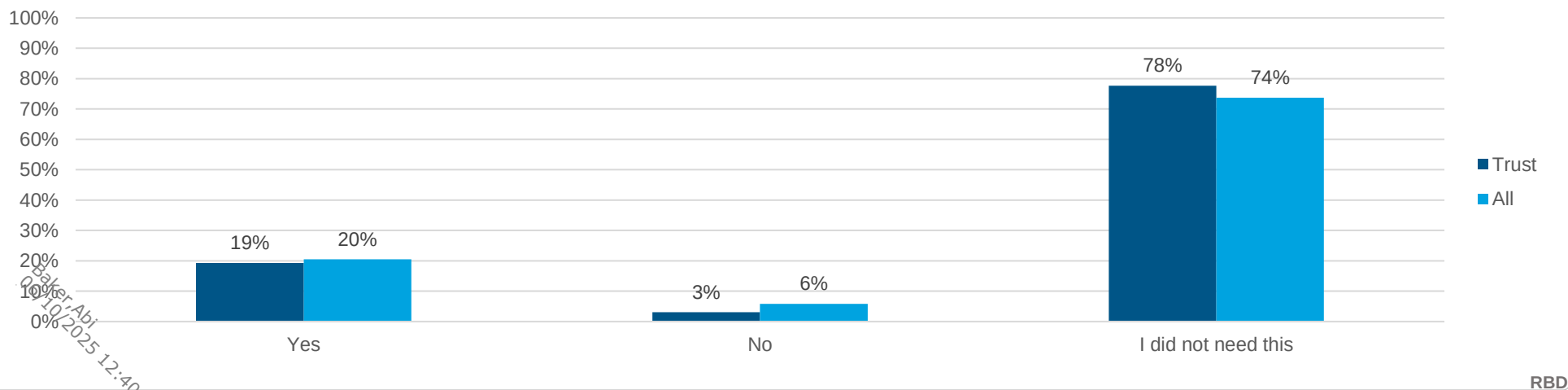


YOUR CARE AND TREATMENT - Benchmark Charts and Tables

Q31d. Thinking about your care and treatment, did hospital staff take into account the following individual needs? Accessibility needs (e.g. mobility needs, room adaptations)

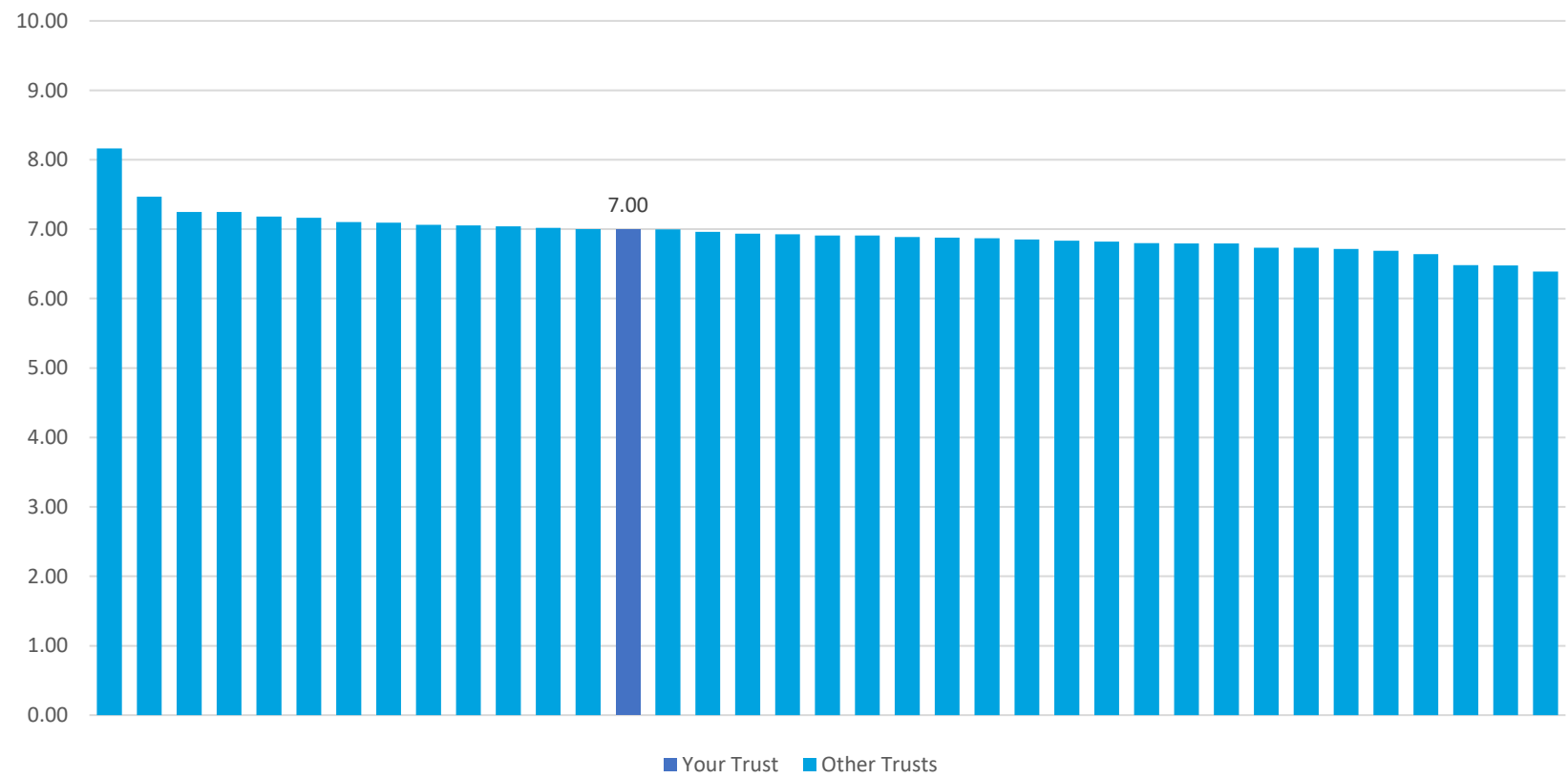


Q31e. Thinking about your care and treatment, did hospital staff take into account the following individual needs? Dietary needs (e.g. medical, allergy, vegan)



Section F

LEAVING HOSPITAL



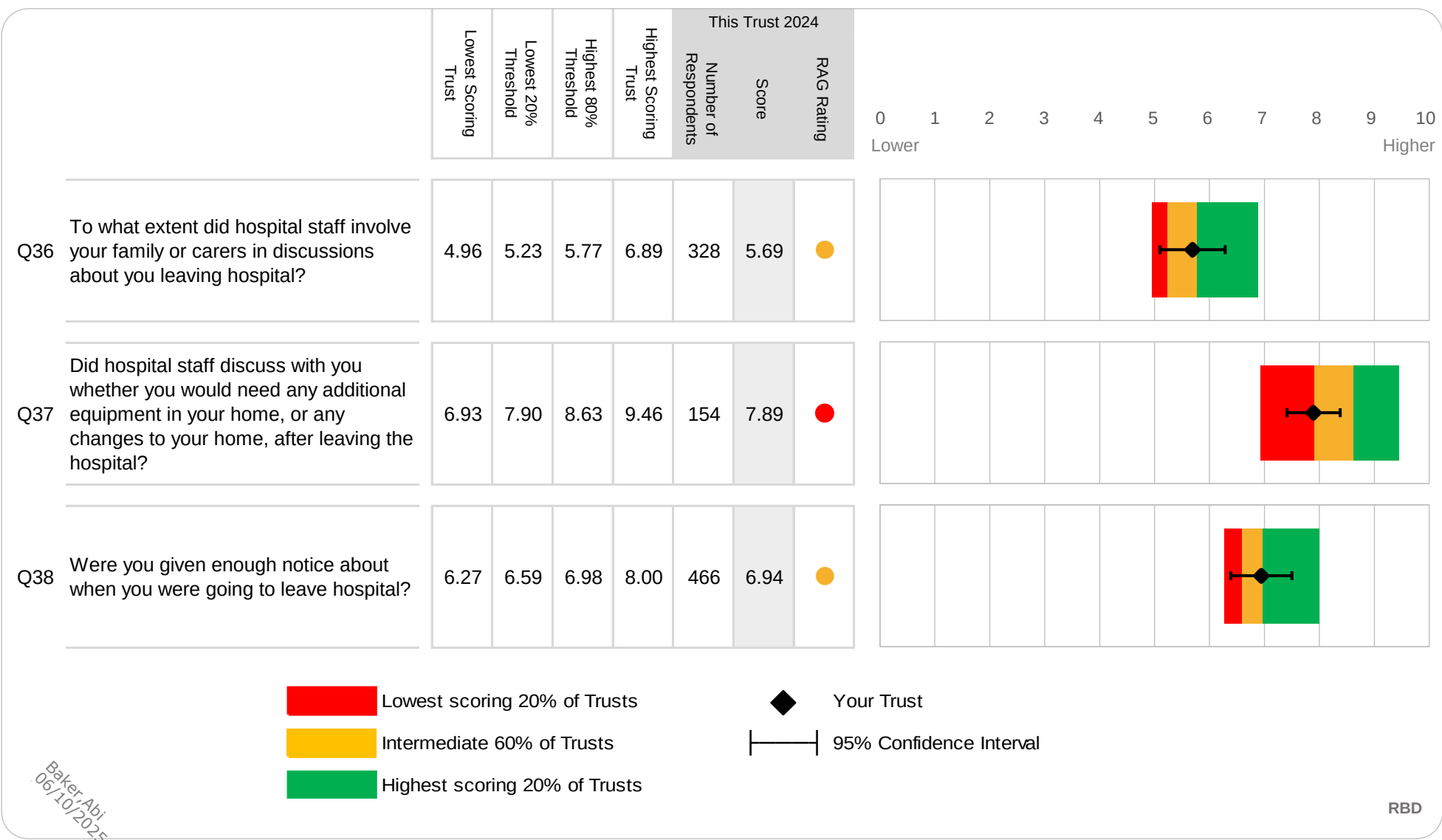
Baker, Abi
06/10/2025 12:40:16

LEAVING HOSPITAL - Benchmark Charts and Tables

Baker, Abi
06/10/2025 12:40:16

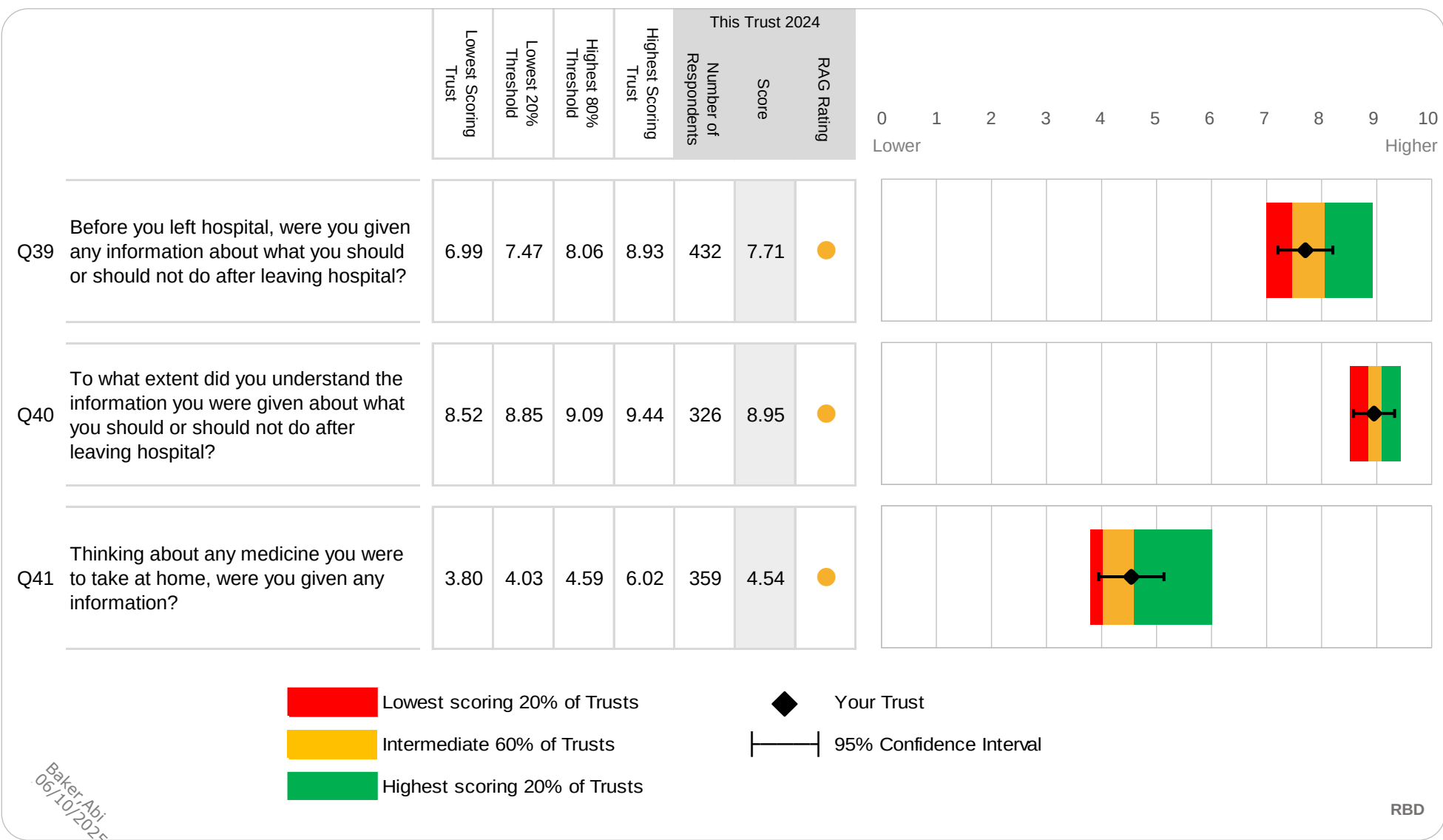
RBD

LEAVING HOSPITAL - Benchmark Charts and Tables



Baker, Abi
06/10/2025 12:40:16

LEAVING HOSPITAL - Benchmark Charts and Tables



Baker, Abi
06/10/2025 12:40:16

LEAVING HOSPITAL - Benchmark Charts and Tables

Baker, Abi
06/10/2025 12:40:16

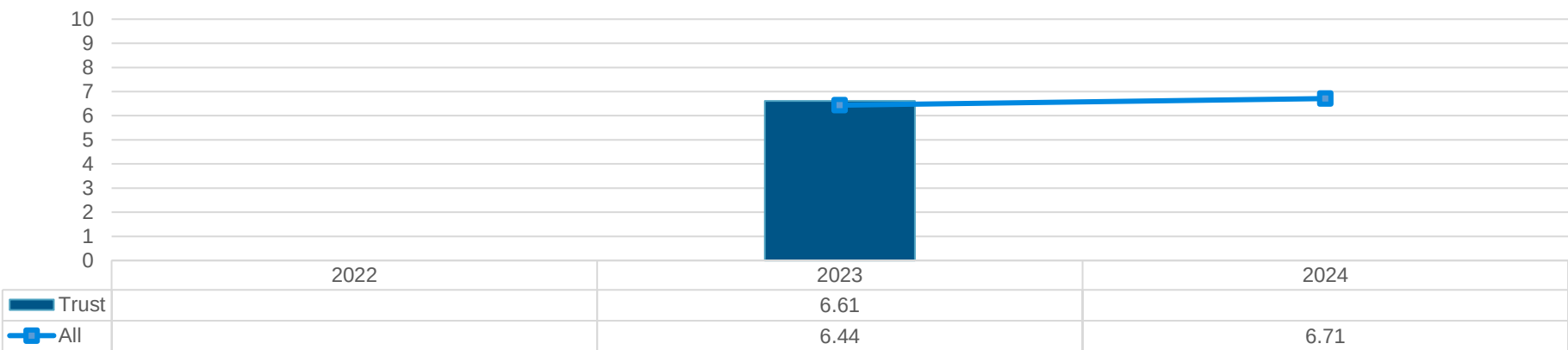
RBD

LEAVING HOSPITAL - Benchmark Charts and Tables



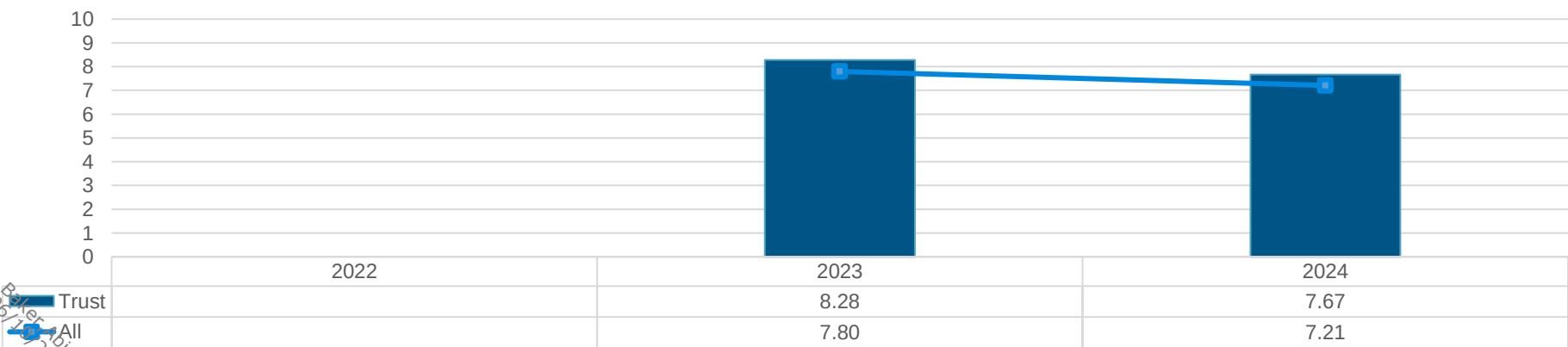
LEAVING HOSPITAL - Longitudinal Charts

Q33. Before being admitted onto a virtual ward, did hospital staff give you information about the risks and benefits of continuing your treatment on a virtual ward?



RBD

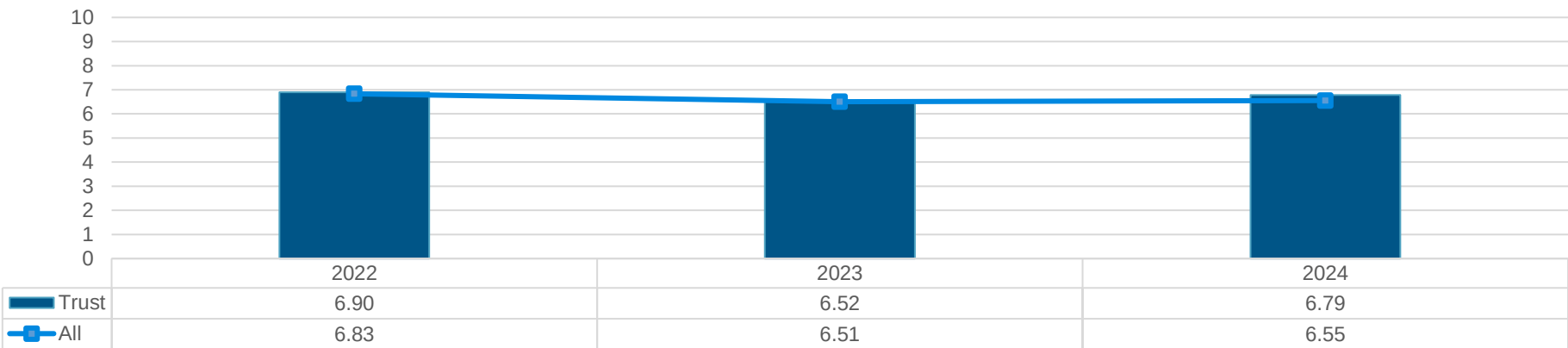
Q34. Were you given enough information about the care and treatment you would receive while on a virtual ward?



RBD

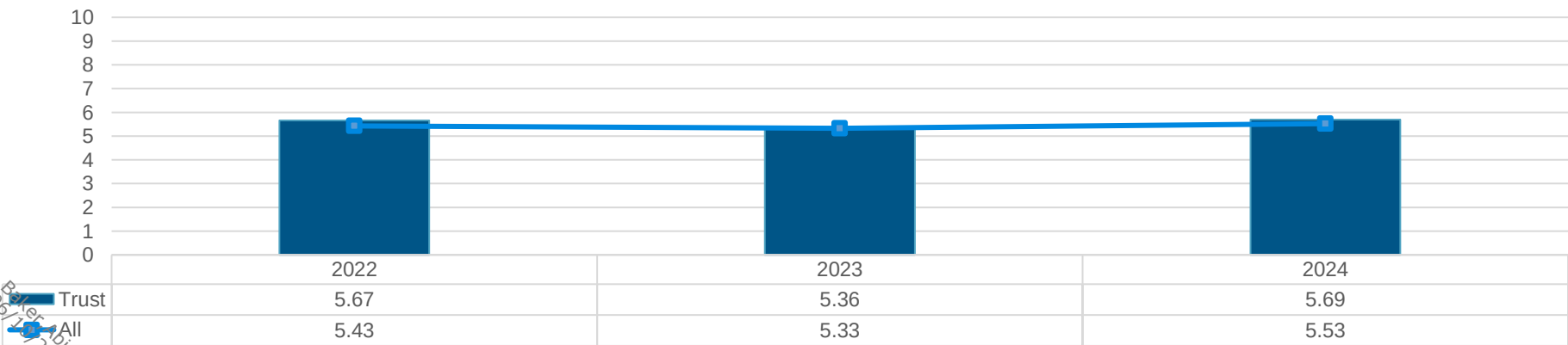
LEAVING HOSPITAL - Longitudinal Charts

Q35. To what extent did hospital staff involve you in decisions about you leaving hospital?



RBD

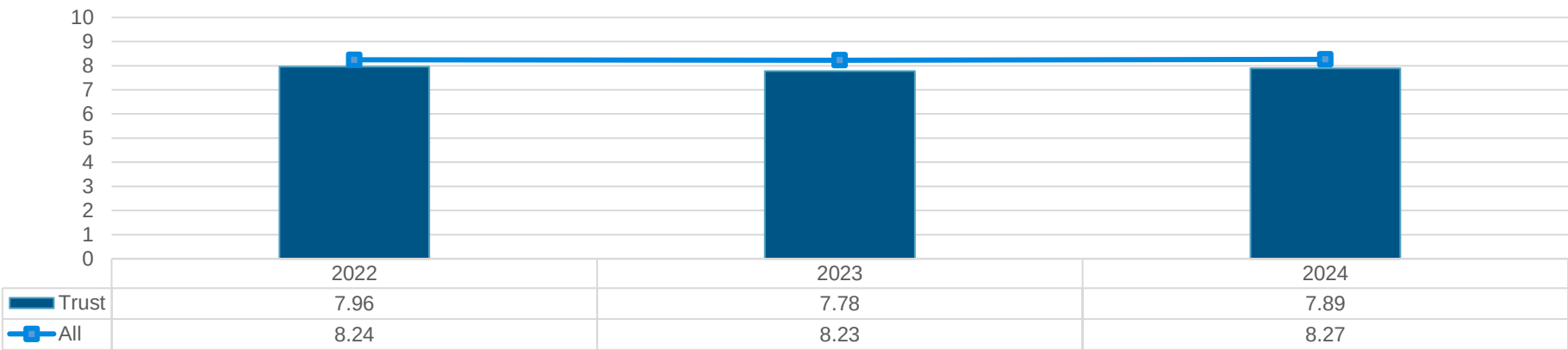
Q36. To what extent did hospital staff involve your family or carers in discussions about you leaving hospital?



RBD

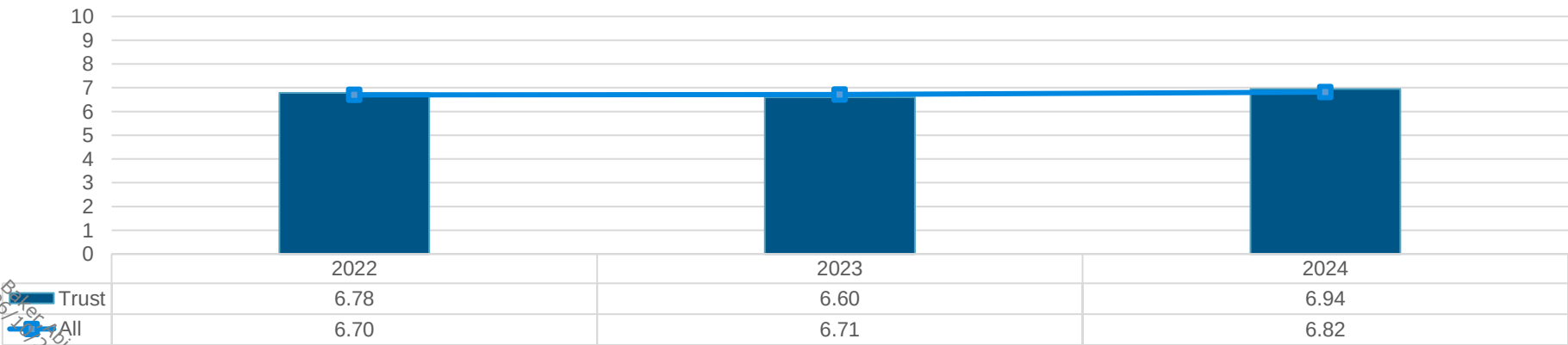
LEAVING HOSPITAL - Longitudinal Charts

Q37. Did hospital staff discuss with you whether you would need any additional equipment in your home, or any changes to your home, after leaving the hospital?



RBD

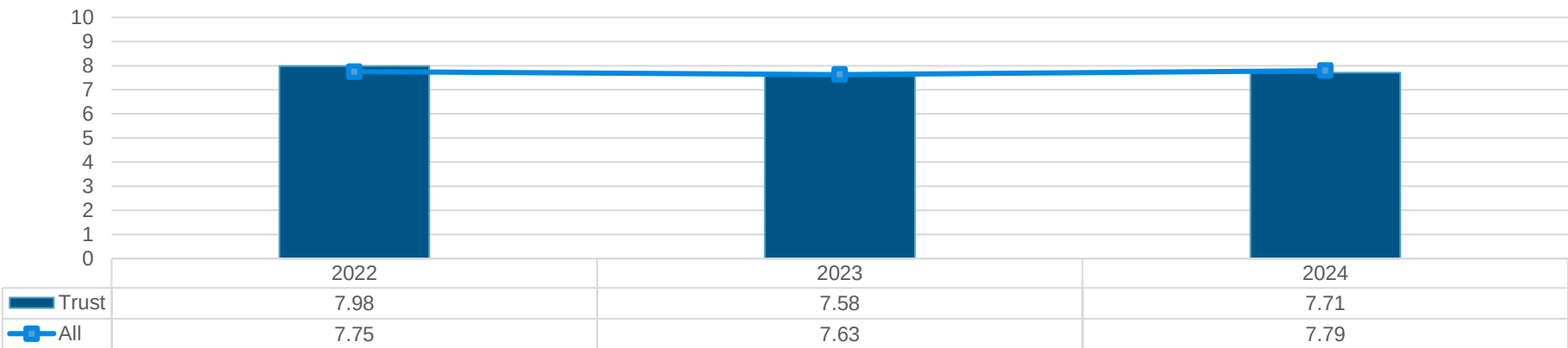
Q38. Were you given enough notice about when you were going to leave hospital?



RBD

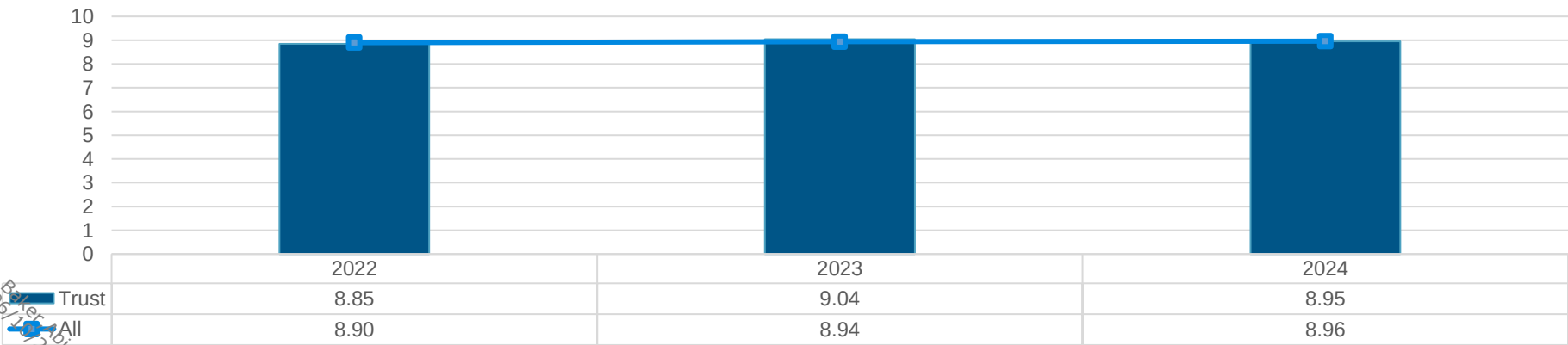
LEAVING HOSPITAL - Longitudinal Charts

Q39. Before you left hospital, were you given any information about what you should or should not do after leaving hospital?



RBD

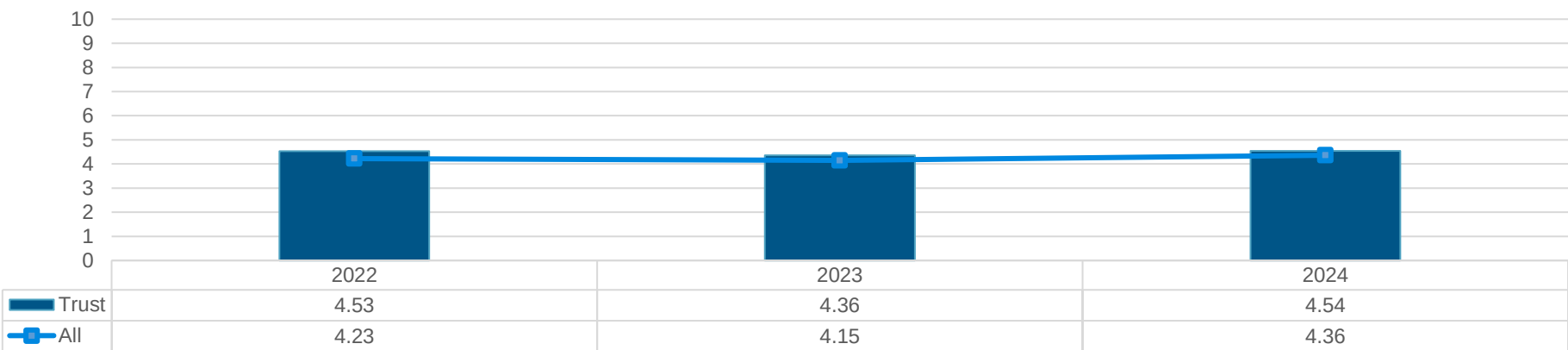
Q40. To what extent did you understand the information you were given about what you should or should not do after leaving hospital?



RBD

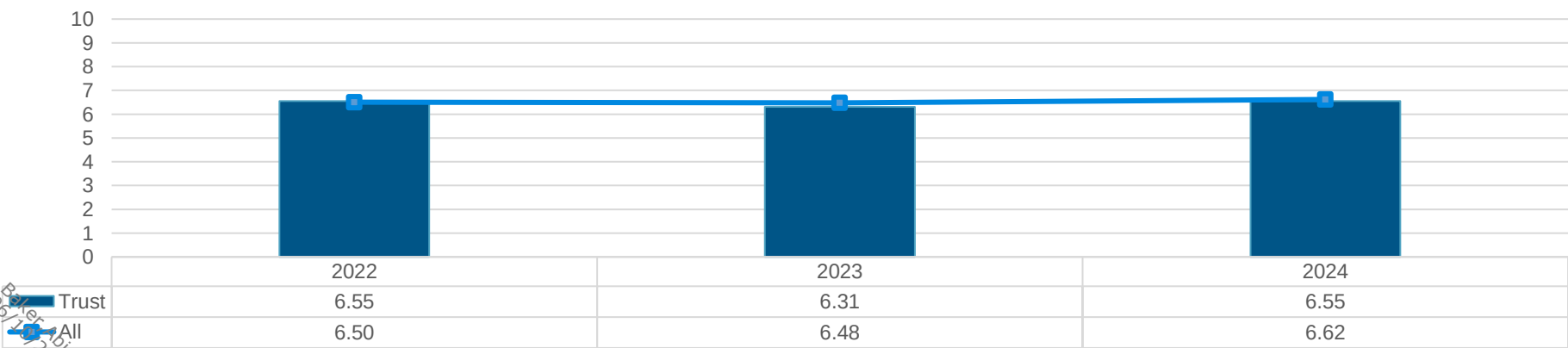
LEAVING HOSPITAL - Longitudinal Charts

Q41. Thinking about any medicine you were to take at home, were you given any information?



RBD

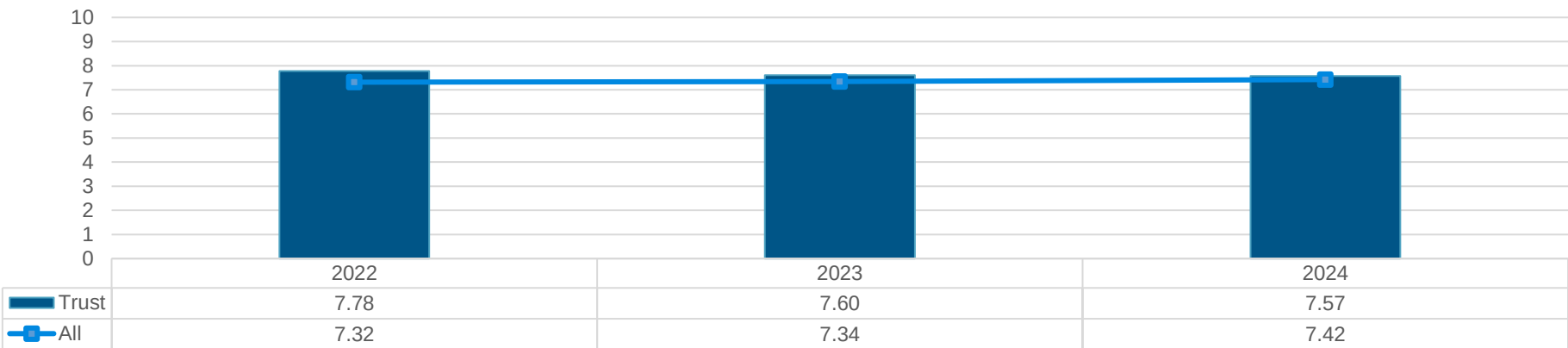
Q42. Before you left hospital, did you know what would happen next with your care?



RBD

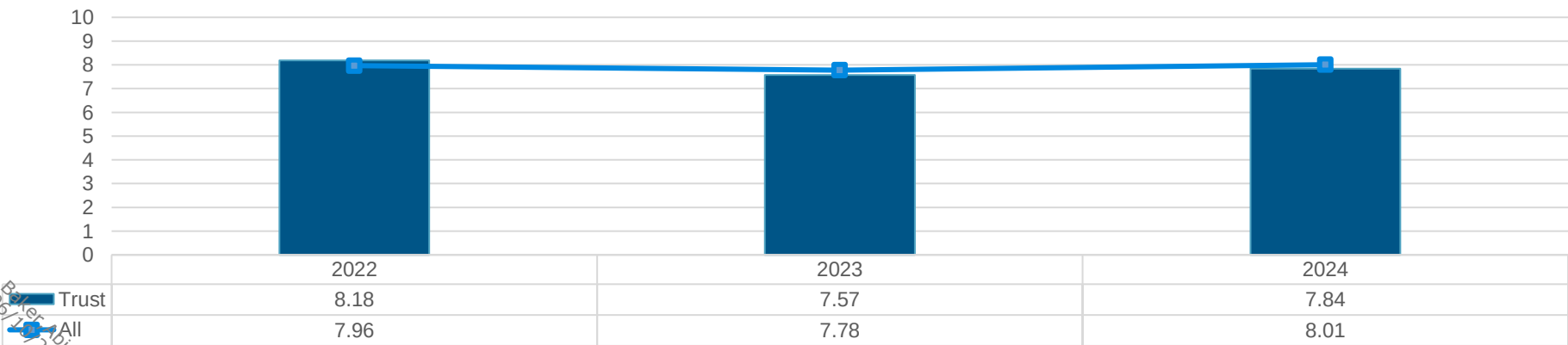
LEAVING HOSPITAL - Longitudinal Charts

Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?



RBD

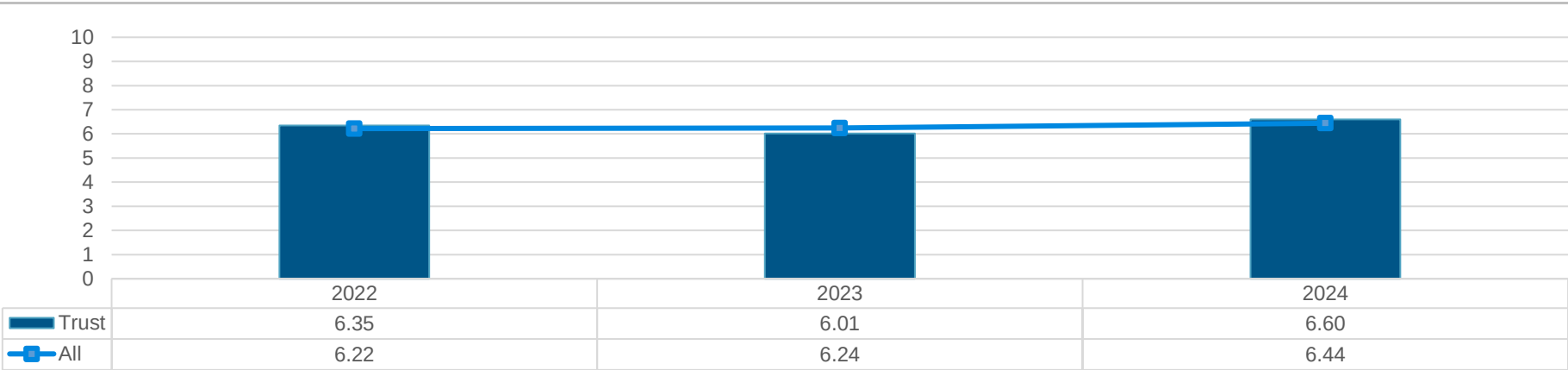
Q44. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?



RBD

LEAVING HOSPITAL - Longitudinal Charts

Q45. After leaving hospital, did you get enough support from health or social care services to help you recover or manage your condition?

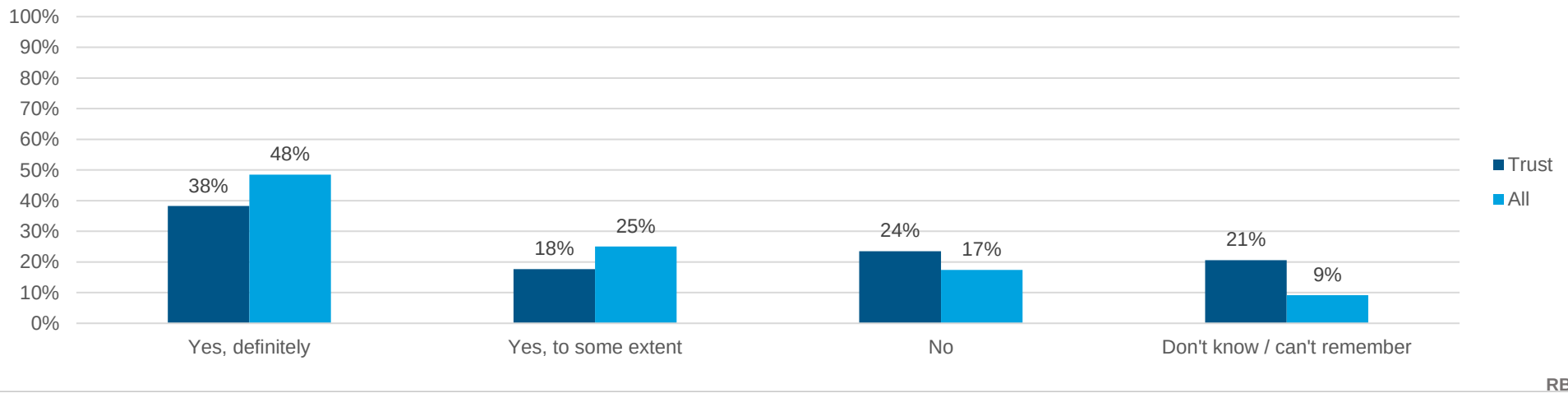


RBD

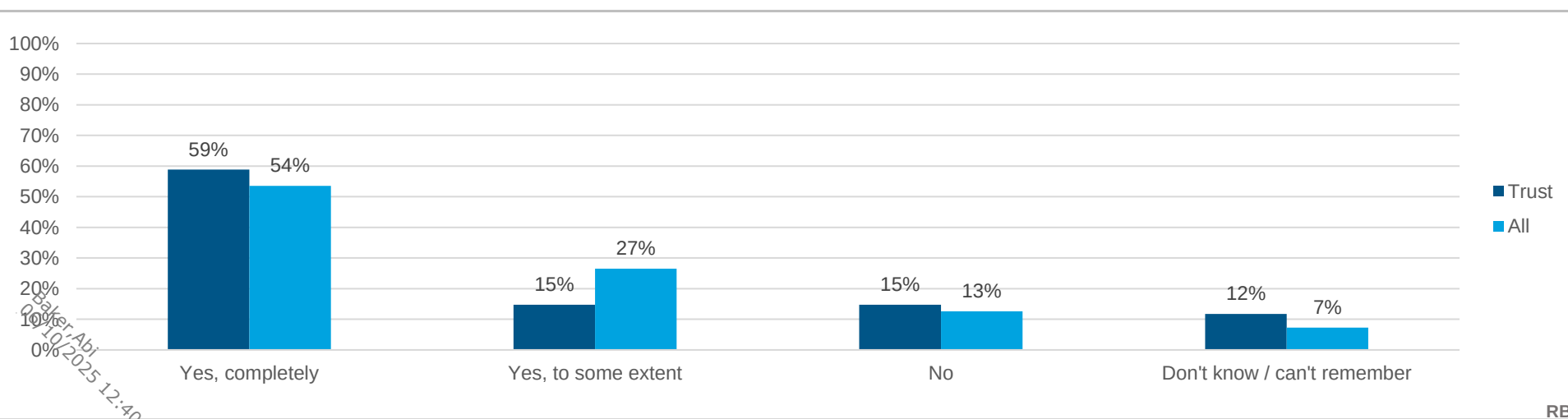
Baker, Abi
06/10/2025 12:40:16

LEAVING HOSPITAL - Benchmark Charts and Tables

Q33. Before being admitted onto a virtual ward, did hospital staff give you information about the risks and benefits of continuing your treatment on a virtual ward?

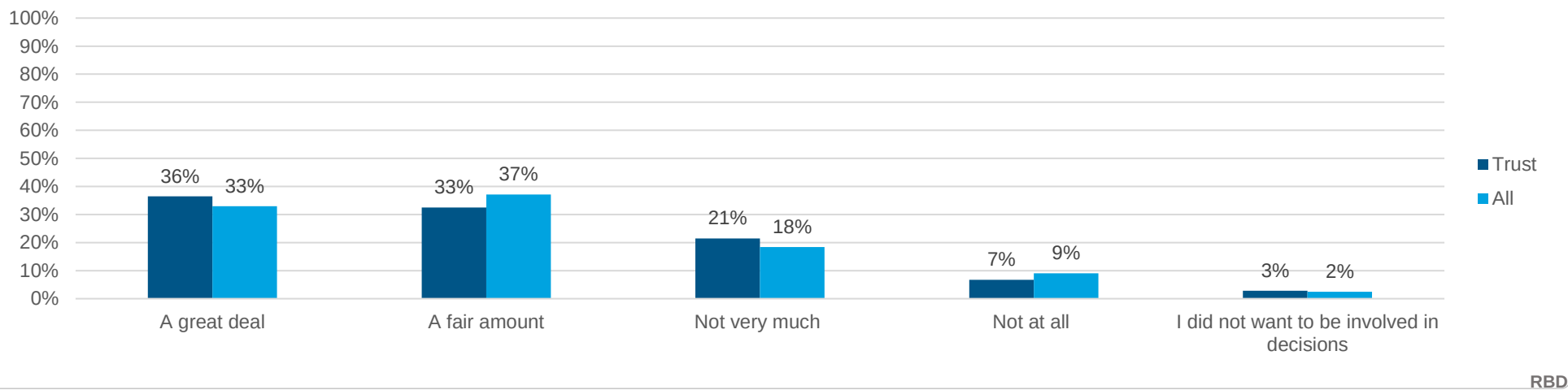


Q34. Were you given enough information about the care and treatment you would receive while on a virtual ward?

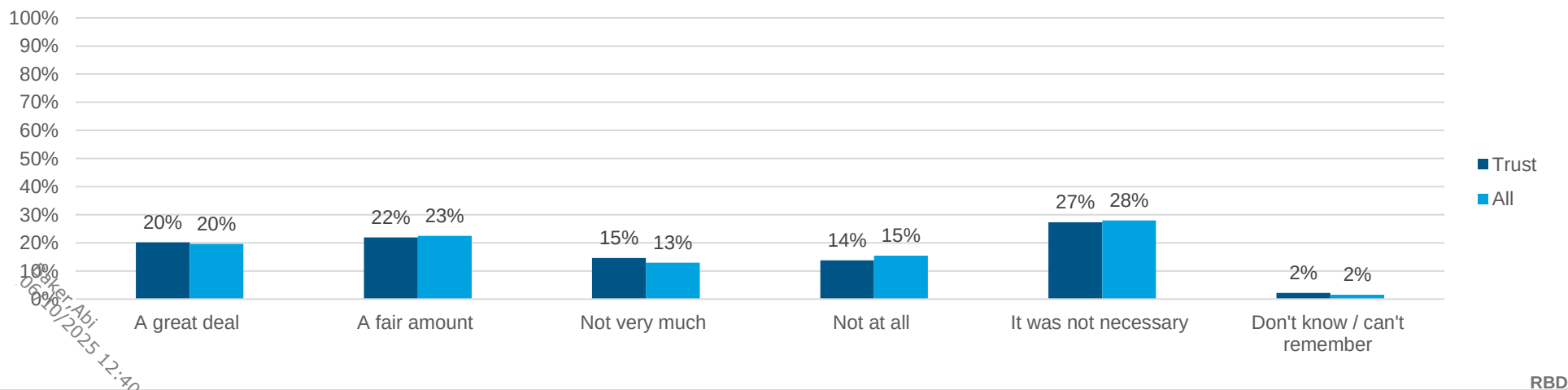


LEAVING HOSPITAL - Benchmark Charts and Tables

Q35. To what extent did hospital staff involve you in decisions about you leaving hospital?

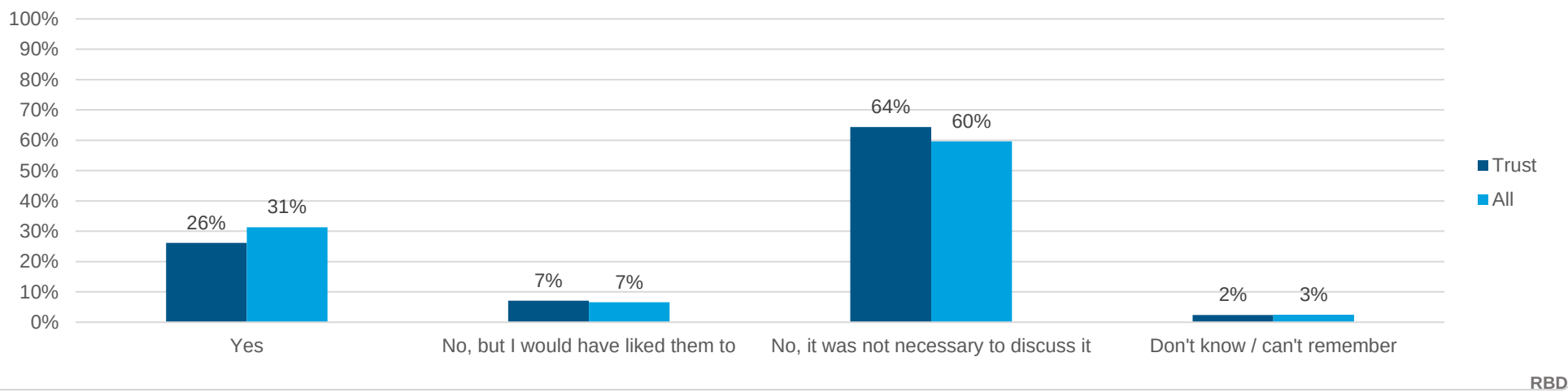


Q36. To what extent did hospital staff involve your family or carers in discussions about you leaving hospital?

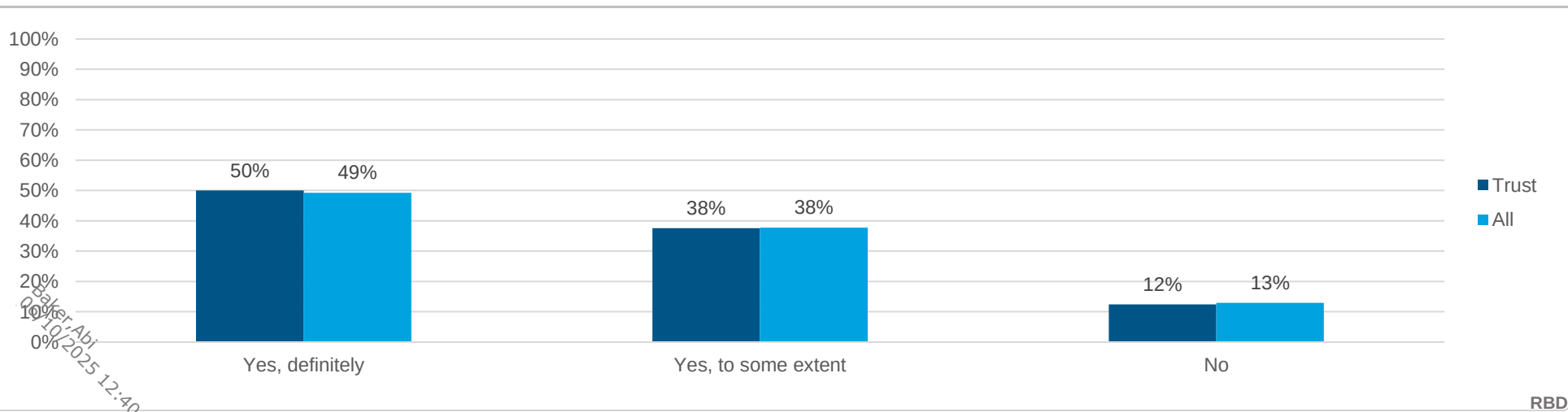


LEAVING HOSPITAL - Benchmark Charts and Tables

Q37. Did hospital staff discuss with you whether you would need any additional equipment in your home, or any changes to your home, after leaving the hospital?

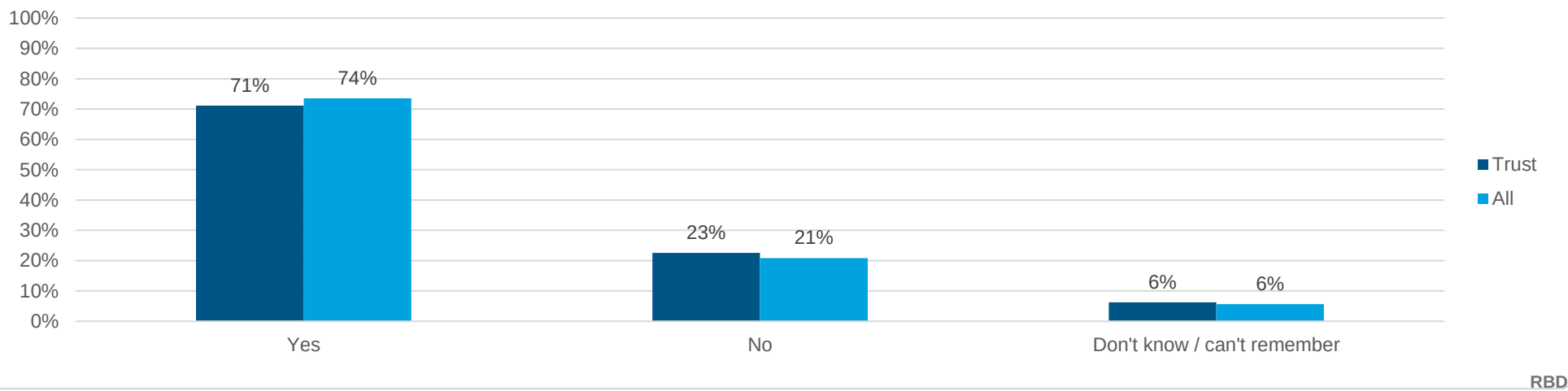


Q38. Were you given enough notice about when you were going to leave hospital?

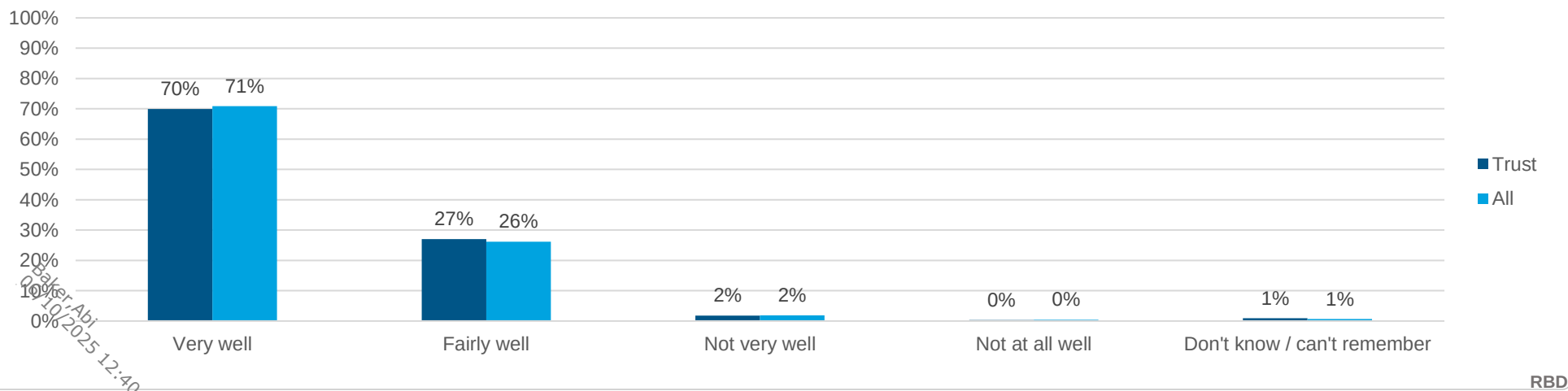


LEAVING HOSPITAL - Benchmark Charts and Tables

Q39. Before you left hospital, were you given any information about what you should or should not do after leaving hospital?

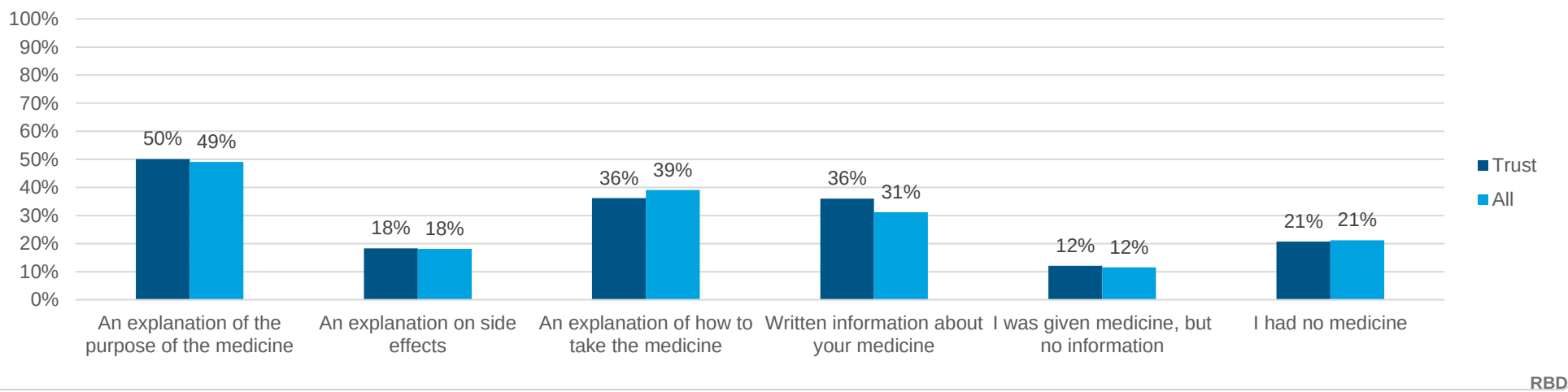


Q40. To what extent did you understand the information you were given about what you should or should not do after leaving hospital?

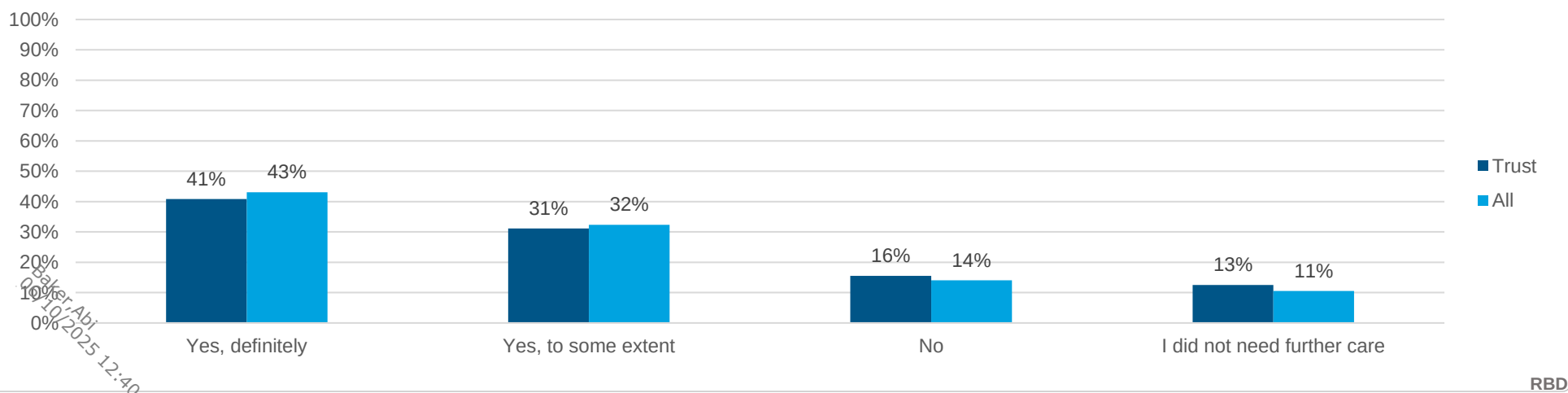


LEAVING HOSPITAL - Benchmark Charts and Tables

Q41. Thinking about any medicine you were to take at home, were you given any of the following?

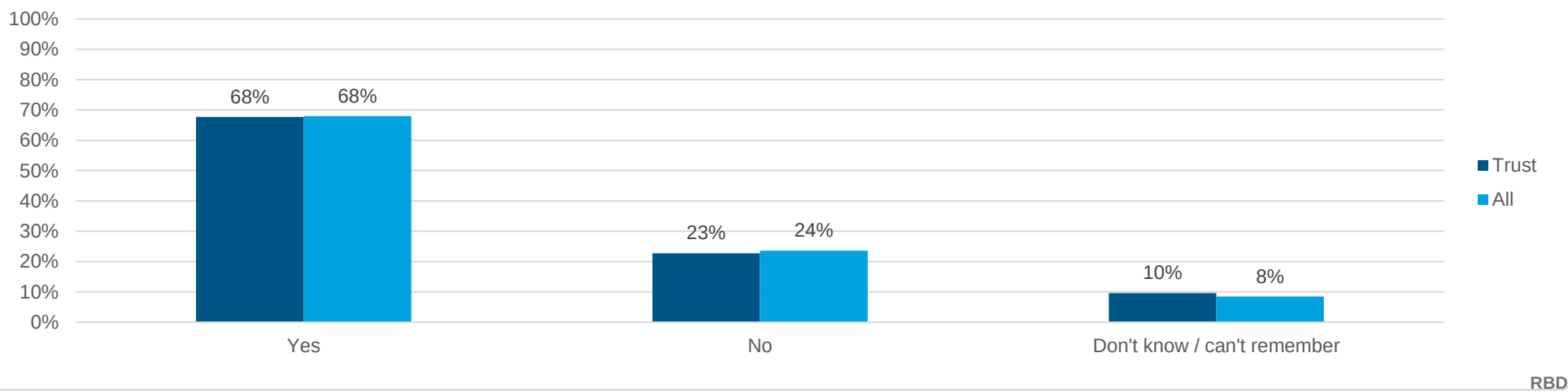


Q42. Before you left hospital, did you know what would happen next with your care?

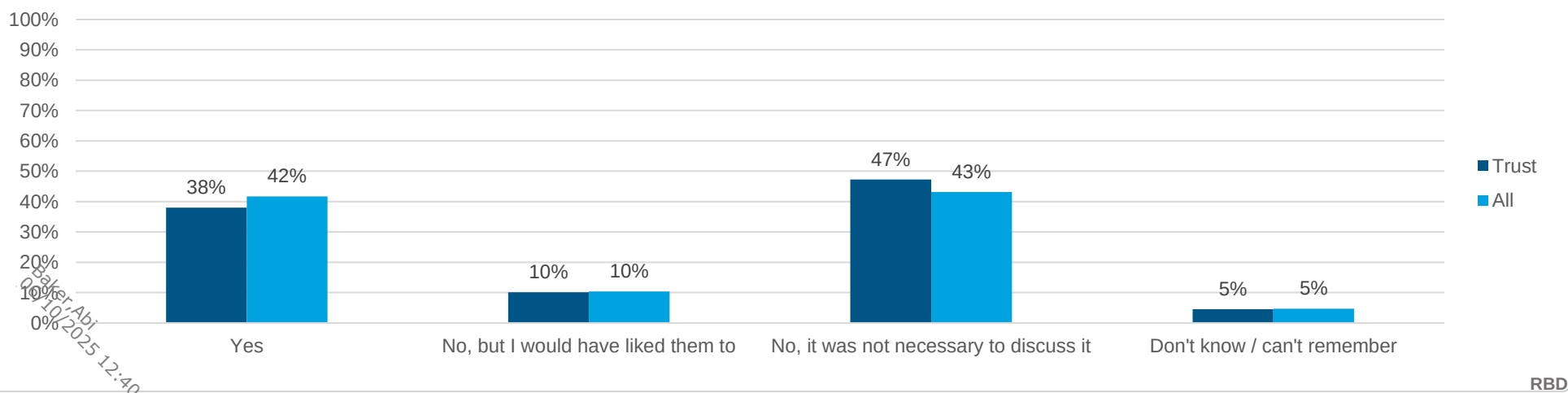


LEAVING HOSPITAL - Benchmark Charts and Tables

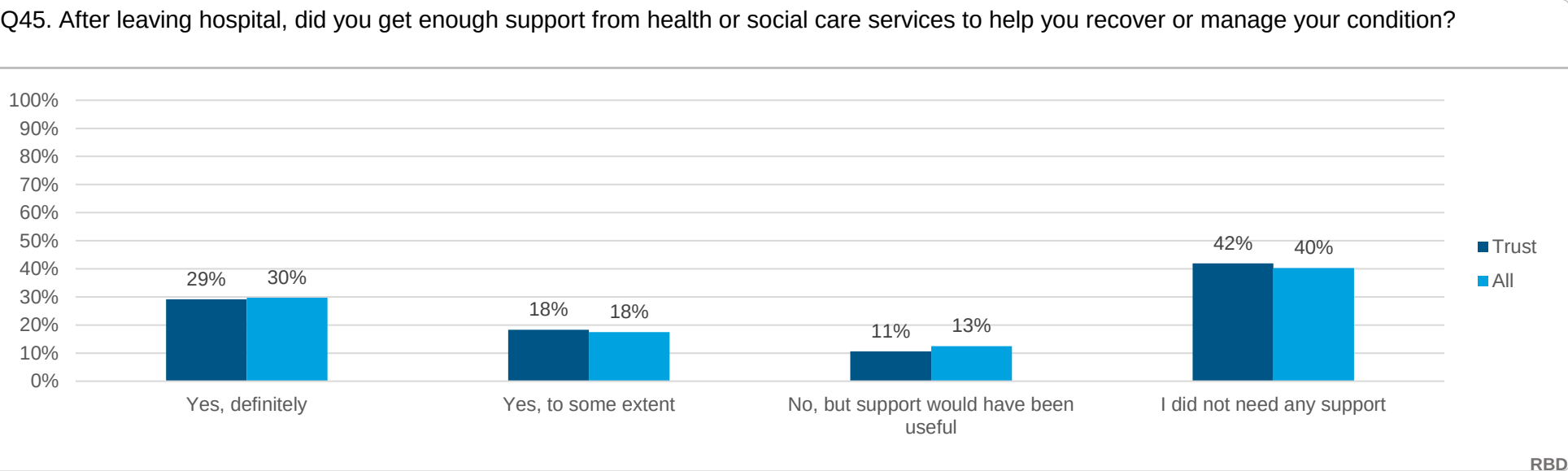
Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?



Q44. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?



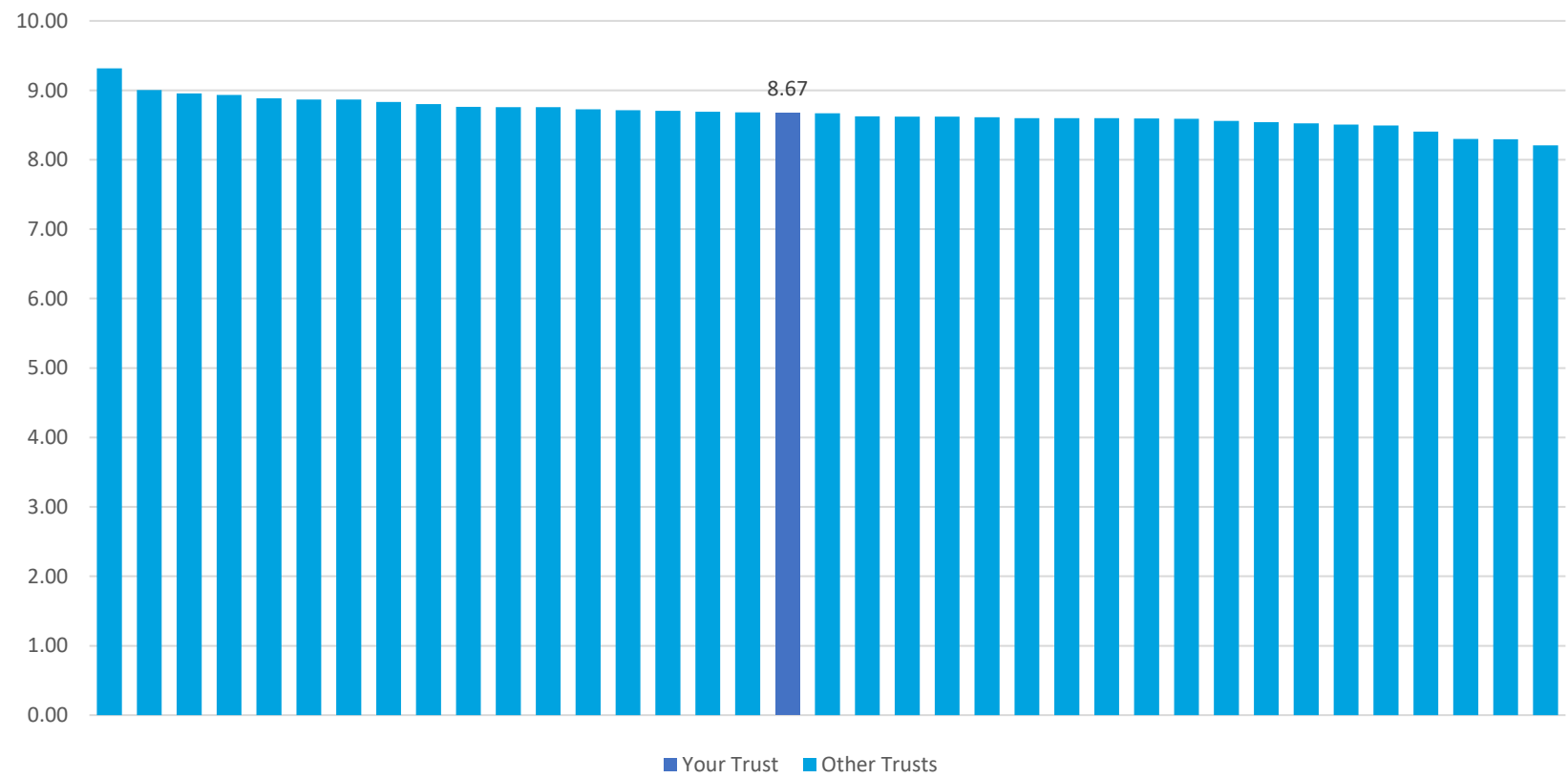
LEAVING HOSPITAL - Benchmark Charts and Tables



Baker, Abi
06/10/2025 12:40:16

Section G

OVERALL



Baker, Abi
06/10/2025 12:40:16

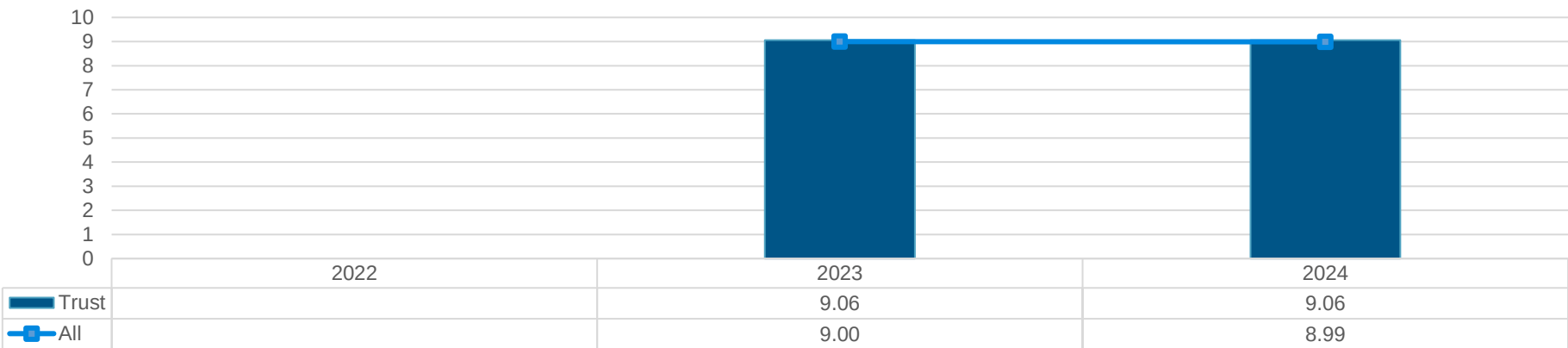
OVERALL - Benchmark Charts and Tables



Baker, Abi
06/10/2025 12:40:16

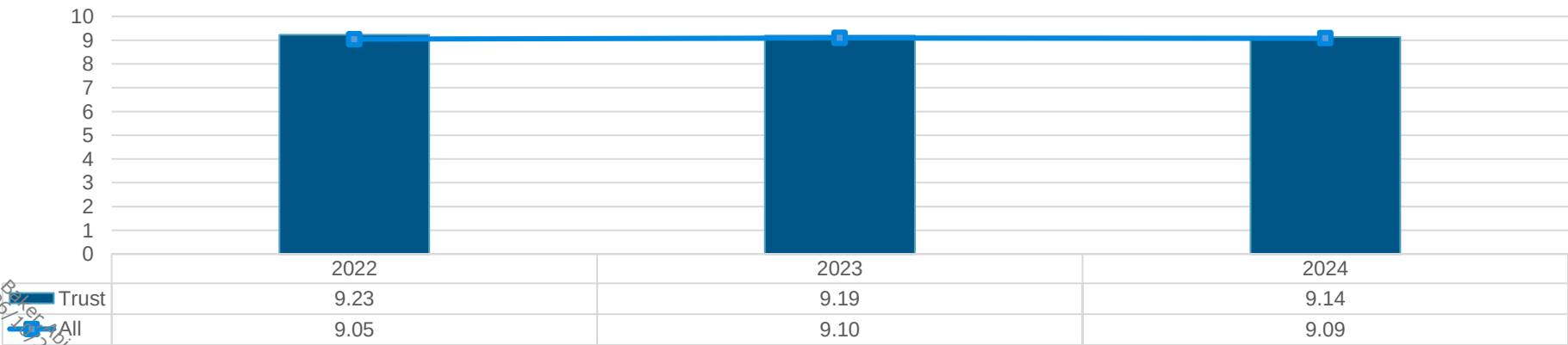
OVERALL - Longitudinal Charts

Q46. Overall, did you feel you were treated with kindness and compassion while you were in the hospital?



RBD

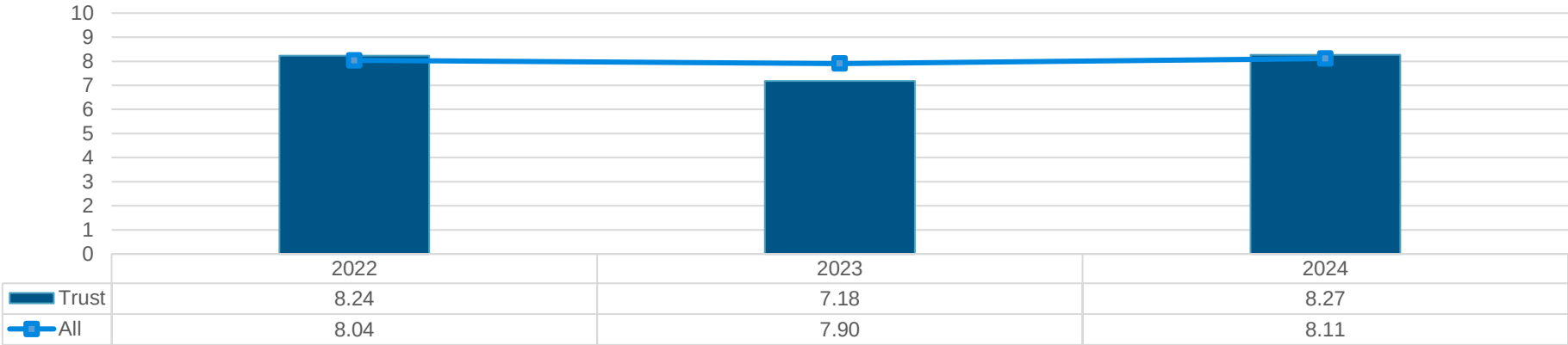
Q47. Overall, did you feel you were treated with respect and dignity while you were in the hospital?



RBD

OVERALL - Longitudinal Charts

Q48. Overall, how was your experience while you were in the hospital?

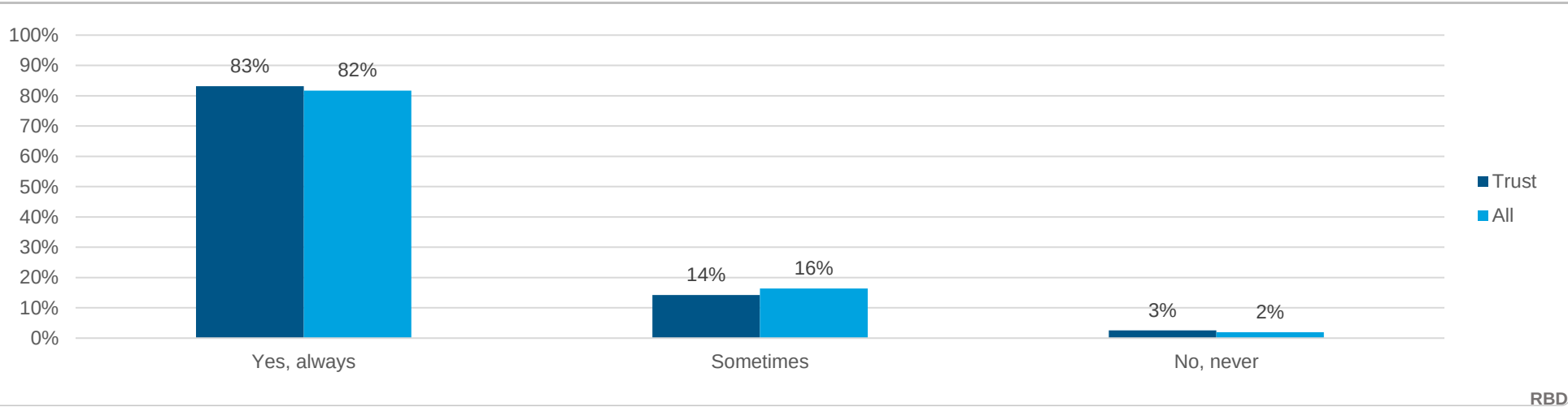


RBD

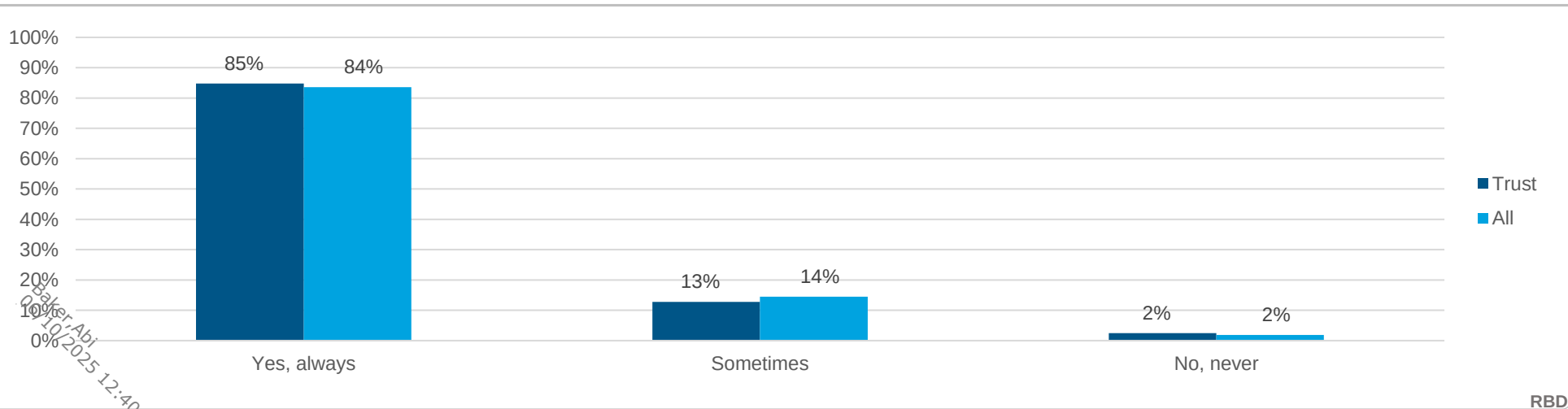
Baker, Abi
06/10/2025 12:40:16

OVERALL - Benchmark Charts and Tables

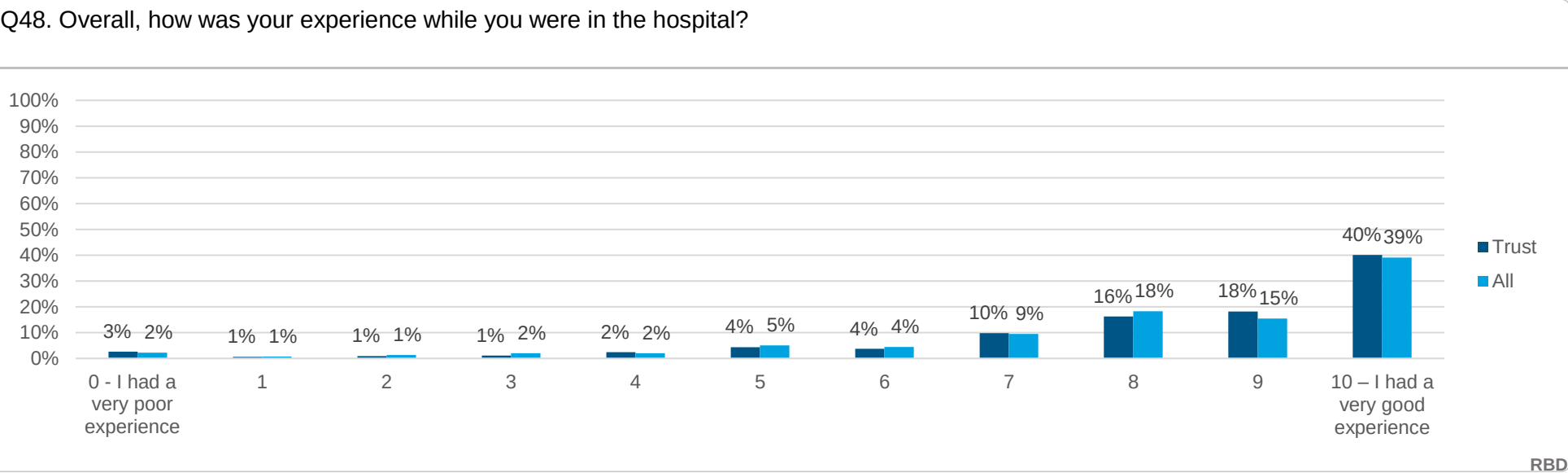
Q46. Overall, did you feel you were treated with kindness and compassion while you were in the hospital?



Q47. Overall, did you feel you were treated with respect and dignity while you were in the hospital?

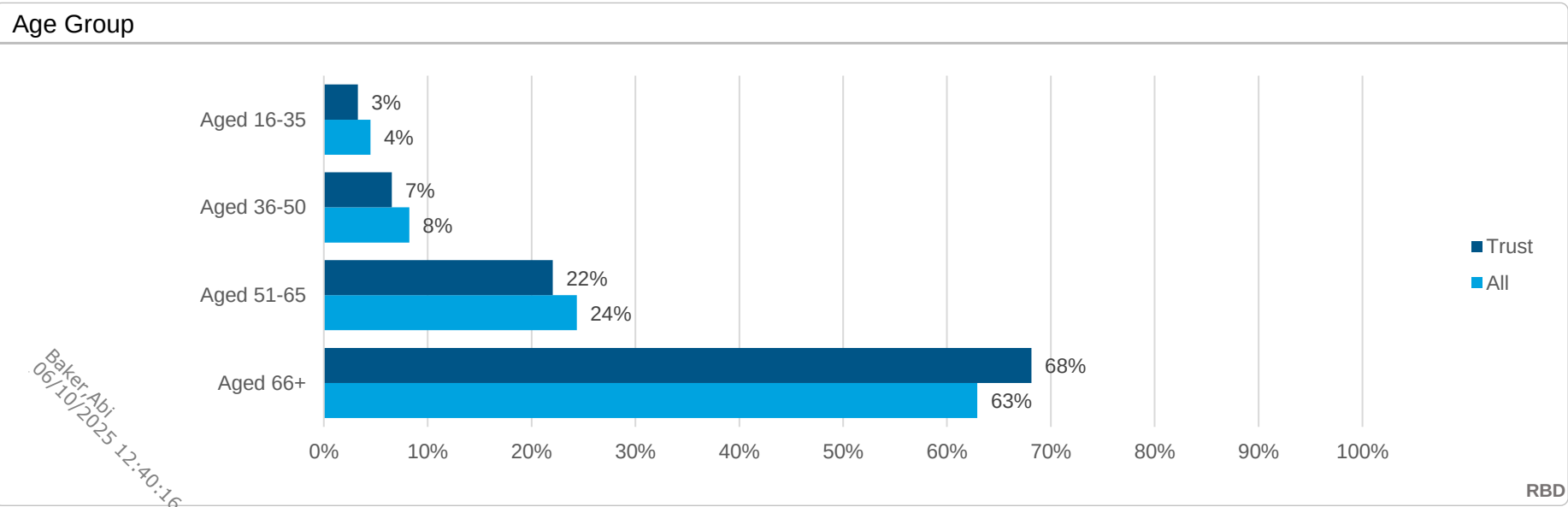
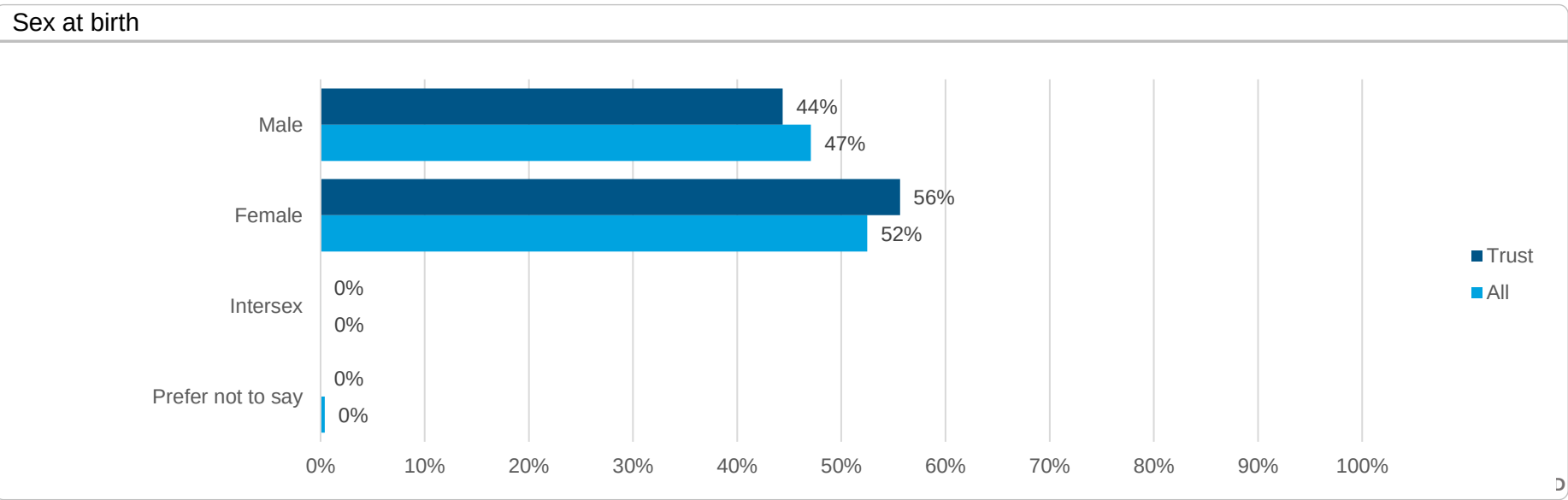


OVERALL - Benchmark Charts and Tables

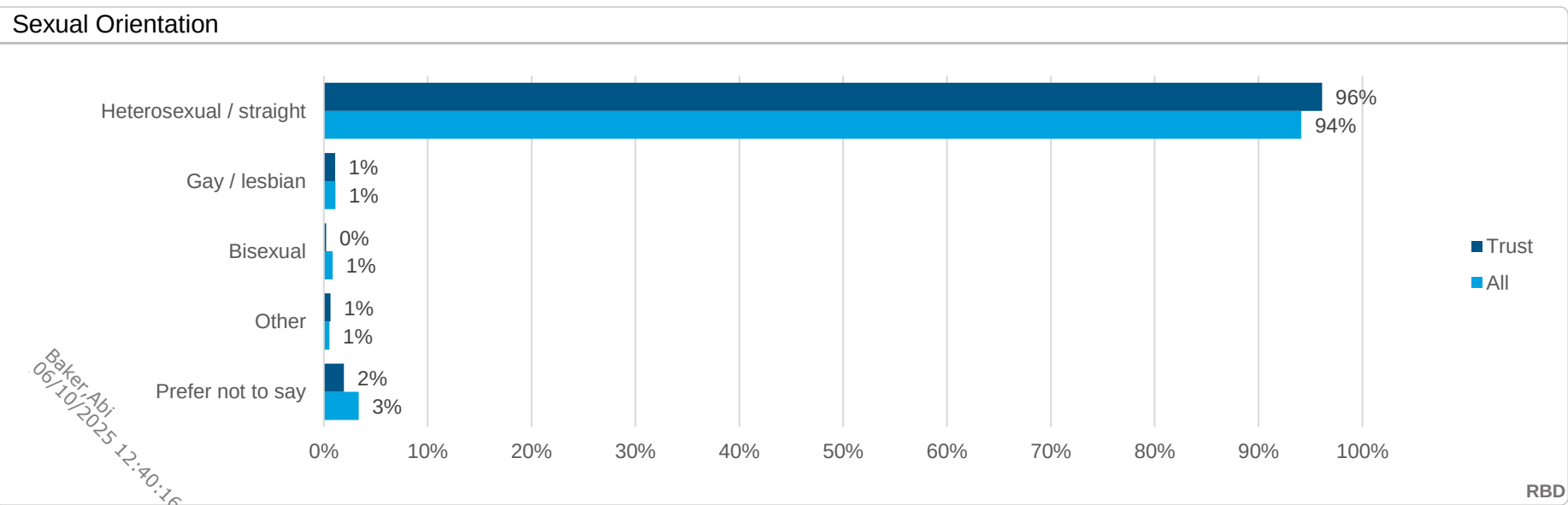
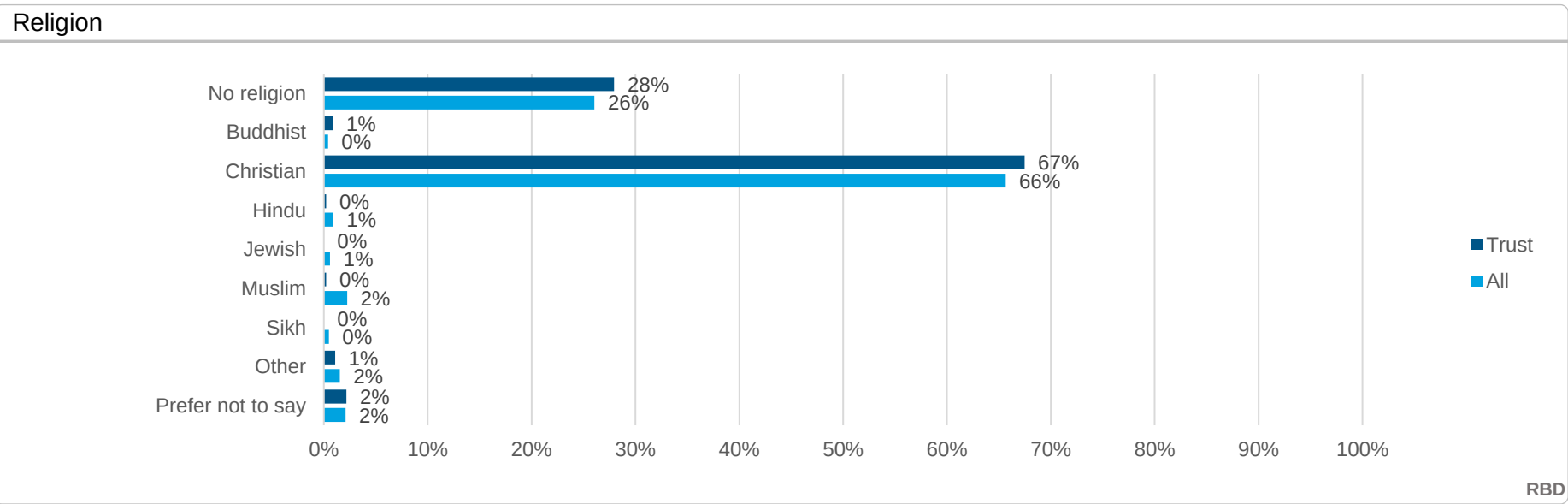


Baker, Abi
06/10/2025 12:40:16

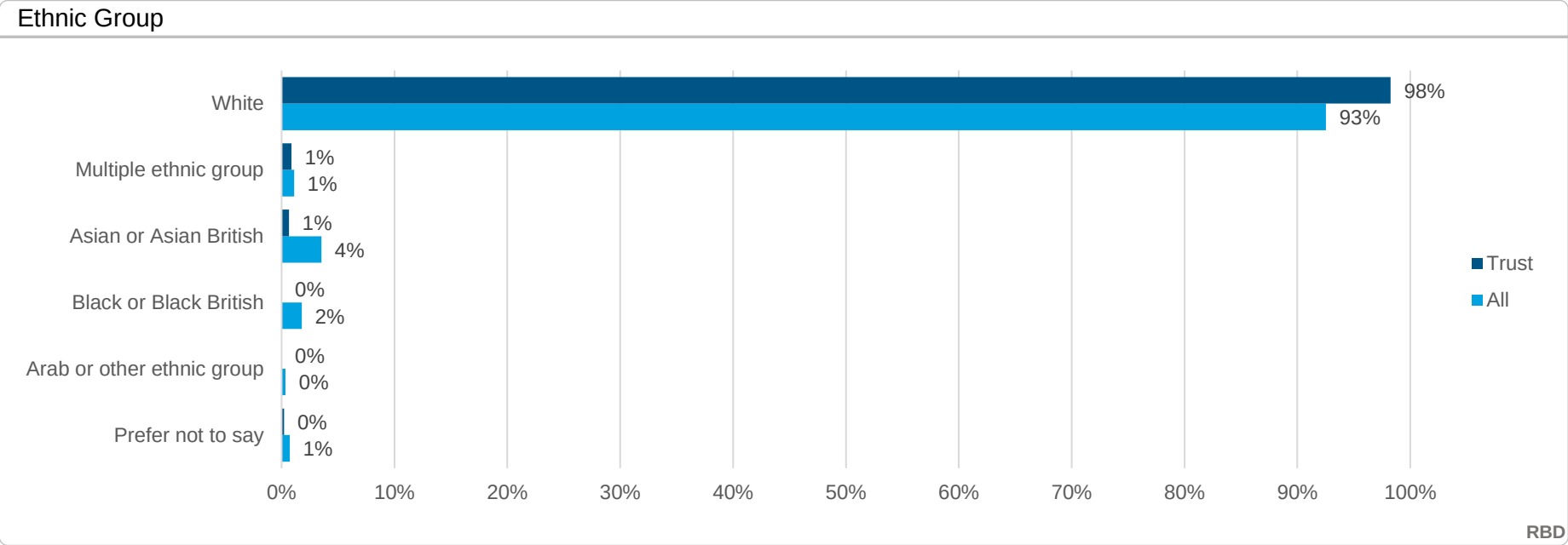
Demographic Characteristics



Demographic Characteristics (continued)



Demographic Characteristics (continued)



Baker, Abi
06/10/2025 12:40:16

Finance and Performance Committee in Common Assurance Report
for the meeting held on Wednesday 24 September 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	• Note the increase in activity in urgent and emergency care pathways at DCH and the wider impact of this. • Comprehensive plans in place to review and amend performance reporting across both trusts. • Board Assurance Statements approved for both the Winter Surge Plans. • Emergency Planning Response and Resilience self-assessments 100% compliant. • Note the revised DCH Bed Capacity Plan and associated financial impact.

Key issues / matters discussed at the meeting	The committee received, discussed and noted the following reports: DCH Performance Report (including future reporting at DCH) - ED attendances, emergency admissions and length of stay have increased in the summer months beyond ‘normal’ expected levels impacting and creating pressure on all other areas of acute care. The main drivers for this are understood. - 12 Hour ED waits have increased and is an area of concern that is being addressed through deep-dive work. - The bed base has been reduced but been fully occupied. - High numbers of patients with no criteria to reside continue and recognised as an area of concern. - Referrals continue to grow on the elective pathways particularly for urgent referrals and dermatology. - Cancer performance is not meeting the trajectories, due to delays in the diagnostic stage of the pathway. Treatment times from diagnosis remain strong. - Theatre utilisation remains an area of focus with improvement in some specialties/pathways and deterioration in others. - Committee recognition of the strong performance of Outpatient Initiated Follow Up (PIFU).

Baker, Abi
06/10/2025 12:40:16

- Largely positive operational productivity report as DCH benchmarks favourably against peer organisations and nationally. Outpatient attendances per consultant WTE was highlighted as being lower than the national and regional median and it being investigated further.

The future performance reporting proposal (paragraph 5.5 of the paper pack) was approved by the committee recognising that DCH will align their approach to modernising the report with DHC as outlined below.

DHC Performance Report (including Approach to Review and Modernisation of the Report)

- Zero inappropriate out-of-area placements were achieved by 31st August 2025 as planned (although there were two reported in month). Recognition that permanently achieving zero is a challenge and some fluctuation would be anticipated in future months.
- Patient flow remains a challenge. In August, 54 patients were identified as being Clinically Ready for Discharge consuming 565 occupied bed days.
- The CAMHS Gateway 4 week-wait metric has dropped significantly to 32% and highlighted as an area for concern. Plan to regain compliance by the end of September.
- 20-minute call back time for the IUCS is tracking below the 90% target. Demand and Capacity modelling is ongoing to help resolve.
- There is focus on referral to treatment waiting times for non-consultant led services where there is likely to be long waiters identified, some of which will be over 52 weeks.

The committee received a comprehensive presentation on the proposed approach to reviewing and modernising performance reporting, based on the Performance Assurance Framework and Insightful Board Guidance. The committee approved the proposed three-stage review (review & streamline, align & prioritise, automate & enable) which will also be adopted by DCH.

Seasonal Surge (Winter) Plan Board Assurance Statement

The DCH Winter plan and associated Board Assurance statement was approved along with the DCH Assurance statement (full DHC surge plan already received approvals). This is required to ensure the Board has oversight that all key considerations have been met for both organisations.

EPRR Assurance Self-Assessment Report

Assurance was provided that The Emergency Planning Response and Resilience (EPRR) self-assessment against the core standards were reported as 100% compliance for DHC and DCH; and have been through a comprehensive review process in collaboration with the ICB.

Baker, Abi
06/10/2025 12:40:16

Medium Term Financial Plan Update

A verbal update was provided for assurance. There are two key pieces of work underway. The first is a detailed review of the underlying deficits the results of which will be brought back to a future committee and Board. The second is part of national work on 'deconstructing the block contracts' with movement back to payment by delivery (or results). This is more straight forward for DCH as data is more refined and robust, but data is less mature for DHC. In addition, the Dorset system is in the process of commissioning a clinical services review with a particular focus on acute services. This will be discussed in more detail at the next Board to Board-to-Board meeting at the end of September which will help inform the plan further for the remainder of the year.

Shared Service Update

A verbal update was provided on the current process. Dispute with the unions is ongoing. The case has been heard by the internal dispute panel as part of steps to resolution, the outcome of which is being communicated to Unison. In tandem there is an NHS England panel process which is not yet concluded, and more information has been requested from the Trusts. A critical decision point is approaching for 2025/26 implementation feasibility

DCH Finance Report

At month 5, DCH delivered a deficit of £3.2m which is very closely in line with plan leading to a YTD planned deficit of £14.3m. Pay costs for temporary workforce have increased due to operational pressures and increased activity. Pay expenditure is £1.2m above plan. Bank workforce usage remains overspent and remains a financial recovery focus. The DCH efficiency target for the year is £29.1m which is 9% of expenditure budgets. At month 5, £4.5m has been delivered against £4.6m plan. Total schemes identified stand at £24.5m with £4.5m of unidentified schemes with a further £1.5m if system transformation schemes at risk. The cash position as of 31 August was £24.2m and remains ahead of plan. Capital plans spend is ahead of plan by £0.8m.

DHC Finance Report

At month 5, DHC delivered a deficit of £1.1m which is broadly against plan. The Trust has delivered savings of £4.2m against a month 5 yd. target of £3.5m. recognition that cost improvement becomes more challenging in future months as the planned targets increase. The Trust's full year efficiency target is £38.5m. The forecast indicates an actual year-end deficit of £3.87m against a planned surplus of £9.77m. This assumes no further savings are found and spend continues at current rates. Bank expenditure remains high.

Baker, Abi
06/10/2025 12:40:16

Financial Recovery Board (FRB) Process and Progress Update

In response to the Financial Recovery Review undertaken by David Moon and Mark Mansfield a Financial Recovery Board has been established chaired by the CEO meeting on a fortnightly basis with focus on CIP, WTE, Bank Workforce and recovery plan viability matrix. A delivery team is in the process of being formed headed up by a Recovery Director. The FRB also own a 'grip and control' checklist.

NHSE Assurance report for the Dorset, Hampshire and Isle of Wight Adult Eating Disorder Provider Collaborative (Freedom PC)

DHC undertakes a dual role as both the lead provider and commissioner of the Adult Eating Disorder Collaborative. Significant governance and assurance activities are routinely undertaken as a commissioner which are not currently reported internally. Assurance reports will be brought to all future FPC committee meetings. NHS England also receive a comprehensive report every two months and are assured by, and very complimentary of the report.

Unfunded Beds Statement - Bed plan and associated Finance update

A summary was provided of the current bed capacity plan at DCH for assurance. The Futurecare Programme initially outlined a planned bed reduction of 30 beds by March 2026 and a further 21 beds through additional internal schemes. Year to date demand has exceeded the operational plan and along with increases in length of stay and patients with no criteria to reside, has prompted a revised plan to reduce beds by 25 (not 51) delivering a cost saving opportunity of £2.1m against the operational plan which delivers against the Futurecare requirement. Further work is required to identify the final physical location of all beds once bed reconfiguration has taken place.

Capital Plan Update and delegation of authority (DCH)

Since approving the 2025/26 DCH Capital Programme, the Trust has attracted additional external capital funding. As a result, an additional £1.5m is now available for internal distribution to capital schemes and the capital programme has been revised. The committee approved the revised plan and delegated authority for the awarding of contracts to the CFO.

Risk Management System Procurement

A preferred supplier has been identified for a new pan-Dorset risk management system for DHC, DCH and UHD. A summary of the procurement process and financial implications were provided along with the benefits of a new system. Approval was given by the committee for both capital and revenue spend and to proceed with the preferred supplier. The supporting paper to also be submitted to Board under consent items, noting the revenue implication/cost in future years.

Baker, Abi
06/10/2025 12:40:16

Generator Procurement and delegation of authority - DCH

An update was provided on the generator procurement process at DCH. Whilst no compliant bids have been received from the tender exercise, a specialist provider has come forward and alternative sourcing plan/strategy has been produced. The recommended approach utilises a UHD hosted framework to onboard a capable Principal Contractor (PC) that is currently engaged with the Trust as well as the inclusion of the specialist Generator provider as a sub-contractor. The committee supported this revised approach and approved the delegation of authority to the CFO to award the contract within the affordability and identified contingency provision if required. The supporting paper to be submitted to Board under consent items to also approve delegation of authority to the CFO.

CAMHS High Intensity Environment Unit – Contract Approval (DHC)

The new build unit is ongoing and expected to be complete in March 2026 (+4 to 8 weeks) commissioned by the Southwest Provider Collaborative. The clinical specification has been approved by the Quality Committee in Common and Commissioners. The financial contract will be on a cost recovery basis and not block which brings financial risk, therefore detailed modelling has taken place to ensure a break-even position as this unit is the first of its kind with no precedent to refer to. The committee approved the contract terms as noted to allow the letter of intent to be issued.

Charitable Funds Annual Report – DHC

The Annual Report and Accounts are complete. These have been subject to independent review by the external auditors. The committee approved the report for onward approval by the Board in Common under consent section.

Premises Assurance Model

A verbal update was provided for assurance on completion of the Premises Assurance Model assessment which is required for submission by the end of September 2025. DHC submission will be late as its incomplete but there is full communication and engagement with NHS England. For DCH, 347 applicable areas have been measured, 27 of which are 'outstanding' and 12 of which are inadequate. 5 of the 12 relate to inadequate food provision, 3 relate to Policies (the main concern being the Lift Safety Policy). Assurance was provided that action plans will be in place to address the inadequate findings.

Six Facet Survey

An update was provided on the estates and facilities backlog and Six Facet Survey. The highest area of identified risk is mainly made up off fire risk assessments and fire compartmentation which is being actively worked on in engagement with the local area fire brigade. Fire risk assessments for patient areas will be fully completed in September. DHC Six Facet Survey is not yet complete.

Decisions made at the meeting	Approvals by DCH and DHC committees: • Approach to review and modernisation of Performance Reporting • Winter Plan Board Assurance Statements • DCH Capital Plan update and delegation of authority to CFO • Risk Management System Procurement (Joint) • Delegation of authority for Generator Procurement (DCH) • Contractual Arrangements for the CAMHS High Intensity Environment Unit (DHC) • Charitable Funds Annual Report (DHC) • Treasury Management Policy
Issues / actions referred to other committees / groups	• None

Quoracy and Attendance				
	29/05/2025	30/07/25	24/09/25	
Quorate?	Y	Y	Y	
Dave Underwood	Y	Y	Y	
Frances West	N	Y	Y	
Stephen Tilton	Y	Y	Y	
Andreas HAIMBOCK-TICHY	Y	Y	N	
Chris Hearn	Y	Y	Y	
Nick Johnson	N	N	N/A	
Rachel Wharton	N	N	N	
Anita Thomas	Y	Y	Y	
Lucy Knight	Y	N	N	
Rachel Small	N	Y	Y	

Baker, Abi
06/10/2025 12:40:16

Report to	Board of Directors (DCH)	
Date of Meeting	7 th October 2025	
Report Title	Integrated Board performance report	
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 Emma Hoyle, Deputy Director of Nursing	
Action Required	Approval	
	Assurance	X
	Information	

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? <i>Delete as required</i>	
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	Reporting against financial key indicators	
Statutory & Regulatory	Reporting against, constitutional and contractual standards	
Equality, Diversity & Inclusion	N/A	
Co-production & Partnership	N/A	

Executive Summary
The Trusts Integrated performance report pulls together each of the domains within the NHS Oversight Framework and provides trend data, analysis and actions for each of the metrics the trust is measured on, within the framework. 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 points to note: - Of the recently published league table, DCH ranked 48 out of 134 acute providers - ED 4-hour standard continues to perform above trajectory, despite the increase in demand - Flow metrics, including 12-hour breaches are all off plan for August where DCH experienced a second month of unplanned excess demand - Elective care performance was slightly off plan for August, but all waiting list metrics will recover for September, with cancer performance recovery not until December - Finance broadly on plan, with high levels of risk going into H2 - Rate of E-Coli infections ranked 1st out of 134 providers in England (positive) - Sickness rates ranked 26, out of 134 (positive)

Recommendation

- Members are requested to:
- Receive the report for **information**
 - Receive the report for **assurance**

Baker, Abi
06/10/2025 12:40:16

1. Introduction

This paper replaces the previous Balanced Scorecard report for Dorset County Hospital (DCH). It pulls together each of the domains within the NHS Oversight Framework and provides tend data, analysis and actions for each of the metrics the trust is measured on, within the framework.

Future iterations of the report will include metrics that a committee has escalated to Board, which may not be within the NHS Oversight Framework, but that a sub-board committee has requested an exception report is submitted to Board, to support the escalation.

For this month, a summary of the NHS Oversight Framework has been provided (section 2). This will be removed for future iterations.

2. Introduction to the NHS Oversight Framework 2025/26

The NHS Oversight Framework 2025/26 sets out NHS England’s approach to assessing and supporting Integrated Care Boards (ICBs) and NHS trusts/foundation trusts. It aims to ensure transparency, accountability, and improvement across the system, aligning with the 10 Year Health Plan and the 2025/26 NHS priorities and operational planning guidance.

2.1 Performance Assessment Framework, oversight and support

Organisations are assessed across six domains, these are:

Domain	Sub-domains
Access to Services	Elective, Cancer, Urgent & Emergency, Mental Health
Effectiveness & Experience	Mortality, Readmissions, Patient Satisfaction
Patient Safety	Infection rates, Crisis response, CQC ratings
People & Workforce	Staff survey, Sickness absence
Finance & Productivity	Surplus/deficit, Productivity indicators
Improving Health & Reducing Inequality	Screening rates, deprivation gaps (non-scoring)

Contextual metrics (e.g. inequalities, population health) are reported but do not affect segmentation scores.

Each trust receives a delivery score (1–4) based on performance metrics, with financial override limiting scores for organisations in deficit to no better than 3.

Segment	Description
1	High-performing across all domains
2	Good performance with specific issues
3	Off-track or in financial deficit
4	Significantly off-track
5	Most challenged; low performance and capability

Segment 5 organisations receive intensive support and may be subject to enforcement action if governance concerns arise. For the other segments NHSE will tailor support based on segment and capability. This support offer will range from universal offers to intensive onsite interventions. This will be inclusive of performance management, tiering, and escalation protocols in line with the current performance tiering approach. It is expected that ICBs will also manage provider performance through contractual leaves, with the oversight of NHSE.

High performing organisations may gain earned autonomy, including capital investment flexibility. NHS England retains enforcement powers, including leadership changes and licence conditions, guided by the NHS Enforcement Guidance. Segment 5 leaders may be ineligible for annual pay awards under the VSM pay framework.

2.2 Transparency and Accountability

There will be quarterly reviews, where segments will be updated based on the most recent data. There is a public dashboard, which will display the segmentation data, domain scores and contextual metrics. This first has been published September 2025, details can be found later in this section.

The annual ICB assessments will continue, focusing on statutory duties and delegated commissioning. ICBs will not be segmented in 2025/26 due to ongoing transformation aligned with the Model ICB Blueprint.

Baker, Abi
06/10/2025 12:40:16

2.3 Published league table

The published league table and domain results can be found here:

<https://data.england.nhs.uk/dashboard/nofacute>

DCH ranked 48 out of 134 acute providers. There are 6 acute types within the league table, DCH is group in the “small acute” type. Of the 134 provides, 19 have been designed a small acute provider, DCH ranked 5th out of 19. There is only 1 other provider designated as small in the South West which is Salisbury, who ranked 57 out of 134 and 6th out of the 19 small providers. The table overpage details each metric within the framework, performance against it, the ranking and the committee that the metric reports to.

The table of the following details all the metrics included in the framework, how DCH has performed for quarter 1 and which committee the metric reports to. The table is an exact copy from the NHSE Dashboard, with the addition of the “committee” reported to column.

Since the initial publication of the metrics, the percentage of patients waiting over 52 weeks for community services has been included. This metric hasn’t gone to the Finance and Performance committee and will be going for the next meeting. It has therefore been excluded from this report. The community waiting list performance was not included in the 2025/26 Operating plan.

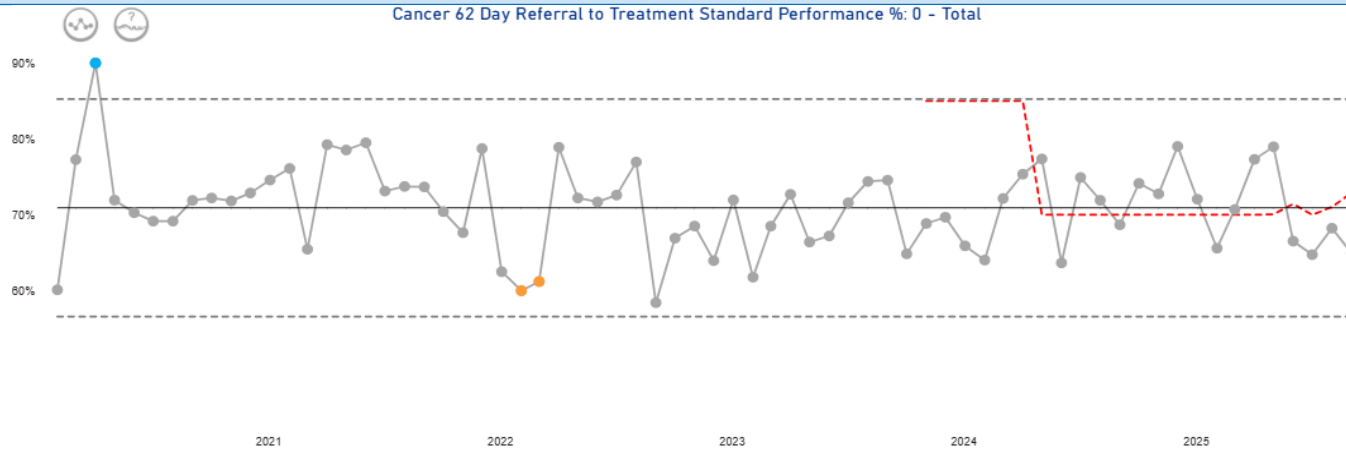
Section 3 of this paper includes an exception report, for each of the metrics and starts on page 6 of this document.

Baker, Abi
06/10/2025 12:40:16

Domain	Sub-domain	Description	Committee reported to	Reporting date	Metric value	Units	Metric score	Rank	Average value	Standard
Access to services	Cancer care	Percentage of patients treated for cancer within 62 days of referral	FPCiC	Q1 2025/26	72.57	percent	2.31	46 out of 118	71.12	75
Access to services	Cancer care	Percentage of urgent referrals to receive a definitive diagnosis within 4 weeks	FPCiC	Q1 2025/26	71.22	percent	3.6	100 out of 118	76.88	80
Access to services	Elective care	Difference between planned and actual 18 week performance	FPCiC	Jun-25	0.28	percentage points	1	77 out of 131	0.99	0
Access to services	Elective care	Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	FPCiC	Jun-25	58.98	percent	2.85	81 out of 131	60.72	
Access to services	Elective care	Percentage of patients waiting over 52 weeks for community services	FPCiC	Jun-25	52.25	percent	3.88	76 out of 80	1.11	
Access to services	Elective care	Percentage of patients waiting over 52 weeks for elective treatment	FPCiC	Jun-25	1.68	percent	2.24	42 out of 131	2.4	1
Access to services	Urgent and emergency care	Percentage of emergency department attendances admitted, transferred or discharged within four hours	FPCiC	Q1 2025	83	percent	1	11 out of 123	76	78
Access to services	Urgent and emergency care	Percentage of emergency department attendances spending over 12 hours in the department	FPCiC	Q1 2025/26	6.3	percent	2.03	43 out of 123	8.36	
Effectiveness and experience	Effective flow and discharge	Average number of days from discharge ready date to actual discharge date (including zero days)	FPCiC	Jun-25	0.9	days	2.92	81 out of 126	0.7	
Effectiveness and experience	Patient experience	CQC inpatient survey satisfaction rate	QCIC	2023		score	2			
Effectiveness and experience	Patient experience	Summary Hospital Level Mortality Indicator	QCIC	Apr 24 - Mar 25		score	2			
Finance and productivity	Finance	Combined finance	FPCiC	Q1 2025/26		score	2			
Finance and productivity	Finance	Planned surplus/deficit	FPCiC	2025/26	-3.18	percent	4	90 out of 134	-1.62	0
Finance and productivity	Finance	Variance year-to-date to financial plan	FPCiC	Month 3 2025	0.01	percent	1	35 out of 134	0	
Finance and productivity	Productivity	Implied productivity level	FPCiC	To M12 2024/25 vs 2023/24	6.84	percent	1.25	12 out of 134	2.91	
Patient safety	Patient safety	NHS Staff survey - raising concerns sub-score	PCCiC	2024	6.54	out of 10	1.99	45 out of 134	6.42	
Patient safety	Patient safety	Rate of C-Difficile infections	QCIC	Jul 24 - Jun 25	1.06	rate	2.22	32 out of 134	1.22	1
Patient safety	Patient safety	Number of MRSA infections	QCIC	Jul 24 - Jun 25	2	count	2.37	40 out of 134	3	0
Patient safety	Patient safety	Rate of E-Coli infections	QCIC	Jul 24 - Jun 25	0.98	rate	1	1 out of 134	1.16	1
People and workforce	Retention and culture	NHS staff survey engagement theme sub-score	PCCiC	2024	7.03	out of 10	1.83	38 out of 134	6.88	
People and workforce	Retention and culture	Sickness absence rate	PCCiC	Q4 2024-25	4.5	percent	1.44	26 out of 134	5.21	

Domain: Access to Services. Sub domain: Cancer care. Measure: Percentage of patients treated for cancer within 62 days of referral.

Cancer 62 Day Referral to Treatment Standard Performance %: 0 - Total



Description of metric

Percentage of patients treated for cancer within 62 days of referral.

Contractual target 85%, but 2025/26 planning guidance trajectory is 75% by March 2026.

Analysis

Performance of the 62-day combined standard did not achieve the trajectory. The challenges at the start of the pathway (28-day standard) have impacted delivery of the 62-day standard. It is expected this will start to show recovery in September, returning to achievement of the trajectory by December.

Metric	Ops plan 25/26	Apr-25	May-25	Jun-25	Jul-25	Aug-25
Cancer: 62 RTT (combined)	Plan	70.08%	71.43%	70.00%	71.03%	72.90%
	actual	78.97%	66.54%	65.22%	67.60%	64.96%
	variance	8.89%	-4.89%	-4.78%	-3.43%	-7.94%

In August, the backlog (62-103 days) decreased by 7 to 56, the lowest it has been all year and the backstop (over 104 days) decreased by 10 patients to 12.

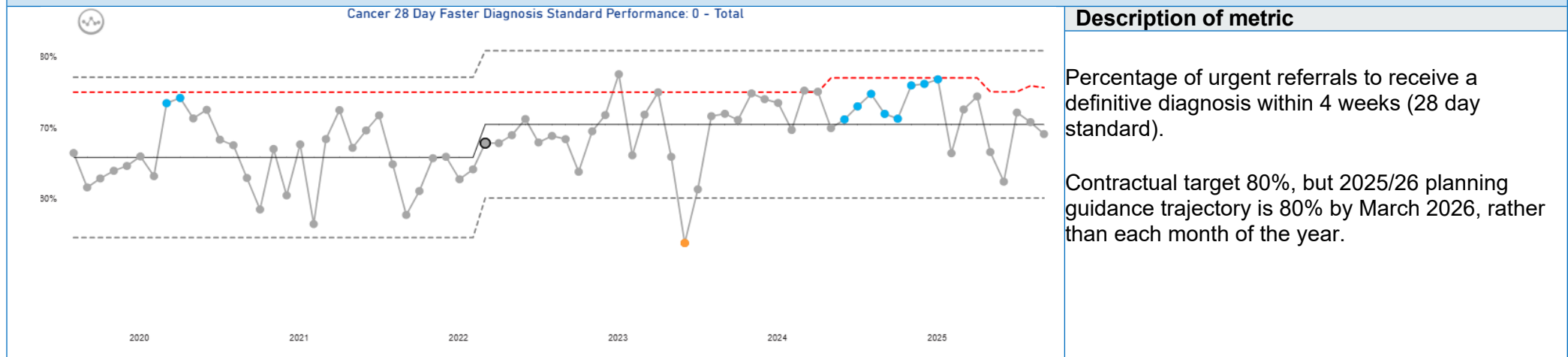
Actions

For patients that breach the 104-day backstop, on a 62-day pathway, a full route cause analysis is completed, which includes a harm review.

Tumor site pathway reviews underway, to identify barriers that are delaying getting to treatment. Focus is Dermatology for the next reporting month.

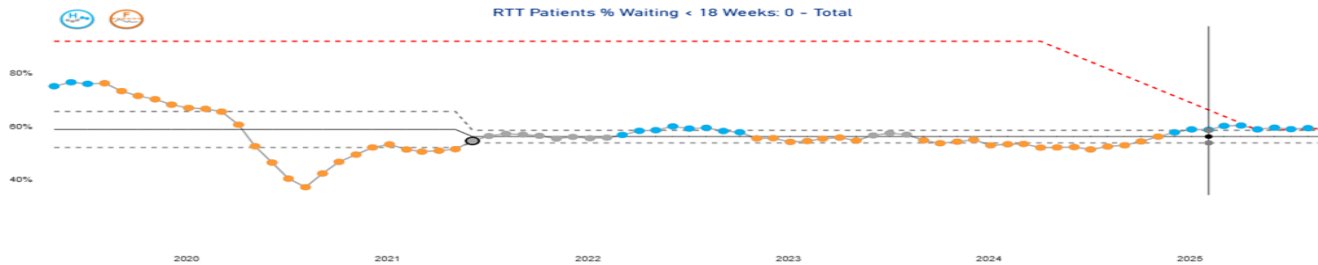
Tertiary Centre delays are contributing to the trust's underperformance. These have been escalated to Service Directors in September.

Domain: Access to Services. Sub domain: Cancer care. Measure: Percentage of urgent referrals to receive a definitive diagnosis within 4 weeks.



Analysis	Actions																										
Performance of the 28-day standard fell in the reporting month of August fell from 71.21% to 69.11%. The 28-day standard has continued to be impacted by diagnostic capacity, particularly in Endoscopy and Breast Radiology <table><tr><th>Metric</th><th>Ops plan 25/26</th><th>Apr-25</th><th>May-25</th><th>Jun-25</th><th>Jul-25</th><th>Aug-25</th></tr><tr><td rowspan="3">Cancer: 28 days FDS</td><td>Plan</td><td>75.07%</td><td>75.04%</td><td>75.06%</td><td>75.89%</td><td>76.65%</td></tr><tr><td>actual</td><td>66.58%</td><td>62.43%</td><td>72.13%</td><td>71.21%</td><td>69.11%</td></tr><tr><td>variance</td><td>-8.49%</td><td>-12.61%</td><td>-2.93%</td><td>-4.68%</td><td>-7.54%</td></tr></table> 2 week wait referrals year to date, April-August is 3% up compared to last year. Demand April to August this year, compared to 2023/24 is 18.91% up.	Metric	Ops plan 25/26	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Cancer: 28 days FDS	Plan	75.07%	75.04%	75.06%	75.89%	76.65%	actual	66.58%	62.43%	72.13%	71.21%	69.11%	variance	-8.49%	-12.61%	-2.93%	-4.68%	-7.54%	Insourcing where demand is outstripping capacity at the front of the pathway. Reviewed and changed booking process in Endoscopy, to ensure cancer pathways are taking priority. This was implemented in September, with the booking team being centralised with the Admissions team. Patient level pathway tracking in place, proactivity unblocking barriers and pulling patients through the pathway. Demand management, particularly in Dermatology raised with the ICB and Regional colleagues. Actions including the extension of AI supported pathways are in discussion at the ICB and Cancer Network.
Metric	Ops plan 25/26	Apr-25	May-25	Jun-25	Jul-25	Aug-25																					
Cancer: 28 days FDS	Plan	75.07%	75.04%	75.06%	75.89%	76.65%																					
	actual	66.58%	62.43%	72.13%	71.21%	69.11%																					
	variance	-8.49%	-12.61%	-2.93%	-4.68%	-7.54%																					

Domain: Access to Services. Sub domain: Elective Care. Measure: Difference between planned and actual 18 week performance and Percentage of cases where a patient is waiting 18 weeks or less for elective treatment



Metric	Ops plan 25/26	Apr-25	May-25	Jun-25	Jul-25	Aug-25
RTT: %patients waiting <18wks	plan	58.70%	58.70%	58.70%	58.70%	59.00%
	actual	58.90%	59.59%	58.98%	59.40%	58.69%
	variance	0.20%	0.89%	0.28%	0.70%	-0.31%

Description of metric

Difference between planned and actual 18-week performance:

Hit or miss planning trajectory, as per the operating plan.

Percentage of cases where a patient is waiting 18 weeks or less for elective treatment:

Contractual target 92%
Planning guidance target, 63.89% by March 2026

Analysis

DCH slightly missed the target in August but is expecting to recover this for September.

Performance against the standard is impacted by demand (referrals) and activity delivered (clock stopping activity). A 4% referral growth factor was applied as part of the operating plan. For 2024/25 total referral demand growth was over 6%. Total referrals year to date, April-August are 3.43% up compared to last year. Demand April-August this year, compared to 2023/24 is 12.47% up.

Year to date, the trust has completed 6,054 more 1st OPAs than planned, as part of a push to hit zero 52+ week waiters (non-admitted) by September. The trust has provided 1,435 more outpatient procedures. Theatre activity is behind plan by 39 day case spells and 68 inpatient spells.

Actions

The trust has been on plan for this metric for every month, apart from August.

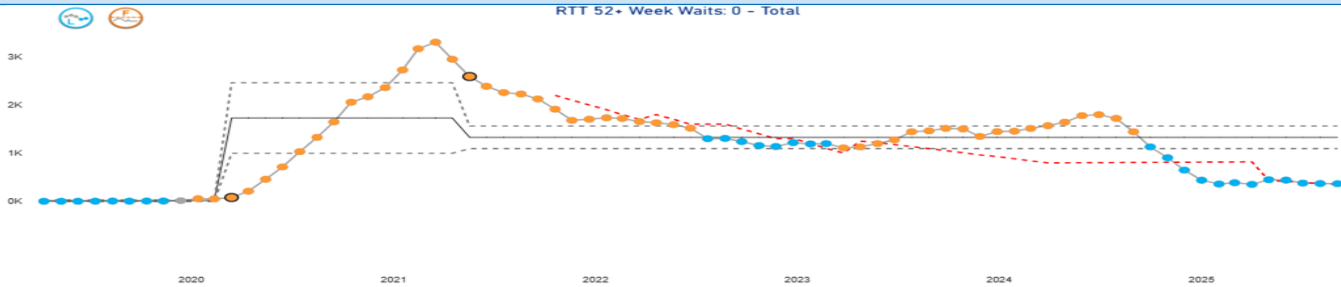
Actions taken to ensure September is delivered included:

Focus on validation of pathways over 18 weeks, not just those over 52 weeks.

Ensuring activity is targeted in the correct way, that booking is following clinical order, followed by chronological order.

Where diagnostic tests have been completed, proactively chase clinical review for next steps, supported by the validation team.

Domain: Access to Services. Sub domain: Elective care. Measure: Percentage of patients waiting over 52 weeks for elective treatment



Description of metric

Percentage of patients waiting over 52 weeks for elective treatment

Contractual standard is zero, 52+ week breaches

Planning guidance requests less than 1% of the waiting list waiting over 52+ weeks by March 2026.

Metric	Ops plan 25/26	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Metric	Ops plan 25/26	Apr-25	May-25	Jun-25	Jul-25	Aug-25
RTT: 52wk wait	plan	431	410	390	369	348	RTT: 52wk cohort % of Waiting List	plan	2.00%	1.90%	1.80%	1.70%	1.60%
	actual	448	439	377	368	365		actual	1.99%	1.94%	1.68%	1.64%	1.64%
	variance	17	29	-13	-1	17		variance	-0.01%	0.04%	-0.12%	-0.06%	0.04%

Analysis

For August, DCH were 17 off plan. The proportion of the waiting list that is waiting over 52+ weeks, was also off plan, by 0.04%. This position is expected to recover in September.

There were two 65+ week breaches in August as a result of the resident doctor industrial action. There is one breach in September due to clinical sickness.

Zero breaches expected in October.

Actions

Every patient in month, that is over 52 weeks, is reviewed (validated) weekly. This enables proactive pathway management.

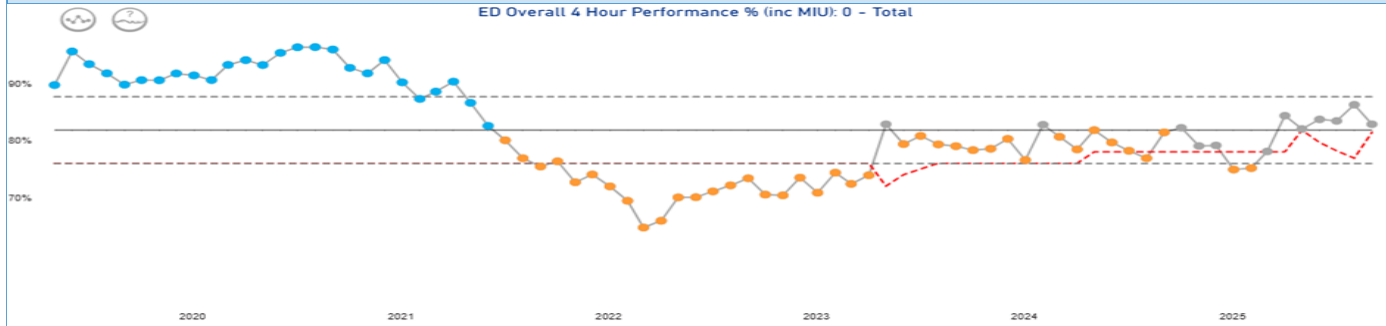
Total cohort is modelled against activity plans and reviewed monthly via the Elective Performance Management Group.

All patients on the waiting list are contacted to confirm they what to remain on the waiting list, once every 12 weeks.

Patients with a confirmed date for surgery are contacted 7 days before to confirm nothing has changed i.e. fitness. This ensures capacity is maximised by avoiding some on-the-day cancellations.

Baker, Abi
06/10/2025 12:40:16

Domain: Access to Services. Sub domain: UEC. Measure: Percentage of emergency department attendances admitted, transferred or discharged within four hours



Description of metric

Percentage of emergency department attendances admitted, transferred or discharged within four hours.

Contractual target 95%

Planning guidance, 78% monthly

Metric	Ops plan 25/26	Apr-25	May-25	Jun-25	Jul-25	Aug-25
A&E 4 hour wait %(all)	plan	81.80%	79.64%	78.18%	76.89%	81.43%
	actual	82.00%	83.7%	83.4%	86.3%	82.8%
	variance	0.20%	4.05%	5.22%	9.41%	1.37%

Analysis

Performance against the 4-hour standard in August was 82.8% (including UTCs), this was 1.37% higher than trajectory. The national planning guidance required a minimum of 78% for 2025/26.

The monthly performance trajectory has been phased to match seasonal variation the full year aggregate delivers 78%.

Attendances year to date (April- August) are 7.99% up compared to last year. For July and August, the two peak summer months, attendance were 12.4% up compared to last year. For the full year 2025/26, a projected growth rate of 1.8% was applied to 2024/25 figures.

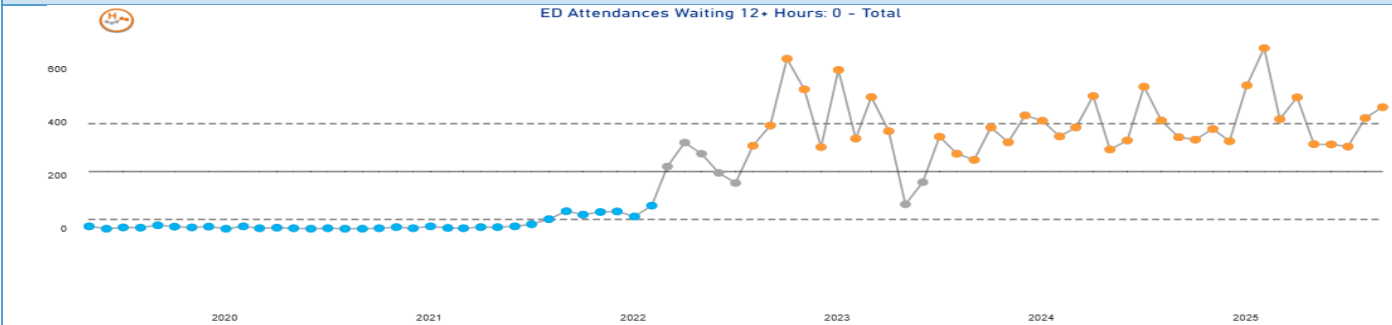
Year to date, the Trust has recorded 1,482 more attendances through ED than forecast in the operating plan.

Actions

4-hour standard is meeting trajectory.

Demand has been escalated to all system partners and brought to the attention of NHSE, as part of the Regional Performance meetings.

Domain: Access to Services. Sub domain: UEC. Measure: Percentage of emergency department attendances spending over 12 hours in the department



Metric	Ops plan 25/26	Apr-25	May-25	Jun-25	Jul-25	Aug-25
Percentage of A&E attendances over 12 hours	plan	6.57%	6.96%	11.52%	8.30%	6.97%
	actual	0.00%	6.45%	6.16%	7.53%	8.23%
	variance	-6.57%	-0.51%	-5.36%	-0.77%	1.26%

Description of metric

Percentage of emergency department attendances spending over 12 hours in the department.

Contractual target- none stated for 2025/26

Planning guidance: a higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25

Analysis

For the reporting month of August, the trust did not achieve the trajectory. As a percentage of attendances, 8.23% of patients waited 12 hours or more, which is 1.26% worse than plan.

Of the 458 12-hour breaches, 382 were admitted. Whilst this indicates a need for bed, data supports that during periods of high pressure in ED, referrals to admit increase.

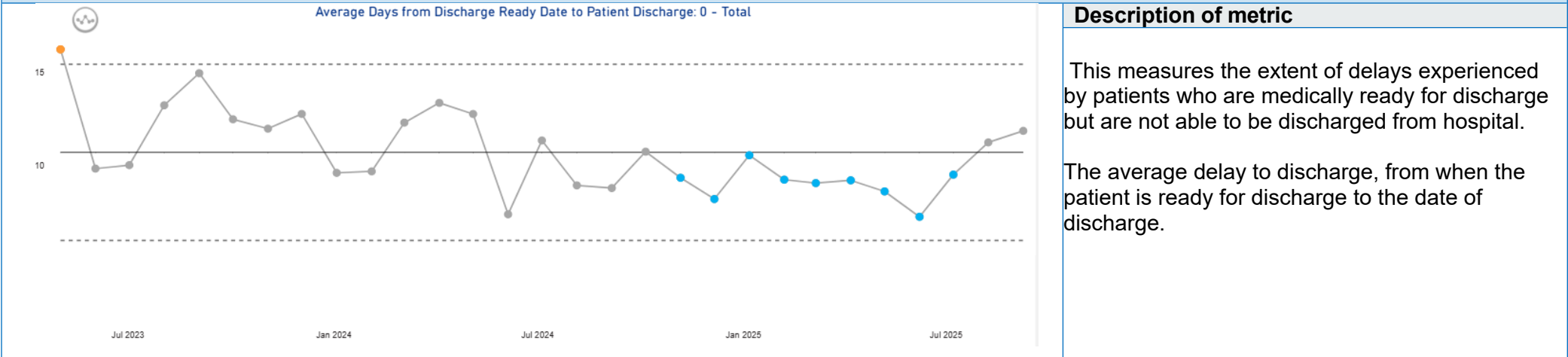
Actions

Triangulation of all data points to understand the root cause of 12-hour breaches. This includes how flow in ED impacts the proportion of patients referred to admit, to inform an action plan.

Your next patient (onboarding) has been adopted and now used on all suitable wards.

Baker, Abi
06/10/2025 12:40:16

Domain: Effectiveness and experience. Sub domain: Flow. Measure: Average number of days from discharge ready date to actual discharge date (including zero days)

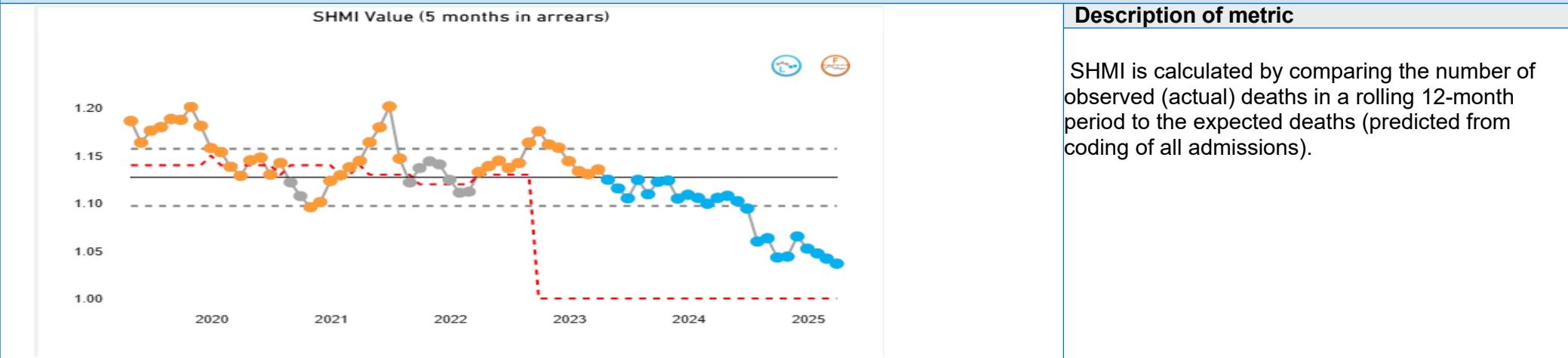


Analysis	Actions																												
The number of patients occupying a bed with no reason to reside is at the highest level for the last two years. This in turn increases the number of days from a patient being ready to discharge, to actual discharge. The proportion of patients that are converting to a no criteria to residue status has increased by 2%. Admissions have increased by 8% since last year, with 500 more admissions than the operating plan. The combined effect results in the non-elective LoS being over plan. <table><tr><th>Metric</th><th>Ops plan 25/26</th><th>Apr-25</th><th>May-25</th><th>Jun-25</th><th>Jul-25</th><th>Aug-25</th></tr><tr><td>Non-elective average LoS (excl 0 LoS and AHAH)</td><td>Plan</td><td>8.2</td><td>7.5</td><td>8.3</td><td>7.6</td><td>7.8</td></tr><tr><td></td><td>actual</td><td>10.22</td><td>11.1</td><td>10.7</td><td>11.1</td><td>10.6</td></tr><tr><td></td><td>variance</td><td>2.02</td><td>3.6</td><td>2.4</td><td>3.5</td><td>2.8</td></tr></table>	Metric	Ops plan 25/26	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Non-elective average LoS (excl 0 LoS and AHAH)	Plan	8.2	7.5	8.3	7.6	7.8		actual	10.22	11.1	10.7	11.1	10.6		variance	2.02	3.6	2.4	3.5	2.8	Escalation to all system partners, with Executive involvement for patients with extended length of stay. Focus on P1 capacity (care at home) and improved P2 (community bedded care) length of stay work agreed early October. FutureCare programme, with admission avoidance schemes and the introduction of the Transfer of Care Hub, which is now fully operational. Roll out criteria led discharge and standardised board rounds. New Models of Care (DCH Flow Improvement Programme) with QI improvement plans launched in September 2025.
Metric	Ops plan 25/26	Apr-25	May-25	Jun-25	Jul-25	Aug-25																							
Non-elective average LoS (excl 0 LoS and AHAH)	Plan	8.2	7.5	8.3	7.6	7.8																							
	actual	10.22	11.1	10.7	11.1	10.6																							
	variance	2.02	3.6	2.4	3.5	2.8																							

Baker, Abi
06/10/2025 12:40:16

Domain: Effectiveness and experience. Sub domain: Patient experience. Measure: CQC inpatient survey satisfaction rate	
Overall Rating 8.67	Description of metric 2023 – 2024 Survey The survey required a sample of 1,250 consecutively discharged inpatients, working back from the last day of November 2024, who had a stay of at least one night in hospital. There were a number of categories of patients excluded from the survey e.g. psychiatric and maternity patients.
Analysis 473 completed questionnaires were returned from the sample of 1105. The final response rate for the Trust was 45%. At Question level, 2 scores have improved significantly since 2023, 1 significantly declined. When compared to other sector organisations, 8 scores are in the top-20% range, 36 scores in the intermediate – 60% range and 5 in the bottom – 20% range. The scores for the Trust are mostly in line with the sector scores and stable year on year. The findings highlight areas for recommendation, but it is noted that the Trust should also celebrate areas where scores are higher than the sector benchmark.	Actions Wider sharing of the survey results and a stakeholder meeting to discuss next steps and a quality improvement plan will form the basis to consider and act on the survey recommendations. Quality improvement projects will be established or linked to ongoing programmes of work. These will be monitored through Patient Experience & Public Engagement Committee and escalated by exception via Quality Governance Group to Quality Committee in Common.

Domain: Effectiveness and experience. Sub domain: Patient experience. Measure: Summary Hospital Level Mortality Indicator.



Analysis

The SHMI continues on a downward trajectory at 1.036, the best it has been for several years. The average across the county is always reset every year at 1.00. Trust with the highest SHMI are up around 1.26.

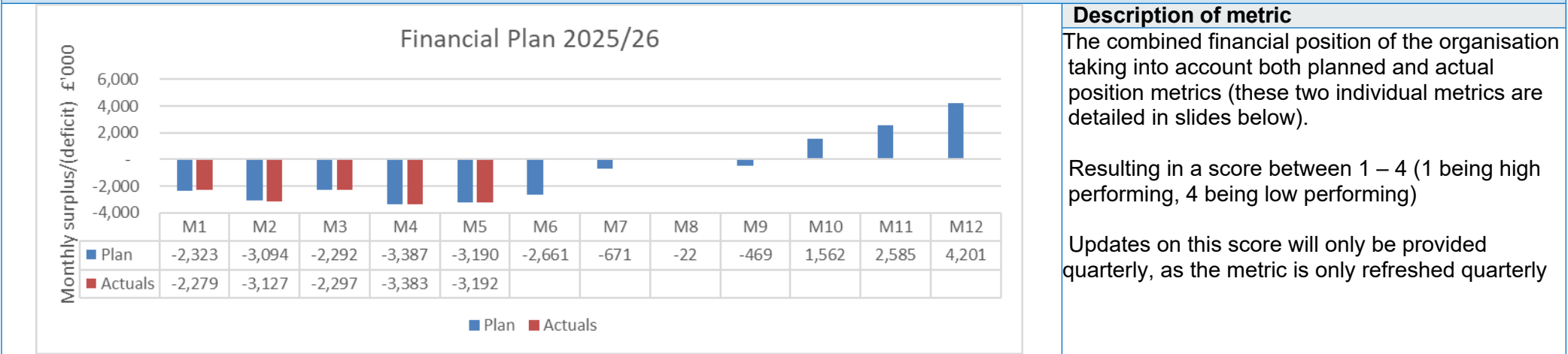
If your SHMI of 1.00 this means your expected number of deaths is the same as your actual number of deaths. If your SHMI is 1.10 it means 10% more people have died, then expected. These are calculations based on patient case mix and may not mean excess deaths are occurring. Extremes of age of population can affect the algorithm.

Actions

DCH 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.

Baker, Abi
06/10/2025 12:40:16

Domain: Finance and productivity. Sub domain: Finance. Measure: Combined finance

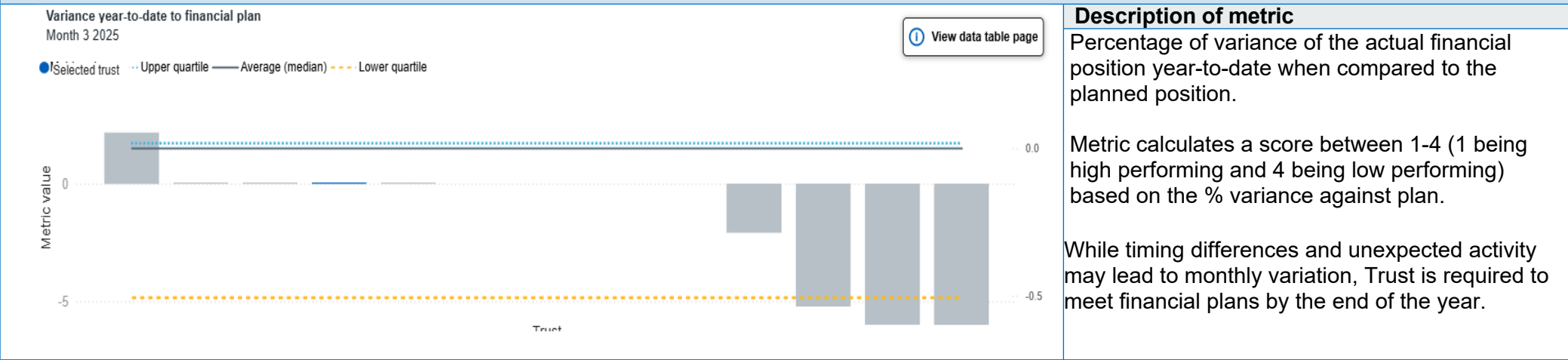


Analysis	Actions
The planned deficit score was a 4 and the actual YTD position against plan was a score of 1, these metrics when considered together have given a combined overall finance score of 2 indicating above average. In summary while our planned deficit of £9.8m is not the break-even Trusts are aiming for, at this point in year we are where we planned to be which is positive. The graph above details the Trust's 2025/26 financial plan to reach £9.8m deficit plus the actuals achieved to month 5. No further data or ranking has been given against this metric.	As this score is a combination of the following two metrics, actions have been listed against their individual metrics.

Baker, Abi
06/10/2025 12:40:16

Domain: Finance and productivity. Sub domain: Finance. Measure: Planned surplus/deficit	
The Trust showing blue against other providers in the South West region. Planned surplus/deficit 2025/26 Selected trust Upper quartile Average (median) Lower quartile 0 -2 -4 -6 Trust View data table page	
Description of metric The overall level of planned surplus/deficit of the organization for the financial year once deficit support funding has been removed. Metric calculates a score between 1-4 (1 being high performing and 4 being low performing). This is an annual scoring metric based on the planned deficit, therefore no further updates will be given for this measure.	
Analysis Due to the planned £9.8 deficit the resulting score was a 4 for the Trust, indicating low performance. A score of 4 recognises a performance of -2% or below when compared against other Trust’s surplus/deficit plans, the Trust plans stand at -3.18%. This was between the lower and average quartiles as detailed below: Lower quartile Average (median) Upper quartile -3.99 -1.62 0.00 The Trust placed 90th out of the 134 Trusts and 11th out of the 13 South West based Trusts, as the graph is showing above.	Actions While this metric cannot be changed for the year as it is only calculated annually, work continues to identify areas of saving opportunity and address the underlying deficit. In addition, NHSE has commenced a data gathering exercise to establish if there are under and over funded Trust’s. While this exercise is still in progress and no conclusions can be given at this stage, DCH has previously flagged as possibly underfunded. Further attention is being given within DCH to address both nationally set target areas and those internally highlighted as an area of opportunity to bring the Trust back into financial balance.

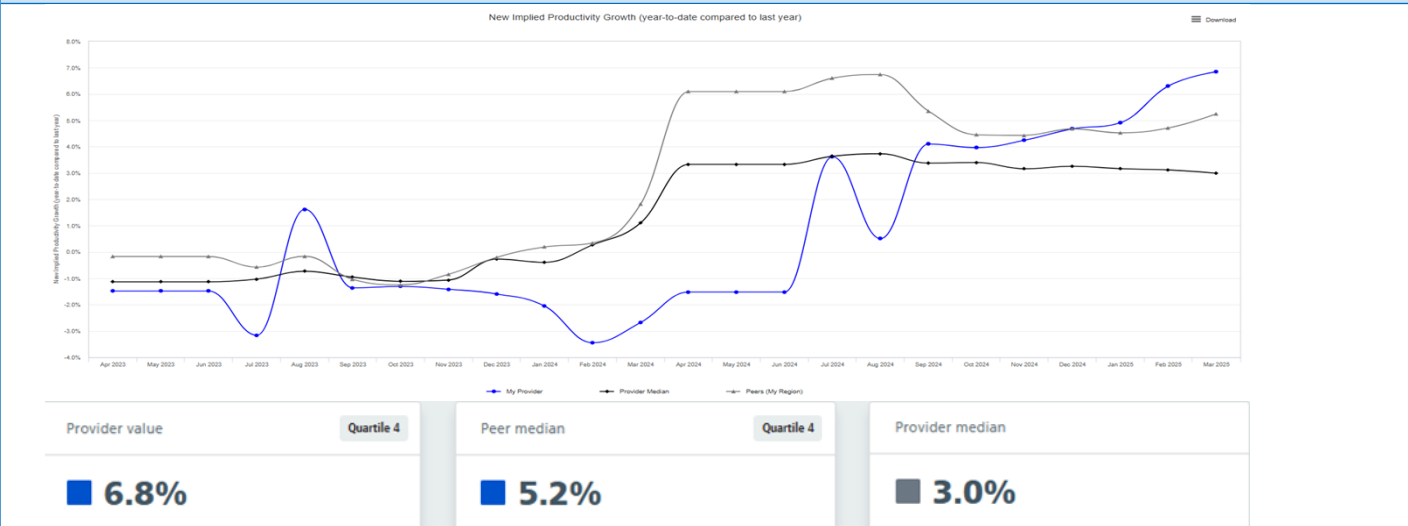
Domain: Finance and productivity. Sub domain: Finance. Measure: Variance year-to-date to financial plan



Analysis			Actions						
Due to the Trust being on plan as at month 3 the resulting score was a 1 for the Trust, indicating high performance. A score of 1 recognises a Trust on plan or doing better, which is considered as anything higher than -0.5%, the Trust has a 0.01% variance to plan at month 3. This was between the average and upper quartiles as detailed below: <table><tr><th>Lower quartile</th><th>Average (median)</th><th>Upper quartile</th></tr><tr><td>-0.51</td><td>0.00</td><td>0.02</td></tr></table> The Trust placed 35th out of the 134 Trusts, as indicated in the graph above, and 4th out of the 13 South West based Trusts.			Lower quartile	Average (median)	Upper quartile	-0.51	0.00	0.02	The Trust is aligned to the financial plan as at month 3 but it should be recognised that there is a challenging CIP programme, required for the Trust to reach the planned £9.8m deficit, which is heavily weighted to quarter 3 and 4. Work is ongoing to maximise delivery of CIP and the Recovery Group is in place to consider mitigations and unpalatables to address any gap. Additional controls are being brought in around workforce including more defined bank and agency SOPs and enhanced RCP controls.
Lower quartile	Average (median)	Upper quartile							
-0.51	0.00	0.02							

Baker, Abi
 06/10/2025 12:40:16

Domain: Finance and productivity. Sub domain: Productivity. Measure: Implied productivity level



Description of metric

As a core headline metric, improving this value means outputs (cost-weighted activity) relative to inputs (operating expenditure) are improving resulting in an improvement in Implied Productivity.

Analysis

Last date reviewed by FPC was March 2025:

DCH performed well, with implied productivity growth exceeding that of both the national and South West Region performance. DCH were the 2nd best performing provider against this metric, in the South West region at the end of 2024/25.

Activity plans were met and, in some cases, exceeded, with good insourcing contracts, priced below tariff rate, which supported this metric.

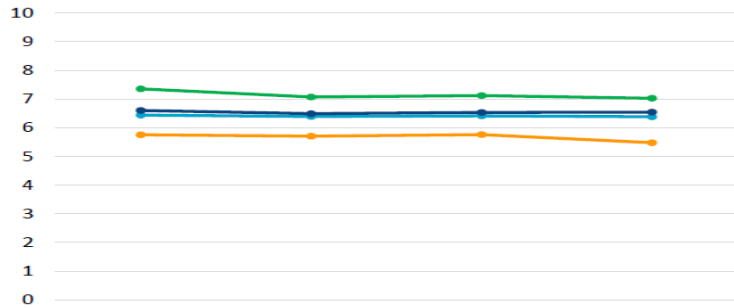
Actions

- Proactive counting and coding exercise, working with clinical services to identify activity they are doing, which isn't being counted.
- Benchmarking clinic template design, through the GIRFT outpatients work, with the aim of increasing clinic slots.
- Early engagement with insourcing and outsourcing providers, to negotiation best possible rates.
- Delivery of identified CIP, drives improved implied productivity.

Baker, Abi
06/10/2025 12:40:16

Domain: Patient safety. Sub domain: Patient safety. Measure: NHS Staff survey - raising concerns sub-score

Raising concerns



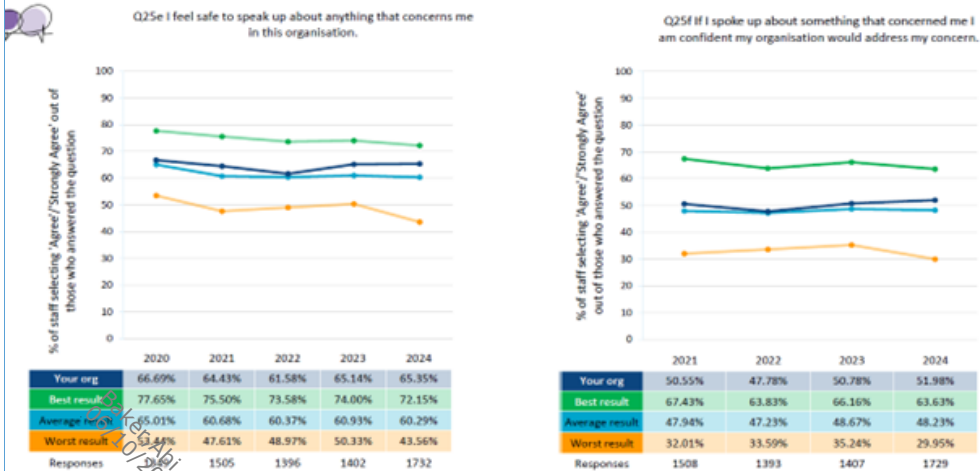
	2021	2022	2023	2024
Your org	6.60	6.49	6.53	6.54
Best result	7.35	7.07	7.12	7.02
Average result	6.44	6.39	6.41	6.38
Worst result	5.75	5.70	5.76	5.48
Responses	1499	1395	1404	1716

Description of metric

Raising concerns sub-score from 2024 NHS Staff Survey

The DCH score (6.54) is above the average (6.38) and ranks us 45 out of 134.

Analysis

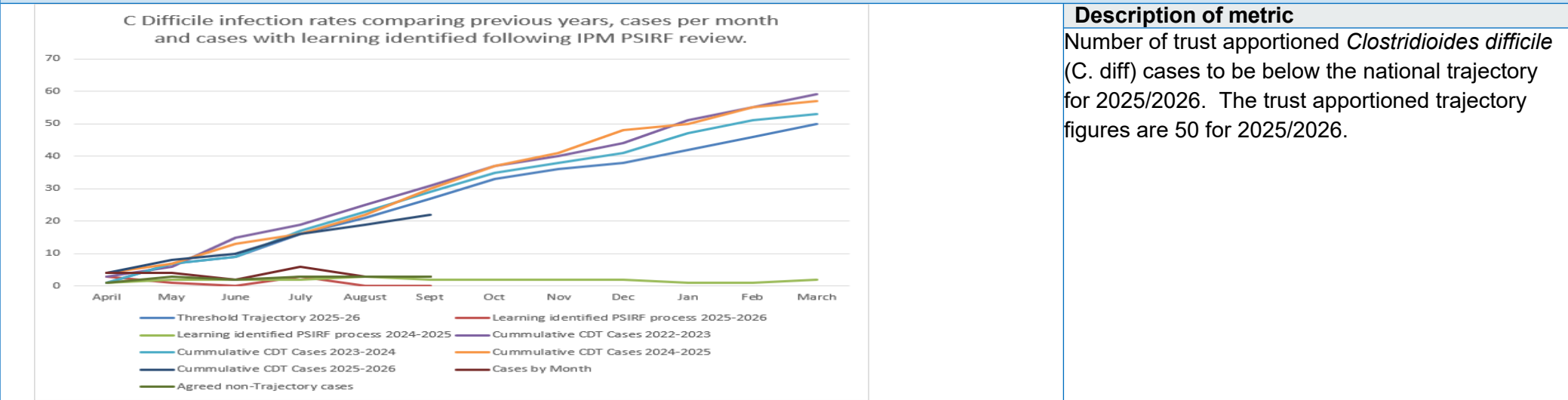


Actions

Since 2022 there have been improvements in both survey questions relating to raising concerns and these scores also remain above average. This improvement can be attributed to the introduction of the Freedom to Speak Up Guardian role and to the implementation of mandatory essential skills training relating to raising matters of concern.

More recently an online reporting tool has been implemented to facilitate anonymous reporting of FTSU and sexual safety issues. Once the tool is embedded within the Trust it will be expanded to capture any issue of concern.

Domain: Patient safety. Sub domain: Patient safety. Measure: Rate of C-Difficile infections

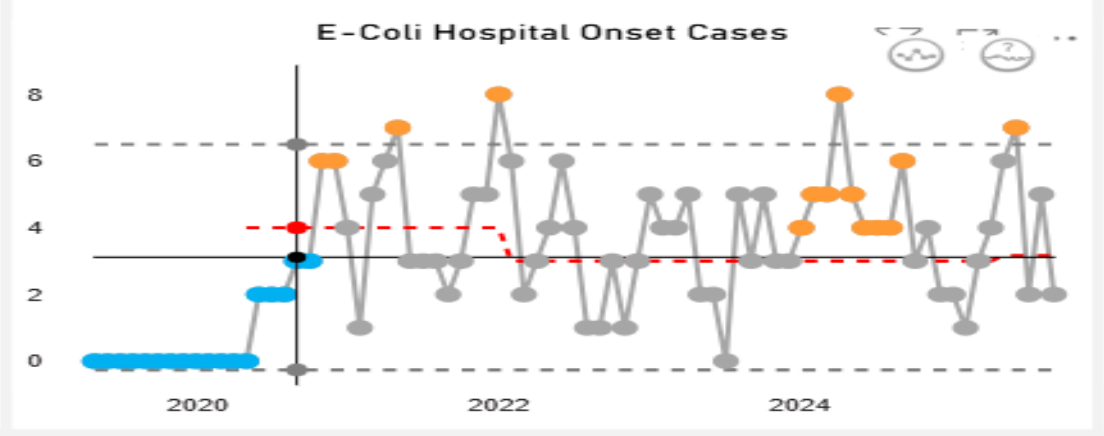


Analysis	Actions
Current Reporting as of August 2025 5 Hospital Onset Healthcare Associated (HOHA), and 4 Community Onset Healthcare Associated (COHA) C. difficile cases reported for July and August 2025. This brings the total of HOHA/COHA cases this year to 19. The graph above compares DCH figures for the last few years. All the cases have followed the IPC PSIRF (Patient Safety Incident Response Framework) review process. Clostridioides difficile cases ran slightly above the trajectory level for 2024-2025. CDI cases for 25-26 have reduced compared to 24-25 case figures for the same time last year	The IPC Education Framework sets out a vision for the design and delivery of IPC education that supports effective and safe care. The training has a strong Antimicrobial Stewardship (AMS) focus and feedback from the DCH training has been very positive. We are the first Trust in the Integrated Care System, and most of the Southwest, to implement this training using the tiered approach. The Antimicrobial Consultant Pharmacist delivers AMS training to all the new junior Dr's and in accordance with the AMS Improvement Plan. The Infection Prevention Management team have started performing ward-based face to face scenario-based training. Gentamicin calculator being adopted and adapted from UHD to support improvements in dosing.

Domain: Patient safety. Sub domain: Patient safety. Measure: Number of MRSA infections		
MRSA Hospital Onset Cases 48+ Hours MSSA Hospital Onset Cases		Description of metric Number of Trust apportioned gram +ve BSI cases to remain low for 2025/2026. There is no trajectory figures set for gram +ve BSIs.
Analysis Current Reporting as of August 2025 There were 2 Hospital Onset Healthcare Associated (HOHA) & 0 COHA (Community Onset Healthcare Associated) cases gram +ve BSI cases in July and August 2025. In total there were the following HOHA/COHA cases in July and August 2025: MRSA0 Running total for this year 1. MSSA2 Running total for this year 8.		Actions The IPM lead specialist nurse has joined the Southwest MSSA collaborative.

Baker, Abi
06/10/2025 12:40:16

Domain: Patient safety. Sub domain: Patient safety. Measure: Rate of E-Coli infections



Description of metric

Number of trust apportioned gram-ve cases to be below the national trajectory for 2025/2026. The trust apportioned trajectory figures are to be 54 as a total for Gram-ve BSI for 2025/2026.

Analysis

Current Reporting as of August 2025

There were 11 Hospital Onset Healthcare Associated (HOHA) & 3 COHA (Community Onset Healthcare Associated) cases gram -ve BSI cases in July and August 2025.

The trajectory levels for 2025/2026:

- *E. coli* 45
- *P. aeruginosa* 3
- *Klebsiella* spp 6

In total there were the following HOHA/COHA cases in July and August 2025:

- *E. coli* 7 Running total for this year 22.
- *P. aeruginosa* 2 Running total for this year 2.
- *Klebsiella* spp 5 Running total for this year 11.

Actions

Gram -ve Klebsiella BSI cases are running above threshold level. DCH has a very low threshold figures for Pseudomonas and Klebsiella blood stream infections for 2025-2026. As mitigation for not remaining within these thresholds all Hospital Onset Healthcare Associated (HOHA) are investigated using the IPM PSIRF (Patient Safety Incident Response Framework) review process, and any learning is addressed, and quarterly reports are provided to the Patient Safety and IPM committees.

The IPM team are undertaking a quality improvement project to improve catheter insertion and monitoring documentation. We have increased our face-to-face teaching over the last few months.

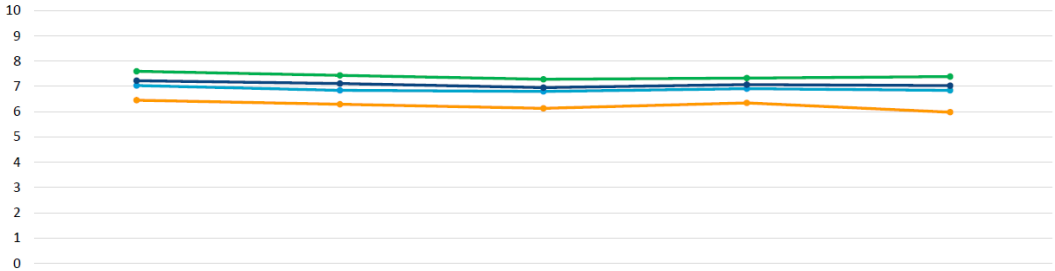
This includes ward-based scenario teaching, Dr induction training and housekeeping training.

Domain: People and workforce. Sub domain: Retention and culture. Measure: NHS staff survey engagement theme sub-score



Theme: Staff Engagement

Staff Engagement



	2020	2021	2022	2023	2024
Your org	7.22	7.11	6.95	7.07	7.03
Best result	7.60	7.44	7.28	7.32	7.39
Average result	7.03	6.84	6.80	6.91	6.84
Worst result	6.45	6.29	6.13	6.34	5.98
Responses	1356	1515	1402	1418	1746

Description of metric

Engagement theme sub-score from 2024 NHS Staff Survey

The DCH score (7.03) is above the average (6.84) and ranks us 38 out of 134.

Analysis

Despite a small reduction from 2023 to 2024, the staff engagement score for DCH has improved since 2022 and remains above average.

Actions

DCH and DHC jointly participated in the second cohort of the People Promise Exemplar Programme, a 12-month programme focused on improving staff engagement. The programme ended in April 2025 but much of the work undertaken continues to positively impact engagement, including improved induction, management training and flexible working options.

More recent engagement actions have included the launch of a monthly joint briefing by the CEO and the introduction of the Inspire Awards, a quarterly joint recognition scheme. Of particular focus at present is encouraging participation in the 2025 staff survey which runs from 1 October to 28 November.

Baker, Abi
06/10/2025 12:40:16

Domain: People and workforce. Sub domain: Retention and culture. Measure: Sickness absence rate																																																					
Long and short term absence - last 12 months <table><thead><tr><th>Month</th><th>Long Term Absence (%)</th><th>Short Term Absence (%)</th><th>Total Absence (%)</th></tr></thead><tbody><tr><td>October 2024</td><td>2.00%</td><td>2.60%</td><td>4.60%</td></tr><tr><td>November 2024</td><td>1.64%</td><td>2.76%</td><td>4.40%</td></tr><tr><td>December 2024</td><td>2.00%</td><td>2.94%</td><td>4.94%</td></tr><tr><td>January 2025</td><td>2.01%</td><td>2.76%</td><td>4.77%</td></tr><tr><td>February 2025</td><td>2.05%</td><td>2.38%</td><td>4.43%</td></tr><tr><td>March 2025</td><td>1.82%</td><td>2.47%</td><td>4.29%</td></tr><tr><td>April 2025</td><td>2.09%</td><td>1.99%</td><td>4.08%</td></tr><tr><td>May 2025</td><td>1.90%</td><td>2.14%</td><td>4.04%</td></tr><tr><td>June 2025</td><td>2.04%</td><td>2.09%</td><td>4.13%</td></tr><tr><td>July 2025</td><td>2.16%</td><td>2.02%</td><td>4.18%</td></tr><tr><td>August 2025</td><td></td><td></td><td></td></tr><tr><td>September 2025</td><td></td><td></td><td></td></tr></tbody></table>	Month	Long Term Absence (%)	Short Term Absence (%)	Total Absence (%)	October 2024	2.00%	2.60%	4.60%	November 2024	1.64%	2.76%	4.40%	December 2024	2.00%	2.94%	4.94%	January 2025	2.01%	2.76%	4.77%	February 2025	2.05%	2.38%	4.43%	March 2025	1.82%	2.47%	4.29%	April 2025	2.09%	1.99%	4.08%	May 2025	1.90%	2.14%	4.04%	June 2025	2.04%	2.09%	4.13%	July 2025	2.16%	2.02%	4.18%	August 2025				September 2025				Description of metric Average Sickness Absence Percentage Q4 24-25 The DCH score (4.5%) is below the average (5.2%) and ranks us 26 out of 134.
Month	Long Term Absence (%)	Short Term Absence (%)	Total Absence (%)																																																		
October 2024	2.00%	2.60%	4.60%																																																		
November 2024	1.64%	2.76%	4.40%																																																		
December 2024	2.00%	2.94%	4.94%																																																		
January 2025	2.01%	2.76%	4.77%																																																		
February 2025	2.05%	2.38%	4.43%																																																		
March 2025	1.82%	2.47%	4.29%																																																		
April 2025	2.09%	1.99%	4.08%																																																		
May 2025	1.90%	2.14%	4.04%																																																		
June 2025	2.04%	2.09%	4.13%																																																		
July 2025	2.16%	2.02%	4.18%																																																		
August 2025																																																					
September 2025																																																					
Analysis Sickness absence in Month 5 was 4.25%. The 12-month rolling sickness absence percentage is currently 4.4% In the past quarter there has been a reduction in short term absence, but a corresponding increase in long term absence. The top reason for absence is Anxiety/Stress/Depression, accounting for a quarter of all absences every month.	Actions HR support is provided in the ongoing management of absence. A comprehensive health and wellbeing offer is in place for staff, including access to Occupational Health services, a 24/7 Employee Assistance Programme, expediated access to Physiotherapy and onsite counselling provision. 78 Health and Wellbeing Champions are in place across the organisation, supported by the OD Team. A further 7 champions will be inducted this month.																																																				

Baker, Abi
06/10/2025 12:40:16

Report to	Board of Directors	
Date of Meeting	7 October 2025	
Report Title	Integrated Corporate Dashboard – August 2025	
Prepared By	Daniel Cunningham Corporate Performance Business Partner	
Approved by Accountable Executive	Chris Hearn Chief Finance Officer	
Previously Considered By	Senior Leadership Group (draft) 17 September 2025	
Action Required	Approval	
	Assurance	Y
	Information	

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? <i>Delete as required</i>	
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 SR3: Workforce Capacity SR4: Capacity and Demand SR6: Finance	
Financial	Finance metrics for assurance.	
Statutory & Regulatory	Many of the metrics within the report are statutory or regulatory and so these are provided for assurance.	
Equality, Diversity & Inclusion	Completeness of Patient Ethnicity Data for assurance.	
Co-production & Partnership	No implication	

Executive Summary		
This paper is to provide the Board with insight and foresight concerning Trust performance. It summarises key messages and the current position against the Trust strategic priorities. It aims to support effective decision making, highlighting key areas of exception and good practice.		
Strategic Objective	Total Metrics	No. focussed on in detail in report
Care	52	30
Communities	4	4
Colleagues	8	7
Sustainability	4	4
Grand Total	68	45

Recommendation
Members are requested to: Receive the report for assurance

Contents

Section			Page No.
1.0		Performance	
		Integrated Corporate Dashboard Analysis	3
		Care	5
		Communities	50
		Colleagues	56
		Sustainability	69
2.0		National Reporting Frameworks	
	2.1	CQUINs (Quarterly) paused for 2024/25 by NHSE	N/A
	2.2	External Benchmarking (as appropriate)	N/A
	2.3	NHS Oversight Framework	70
	2.4	Research and Development Metrics (Quarterly)	75
	2.5	Inpatient Nursing Staffing	76

Integrated Corporate Dashboard Analysis – October 2025 (based on August 2025 data)

This paper summarises key messages and the current position against the Trust strategic priorities. Detailed reports are provided for metrics that meet the following criteria:

- Metrics with SPC charts where the chart shows:
 - special cause
 - that the metric is unlikely to achieve the threshold
 - that the metric will not consistently hit the threshold AND the threshold was missed in the last month
- Metrics without SPC charts that have missed the threshold
- Metrics where occurrences are rare and there has been an occurrence in the last month
- Metrics where changes are rare and there has been a change in the last month e.g., CQC rating
- Workforce metrics
- Finance metrics

Statistical Process Control (SPC) analysis is used within this report to determine whether processes are stable and predictable by looking at variation. **‘Natural/ Standard variation’ is regular or ordinary predictable variation. ‘Special cause variation’ is unexpected or abnormal variation which warrants further investigation.** Special cause variation is shown by coloured dots; blue dots show areas of improvement and orange dots show areas of potential concern. The assurance icons show whether the process is capable of achieving a target.

Assurance			Variation						
Consistently Pass target	Pass and fail target subject to random variation	Consistently Fail target	Special Cause Concerning variation either Higher or Lower		Special Cause Improving variation either Higher or Lower		Special Cause Neither improving nor concerning variation		Common Cause

STRATEGIC OBJECTIVES

CARE



We provide compassionate, safe, person-centred care.

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

COMMUNITIES



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

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

COLLEAGUES



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

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

SUSTAINABILITY



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

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



Description of icons

Assurance			Variation						
Consistently Pass target	Pass and fail target subject to random variation	Consistently Fail target	Special Cause Concerning variation either Higher or Lower		Special Cause Improving variation either Higher or Lower		Special Cause Neither improving nor concerning variation		Common Cause

Care Metrics	In Month	Assurance	Variation	Data Quality
Methicillin resistant Staphylococcus aureus (MRSA) bacteraemia infections (blood stream infection)	0			High
Clostridioides difficile infections	0			High
E. coli bloodstream infections	0			High
Other significant HCAI – number of patients affected	0			High
NHS England Patient Safety Alerts Outstanding	0			High
Patient Safety Events (excludes falls & all no/low harm)	75			High
Falls on inpatient wards per 1,000 OBD	7.4			High
Medication incidents	59			High
Violent incidents - patient on patient in hospital	17			High

Baker
06/10/2025 12:40:16



Care Metrics (continued)	In Month	Assurance	Variation	Data Quality
Falls Assessment within 24 hours	96.6%			High
Venous Thromboembolism (VTE) risk assessment within 24 hours	88.3%			High
Pressure ulcer risk assessments (Purpose T) within 6 hours	96.6%			High
MUST risk assessment within 24 hours	94.4%			High
Bed occupancy rate community hospital wards	91.4%			High
ICS in-patients not feeling safe	0.0%			Medium
MH in-patients not feeling safe	7.6%			Medium
OOA Incidents (MH only)	2			Low
Prone Restraint (Adult)	3			Medium
Supine Restraint (Adult)	5			Medium
Seclusion (Adult)	2			Medium
Rapid Tranquilisation (Adult)	2			Medium
Prone Restraint (<18 y.o.)	0			Medium
Supine Restraint (<18 y.o.)	0			Medium
Seclusion (<18 y.o.)	0			Medium
Rapid Tranquilisation (<18 y.o.)	0			Medium

Baker, Aji
06/10/2025 12:40:16



Care Metrics (continued)	In Month	Assurance	Variation	Data Quality
IUCS Proportion of call backs by Clinician in agreed timeframe within 20 minutes	51.4%			High
IUCS Proportion of call backs by Clinician in agreed timeframe over 20 minutes	69.3%			High
Community Waiting List sitrep - numbers waiting	12,259			Medium
Community Waiting List sitrep - numbers waiting over 52 weeks	0			Medium
Friends & Family Test - positive experience feedback	91.0%			High
Number of complaints	40			High
Number of complaints with Ombudsman involvement	0			High
Reopened complaints	1			High
Duty of Candour	71.1%			TBC
Percentage of 2-hour Urgent Community Response referrals where care was provided within two hours	80.9%			High
Maximum 6-week wait for diagnostic procedures	87.2%			Medium
Virtual wards bed occupancy rate	76.4%			TBC
Right to reside (CHS)	28.5%			High
Patients reporting being involved in their care	100.0%			High
Number of compliments	449			Medium

Baker, R
06/10/2025 12:40:16



Care Plot Area continued)	In Month	Assurance	Variation	Data Quality
Children & Young People (CYP) Access 1+ Contact, DHC Under 18s rolling 12 months	6325			High
Community Mental Health (CMH) 2+ Contacts, Local Provider Data rolling 12 months	9218			High
Children & Young People Eating Disorders (CYPED) Urgent - 1 week rolling 3 month	67.0%			High
Children & Young People Eating Disorders (CYPED) Routine - 4 weeks rolling 3 months	81.0%			High
Talking Therapies Courses of Treatment	789			High
Talking Therapies 1st to 2nd treatment (Dorset only)	27.4%			High
Talking Therapies Reliable Recovery	344			High
Talking Therapies Reliable Improvement	527			High
Talking Therapies Waiting Times - 6 weeks (Dorset only)	95.7%			High
Southampton Priory Placements - Appropriate Out of Area Placements (number of active placements at end of month)	9			High
Out of Area Placements - Inappropriate Placements (active placements at end of month)	2			High
Perinatal & Maternal Mental Health Access rolling 12 months	756			High

Baker, Abi
06/10/2025 12:40:16

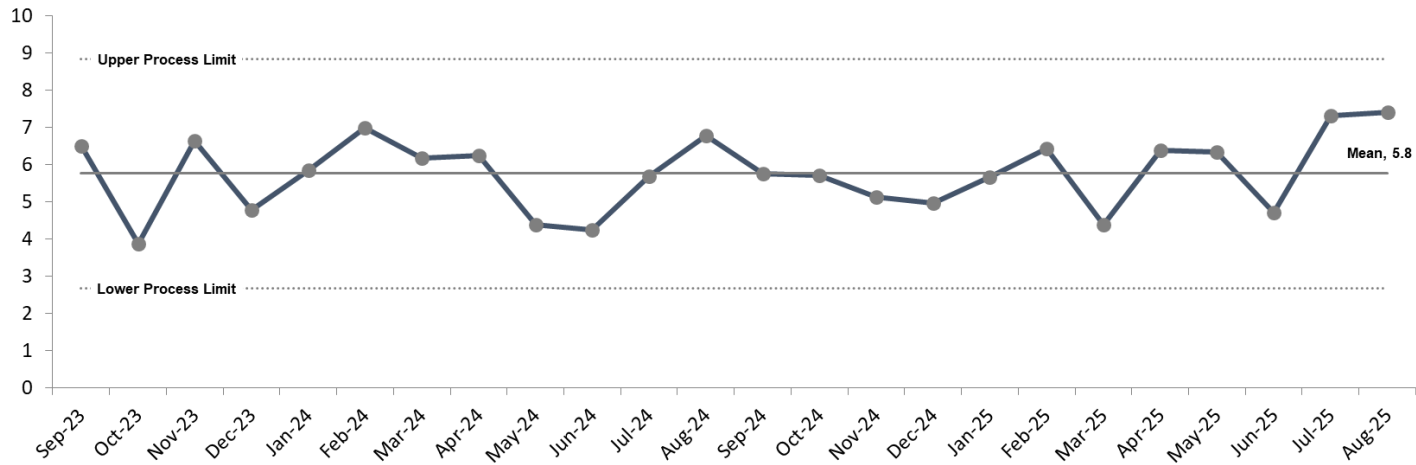
Falls on inpatient wards per 1,000 Occupied Bed Days

CQC Question: Are We Safe?

Description of metric

The rate is calculated from the number of incidents of falls reported on Ulysses in the month in hospitals as a proportion of occupied bed days (multiplied by 1,000) in the month.

Threshold: None



Analysis

A notable increase in rate of falls across the ICS Community Hospitals has been observed, with a particularly significant rise on Hanham Ward, which recorded 16 falls in August 2025. Of these, four patients experienced multiple falls, accounting for over half of the incidents on the ward. A key theme emerging from the frequent faller profile is that many of these falls were unwitnessed.

Similarly, Guernsey Ward has a patient who fell five times in August alone, underscoring the heightened vulnerability of patients with cognitive impairments.

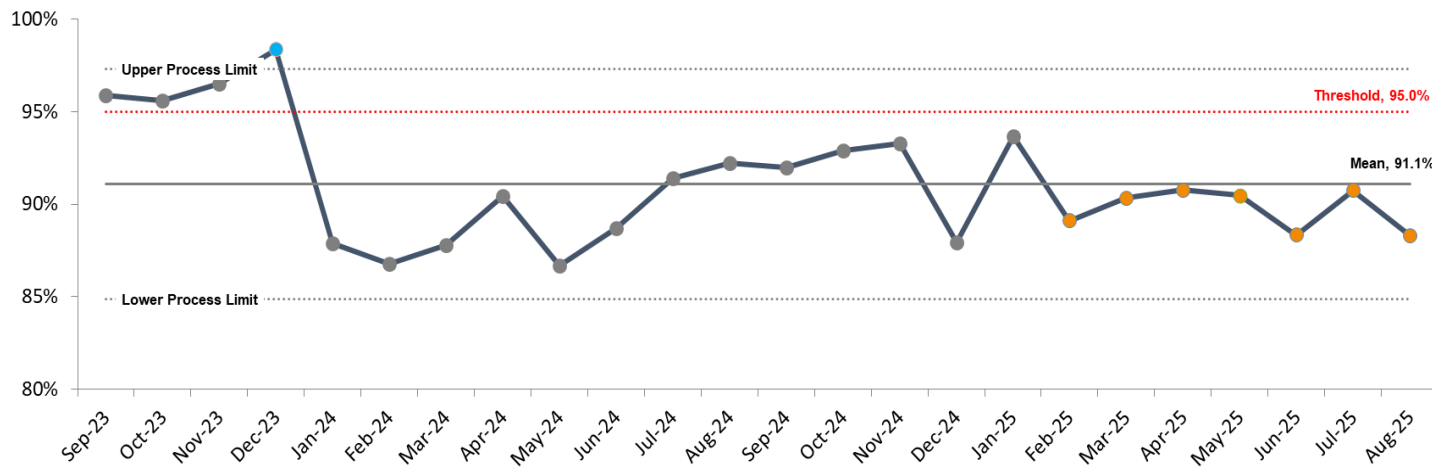
Actions

These trends highlight the need to undertake a thematic analysis in areas where there has been a significant rise in falls, particularly where there is a high number of frequent fallers. A deep dive is currently underway on Hanham Ward, focusing on identifying key themes and trends related to time of day, location, and activity at the time of each fall. This analysis will be further supported by the application of the SEIPS (Systems Engineering Initiative for Patient Safety) methodology and observational studies during periods when falls are most likely to occur.

The aim is to gain a clearer understanding of "work as done" in real-time, enabling us to generate meaningful insights, identify contributing factors, and develop evidence-based recommendations. These findings will inform a targeted improvement plan to strengthen falls prevention and enhance patient safety. The fall with harm on Melstock is currently being reviewed through the PSIRF process.

Venous Thromboembolism (VTE) risk assessment within 24 hours

CQC Question: Are We Effective?



Description of metric

Percentage of applicable patients who receive venous thromboembolism risk assessment within 24 hours of admission to hospital. Community hospital patients and mental health patients.

Contractual target: $\geq 95\%$

Analysis

The Trust reported 88.3% compliance against a threshold of 95%, 173/196 (23 breaches).

Mental Health Services reported 85.7% compliance, eight breaches out of 56 admissions:

- Alumhurst Ward (2/6)
- Harbour Ward (1/1)
- Haven Ward – female (1/4)
- Haven Ward – male (2/4)
- Waterston Ward (2/7)

Six assessments were omitted at time of admission, one by a bank/agency nurse and five by the admitting doctor/consultant and one assessment no reason was given to why. Staff completed the assessments outside of the

Actions

Mental Health Services:

Ward managers have emailed all staff/consultants and junior doctors highlighting the need to check assessments have been completed for all admissions and included in handovers if outstanding. The Head of High Acuity has oversight of all inpatient risk assessment breaches.

Community Services:

Risk Assessments discussed during Matrons meeting with a focus on VTE with further guidance having been circulated to Wards.

Sickness has impacted nursing cover and a number of shifts were understaffed where temporary staffing was not available to cover. Medical cover was impacted by leave however plans are in place to help this next year with the medical rota coordinator.

Venous Thromboembolism (VTE) risk assessment within 24 hours (Continued)

CQC Question: Are We Effective?

Analysis (cont.)	Actions (cont.)
24-hour target time. One assessment was completed at time of admission however the patient's electronic record was updated prior to admission to bed state. Community Services reported compliance of 89.3% against a target of 95% with 15/140 breaches. All of these were completed outside of the target time: • Beech: 2/6 breaches • Guernsey: 3/10 breaches • Hanham: 1/8 breaches • Jersey: 4/17 breaches • Radipole: 2/21 breaches • Shaston: 2/15 breaches • Stanley Purser: 1/12 breaches Baker, Abi 06/10/2025 12:40:16	The Service Lead is linking in with Business and Performance, and with Clinical Systems to make changes to facilitate accurate reporting, including using assessments that are already in place when patients are transferred from acute hospital. Currently these would be recorded as non-compliant despite being in date with prophylaxis in place

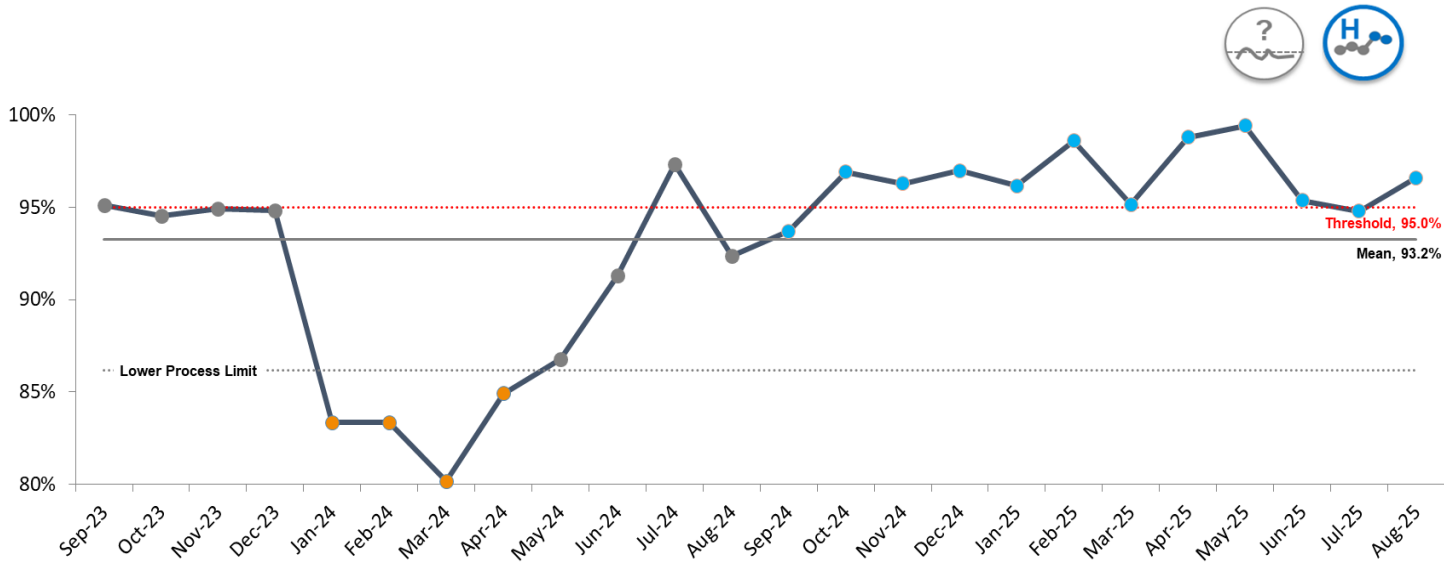
Pressure ulcer (Purpose T) risk assessments within 6 hours

CQC Question: Are We Effective?

Description of metric

Percentage of applicable patients who receive pressure ulcer risk assessment within 6 hours of admission to hospital. Community hospital patients and mental health patients >=65 years old.

Contractual target: >=95%



Analysis

The Trust reported 96.6% compliance against a threshold of 95%, 171/177 (6 breaches) in August.

The metric has tracked 12 consecutive months above the mean showing special cause improvement. The improved compliance is predominantly driven by ICS reporting fewer breaches than mental health wards. The common cause for breaches on mental health wards is patient choice/patient declining the assessment at time of admission. Assessments are completed by staff once the patient is more settled on the ward and this can occur outside of the 6-hour target time.

Actions

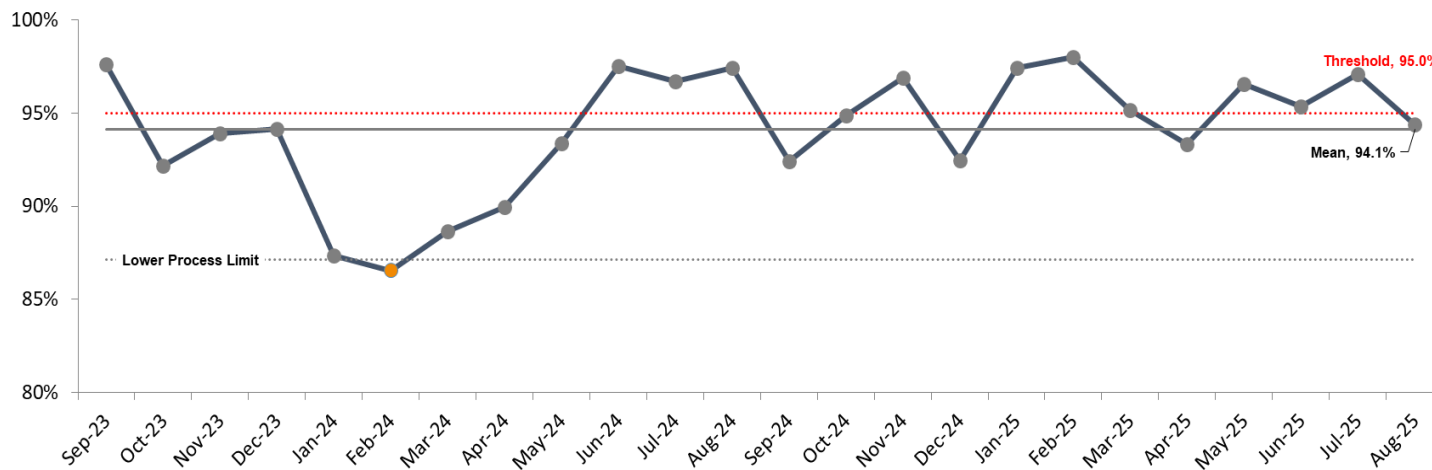
MUST risk assessment within 24 hours

CQC Question: Are We Effective?

Description of metric

Percentage of applicable patients who are screened using the MUST within 24 hours of admission to hospital. Community hospital patients and mental health patients >=65 years old.

Contractual target: >=95%



Analysis

The Trust reported 94.4% compliance against a threshold of 95%, 167/177 (10 breaches).

Mental Health Services reported 81.8% compliance, four breaches out of 22 admissions:

- Haven Ward – female (1/1)
- St Brelade's Ward (3/9)

One assessment was omitted at time of admission by the bank/agency nurse and not included in the handover, staff completed outside of the 24-hour target time. For three of the assessments the patient's height and weight was taken at time of admission but not recorded correctly in the patient electronic record.

Actions

Mental Health Services:

One ward manager has emailed all staff highlighting the need to check assessments have been completed for overnight admissions and included in handovers. The other ward manager has given feedback at the staff nurse meeting and shared the minutes with all staff nurses.

The Head of High Acuity has oversight of all inpatient risk assessment breaches.

MUST risk assessment within 24 hours (Continued)

CQC Question: Are We Effective?

Analysis (cont.)

Actions (cont.)

Community Services achieved compliance of 96.1% against a target of 95% with 6/155 breaches. All of these were completed outside of the target time.

- Guernsey: 1/11 breaches
- Jersey: 1/19 breaches
- Radipole: 1/24 breaches
- Shaston: 3/16 breaches

Baker, Abi
06/10/2025 12:40:16

Out of Area incidents (Mental Health)

CQC Question: Are We Safe?

Analysis	Description of metric
Two adult mental health Out of Area incidents were reported in August: <u>Incident 1</u> An incident was logged by Dorset Healthcare staff following a discussion with the Patient Safety Team. The patient was placed in an out of area Rehabilitation bed in February 2025, the incidents relate to Violence/Assault, Verbal-Abuse Patient on Staff and Verbal-Abuse Patient on Patient. Since February multiple counts of Violence/Assault incidents have been reported by the out of area provider for the patient. <u>Incident 2</u> The second incident occurred whilst the patient was placed in an out of area commissioned Psychiatric Intensive Care bed. The incident related to Violence/Assault, Physical – Abuse (No Injury) Staff on Patient. The out of area provider contacted Dorset Healthcare to advise there had been an allegation of physical abuse by a staff member against the patient. Baker, Abi 06/10/2025 12:40:16	A count of all incidents involving OOA patients, reported to DHC by OOA providers and recorded on Ulysses. Threshold: None Actions <u>Incident 1</u> All future incidents will be recorded in the DHC incident system as soon as they are reported. DHC staff have liaised with the Patient Safety Lead who has been made aware of the incidents. The Community Rehab Team plan to remain in contact with the out of area provider, the plan is to attend monthly ward rounds, review any escalation in behaviour relating to the patient and visit the patient if required. <u>Incident 2</u> The out of area provider informed the local authority Safeguarding Team, two staff members were suspended and an internal investigation was launched. The incident was reported to the police who attended the site and spoke to a senior manager and the patient. The patient's family were kept updated. The DHC Safeguarding Team reviewed the incident and noted that a safeguarding referral was with the provider's local authority and advised that the Safeguarding Policy continue to be followed. The Trust has worked closely with the Northamptonshire Integrated Care Board to review the concerns and an alternative placement for the patient has been sourced.

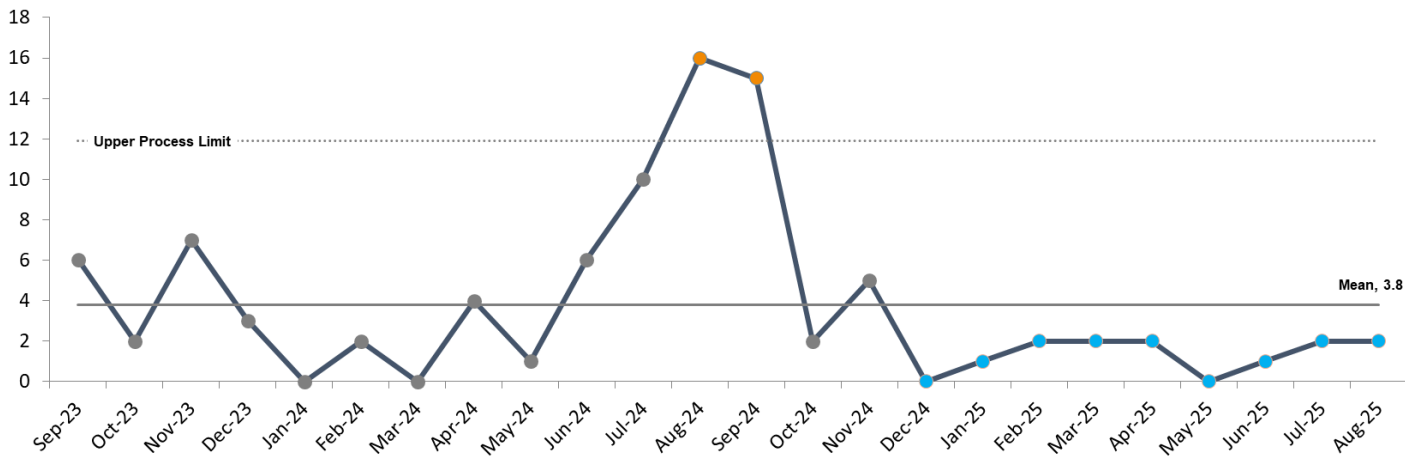
Seclusions (Adult)

CQC Question: Are We Safe?

Description of metric

Number of seclusion incidents reported on Ulysses for adult patients.

Threshold: None



Analysis

The metric continues to track below the mean showing special cause improvement. Sustained improvement has been reported for 10 consecutive months, since December 2024.

In all the incidents of seclusion staff use de-escalation techniques prior to the decision being made to seclude. Seclusion is utilised as this is the least restrictive practice option of PMVA (Prevention and Management of Violence and Aggression). Any prolonged periods of seclusion are overseen by the Medical Director for MH, LD, and CYPF and the Service Director for additional assurance.

Actions

All wards remain on track with their quality improvement projects with the aim of reducing restrictive practice in their areas, individual seclusions are reviewed by the ward, learning events undertaken and care plans updated accordingly. The Reducing Restrictive Practice (RRP) Group has oversight of restrictive interventions across mental health inpatient services.

Under 18 Restrictive Interventions

CQC Question: Are We Safe?

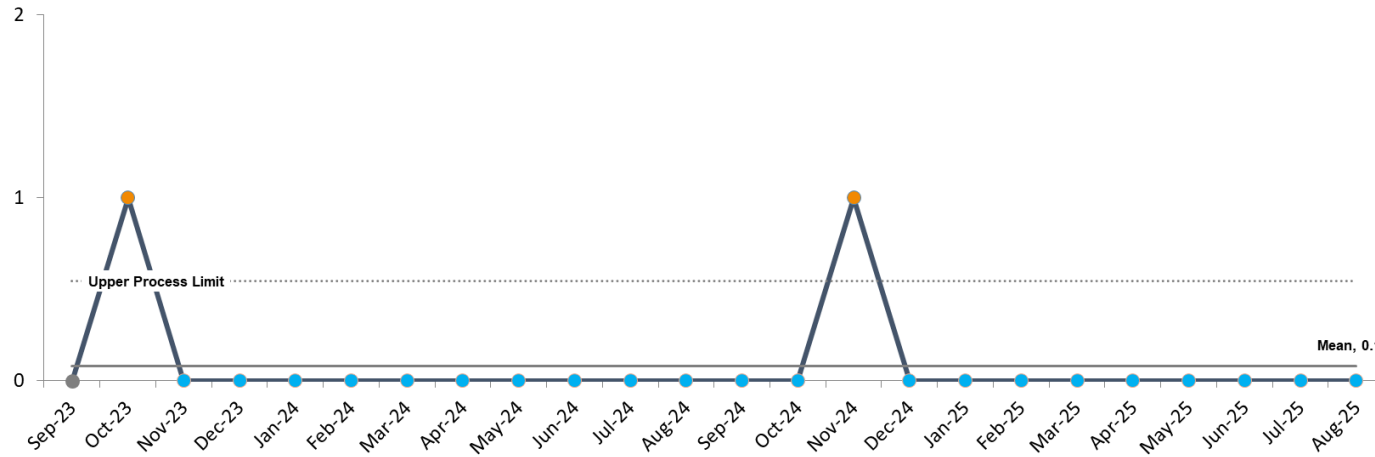
Description of metric

Seclusion (<18 y.o.) - Number of seclusion incidents reported on Ulysses for patients under the age of 18 years.

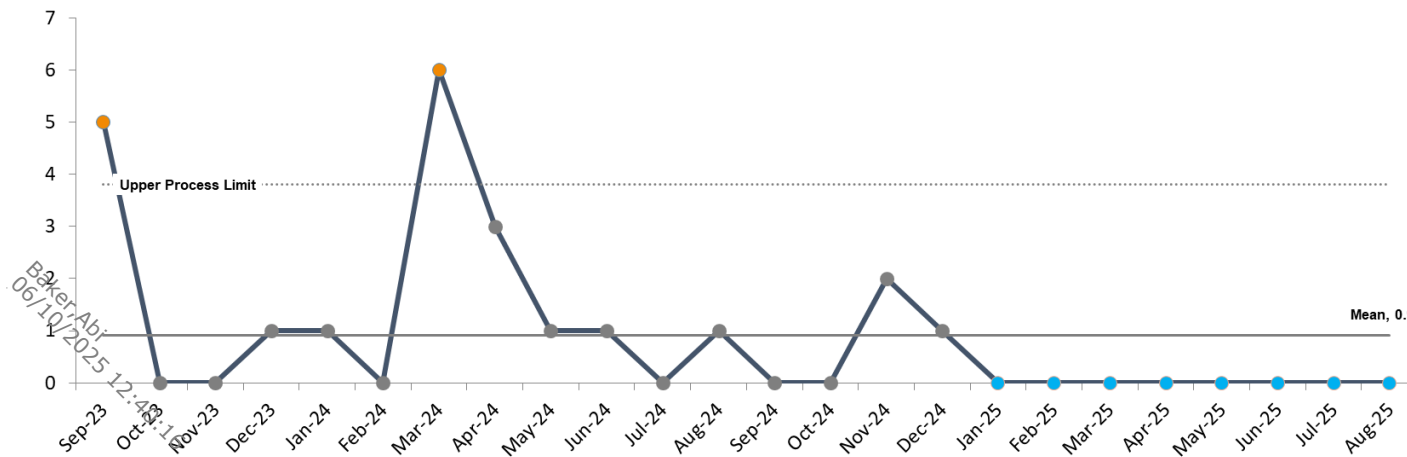
Threshold: None



Seclusion (<18 y.o.)



Rapid Tranquilisation (<18 y.o.)



Rapid Tranquilisation (<18 y.o.) - Number of rapid tranquilisation incidents reported on Ulysses for patients under the age of 18 years.

Threshold: None

Under 18 Restrictive Interventions (continued)		CQC Question: Are We Effective?
Analysis	Actions	
The team continue to work in the least restrictive ways, and engage the young person proactively to reduce incidents Baker, Abi 06/10/2025 12:40:16		

Integrated Urgent Care Service: Proportion of call backs by Clinician in agreed timeframe within 20 minutes

CQC Question: Are We Effective?

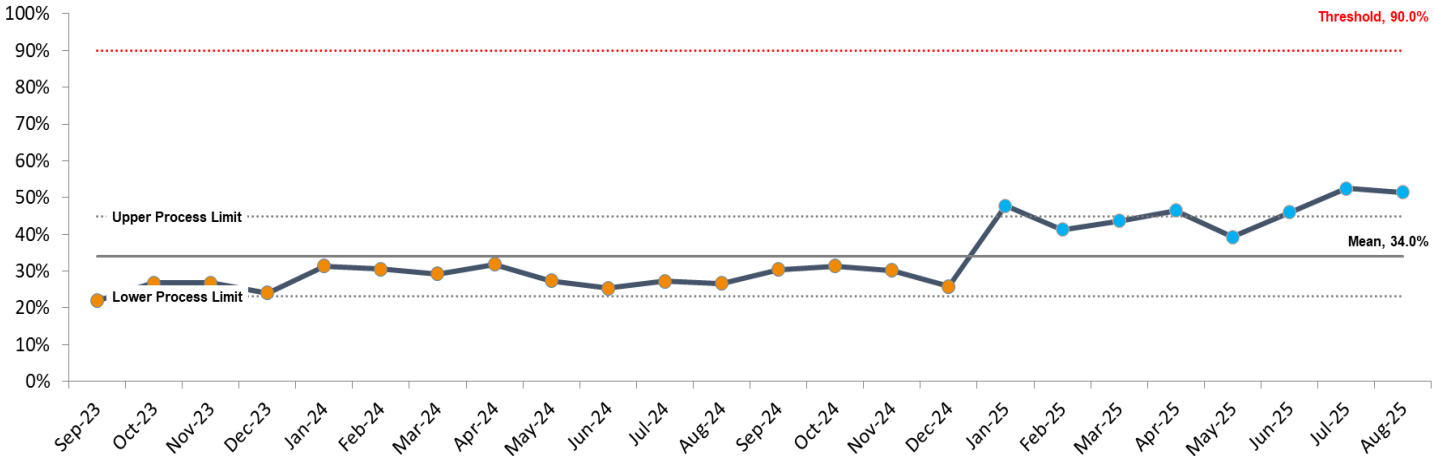
Description of metric

Proportion of call backs by Clinician in agreed timeframe within 20 minutes

Threshold: 90%



Threshold, 90.0%



Analysis

Performance has dipped slightly to 51.4% for August, with the bank holiday weekend a likely contributor, as in 2024. The service has also experienced increased sickness absence over the month, at the same time as summer leave. Despite this, we have had the second best month of performance within the past two years.

Actions

- New service model designed as part of the IUCS procurement process aims to reduce cases reaching the queue.
- Summer annual leave allowances to be reviewed to consider whether future summer allocation is slightly reduced to allow for potential increased sickness.
- Clinical visualisation dashboard now live, allowing easier oversight of the number and types of cases on the queue and their allocation.
- Regular reviews of clinician performance, including warm transfers, with aim to reduce cases being added to the queue.
- Work to promote and embed Attend Anywhere within service.

Baker, Abi
06/10/2025 12:40:16

Integrated Urgent Care Service: Proportion of call backs by Clinician in agreed timeframe within 20 minutes (Continued)

CQC Question: Are We Effective?

Analysis (cont.)	Actions (cont.)
	Trial of new complex clinical advice line to support Health Advisors with complex cases, guide decision making and reduce cases entering the clinical queue as 20 minute cases. Recruitment of clinical team continues.

Baker, Abi
06/10/2025 12:40:16

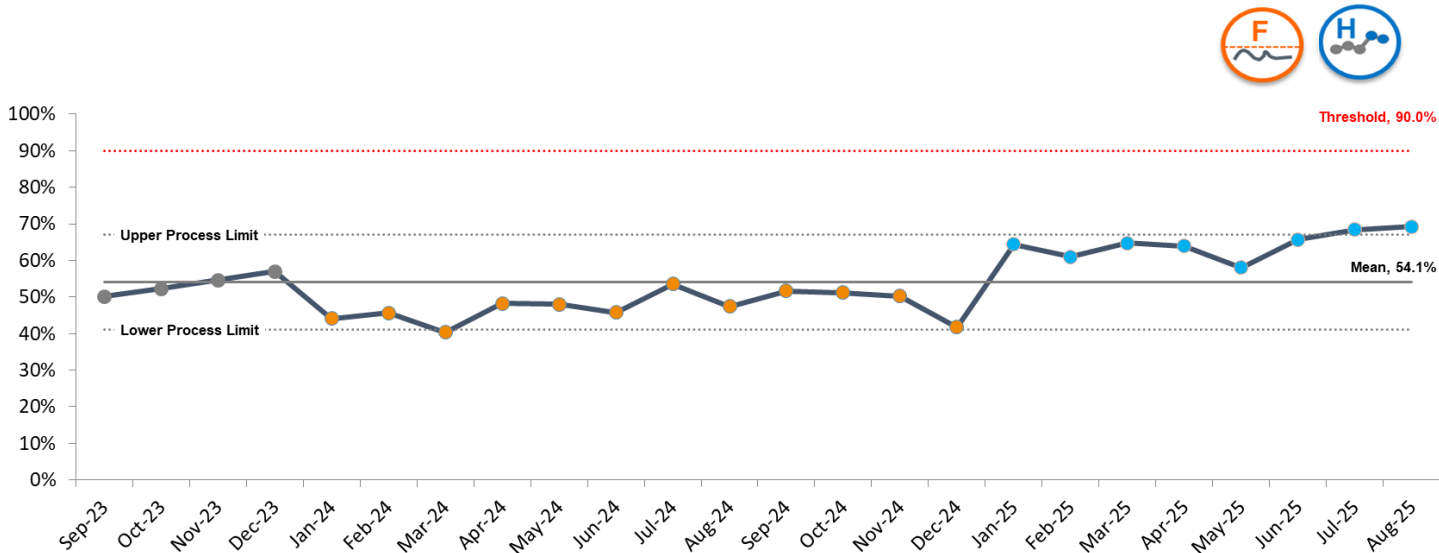
Integrated Urgent Care Service: Proportion of call backs by Clinician in agreed timeframe over 20 minutes

CQC Question: Are We Effective?

Description of metric

Proportion of call backs by Clinician in agreed timeframe over 20 minutes

Threshold: 90%



Analysis

Performance has risen again this month, to 69.3%. Due to a change in national KPIs, we are no longer able to accurately benchmark our performance against other providers for this indicator.

Actions

Please see Call Backs within 20 minutes for actions.

Baker, Abi
06/10/2025 12:40:16

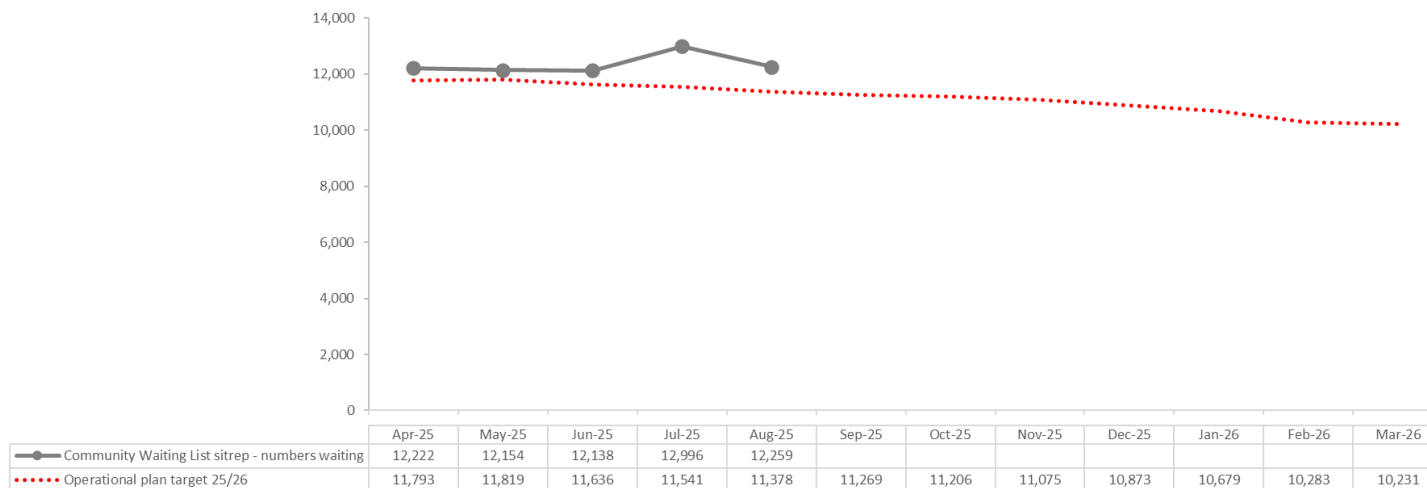
Community Waiting List sitrep - numbers waiting

CQC Question: Are We Effective?

Description of metric

Community Waiting List sitrep - total number waiting

Threshold: None



Analysis

Total numbers rose slightly in July but have seen a reduction in August, although this remains behind the stretch target set for 2025/26. Physiotherapy, Continence and Newborn Hearing Screening Programme (NHSP) services which all rose in July saw the greatest increases in August. Physiotherapy welcomed a number of new starters this month which has assisted backlogs. Wheelchairs and Dorset MSK total wait lists rose slightly.

Baker, Abi
06/10/2025 12:40:16

Actions

Physiotherapy workforce turnover continues to be of concern but recent recruitment to roles is starting to impact the wait list.

Community appointment days are being trialled in Physio and Podiatry in Q3.

Deployment of a new self-management app "GetUBetter" continues to be shared with more patients – both those who have been seen for ongoing self-management and for those on the wait list.

Audiology continue to seek locum cover and are working with HR recruitment team to ensure vacancies are filled as quickly as possible but

Community Waiting List sitrep - numbers waiting (Continued)		CQC Question: Are We Effective?
Analysis (cont.)	Actions (cont.)	
	workforce availability remains difficult. Admin capacity is limited but there are plans to address the delays in registering patients to the unit by end of September.	
	Focused work continues with the B&P Community Rehabilitation team on considering how to separate caseloads into stroke/neuro and trauma/falls cases. The work will require time to progress but also provides a focus for the team on considering different ways of working to address differing needs such as the model tried in MSK for community appointment days. Validation of the longest waits is being addressed although there is potential to improve this further.	

Baker, Abi
06/10/2025 12:40:16

Community Waiting List sitrep - numbers waiting over 52 weeks																																						
CQC Question: Are We Effective?																																						
Description of metric																																						
Community Waiting List sitrep - numbers waiting over 52 weeks Operational plan target 25/26 2 1 0 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26 Feb-26 Mar-26 0 1 0 0 0 <table><tr><td>Community Waiting List sitrep - numbers waiting over 52 weeks</td><td>0</td><td>1</td><td>0</td><td>0</td><td>0</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>Operational plan target 25/26</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr></table>													Community Waiting List sitrep - numbers waiting over 52 weeks	0	1	0	0	0								Operational plan target 25/26	0	0	0	0	0	0	0	0	0	0	0	0
Community Waiting List sitrep - numbers waiting over 52 weeks	0	1	0	0	0																																	
Operational plan target 25/26	0	0	0	0	0	0	0	0	0	0	0	0																										
Community Waiting List sitrep - total number waiting over 52 weeks																																						
Threshold: None																																						
Analysis						Actions																																
Zero waits over 52 weeks this month.						Directorate Performance meetings in place to identify potential breaches of 52 week and provide oversight of longest waiters																																
Baker, Abi 06/10/2025 12:40:16																																						

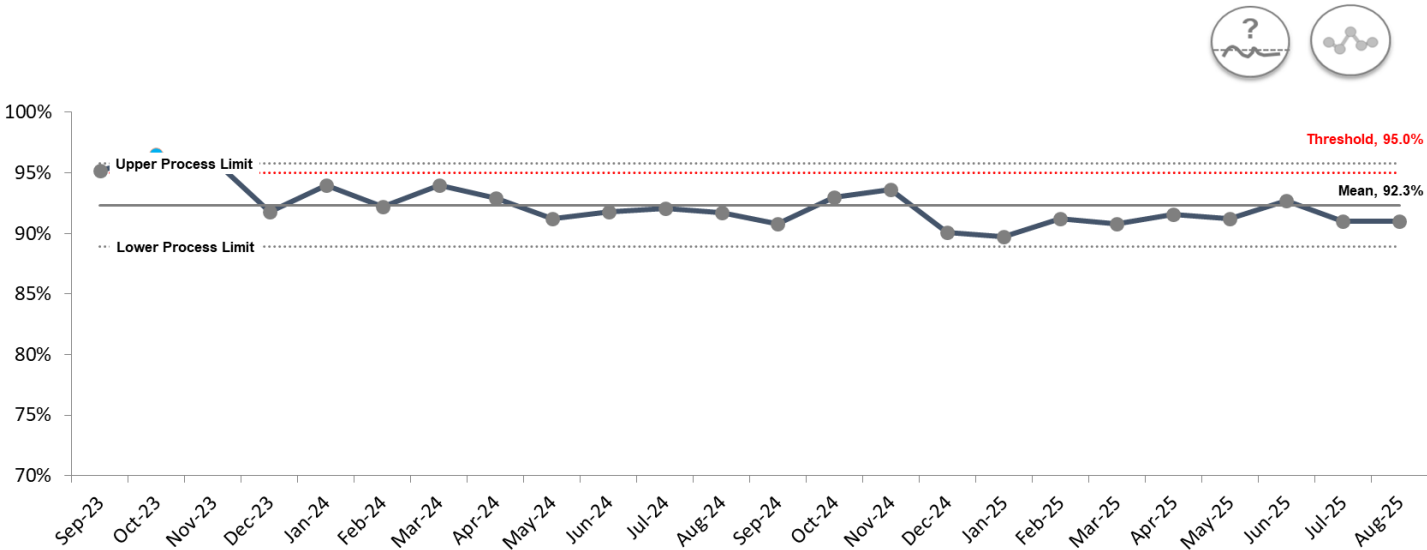
Friends and Family Test (FFT) - Positive Experience Feedback

CQC Question: Are We Safe?

Description of metric

Those responding 'very good' plus those responding 'good' as a percentage of all responses in the month.

Threshold - None



Analysis

For the month of August, we maintained a response rate of 91% as July. This is expected within the summer holiday period.

Actions

The Patient Experience Team will continue to support service to encourage patient/carer feedback to learn from responses and develop services.

Baker, Abi
06/10/2025 12:40:16

Complaints

CQC Question: Are We Responsive?

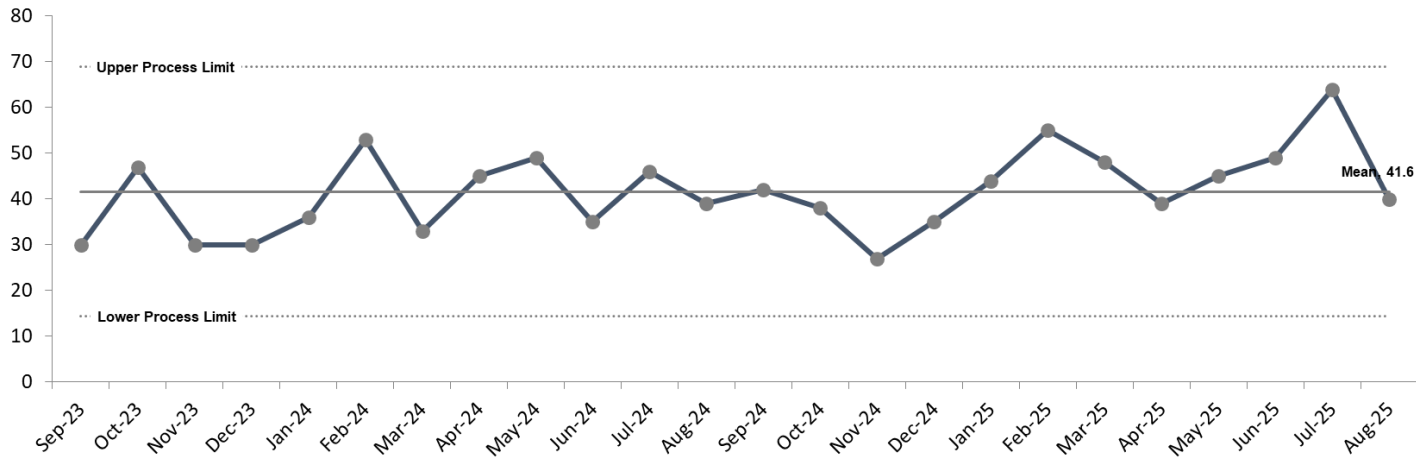
Description of metric

Complaints - Number of complaints received, both written and verbal, including any themes identified.

Number of complaints with Ombudsman involvement - The number of complaints that, the Parliamentary and Health Service Ombudsman has notified the Trust, have been referred to the Ombudsman.

Reopened complaints - The number of complaints, both written and verbal, that have been reopened during the month.

Threshold - None



Analysis

The number of complaints reported in the month was 40. The metric is reporting within natural variance.

Themes include Communications (10), Clinical Treatment (six), Patient Care (six), Values And Behaviours (six), Access To Treatment Or Drugs (three), Appointments (three), Trust Admin/Policies/Procedures (three), Admission/Discharge (one), Facilities (one), Restraint (one).

No complaints were referred to the Ombudsman.

Of the 15 complaints closed following investigation, 12 were closed within the agreed timescale. At the time of writing, 25 complaints remained open of which seven cases had breached the agreed timescale.

One complaint relating to Tarrant Ward (Patient Care / Failure To Provide Adequate Care / Upheld) was reopened due to unresolved issues.

Actions

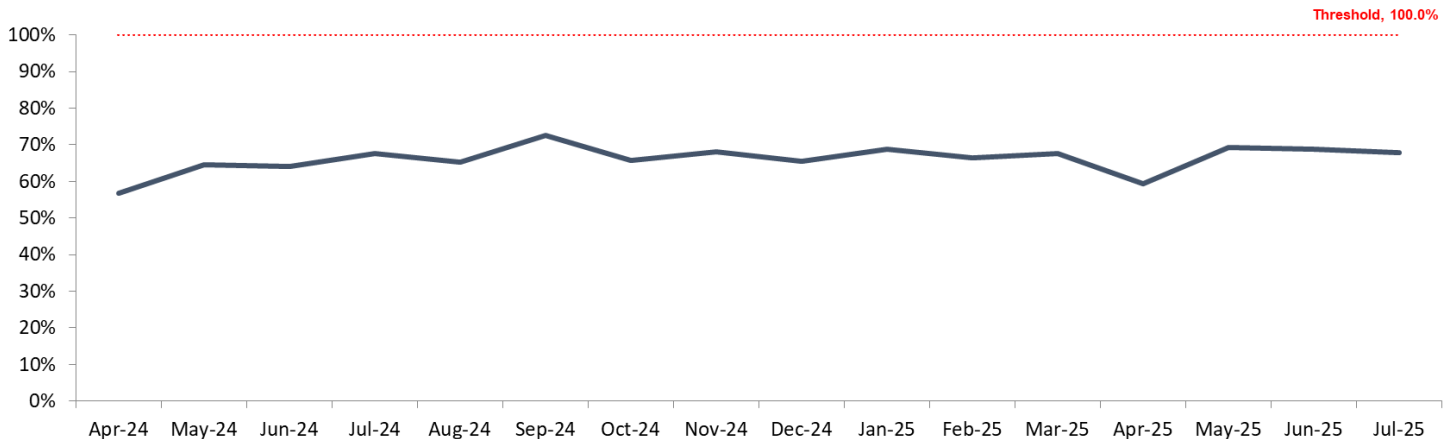
Duty of candour

CQC Question: Are We Safe?

Description of metric

Number of times duty of candour disclosure was initiated following incidents resulting in moderate, major or catastrophic harm.

Threshold: 100%



Analysis

The figure of 71.1% compliance requires further exploration to understand the areas of non-compliance. It should be noted that currently, our Ulysses reporting tool has two sections with overlapping details:

- People involved in the incident
- Duty of Candour (DoC)

DoC compliance data is pulled from the “People involved” section, not the DoC section, which may affect data accuracy.

Additionally, our reporting does not clearly identify incidents meeting statutory DOC criteria, limiting insight and detail surrounding the level of compliance.

Identification of reasons will support a plan for improving. A review was undertaken by the Director of Nursing, Therapies and Quality, who identified

Actions

Merge the two existing sections into a single “DoC” section with three mandatory questions to determine if the incident meets Statutory DOC criteria:

- It must have been unintended or unexpected.
- It must have occurred during the provision of an activity we regulate.
- In the reasonable opinion of a healthcare professional, already has, or might, result in death, or severe or moderate harm to the person receiving care.

Prior to this change an online training video will be sent to all staff alerting them of the change, explaining the need for change and definition given to the terminology to assist the reporter through the new process.

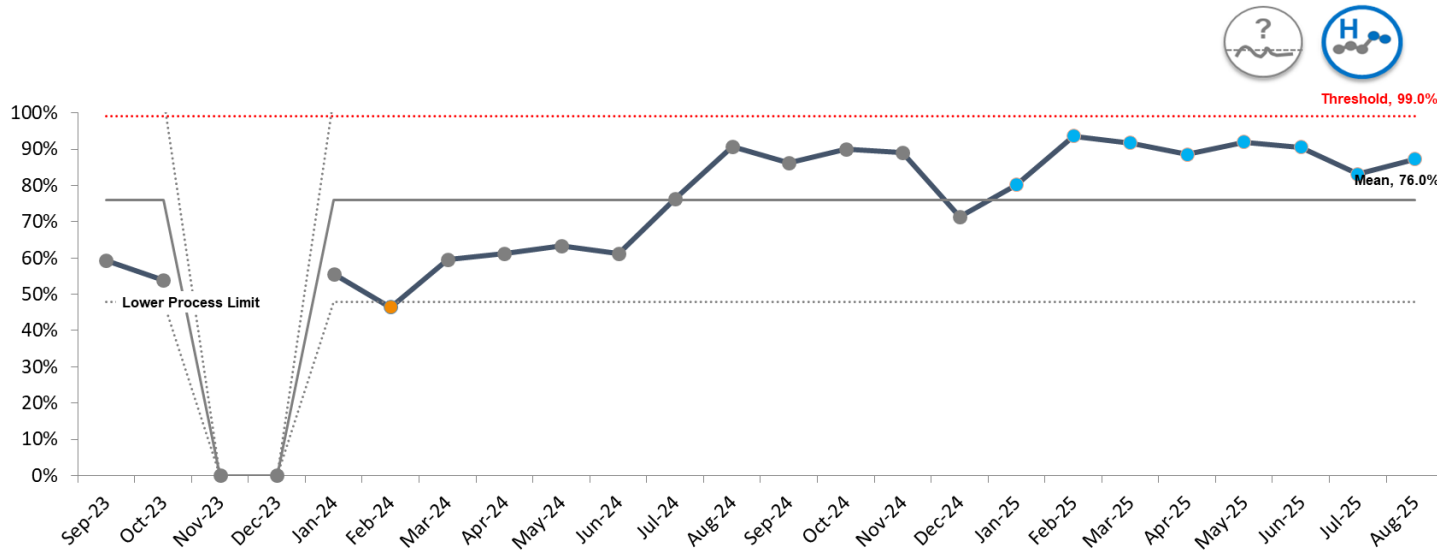
To improve training and understanding: a new simulation-based training

Duty of candour (Continued)		CQC Question: Are We Safe?
Analysis (cont.)	Actions (cont.)	
that whilst it was evident that contact and conversations had occurred with patients/families there were recording issues and a misunderstanding of what actually meets “Statutory” DOC vs a “Being Open” conversation (Professional DOC).	module is in development: This will further support staff to confidently navigate the DoC process while delivering sincere, compassionate apologies during difficult conversations.	
Baker, Abi 06/10/2025 12:40:16		

Maximum 6-Week Wait For Diagnostic Procedures (ICS)

CQC Question: Are We Effective?

Description of metric



NB data not available in November & December 2023

The purpose of this metric is to measure waits for key diagnostics tests. Diagnostic services in the Trust include audiology, echocardiography and ultrasound.

This metric includes all patients and is a contractual target.

Threshold: >=99%

Analysis

Audiology performance this month is 86.9%, 163/1,226 breaches (Jul 82.9%, 289/1689, breaches).

Operational plan forecast 93.1%, 110/1,600 (below target).

Longest waiters:

- Longest waiter 20 weeks (July longest waiter 16 weeks).
- 10 waiting 13+ weeks (July 13 waiting 13+ weeks).

Actions

Already in Place

- Increased oversight of longest waiters at Directorate performance meeting. Monthly report is being produced.
- Improved administrative validation as the numbers requiring validation have reduced.
- Locums are in place - 2.4 wte as agreed via Vacancy Control Panel. Once HR processes are complete, we will reduce this back to 1.4 wte as one of person is joining us on a substantive post, 1.0 wte B6.
- Use of clinical staff on Bank and making use of clinical students/apprentices within their scope of practice.

Further actions planned/underway:

- We continue to work with secondary care ENT providers across

Baker, Abi
06/10/2025 12:40:16

Maximum 6-Week Wait For Diagnostic Procedures (ICS) (Continued)

CQC Question: Are We Effective?

Analysis (cont.)

Actions (cont.)

Dorset to ensure best use of audiology activity as this currently continues to be a challenge for underutilised audiology activity in the West. Unused audiology appointments (West hub) have improved for July.

- The service will go live with self-referral for over 50-year-old hearing related referrals, across Dorset following a successful pilot in June. This is due to start on 22 September.
- A recovery plan has been requested by the ICB, and this will be reviewed in September.

Data Quality:

During July the service had an essential IT upgrade. This took four working days and during this time, we could not use the IT system and therefore activity was restricted to manual systems only which will impact on our DM01. The ability to add referrals during this time was restricted and therefore we have been behind in adding them to the IT system, but this will be resolved by mid-September.

Work between the Audiology service and Business and Performance team to improve data quality is providing greater assurance of accuracy of wait list reporting for general data and Community Diagnostic data. Plans to move the service data into the data warehouse are complete.

Demand and capacity to address the longest waits:

Additional Paediatric sessions will continue an ad hoc basis until longest waits are addressed. To address the adult longest waiters in the Bournemouth area, patients are being offered appointments (if willing to travel) to Weymouth who have shorter waits.

Baker, Abi
06/10/2025 12:40:16

Maximum 6-Week Wait For Diagnostic Procedures (ICS) (Continued)		CQC Question: Are We Effective?
Analysis (cont.)	Actions (cont.)	
	Our most challenging areas of the waiting lists are: Balance patients (particularly in the East hub). In July, the team completed a super week to try to reduce the waiting list. This is specialised work, requiring two clinicians and each appointment is two hours long. Improving clinic utilisation: Text messaging to help with DNA rates is being introduced however we have been delayed due to the process within the Trust, is progressing and we are hopefully will be in place in September.	

Baker, Abi
 06/10/2025 12:40:16

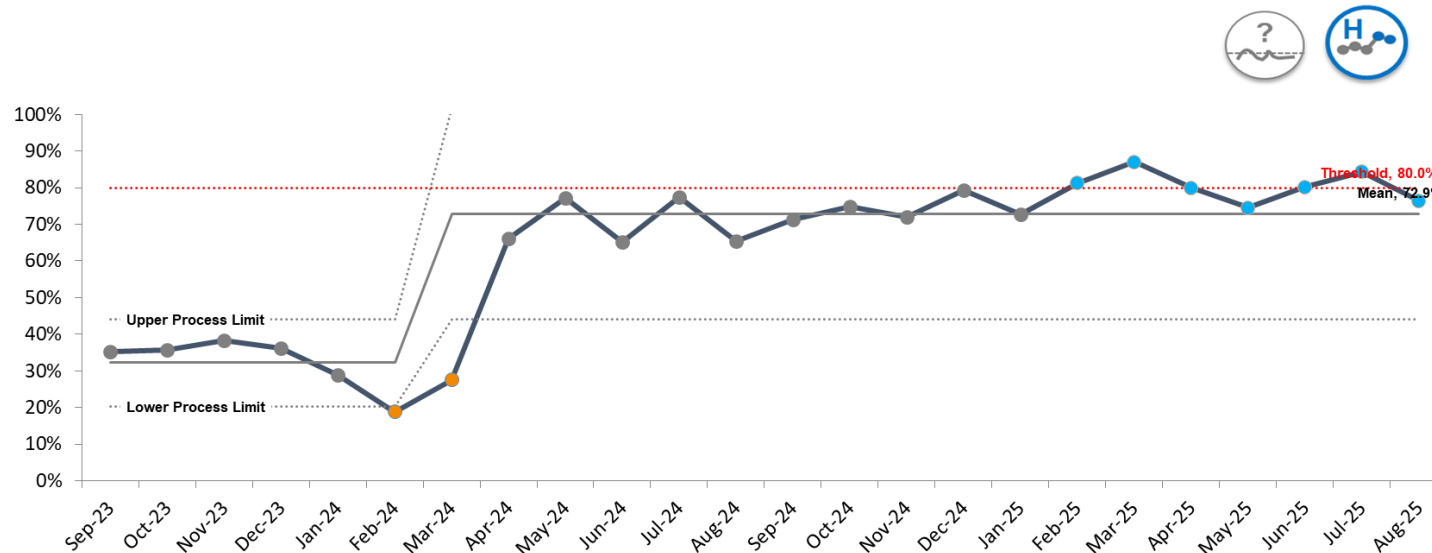
Virtual Wards Bed Occupancy

CQC Question: Are We Well Led?

Description of metric

The reported virtual ward occupied capacity divided by the total available virtual ward capacity (the number of patients who can simultaneously be managed within a virtual ward service) across all such existing services.

Threshold: 80%



Analysis

The metric is improving, and the target lies within the process limits so may or may not be met. Compliance for the combined (MH & CHS) trajectory of over 80% has declined slightly in August.

There were 3,007 bed days available during August of which 2,297 beds were used (76.4%) against the national target of 80%.

Mental Health (ICSD): 47 Beds for 1,457 Bed days in the reporting period of which, 1,075 used (73.8%). There were 28 admissions (mean LoS 51, median 32 days on the ward). There has been an increase in the LoS from the previous month.

Community Frailty: 50 Beds for 1,550 bed days in the reporting period of which, 1,222 bed days used (78.8%). There were 208 admissions (mean LoS

Actions

The frailty H@H offer is currently just under the 80% national target, systemwide actions are being refreshed to see how the three virtual ward offers can come together to offer a more robust service offer and meet national guidance. The Vertical alignment programme for both East and West via the provider collaborative is evolving to support this change in practice and workstream being developed. A pilot has begun to increase referrals from SWAST in Bournemouth and Weymouth/Portland, running alongside the development of the care coordination hub at IUCS hub.

The operational plan for Mental Health ICSD West Services was based on successful recruitment to provide the additional activity to meet the planned capacity. The Mental Health Support Workers in the West team (MHSWs) resumed working 07.30am – 10pm. However, due to unsuccessful recruitment registered staff are working 9am – 5pm, with ICSD East covering

Virtual Wards Bed Occupancy (Continued)

CQC Question: Are We Well Led?

Analysis (cont.)

5, median 4 days on the ward).

Actions (cont.)

from 5 – 8pm. 1.6 WTE registered staff have recently been recruited (1 WTE has started and the 0.6 WTE is due to start in September 2025). The registered staff commenced a revised shift pattern (7.30am – 10pm) from 10 August 2025, with telephone support from ICSD East when only one registered staff is on duty. However, since this change was planned, a further 1.4 WTE registered staff have resigned and are now working their notice period. Recruitment adverts have been placed, and the new shift pattern will continue to be monitored. ICSD East are supporting gaps in the new shift system, and this is currently being reviewed.

Baker, Abi
06/10/2025 12:40:16

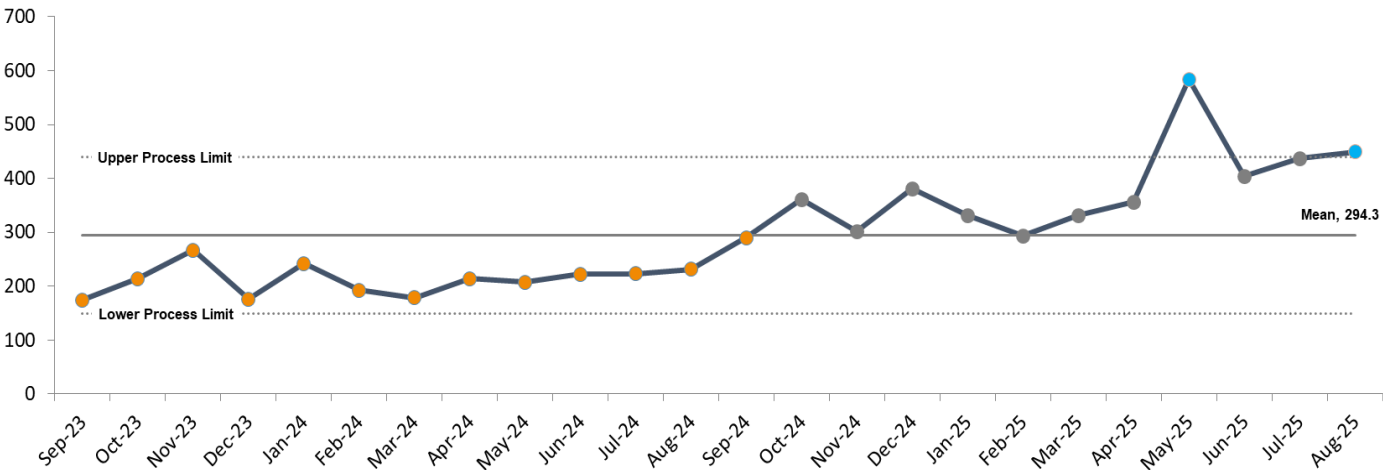
Compliments

CQC Question: Are We Effective?

Description of metric

Number of compliments received.

Threshold: None



Analysis

The Trust again sees a minimal but encouraging increase in Compliments for the month of August, 449 compared to 438 in July.

Actions

The team continues to raise awareness when conducting reviews throughout the Trust.

Baker, Abi
06/10/2025 12:40:16

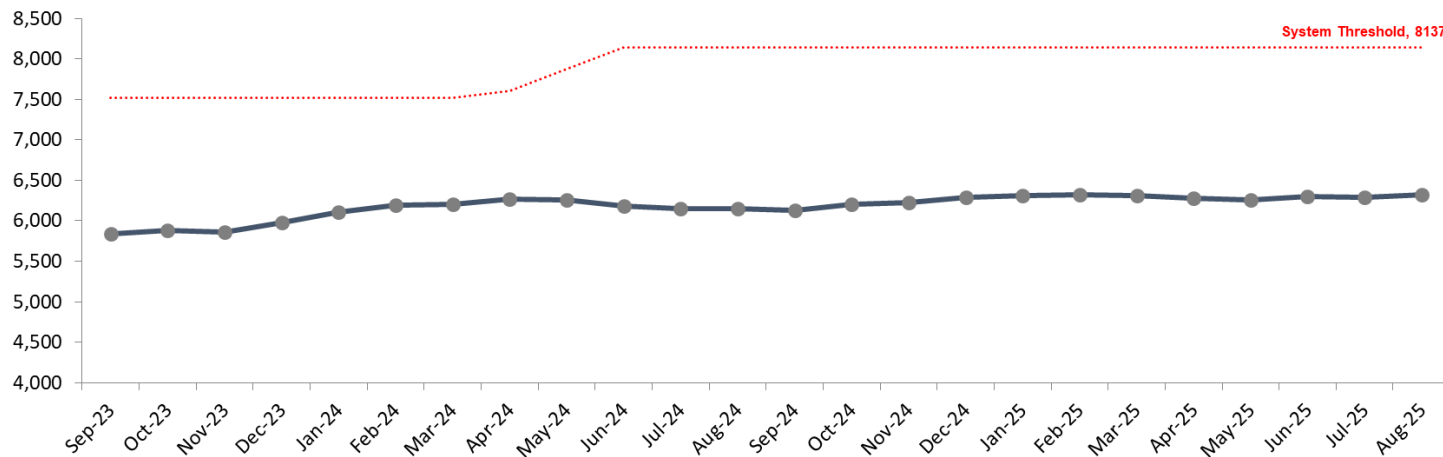
Children & Young People (CYP) Access 1+ Contact, DHC Under 18s – rolling 12 months

CQC Question: Are We Effective?

Description of metric

Number of CYP aged under 18 supported through NHS funded mental health with at least one contact. This is a count of people aged 0 to 17 who have had at least one contact (either direct or indirect) in the previous 12 months. 12 month rolling period.

Threshold: 8,137



Analysis

This is DHC's contribution towards the system level target. There is no individual target for DHC for the 1+ contact metric, which is based on a 12-month rolling period.

There are 3,594 open referrals across all DHC CAMHS teams (unique clients) as at the end of August 2025, of which 2,944 are deemed to be 'on caseload' this is calculated based on an open referral with at least two outcomed contacts at reporting period. The monthly average for attended (seen) appointments across all CAMHS teams is 4,316, this excludes Mental Health Support Teams (MHST) Whole School Approach activity, which is on average an additional 3,069 contacts per month.

The Kooth Counselling Service commissioned by the ICB, is also eligible towards this metric and the activity is included under national reporting.

Actions

Data is a count of children & Young People recorded as having at least one outcomed appointment in a DHC Children, Adolescent Mental Health Service (CAMHS). Data is based on a 12-month rolling period. The 2025/26 end of year system level target is 8,137 CYP accessing services.

CAMHS is about to commence the implementation of its transformation programme, which will see a move to a delivery model which provides significantly increased access for CYP and families. The “Thrive model” is based on need, with the following assumptions:

- 100% of the population would benefit from receiving advice and guidance (for some this would be received alongside more individualised help).
- The needs of 60% of the prevalent population would be effectively met by the targeted help offered in Getting Help services.

Children & Young People (CYP) Access 1+ Contact, DHC Under 18s – rolling 12 months (Continued)

CQC Question: Are We Effective?

Analysis (cont.)

Actions (cont.)

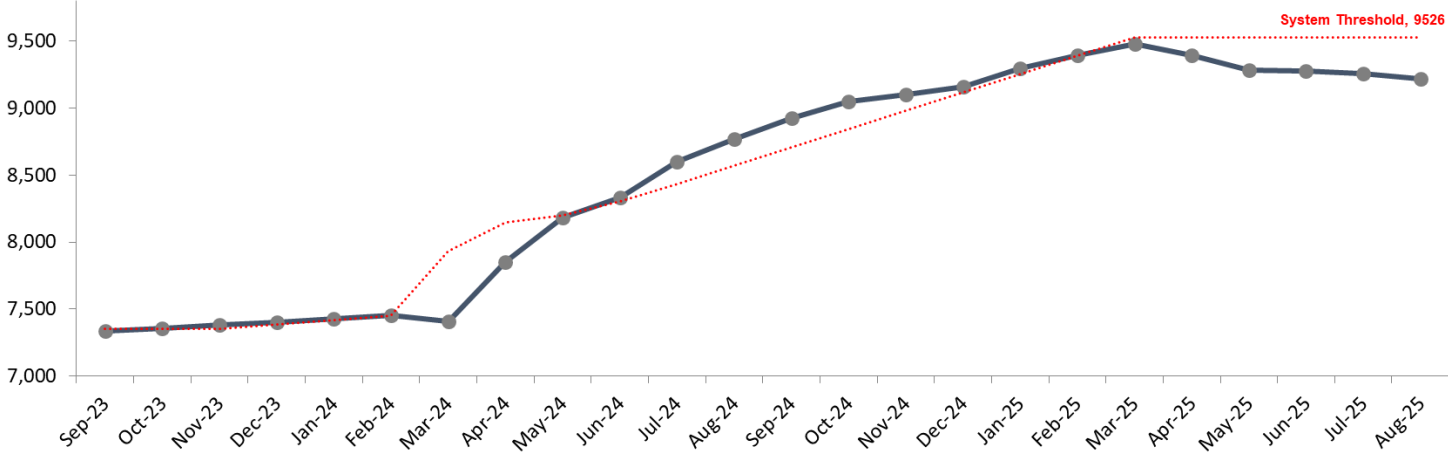
- The needs of 40% of the prevalent population would be effectively met by the more extensive help offered in Getting More Help services.
- At any one time there are 5% of the prevalent population in need of risk management only (Getting Risk Support).

With the addition of the Getting Help quadrant, which includes a new integrated front door with the Local Authority (place-based), the service will operate a “no wrong referral model”, which means more CYP will be able to access help based on their need, and the service will not be bound by exclusion and inclusion criteria.

The recruitment for phase 1 is due to commence imminently, which will increase capacity for access to services, and this trajectory will continue to improve as recruitment and implementation of the new model continues.

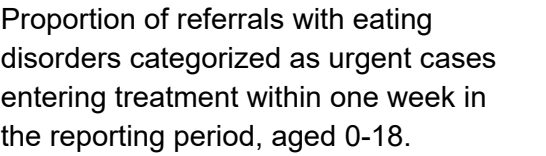
The trajectory for the projected contact increase as recruitment continues shows a quarter-on-quarter increase in access from Q4 2025/26 through to Q4 2026/27.

Baker, Abi
06/10/2025 12:40:16

Community Mental Health (CMH) 2+ Contacts, Local Provider Data - rolling 12 months																																																			
CQC Question: Are We Effective?																																																			
Description of metric																																																			
<table border="1"><caption>Estimated Data for CMH 2+ Contacts (Rolling 12 months)</caption><thead><tr><th>Month</th><th>Contacts</th></tr></thead><tbody><tr><td>Sep-23</td><td>7300</td></tr><tr><td>Oct-23</td><td>7350</td></tr><tr><td>Nov-23</td><td>7400</td></tr><tr><td>Dec-23</td><td>7450</td></tr><tr><td>Jan-24</td><td>7500</td></tr><tr><td>Feb-24</td><td>7550</td></tr><tr><td>Mar-24</td><td>7400</td></tr><tr><td>Apr-24</td><td>7850</td></tr><tr><td>May-24</td><td>8200</td></tr><tr><td>Jun-24</td><td>8350</td></tr><tr><td>Jul-24</td><td>8600</td></tr><tr><td>Aug-24</td><td>8750</td></tr><tr><td>Sep-24</td><td>8900</td></tr><tr><td>Oct-24</td><td>9050</td></tr><tr><td>Nov-24</td><td>9100</td></tr><tr><td>Dec-24</td><td>9150</td></tr><tr><td>Jan-25</td><td>9300</td></tr><tr><td>Feb-25</td><td>9400</td></tr><tr><td>Mar-25</td><td>9450</td></tr><tr><td>Apr-25</td><td>9400</td></tr><tr><td>May-25</td><td>9300</td></tr><tr><td>Jun-25</td><td>9250</td></tr><tr><td>Jul-25</td><td>9250</td></tr><tr><td>Aug-25</td><td>9200</td></tr></tbody></table> Number of people accessing community mental health services for adults and older adults with serious mental illness who received 2 or more care contacts within the Reporting Period. Patients who had an inpatient stay have been removed from the count. From April 2023 this measure includes IPS and EIP. Threshold: 9,526		Month	Contacts	Sep-23	7300	Oct-23	7350	Nov-23	7400	Dec-23	7450	Jan-24	7500	Feb-24	7550	Mar-24	7400	Apr-24	7850	May-24	8200	Jun-24	8350	Jul-24	8600	Aug-24	8750	Sep-24	8900	Oct-24	9050	Nov-24	9100	Dec-24	9150	Jan-25	9300	Feb-25	9400	Mar-25	9450	Apr-25	9400	May-25	9300	Jun-25	9250	Jul-25	9250	Aug-25	9200
Month	Contacts																																																		
Sep-23	7300																																																		
Oct-23	7350																																																		
Nov-23	7400																																																		
Dec-23	7450																																																		
Jan-24	7500																																																		
Feb-24	7550																																																		
Mar-24	7400																																																		
Apr-24	7850																																																		
May-24	8200																																																		
Jun-24	8350																																																		
Jul-24	8600																																																		
Aug-24	8750																																																		
Sep-24	8900																																																		
Oct-24	9050																																																		
Nov-24	9100																																																		
Dec-24	9150																																																		
Jan-25	9300																																																		
Feb-25	9400																																																		
Mar-25	9450																																																		
Apr-25	9400																																																		
May-25	9300																																																		
Jun-25	9250																																																		
Jul-25	9250																																																		
Aug-25	9200																																																		
Analysis	Actions																																																		
This metric is no longer an Operational Planning KPI and therefore has no associated target for 2025/26, although the ambition is to maintain 9,526. Compliance has dipped since March 2025 but is relatively stable and no current cause for concern. Data reconciliation has been completed between local (MHSDS) and national (Future NHS) reporting to ensure all appropriate data is being captured. Data is assured and now includes the Access Wellbeing activity captured via the IAPTus System. This metric forms part of the clock stop for the new Adult Mental Health 4 Week RTT indicator which is currently being worked up. There is no associated target for the new metric during 2025/26.	No action required.																																																		

Children & Young People Eating Disorders (CYPED) Urgent – 1 week CQC Question: Are We Responsive?	

Description of metric



Threshold: 95%

Analysis

August urgent referrals - 50%, one young person was seen within the target time and one outside, this was due to parent/patient choice.

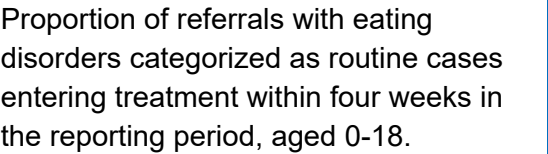
Baker-Abi
06/10/2025 12:40:16

Actions

No action needed.

Children & Young People Eating Disorders (CYPED) Routine – 4 weeks		CQC Question: Are We Responsive?

Description of metric



The waiting list is being closely managed, a small proportion of longer waits are regularly contacted by phone and/or letter however are not engaging or responding to an offer of an assessment.

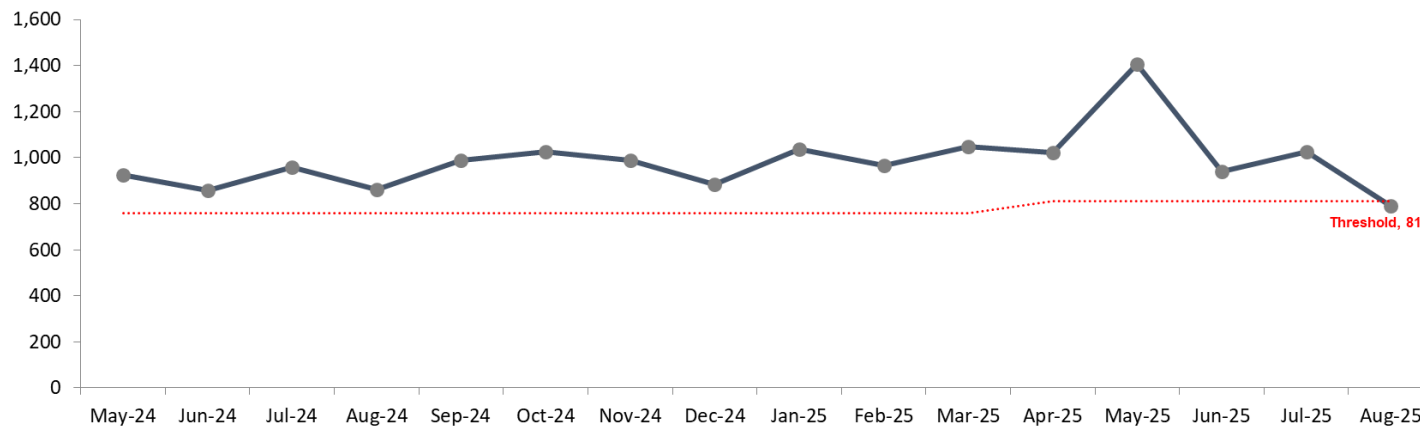
Talking Therapies Courses of Treatment

CQC Question: Are We Effective?

Description of metric

The number of people who have a course of treatment (2+ contacts).

Threshold: 812



Analysis

NHS Talking Therapies offer free psychological support to adults, addressing common mental health issues such as anxiety and depression. Challenges persist in meeting increasing demand and ensuring equitable access for all communities. The programme was due to have expanded in 2024/25 however the Dorset system did not allocate the ring-fenced funding, despite this the national targets have been set based on the planned expansion.

The primary purpose of this indicator is to measure the number of people who have been treated by NHS Talking Therapies Service and represents a shift from the number of patients being assessed, to the number of people being discharged following a course of psychological treatment.

The access targets for Dorset NHS Talking Therapies Service (in-year target 2025/26) is to fully treat an additional 650 patients (9,741) compared to the previous year (9,091). This represents a 7.1% increase in the service size.

Actions

The government has committed to achieving full national coverage for Talking Therapies by 2028, with a focus on addressing inequalities, improving service outcomes, and integrating mental health support into primary care networks. This investment proposal outlines the steps needed to future-proof the service, emphasising that only through immediate investment can it keep pace with national expansion goals.

The service is set to receive some funding, but not to the level of that which was modelled by the service to achieve all KPIs. This was confirmed in August 2025, meaning implementation has been significantly delayed.

This KPI threshold for courses of treatment is currently being met, however other areas are where the pressure will be noticed.

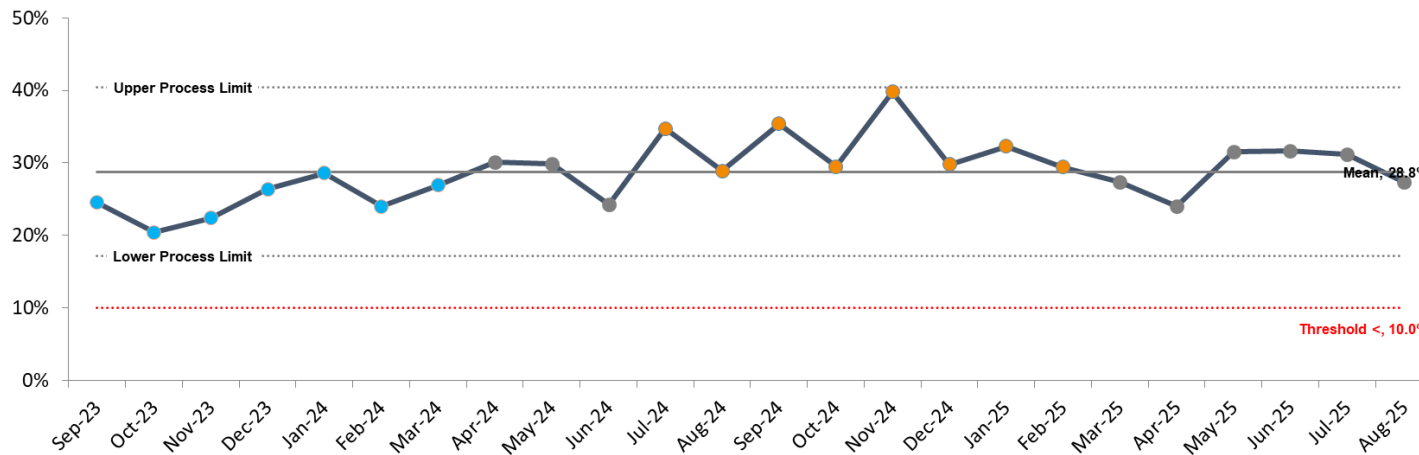
Talking Therapies 1st to 2nd treatment (Dorset only)

CQC Question: Are We Responsive?

Description of metric

The proportion of people who waited over 90 days between first and second treatment appointment (where the second treatment appointment occurred within the month) in the reporting period.

Threshold: 10%



Analysis

The primary purpose of this indicator is to measure the number of people who have waited more than 90 days between first and second appointments. There should be no in treatment pathway waits (where the person has an early appointment but is then put on an 'internal' waiting list before a full course of treatment starts). There should be appropriate measures taken to reduce the numbers of people who have waited over 90 days for a second appointment.

This indicator remains above the 10% target. The service has made significant efforts in reducing wait times for treatment through a service improvement project. Wait lists for counselling and Guided Self Help have significantly reduced in the last six months.

Actions

Service wide project to reduce wait times to treatment is ongoing, this includes working with assessors to offer least intrusive interventions, adherence to a new attendance policy and reviewing treatment in supervision. Service Leads are currently working with the assessors who are performing best at getting patients into the least intrusive interventions, with the plan for them to help those putting high rates of patients into 1-1 waiting lists.

It is the high intensity 1-1 waiting lists that are above the 90-day threshold, so this measure essentially shows the percentage of patients going into 1-1 high intensity each month. The current expansion of Talking Therapies services will be tailored towards the expansion of the High Intensity workforce, and this should naturally help to reduce waiting times, as long as the service receives the required investment.

Talking Therapies 1st to 2nd treatment (Dorset only) (Continued)	
CQC Question: Are We Responsive?	
Analysis (cont.)	Actions (cont.)
	The service is set to receive some national funding, but not to the level of that which was modelled by the service to achieve all KPIs. This was confirmed in August 2025, meaning implementation has been significantly delayed. It is unlikely that the investment received will have any demonstratable impact on waiting times in 2025/26.

Baker, Abi
06/10/2025 12:40:16

Talking Therapies Reliable Recovery

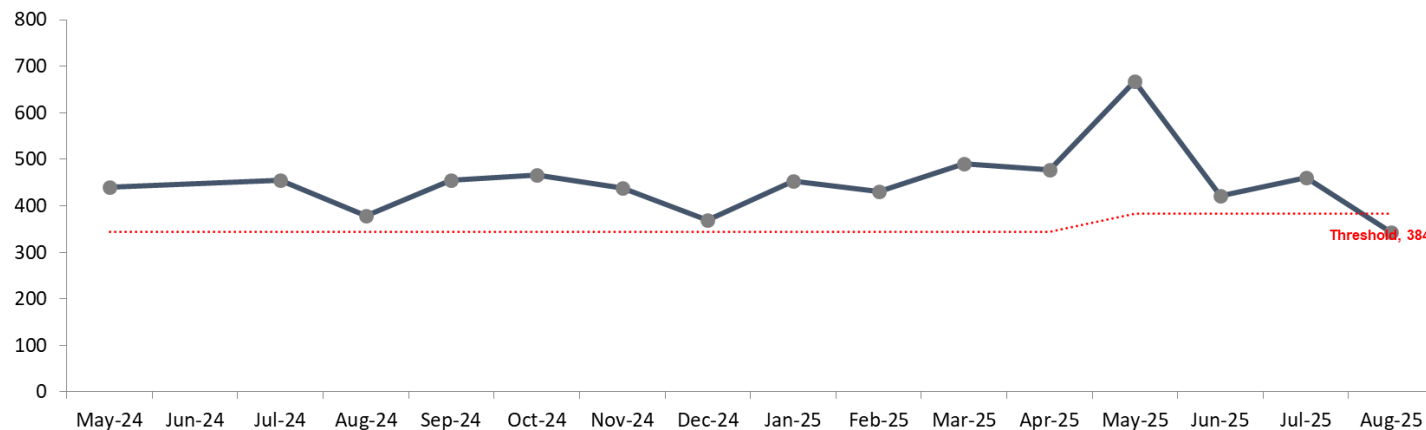
CQC Question: Are We Effective?

Description of metric

Numerator: Number of patients that achieved reliable recovery.

Denominator: Number of patients discharged having received at least 2 treatment appointments in the reporting period, that meet caseness at the start of treatment.

Threshold: 384



Analysis

In 2024/25, NHS Talking Therapies has recorded a reliable recovery rate of 45.4%. A key part of the planned expansion is to increase the therapeutic dosage by an average of one session per patient. This is therefore a significant increase in prescribed service size. In 2025/26 the threshold has increased from 344 per month to 383.5 (+39.5), which is a 2% increase in compliance 50% threshold and is set to increase by 1% year on year to 2028/29.

The primary purpose of this indicator is to measure the number of people who have been discharged having achieved recovery by NHS Talking Therapies. The service is performing well compared to the numerical target so far this year.

Actions

The government has committed to achieving full national coverage for Talking Therapies by 2028, with a focus on addressing inequalities, improving service outcomes, and integrating mental health support into primary care networks. This investment proposal outlines the steps needed to future-proof the service, emphasising that only through immediate investment can it keep pace with national expansion goals.

The service is set to receive some national funding, but not to the level of that which was modelled by the service to achieve all KPIs. This was confirmed in August 2025, meaning implementation has been significantly delayed. It is unlikely that the investment received will have any demonstrable impact on waiting times in 2025/26.

Talking Therapies Reliable Improvement

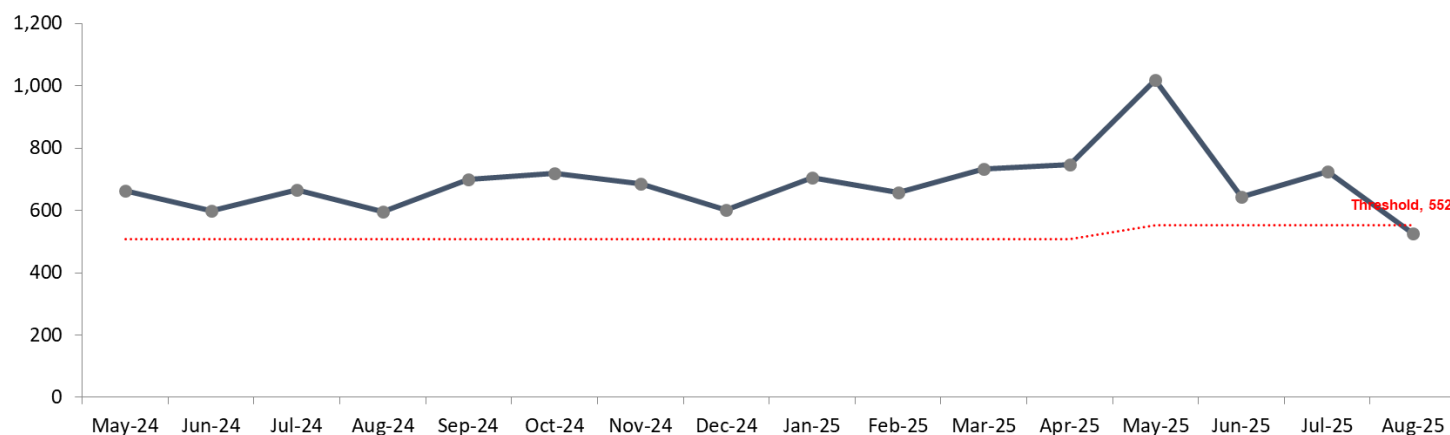
CQC Question: Are We Effective?

Description of metric

Numerator: Number of patients that achieved reliable improvement.

Denominator: Number of people who are discharged having received at least 2 treatment appointments in the reporting period.

Threshold: 552



Analysis

A key part of the planned expansion is to increase the therapeutic dosage by an average of one session per patient. This is therefore a significant increase in prescribed service size. In 2025/26 the threshold has increased from 507.5 per month to 552 (+44.5), which is a 1% increase in compliance 68% threshold and is set to increase by 1% year on year to 2028/29.

The primary purpose of this indicator is to measure the number of people who have been discharged having achieved reliable improvement. The service is performing well compared to the numerical target so far this year.

Baker, Abi
06/10/2025 12:40:16

Actions

NHS Talking Therapies are confident of achieving the 68% reliable improvement target (6624) with the current levels of investment. However, by 2027/28 this is likely to be difficult to achieve based on the target trajectory, unless further investment is received to allow dosage increase. By increasing the therapeutic dosage, the reliable improvement rate should increase.

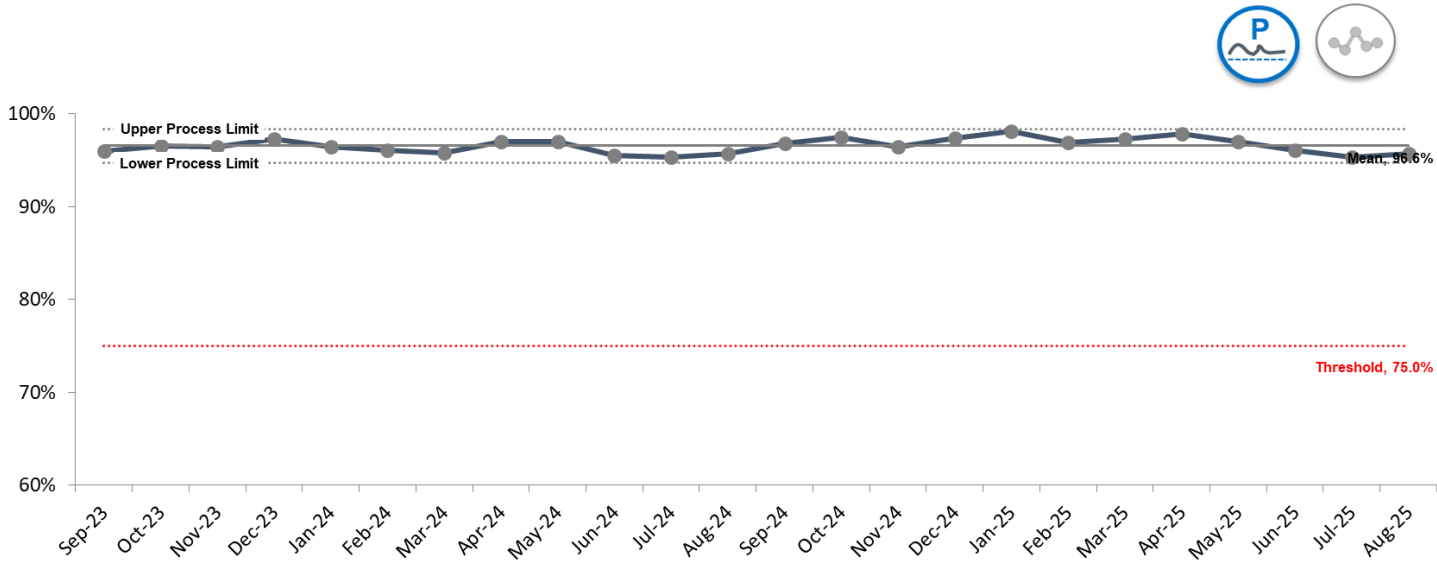
Talking Therapies Waiting Times - 6 weeks (Dorset only)

CQC Question: Are We Responsive?

Description of metric

Proportion of referrals that finished a course of treatment in the reporting period that waited 42 days or less for first treatment.

Threshold: 75%



Analysis

Threshold is consistently exceeded each month and within standard variation meaning the indicator is stable and will continue to meet the required target.

Actions

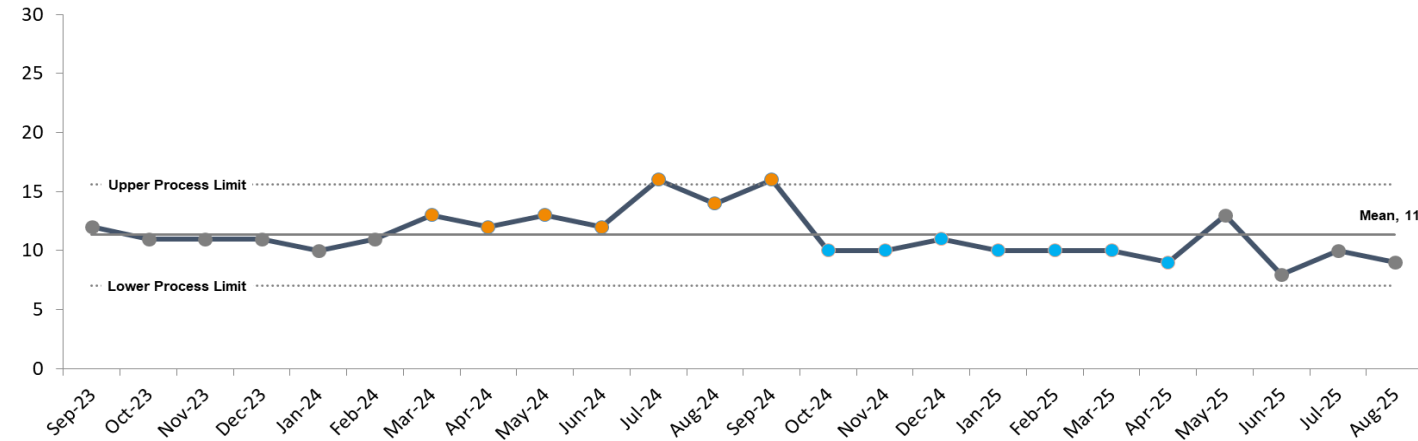
No action required as consistently above threshold.

Baker, Abi
06/10/2025 12:40:16

Southampton Priory Placements - Appropriate Out of Area Placements (Number of Active Placements at End of Month)

CQC Question: Are We Responsive?

Number of people admitted to DHC Priory Beds at end of month



Description of metric

The total number of days in which patients have been placed out of area due to unavailable beds in their usual network. A person with assessed acute mental health needs who requires adult mental health acute inpatient care is admitted to a unit that has been agreed as part of the Trusts footprint but is located outside of Dorset. Meets the criteria for being an appropriate admission.

Threshold: None

Analysis

Patients placed within Marchwood Priory have been designated as appropriate admissions and part of DHC's inpatient footprint by NHSE/NHS Dorset. This is a 10-bed block contract arrangement (commenced December 2022). Data is for oversight of admissions to the Priory Southampton; they do not fall under the definition of "inappropriate".

At the end of August there were nine patients still admitted to the Priory. A total of 275 Occupied Bed Days were utilised.

Baker, Abi
06/10/2025 12:40:16

Actions

Block contract with Priory commenced in December 2022 based on 12 beds. Increased to 13 beds April 2023, block purchase reduced to 10 beds from September 2024, in line with those due to be delivered from the New Hospital Programme in 2026/27.

Building work continues at St. Ann's hospital to increase DHC MH Inpatient bed stock as part of the New Hospital Programme – Due 2026/27.

The 10 block purchased beds at Southampton Priory are being appropriately and fully utilised. Additional beds used may also be used on a spot purchase basis (for admissions over the commissioned 10). These are classified as 'appropriate' admissions due to the close proximity to DHC but are in addition to the block purchased beds.

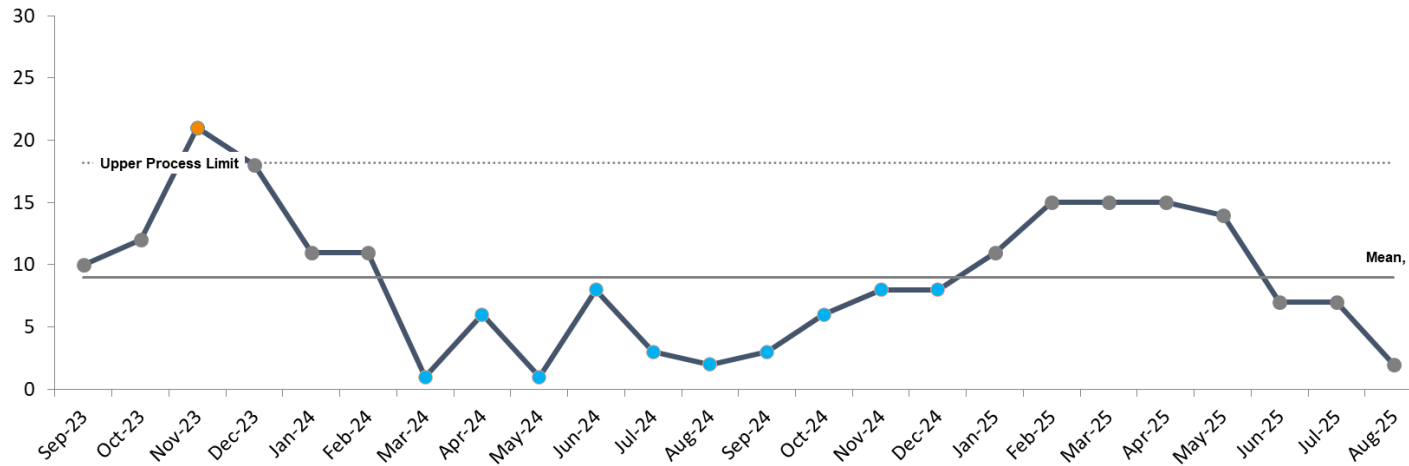
Out of Area Placements - Inappropriate Placements (Active Placements at End of Month)

CQC Question: Are We Responsive?

Description of metric

The number of days which patients have been placed out of area due to solely and primarily because of unavailable local beds (Inappropriate). A person with assessed acute mental health needs requires acute inpatient care is admitted to a unit that does not form part of their usual network of services, that does not usually admit people living in the catchment of the person's local community mental health service, where they cannot be visited regularly by their care coordinator to ensure continuity of care and effective discharge planning.

Threshold: None



Analysis

These admissions do not form part of the trust's usual local network of services. These are deemed "inappropriate out of area placements".

At the end of August there were two people admitted to an inpatient bed placed outside DHC's inpatient footprint – one adult acute and one PICU (Psychiatric Intensive Care Unit) and is below the operational planning trajectory. No one was admitted to an out of area mental health placement during the month and five were either discharged/repatriated to an appropriate setting. A total of 157 occupied bed days (OBDs) were utilised. This is in line with the Trust Directive to reduce OAPs to zero under the new Peri Hospital Mental Health Transformation initiative launched 2 June.

Actions

Internal oversight implemented for inappropriate Adult Acute Out of Area Placements with robust reporting, monitored by the Inpatient Bed Flow Managers and Directorate Management Group. Nursing, Quality, and Therapies undertake regular audit of the providers and the contact with DHC.

An Executive Directive was issued in May 2025, advising that the Peri Hospital Mental Health Transformation Programme is being rolled out. The aim of this programme is 'To care for Dorset patients in Dorset, providing a high-quality inpatient experience and optimising recovery times. With the intention that no person who is ready to go home remains in an inpatient setting, and no person who needs mental health inpatient care, is kept waiting in suboptimal care settings'. It is anticipated we will rapidly have no

Out of Area Placements - Inappropriate Placements (Active Placements at End of Month) (Continued)

CQC Question: Are We Responsive?

Analysis (cont.)	Actions (cont.)
Patient flow remains a challenge, whilst the new process is embedded and until the New Hospital Programme has been delivered. In August, 54 patients were identified as being Clinically Ready for Discharge (CRfD) for 565 occupied bed days, this equated to 21.5% of the eligible bed stock, 49/54 of those CRfD were delays (539 OBDs). For context under the new CRfD definitions a person can be clinically ready for discharge and not a delayed discharge but cannot be a delay without being CRfD. Baker, Abi 06/10/2025 12:40:16	inappropriate out of area patients, without carrying unacceptable levels of risk in the community. This programme was put into action from 2 June and will be enacted by Home Treatment Team (HTT) working with the Patient Flow Team. Drop-in sessions are being set up for all staff working within these pathways.

Perinatal & Maternal Mental Health Access rolling 12 months

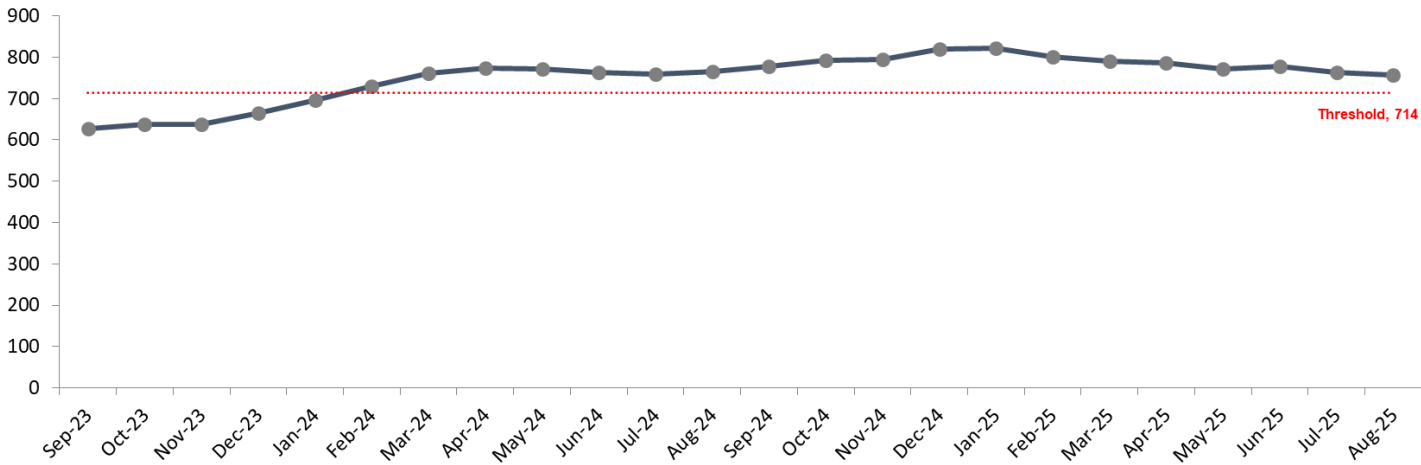
CQC Question: Are We Responsive?

Description of metric

This is a count of females who have had at least one attended contact with Specialist Perinatal Mental Health Community Services in the previous 12 months. This count includes trans patients from April 2023.

The LTP committed that at least 66,000 women with moderate to severe or complex perinatal mental health needs will have access to specialist community care, from pre-conception to 24 months after birth, with increased availability of evidence-based psychological therapies.

Threshold: 714



Analysis

Compliance remains above required threshold.

Actions

Maintain current and planned position during 2025/26.

Baker, Abi
06/10/2025 12:40:16



Description of icons

Assurance			Variation						
Consistently Pass target	Pass and fail target subject to random variation	Consistently Fail target	Special Cause Concerning variation either Higher or Lower		Special Cause Improving variation either Higher or Lower		Special Cause Neither improving nor concerning variation		Common Cause

Communities Metrics	In Month	Assurance	Variation	Data Quality
Completeness of Patient Ethnicity Data	92.0%			TBC
Dementia Diagnosis Rate	57.2%			High
Serious Mental Illness (SMI) Physical Health Checks	68.1%			High
Learning Disabilities Annual Health Checks YTD	23.9%			High

Baker, Abi
06/10/2025 12:40:16

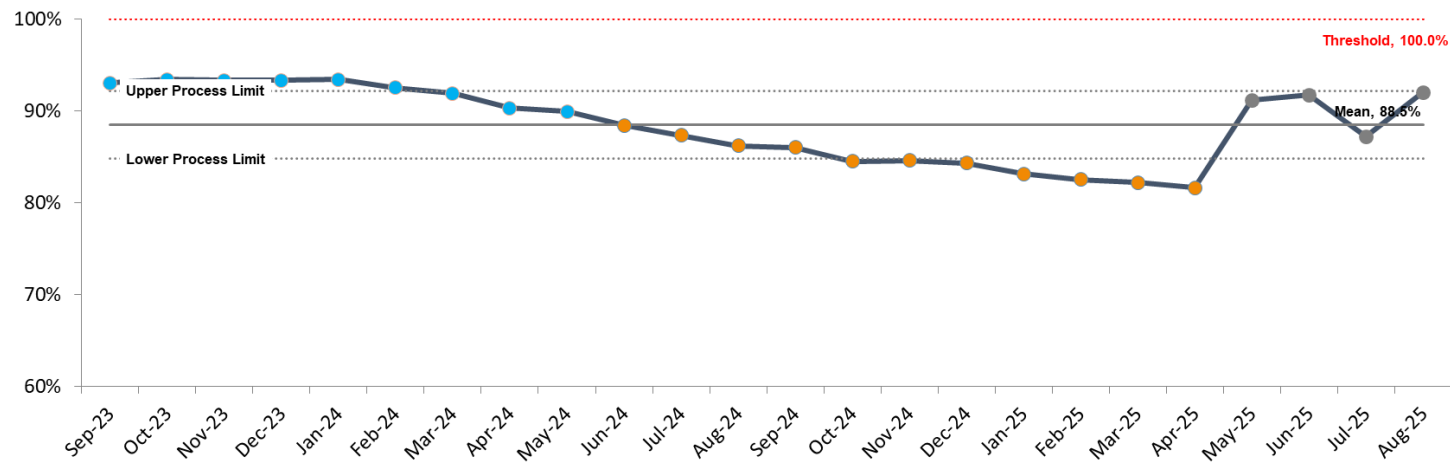
Completeness of Patient Ethnicity Data

CQC Question: Are We Responsive?

Description of metric

The percentage of service users who have their ethnic category recorded on a source system and which can be used for reporting purposes.

Threshold: 100%



Analysis

Without intervention this metric will consistently fail to meet the threshold.

Baker, Abi
06/10/2025 12:40:16

Actions

Already in progress:

- Business & Performance project to review quality & completeness of patient demographics
- current focus on protected characteristics (Ethnicity, Age, Postcode)
- testing dashboard to ensure timeliness of third party (DiiS) data

Planned:

- engagement with services where Ethnicity is not consistently recorded

Dementia Diagnosis Rate

CQC Question: Are We Responsive?

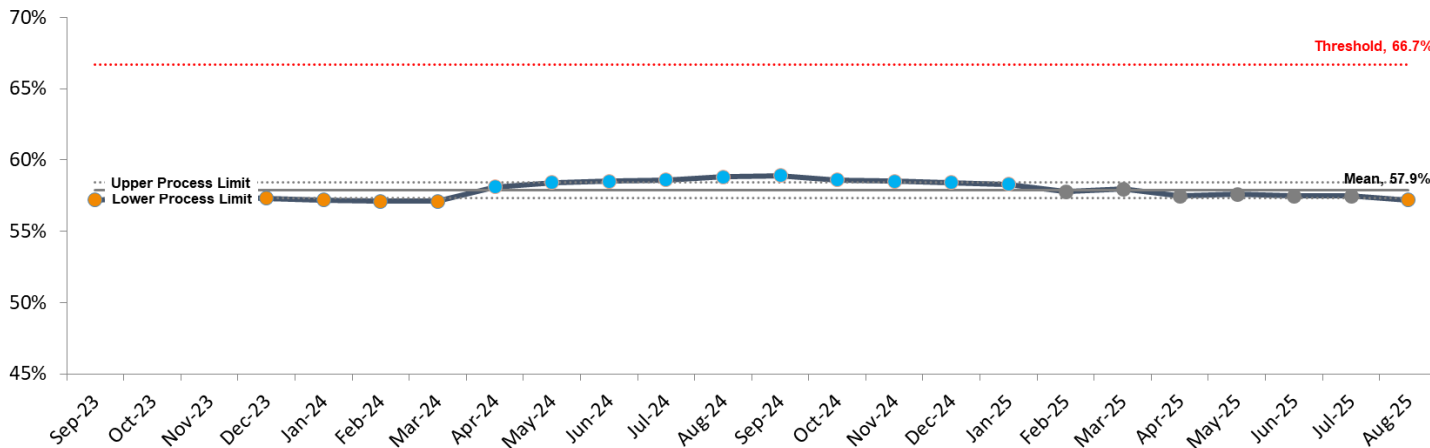
Description of metric

Not everyone with dementia has a formal diagnosis. The indicator compares the number of people thought to have dementia with the number of people diagnosed with dementia, aged 65 and over. The target is for at least two thirds of people with dementia to be diagnosed.

Threshold: 66.7%



Threshold, 66.7%



Analysis

The service is commissioned for a total of 3,200 referrals p.a. Achieving 66.7% equates to 2,134 diagnoses per annum. The service is commissioned to a model of 2,400 diagnosis slots and currently has capacity for 2,940 slots (+540 based on job plans). Approx. 80% of referrals (conversion rate) are eligible for assessment/diagnosis this equates to 3,138 referrals per annum.

There were 218 discharges from the Dorset Dementia service in August. 64.7% (141 people) were discharged with a diagnosis. The data excludes discharges for a Medication Review (9 people) and inappropriate referrals (48 referrals). 68 people (33%) were discharged without a diagnosis, this includes people who died, moved, Patient non-engagement' etc. Once a diagnosis has been given this data is sent to the patients GP to be entered into the GP Dementia Register (QOF), this needs to be accurately updated in the GP clinical record (System1) with the correct codes associated to be

Actions

Following the recommendations made from NHS Dorset Dementia Review, data quality validation and reconciliation completed between RiO (diagnosis), S1 GP Register recording/national submission and published National Data, the review highlighted a number of data quality issues where people have a Dementia related ICD10 code on RiO/diagnosis provided by DHC but no Read coded Dementia Diagnosis on S1 in Primary Care.

This is supported by the DHC provisional diagnosis data outlined above. Updating the data used for national reporting (DDR) sits within Primary Care. The ICB had agreed to a number of actions to support Primary Care improve compliance reporting.

DHC to check if the correct READ codes are included in the patients discharge letters to GP so this data can be accurately recorded.

Dementia Diagnosis Rate (Continued)

CQC Question: Are We Responsive?

Analysis (cont.)

reflected in local and national reporting. The ICB report this metric via the DiiS Dementia Report. The CFAS II estimated prevalence for Dorset is 14,667 there are 8,370 people on the GP dementia register, which is 1.04% of the Dorset Population.

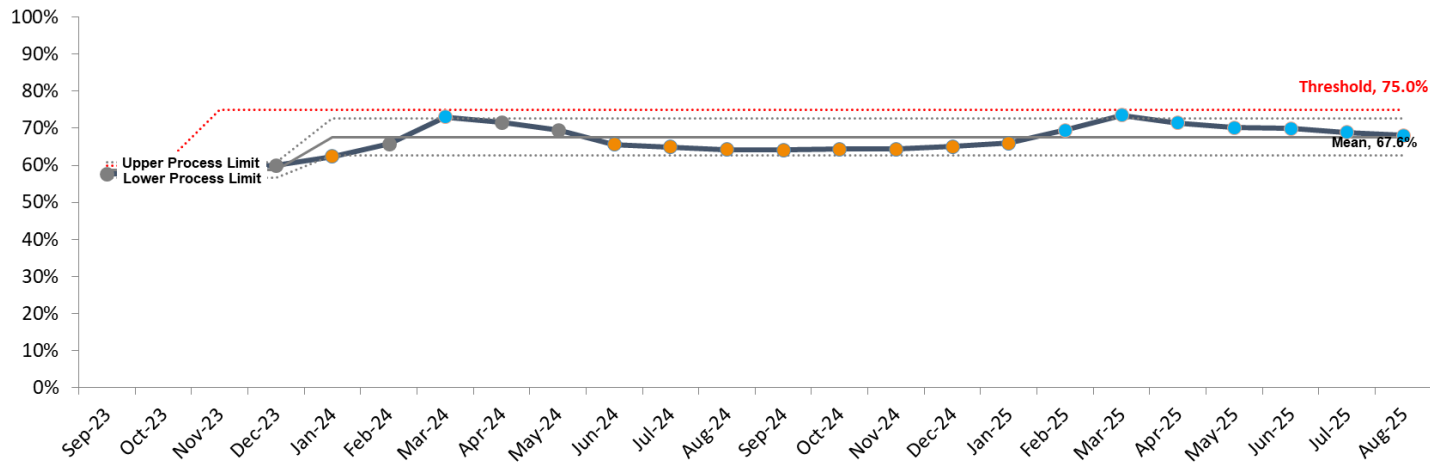
2/18 PCNs are reporting above 66.7% compliance (Shore Medical 69.2% and South Coast Medical 85.2%). The lowest performing PCN is Jurassic Coast 41.9%. An additional 1,413 diagnoses coded in the S1 GP register are required to meet the 66.7% threshold.

Actions (cont.)

Baker, Abi
06/10/2025 12:40:16

Serious Mental Illness (SMI) Physical Health Checks

CQC Question: Are We Effective?



Description of metric

The count (expressed as a percentage) of the number of people on the General Practice (GP) SMI register at the end of the reporting period that have had a full physical health check in the preceding 12 months. A full physical health check includes 6 components: a measurement of weight, a blood pressure and pulse check, a blood lipid including cholesterol test, a blood glucose test, an assessment of alcohol consumption, an assessment of smoking status.

Threshold: 75%

Analysis

The Serious Mental Health (SMI) population as recorded in the GP SMI registers is 8,920 (total register), of which 6,071 (68.1%) have had the full six health checks completed in the past 12 months. This is monitored via PCN compliance and is within standard variation, no cause for concern, however the target may or may not be met as the target lies outside the process limits.

One PCN remains off track (below 60%) due to recruitment and vacancy issues (an improvement from last month) - Shore Medical 51.06%

Compliance is showing a positive upturn and remains above the 60% minimum requirement but is slightly off track against the 75% ambition (data is provisional at the time of publishing).

Actions

The National Target is 60% with an ambition to meet 75% by 31 March 2026. Data submission is via the GPES which is the primary care equivalent of MHSDS. National compliance is reported via NHSE MH Core Data Pack (quarterly %). NHSE are reporting via the 'Active' SMI register instead of 'Total' register which is used for local reporting (includes those in remission), work is underway to ensure the same methodology is being applied.

There was also a significant increase in the GP SMI Register in June 2024 due to national changes to QoF cluster codes (adding additional SMI diagnosis codes), which is impacting on compliance. The DiiS team are awaiting the revised codes before the SMI report vs the SystmOne figures can be reviewed and updated with the aim of fully aligning them.

SMI PHSW vacancies have been successfully recruited (3 new starters) and there is confidence that figures will start to increase.

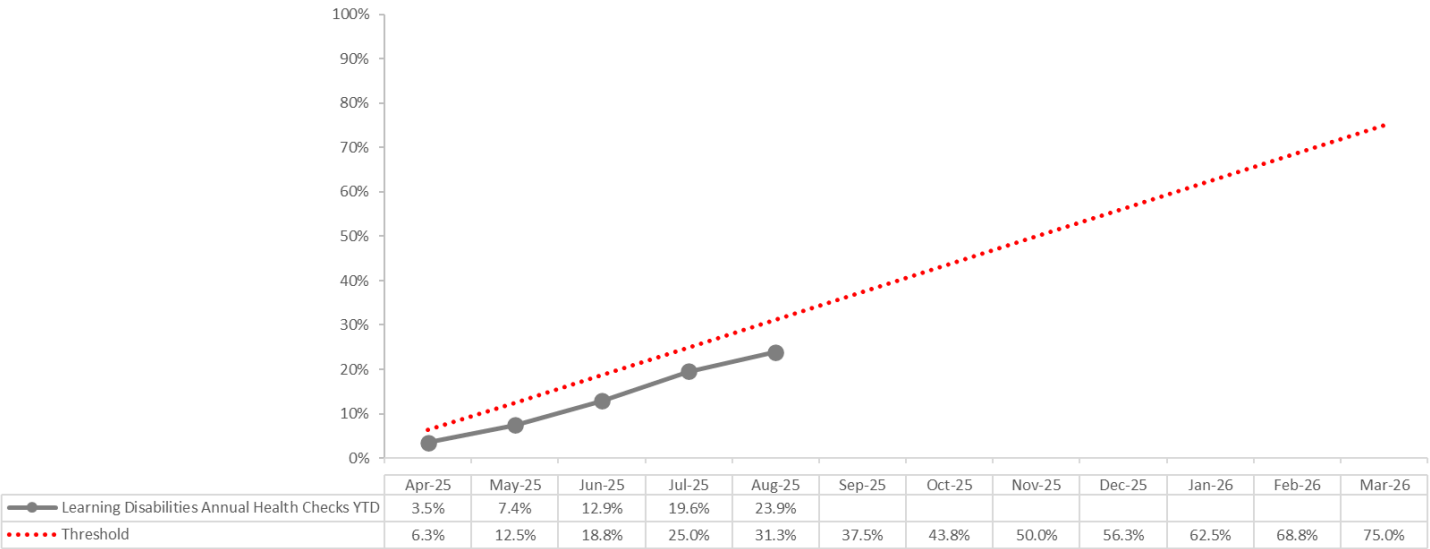
Learning Disabilities Annual Health Checks YTD

CQC Question: Are We Effective?

Description of metric

Compliance with the uptake of Health Checks completed for people on the GP Learning Disability register within Primary Care and how they are performing in relation to the target. Data Source is the LD Report from the DiiS. Based health checks completed by PCN/GP Surgeries per month.

Threshold: 31.3%



Analysis

Actions

There are 4,998 people (aged 14 and over) in Dorset recorded on the Learning Disability Register. This is approx. 0.6% of the Dorset population. The LD Annual Health Check is a reasonable adjustment that can be effective in detecting unmet health needs and leads to the treatment of health conditions which may be serious or life threatening.

Health checks are delivered and recorded by Primary Care, there is no action for DHC

This is a cumulative target of which 75% (3,746) people on the general practitioner (GP) Learning Disability Register should have an annual health check completed by 31 March 2026. 1,195 checks have been completed YTD 2025/26 (43 people have declined).

This is on track (based on previous years trend analysis and no cause for concern).

COLLEAGUES



Description of icons

Assurance			Variation						
Consistently Pass target	Pass and fail target subject to random variation	Consistently Fail target	Special Cause Concerning variation either Higher or Lower		Special Cause Improving variation either Higher or Lower		Special Cause Neither improving nor concerning variation		Common Cause

Colleagues Metrics	In Month	Assurance	Variation	Data Quality
Violent Incidents - patient on staff all settings	77			High
Mandatory training completed	92.3%			High
Completed Appraisals last year	84.4%			Medium
Employee Relations cases (current live cases)	60			High
Staff turnover (monthly)	0.8%			Medium
Leaver rate	6.1%			High
Vacancy rate	7.9%			High
Sickness absence rate (monthly)	4.9%			High

Baker, Abi
06/10/2025 12:40:16

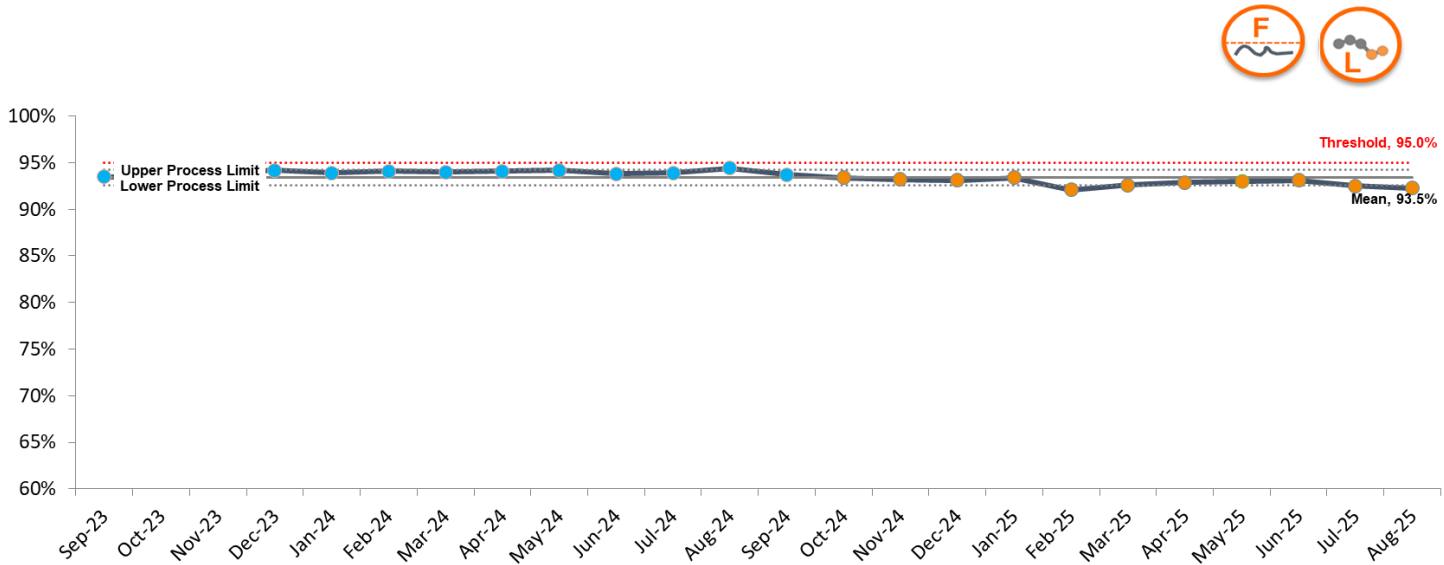
Mandatory Training Completed

CQC Question: Are We Safe?

Description of metric

Percentage of staff at month end having completed the Mandatory training requirements, as set nationally by the UK Core Skills Training Framework (2013). This is Conflict resolution, Equality diversity and Human Rights, Fire, IPC, IG, Health and safety, Manual Handling, Preventing radicalisation, Resus, Safeguarding adults and Children. The required level of training is dependent on profession and workplace and staff group requirements are decided locally.

Threshold: 95%



Analysis

Eleven topics saw an increase this month with a further 11 seeing a slight decrease and one remaining the same which resulted in an overall slight decrease from 92.5% to 92.3%. Five Topics achieved over 95% with a further six topics over 90% and a further nine topics achieving over 85%. There are just three topics under 85% compliance. Patient Safety had another slight increase and achieved 96.2% compliance and Oliver McGowan Tier 1 Part 1 also saw another very slight increase and achieved 96.8% compliance. Healthcare Scientists and Additional Clinical Services maintained over 95% compliance with 96.8% and 95.1% respectively. A further four groups remained over 90% compliance. Medical and Dental had a slight decrease from 79.9% to 79.8% and Estates and Ancillary saw a slight decrease also from 79.7% to 77.5%.

Actions

The slight decrease was not unexpected as likely to be due to the summer holidays and staff taking or covering for annual leave as well as the usual work pressures. Positive feedback continues to be received for the Learning and Development Service Reporting monthly reminders whilst also promoting the eHub manager dashboard and the RAG Report which managers can use on eHub to check staff completions and compliance. Signposting staff promptly to the mandatory training booklet to assist them in identifying the training requirements for their staff group whilst also advising to check for any role specific courses they may require. A manager's training page is being added to the mandatory training booklet for ease of access to managers requirements.

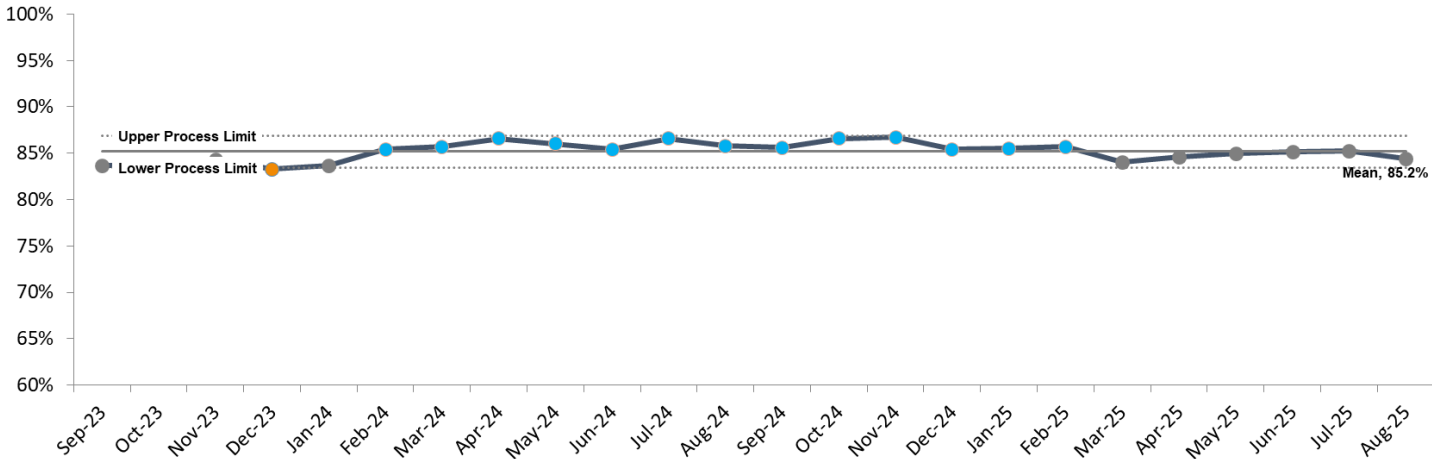
Completed Appraisals (last year)

CQC Question: Are We Safe?

Description of metric

Percentage of staff having recorded an appraisal conversation within the past 13 months.

Threshold: None



Analysis

A slight decrease this month from 85.3% to 84.4% although Estates and Ancillary saw another increase from 63.8% to 65.7% which was a further increase of 1.9%. Allied Health Professionals also saw an increase from 89.6% to 91%. A further four staff groups achieved over 85% compliance.

Actions

The slight decrease was not unexpected as it could be due to the summer holidays and staff taking or covering for annual leave as well as the usual work pressures. Monthly reminder emails sent as usual along with the update to the HR Business Partner for Estates and Facilities staff using the paper appraisal for completions. Responding to appraisal queries promptly and signposting staff/managers to the relevant documents and web pages. Communication has been included in the Weekly Bulletin for the launch of the new appraisal system on eHub with effect from 1 September 2025. Documents and user guides have been embedded into the eHub system and there are drop-in sessions for staff to book on through eHub where HR will advise regarding the process and any questions staff may have.

Baker, Abi
06/10/2025 12:40:16

Employee Relations Cases						CQC Question: Are We Safe?
	Discipline	Grievance	Sickness	Mediation	Total Cases	Description of metric
Case number in rolling 12-month period	54	27	142	8	231	Disciplinary, grievance, sickness absence and mediation cases in the rolling 12-month period and Number of weeks that live cases have been open. Threshold: None
Live Cases: Number of weeks open (so far)	Discipline	Grievance	Sickness	Mediation	Total Cases	
0 – 4 weeks	1	1	7			
5 – 8 weeks	1	1	4			
9+ weeks	10	3	29			
Live Cases: Total	12	5	40	3	60	
Analysis			Actions			
Overall, there has been an increase in the number of live cases since the last report. Breakdown by case type shows: - Disciplinary cases have increased from 11 to 12 cases. - Grievance cases have decreased from six to five cases. - Sickness absence cases have increased from 38 to 40 cases. - Mediation cases have increased from two to three cases. Whilst the aim is to resolve all cases as expediently as possible and to avoid unnecessary delays, it should be noted that the management of sickness absence cases are, by their nature, more long-term. There was one live suspension at the end of August - a Support Worker within Community Hospitals. The disciplinary cases show that one case has been live for up to 4 weeks and one case has been live for more than 4 weeks but less than 8 weeks. The remaining 10 cases have been live for 8 weeks or more. The status of the cases that have been live for more than 8 weeks shows that six are at the investigation stage and four have a hearing date scheduled.			The Respect and Resolution Policy and Procedure is now being embedded across the organisation. It replaces the previous Grievance Policy and Procedure and the Dignity at Work Policy. The new policy, along with its supporting toolkit and process flow, is available to all staff via a dedicated page on the intranet. An addendum is included, specifically focused on managing allegations of discrimination, bullying, harassment, and victimisation. In addition, a standalone Sexual Safety Policy - aligned with the national framework - was ratified by the Trade Union Partnership Forum in April 2025. Feedback from staff networks has been actively incorporated into its development. An interactive online training module is now available to all staff, complemented by informal, action-learning style sessions held via MS Teams. These sessions are open to managers who have completed the training and wish to explore the content in greater depth. The online reporting form has been modified to support anonymous reporting. The HR team continues to collaborate with the Patient Safety team on implementing the Patient Safety Incident Reporting Framework (PSIRF). This partnership ensures alignment with the principles of a Just and Learning Culture and supports a clear, consistent approach to addressing staff-related safety concerns.			

Employee Relations Cases (Continued)

CQC Question: Are We Safe?

Analysis (cont.)	Actions (cont.)
The five grievances relate to working relationships and working conditions. Two are at the informal stage; two are at the hearing stage; and one is at the investigation stage. The three mediation cases have mediators allocated to support the parties to reach a resolution. A new employment tribunal claim has been received, and the status of the five employment tribunal claims is: - One claim has identified two respondents (the Trust and an employee) and we have agreed that the claims can be combined and addressed together, with our grounds of response filed within the deadline of 21 February 2025. A telephone preliminary hearing was held on 6 May 2025 but was unsuccessful in clarifying the claims and a full day video Case Management Preliminary Hearing was held on 2 September 2025. Whilst the claim against the employee has been dismissed, judgement has been reserved on the remaining elements and is expected within 3-4 weeks. (Mental Health Services) - Another claim had a telephone preliminary hearing held on 27 August 2025 and directions have been set with a full hearing listed for 21 September to 2 October 2026. - One claim has a compulsory Alternative Dispute Resolution (ADR) hearing listed for 2 October 2025 and a 12-day hearing from 19 November to 4 December 2025. The Claimant has also filed a second claim, and our response was filed within the deadline of 21 February 2025. Witness statements have been taken, and disclosure documents are being collated in preparation of agreeing the bundle. (Integrated Community Services).	In parallel, we are working closely with Organisational Development (OD) colleagues to co-design training and approaches that promote a Restorative and Learning Culture. This content has now been incorporated into the new Manager's Induction Programme, which is delivered monthly. To promote consistency, early resolution, and continuous improvement, monthly Employee Relations (ER) case meetings are held with the HR team. These structured sessions provide oversight and enable discussion of casework to ensure fairness, compliance, and shared learning. Additionally, monthly review meetings are held between the Head of HR, HR Manager, and the Service Director for People and Culture to monitor cases open for more than eight weeks, as well as those identified as complex or high risk. Strong collaborative relationships continue with the Director of Nursing, Freedom to Speak Up Guardian and Medical Leads. Regular monthly meetings support alignment and coordination across all areas. We also actively participate in the Chief Nursing Officer Advisory Group, the Responsible Officer Advisory Group, and Fitness to Practice meetings. Recognising the importance of robust investigations to support formal processes we have established a cohort of Investigating Officers from each directorate. The first cohort will receive training in September, and we will introduce a rota system for investigations. It is hoped this will avoid delay. Finally, we are piloting a new triage form to support the initial assessment of potential conduct concerns. This tool has been developed to promote a fair, transparent, and consistent approach to managing such matters. It is designed to guide early decision-making, ensure consistency across cases, and reflect our commitment to a Just and Learning Culture. The process has been informed by the Mersey Care Decision Tree. Feedback from the EDI group has been included.

Employee Relations Cases (Continued)

CQC Question: Are We Safe?

Analysis (cont.)

- The fourth claim is being listed for a two-day preliminary hearing by video. A disability impact statement and medical evidence must be submitted by the claimant by 18 August 2025, and we must respond confirming whether we accept or deny disability by 15 September 2025 (Mental Health Services).
- The new claim relates to pregnancy/maternity discrimination and while our response (ET3) is required to be filed by 8 September 2025, a preliminary hearing has already been set for 14 April 2026 (Integrated Community Services).

Actions (cont.)

Baker, Abi
06/10/2025 12:40:16

Staff Turnover and Leaver Rate

CQC Question: Are We Caring?

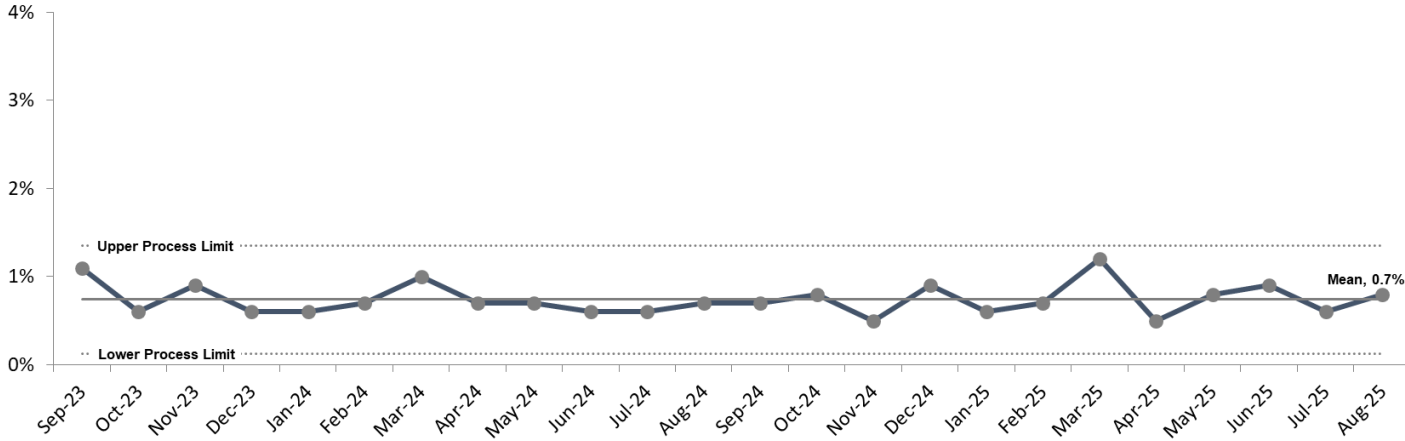
Staff Turnover (monthly)

Description of metric



Voluntary Leavers headcount in the period / Average Headcount in period.

Threshold: None



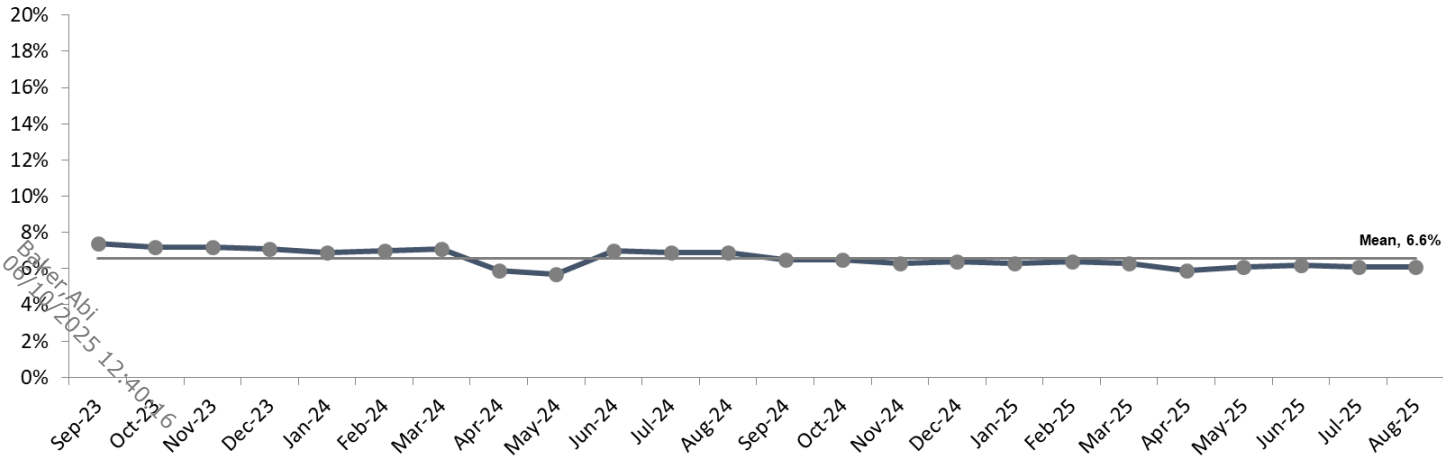
Leaver Rate (monthly)

Description of metric

NHS Oversight Framework

FTE of all staff leaving the NHS during the 12-month period / FTE of all staff in post at the beginning of the 12-month period (percentage).

Threshold: None



Staff Turnover and Leaver Rate (Continued)

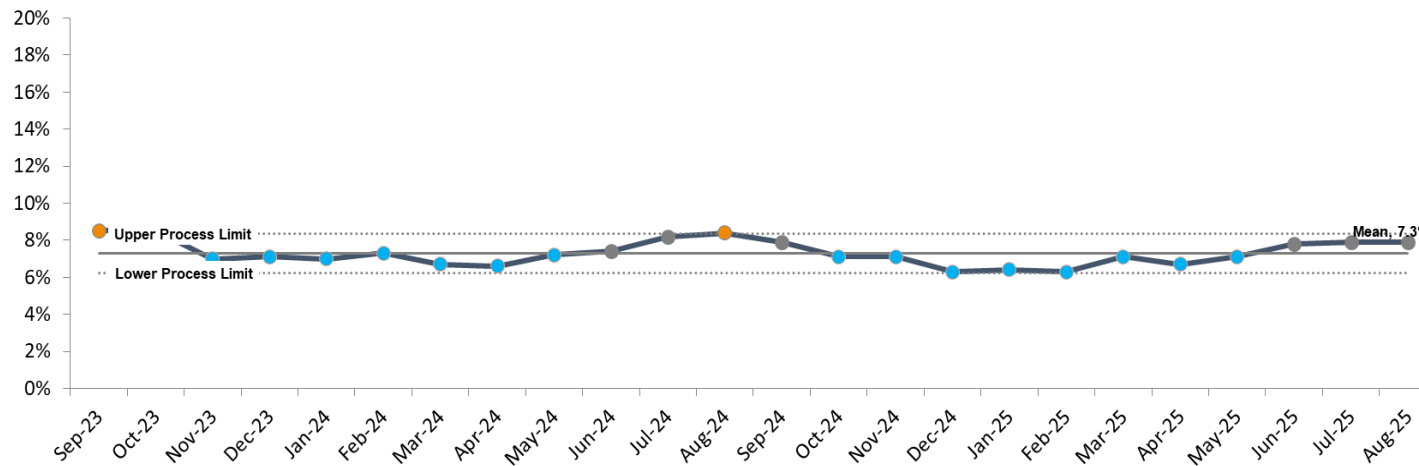
CQC Question: Are We Caring?

Analysis	Actions
This report presents two key workforce metrics: - Monthly turnover is calculated using the total headcount of staff who voluntarily left the Trust, compared to the total staff headcount. - Leavers rate is a nationally defined measure based on all WTE leavers from the Trust. For August 2025, the monthly turnover rate was 0.8%, an increase on July's figure of 0.6%, which puts us firmly in the centre of process control limits. While some month-to-month variation is expected, the monthly leavers rate has remained stable at 6.1%. However, overall turnover for the rolling 12 months has fallen slightly from 8.6% in July to 8.5% in August. This is encouraging although we would like to see this fall further and we will continue to monitor this trend closely. In August 2025, there were 46.1 WTE leavers, equating to a headcount of 59, with three departures due to non-voluntary reasons. By staff group, the highest number of voluntary leavers in August were from Administrative and Clerical (17) and Additional Clinical Services (14). The most commonly cited reasons for leaving were retirement (18), work-life balance (8) and other/not know (8). In terms of age distribution, the highest number of leavers were aged 61-65 (8) and 46-50 (7) and 51-55 (7). Of those leaving, 15 individuals indicated they were moving to another role within the NHS, while 23 reported having no further employment arranged.	Leavers data is routinely shared at key meetings, committees, and working groups to provide meaningful insights into staff departures. While completion of the leavers questionnaire remains voluntary, ongoing promotional efforts are in place to increase response rates across the Trust. In Q1 2025, the following questionnaires were completed: - April: 29 - May: 24 - June: 28 Of these, 15 staff requested an exit interview. Q2 data will be provided in the next report. The Stay and Grow service, launched in autumn 2024, supports staff in Bands 2–4 who are considering leaving or changing careers by offering access to career guidance and development opportunities within the Trust. This builds on the existing career conversation service for support workers. Plans to expand the service to Nursing and AHP staff are under consideration, subject to funding. Further communications have been issued to raise awareness of the service. The Trust, in collaboration with Dorset County Hospital, recently completed participation in the second cohort of the People Promise Exemplar Programme, aimed at improving staff retention. A summary of outcomes was presented to the People Committee in May. Retention remains a key area of system-wide collaboration, particularly in relation to Health Care Support Workers and the development of structured career pathways. A Redeployment Framework for the Dorset system, and associated implementation processes, are currently being developed.

Staff Turnover and Leaver Rate (Continued)		CQC Question: Are We Caring?
Analysis (cont.)	Actions (cont.)	
Baker, Abi 06/10/2025 12:40:16	The Pay and Reward Policy provides a more agile and responsive reward framework, designed to support staff retention, promote high performance, and enhance recognition. Application of the policy is monitored by the People and Culture Directorate, with analysis of applications and approvals by protected characteristics, reasons for requests, and process adherence. This information is regularly shared with the Trade Union Partnership Forum.	

Vacancy Rate

CQC Question: Are We Safe?



Description of metric

The full time equivalent active vacancies at month end from the ledger and expressing them as a percentage of budgeted establishment.

Threshold: None

Analysis

The overall vacancy rate is calculated as the difference between the budgeted establishment (WTE) and the contracted establishment (WTE).

As of July 2025, the budgeted establishment stood at 6,253.7 WTE, rising slightly to 6,264.7 WTE in August 2025. Over the same period, the contracted establishment increased from 5,759.2 WTE to 5,772.3 WTE. This leaves a gap of 492.4 WTE, resulting in a vacancy rate of 7.9%, which remains unchanged from the previous month.

We had anticipated some changes to the budgeted establishment in Q1, linked to finalising the year-end position and setting the 2025/26 pay budgets. However, as posts are not recruited to as part of the Efficiency Programme, we expect a lag in budget adjustments while posts are removed in line with the programme. Consequently, we anticipate that these figures will fluctuate over the course of the year. Recruitment activity continues to be subject to approval by the Vacancy Control Panel (VCP).

Actions

Workforce Planning activity continues across the trust and short, medium, and long-term workforce plans are being developed to address gaps in supply and transformation programmes. A suite of workforce planning tools, including full-cost modelling, has been developed and piloted in selected services ahead of Trust-wide roll out. In support of this, the team has attended directorate meetings to deliver briefings, and workforce planning training is now available for managers to book.

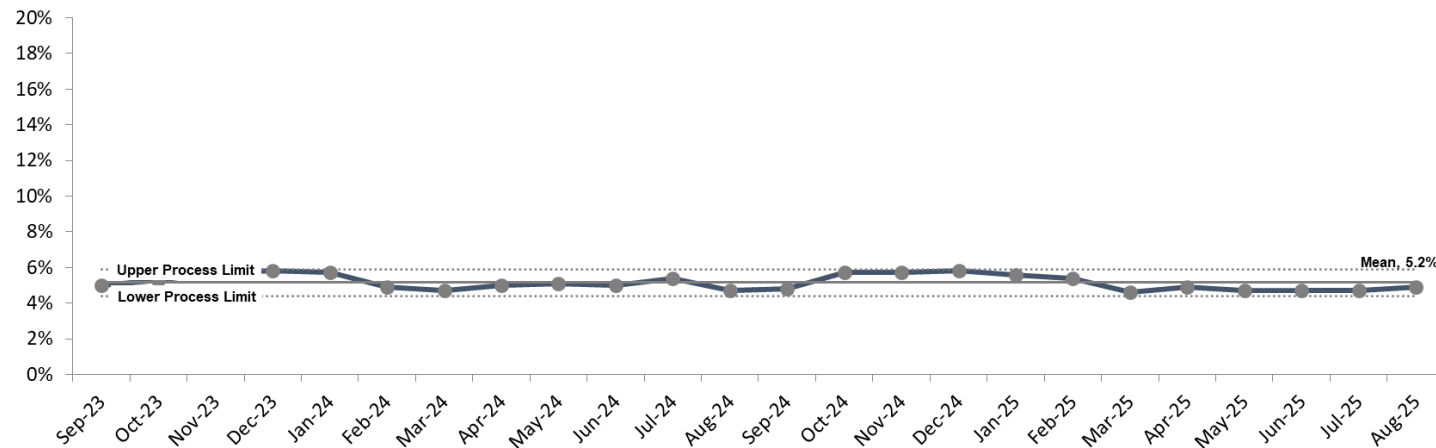
The Vacancy Control Process (VCP) remains in place and aligns with similar approaches used by our system partners. Only roles endorsed by the relevant senior manager are presented to the VCP, and we are increasingly seeing decisions not to proceed with recruitment being made before escalation to the panel.

In response to high agency usage and retention challenges among Health Care Support Workers (HCSW), a competency-based recruitment approach is currently being trialled.

Vacancy Rate (Continued)		CQC Question: Are We Safe?
Analysis (cont.)	Actions (cont.)	
The 2025/26 Efficiency Programme is underway, with each directorate assigned both a financial and a WTE reduction target. For the Trust as a whole, this equates to a reduction of 411 WTE (including bank and agency). While recruitment to essential roles continues, further reductions in overall WTE are required to achieve programme objectives and particular focus on bank is required. Progress is reported regularly to the Executive Team. A summary of VCP decisions—both approvals and declines—is shared with the Executive Team on a weekly basis. In addition, the Safer Staffing Group continues to monitor workforce levels across both inpatient and community services to ensure safe staffing is maintained. Our Resourcing Team continues to support directorates through targeted recruitment campaigns and in particular mental health care support workers. Current vacancy rates by directorate: • Children's, Mental Health and LD Services = 7.3% • Integrated Community Services = 6.5% • Medical = 28.7% • Support Services = 7.8% Baker, Abi 06/10/2025 12:40:16	The latest HCSW campaign has received an overwhelming response, although many applicants have required sponsorship which is not on offer at this stage. We have successfully recruited three HCSW's on this round and have further campaigns planned for June. Targeted efforts also continues to support the recruitment of medical staff. Following a successful application for GMC Sponsorship, an international advert for Associate Specialist / Consultant roles was launched in May 2025 and we received a high number of applications. Interviews have been held, and all the conditional offers have been made following an exercise to match candidates to vacancies. On-boarding those who have accepted the employment offer is underway. A working group is being set up within operational services to look at maximising the efficient use of substantive clinical staff (non-medical) to ensure that efficiencies on bank and agency reduction are achieved across inpatient and community services.	

Sickness Absence Rate (monthly)

CQC Question: Are We Safe?



Description of metric

NHS Oversight Framework

Full Time Equivalent (FTE) Number of Days Sick (including non-working days)/FTE Number of Days Available.

Threshold: None

Analysis

The sickness absence rate for August is 4.9% which is a slight increase from the last 3 months (4.7%) however, we remain within the mid-range of our process limits.

Absence rates by service / directorate:

- Children's Mental Health and LD Services: 4.9%
- Integrated Community Services: 5.5%
- Medical: 1.7%
- Support Services: 3.8%

Key insights from in-month data:

- The most common reasons for absence were stress/anxiety/depression followed by gastrointestinal problems and other musculoskeletal problems.
- Highest absence levels recorded as a percentage of the workforce were in Additional Clinical Services at 5.6%, followed by Nursing and Midwifery at 5.4% and then Estates and Ancillary at 5.1%.

Actions

There is a very slight increase in sickness absence this month so maintaining focus on this area remains a priority. Consistent and effective management of absence across all services is essential to sustain and build on recent progress.

Reducing sickness absence continues to be a key workstream within the Workforce Delivery Framework. Our Sickness Absence Strategy aims to shift from a reactive to a proactive approach, grounded in four core principles: prevention, early intervention, clear and consistent policy, and compassion.

As part of this strategy, we have introduced updated policies for both short- and long-term sickness absence. These are supported by a comprehensive communication and engagement plan, which includes virtual briefing sessions, an interactive process flow, and a practical toolkit designed to guide and support both managers and staff. We have also introduced the new appraisal process that includes a dedicated wellbeing conversation as part of the appraisal cycle. Wellbeing plans are essential to help keep staff

Sickness Absence Rate (monthly) (Continued)

CQC Question: Are We Safe?

Analysis (cont.)

Actions (cont.)

well at work and training and guidance is available to support managers with this.

Manager training is central to this approach. It begins with online pre-course modules covering key procedural content, followed by in-person sessions that emphasise a cultural shift towards proactive and compassionate absence management. These face-to-face sessions focus on improving communication, incorporating tools such as wellness discussions, and fostering supportive team environments. Attendance has been strong, and feedback has been consistently positive.

To enable effective local-level management, detailed sickness absence data is shared with managers, including alerts when staff reach key absence triggers. In parallel, the HR Advisory Team review data to identify patterns and hotspots, working alongside managers to implement targeted interventions. Absence data is also embedded in Directorate Management Group (DMG) reports, ensuring service leads have the insight needed to take timely and informed action.

We continue to review our policies and processes, seeking feedback to understand what is working well, where challenges remain, and what additional support may be needed to drive sustained and meaningful improvement. It is also important to recognise that sickness absence cases are becoming more complex, often involving multiple, interrelated health issues. These complexities require more tailored, compassionate, and coordinated approaches to ensure staff are appropriately supported and to reduce long-term absence.

Baker, Abi
06/10/2025 12:40:16

SUSTAINABILITY



Sustainability Metrics (£000s)	In Month	YTD	Current Status/ YTD Threshold	Data Quality
Cash Balance	35,043		● -	High
Capital Expenditure (current status: Green within 15% of planned, Red <>15% of planned)	2,044	13,442	● 51,404	High
Financial efficiency : variance from efficiency plan	-459	-706	● 3,497	High
Financial stability : variance from NHSE plan	42	56	● 1,116	High

Finance

CQC Question: Are We Well Led?

Metric	Description	Threshold
Cash Balance	Total of cash held in the bank or as investments.	None
Capital Expenditure	Expenditure on capital assets within the business-as-usual capital envelope (CDEL).	Within 15% of planned green >15% or <15% red
Financial efficiency: variance from efficiency plan	Cumulative percentage of efficiency savings achieved against plan.	Annual target of £17,500,000 phased evenly throughout the year
Financial stability: variance NHSE plan	Surplus/(deficit) achieved against NHSE plan.	£0.00

Analysis and Actions

Cash metric for this month is £35,043K. This has increased from last month by £932k. This is due to a reduction in receivables in month.

The capital expenditure target for 2025/26 is £51,404k including leases capitalised under IFRS16 of £2,544k and LoF funded expenditure. Forecast spend in year on the continuing New Hospital Programme build remains at £36,437k, but currently has delays on the CAMHS build. Work is also underway to investigate potential underspend within St Ann's NHP, and opportunities, if there is underspend, to additionally enhance the programme. The NHP programme spend was £1,644k in month against a plan of £4,608k Total capital spend year-to-date is £13,442k, of which £1,628k is internally funded against a YTD plan of £1,936k.

In month savings of £1,578k have resulted in ytd savings of £4,202k which is ahead of plan (£3,497k) by £706k.

An in-month surplus of £324k has resulted in a ytd deficit of £1,172k which is adverse to plan (£1,116k) by £56k.

2.3 NHS Oversight Framework

NHS Oversight Framework – Dorset HealthCare Results

Introduction

The NHS Oversight Framework is the national system used by NHS England to assess and monitor the performance of NHS trusts and foundation trusts. It provides a consistent approach to oversight across providers, focusing on quality, access, finance, and governance.

The framework brings together a range of indicators across five key themes:

- Access to services – how effectively patients can access timely care.
- Effectiveness and experience of care – the quality, safety and outcomes of services, including patient feedback.
- Finance and productivity – financial sustainability and efficient use of resources.
- Patient safety – ensuring systems and cultures are in place to protect patients from harm.
- People and workforce – staff wellbeing, engagement, and organisational culture.

Trusts are assigned an overall Segment score (1–4), where Segment 1 indicates the highest performing organisations requiring minimal support, and Segment 4 indicates those requiring the most intensive support. Under the rules of the Performance Assessment Framework, if a trust is not meeting its financial requirements, the maximum overall score that can be awarded is Segment 3, regardless of performance in other domains.

This framework is used by NHS England, regulators, and commissioners to identify both areas of strong performance and those where additional oversight, support, or intervention may be required. It also provides a clear, comparable view of how Dorset HealthCare is performing relative to peer organisations across the country.

Results

Dorset HealthCare has been assessed as Segment 2 – Above Average overall in the NHS Oversight Framework for non-acute trusts. This reflects a generally strong organisational position, with performance above national averages in several domains, alongside a small number of areas requiring improvement and targeted focus.

Access to Services

Performance in access to services is positive. The Trust reported 0% of patients waiting over 52 weeks for community services (June 2025), ranking first nationally out of 41 trusts. In mental health, there has been a 1.92% increase in children and young people accessing NHS-funded

2.3 NHS Oversight Framework

services compared with the previous year, placing the Trust 30th out of 46. While growth is modest, it demonstrates progress in expanding access to this priority group.

Effectiveness and Experience of Care

This is the Trust's most challenged domain, rated Segment 4 – Low Performing. Areas of concern include:

- Length of stay: 28.38% of inpatients have a stay exceeding 60 days (Q1 2025/26), placing Dorset HealthCare in the lowest quartile nationally (35th of 47).
- Urgent Community Response (UCR): Two-hour response performance stands at 80.08%, ranked 28th of 37, and requires further improvement to meet national standards.
- Patient experience: The 2024 CQC Community Mental Health Survey returned a low satisfaction score of 2.0, indicating a need to address service user experience and engagement.

Finance and Productivity

The Trust has performed strongly in financial management, assessed at Segment 2 – Above Average. Highlights include:

- Delivery of a 2.39% planned surplus for 2025/26, ranking first nationally out of 61.
- Positive variance against the financial plan at Month 3 (0.09%).
- A relative cost difference of 109.98%, placing the Trust 40th of 60, which signals scope for further productivity improvements despite strong overall control.

Patient Safety

Patient safety is also rated Above Average. Staff feedback via the NHS Staff Survey shows a 6.9/10 score for raising concerns (23rd of 61). However, only 54.31% of patients in mental health crisis received face-to-face contact within 24 hours in Q1 2025/26, placing the Trust 26th of 45 and highlighting the need for sustained focus on crisis response capacity.

People and Workforce

Workforce measures are performing well, again in Segment 2 – Above Average. Staff engagement scored 7.1 9/10 (24th of 61), and the sickness absence rate of 5.21% is favourable compared to peers (21st of 61). These indicators suggest a generally positive culture and improving workforce resilience, though there is still opportunity to strengthen retention and wellbeing.

2.3 NHS Oversight Framework

Summary

Overall, Dorset HealthCare demonstrates strong financial management, safe staffing culture, and excellent performance in community access. The principal challenge remains within the effectiveness and experience of care domain, where improvements are needed in patient flow, urgent response times, and patient-reported experience.

It is important to note that under the Performance Assessment Framework, if a trust is not meeting its financial requirements, the maximum overall score achievable is Segment 3, regardless of other performance. Dorset HealthCare's strong financial performance, including delivery of a planned surplus and positive variance against plan, therefore not only supports organisational sustainability but also ensures the Trust remains eligible to achieve the higher performance segments.

Baker, Abi
06/10/2025 12:40:16

2.3 NHS Oversight Framework

RESULTS

Overall Segment Score	Domain Segment	Domain Segment Score	Subdomain	Description	Reported Date	Score	Rank
2 - Above Average	Access to Services	2 - Above Average	Elective Care	Percentage of patients waiting over 52 weeks for community services	June 25	0%	1 out of 41
			Mental Health Care	Annual change in the number of children and young people accessing NHS-funded MH services	Jun 24-Jun 25 vs Jun 23-Jun 24	1.92%	30 out of 46
	Effectiveness and experience of care	4 - Low performing	Effective flow and discharge	Percentage of inpatients with >60 day length of stay	Q1 2025/26	28.38%	35 out of 47
				Urgent Community Response 2-hour performance	Q1 2025/26	80.08%	28 out of 37
				CQC community mental health survey satisfaction rate	2024	2.0	N/A
	Finance and Productivity	2 - Above Average	Finance	Combined finance	Q1 2025/26	1.00	N/A
			Finance	Planned Surplus/Deficit	2025/26	2.39%	1 out of 61

Baker, Abi
06/10/2025 12:40:16

2.3 NHS Oversight Framework

Overall Segment Score	Domain Segment	Domain Segment Score	Subdomain	Description	Reported Date	Score	Rank
			Finance	Variance year-to-date financial plan	Month 3 2025	0.09%	13 out of 61
			Productivity	Relative difference in costs	2023/24	109.98%	40 out of 60
	Patient Safety	2 - Above Average	Patient Safety	NHS Staff Survey – raising concerns sub-score	2024	6.9 out of 10	23 out of 61
			Patient Safety	Percentage of patients in mental health crisis to receive face-to-face contact within 24 hours	Q1 2025/26	54.31%	26 out of 45
	People and workforce	2 - Above Average	Retention and Culture	NHS staff survey engagement theme sub-score	2024	7.19 out of 10	24 out of 61
			Retention and Culture	Sickness Absence Rate	Q4 2024/25	5.21%	21 out of 61

Baker, Abi
06/10/2025 12:40:16

2.4 Research and Development Metrics Q1, 2025-26

The following provides details of the Quality Metrics for the Trust’s Research and Development (R&D) activities.

Metric	In Quarter	Current Status	Additional details																
Time taken to issue confirmation of capacity and capability	No exceptions	G	All studies received confirmation of capacity and capability within the agreed timeline from site selected date for Q1	Areas/specialities involved in research Research & Development Status per Quarter <table><tr><th>Quarter</th><th>Status</th><th>Value</th></tr><tr><td>1</td><td>Green</td><td>4</td></tr><tr><td>2</td><td>Green</td><td>4</td></tr><tr><td>3</td><td>Green</td><td>4</td></tr><tr><td>4</td><td>Green</td><td>4</td></tr></table> • Perinatal • Dementia • Eating Disorder • Physiotherapy • Psychosis Pathway • Mental Health • Tissue Viability • Diabetes • Stroke • Vaccine studies • Musculoskeletal	Quarter	Status	Value	1	Green	4	2	Green	4	3	Green	4	4	Green	4
Quarter	Status	Value																	
1	Green	4																	
2	Green	4																	
3	Green	4																	
4	Green	4																	
Recruitment to target	47	G	Recruitment for Q1 is currently at 47; no target has been agreed for 2025-26.																
Recruitment of first participant to the study	No exceptions	G	All studies recruited to time for Q1																
Number of incidents (target < 2)	0	G	There were no incidents in Q1																
Number of studies in progress	16	-	Currently active in 16 studies: 12 open to recruitment (one is a National Confidential Inquiry study)																
Number of studies in set-up	6	-	6 studies currently in set-up																
Other: R&D staff continue to support the Weymouth Research Hub (WRH), a venture supported by the Research Delivery Network Wessex and Wessex Health Partners and is one of four flagship research Hubs across the Wessex Region. To date, four commercial research studies have been hosted at the WRH. The WRH is now a host site for the Wessex Commercial Research Delivery Centre (CRDC). The R&D team’s Lead Research Practitioner has been appointed as the NIHR Lead Practice Facilitator to support rater training in the Wessex region. This training will enable the research team to deliver commercial dementia research trials, many of which have specific requirements for sites to be experienced and competent in delivering and scoring assessments. As a site we have developed this further, extending training and maintaining rater competencies through the Brain Health Clinic, a model which has been supported across Trusts and the Regional Research Delivery Networks.																			

75

Safer Staffing Summary

This information is reported to the monthly Safer Staffing Forum and Quality Governance Group, with escalation to the Quality Governance Committee as required. Detailed staffing data is provided in the monthly Right Staffing Report.

Staffing Challenges

Workforce data and staff feedback highlight that safer staffing levels across the Trust were adversely affected by sickness absence and ongoing vacancies. The most common causes of sickness were:

- Anxiety, stress, and depression
- MSK issues increased, taking over from gastrointestinal illnesses

Staffing Incidents

Fifty two staffing related incidents were formally reported across all clinical services. However, anecdotal feedback suggests underreporting.

Four falls were reported by Community Hospitals during shifts with below planned levels of staffing. One fall resulted in no harm, while the remaining three were classified as causing minor, non-permanent harm. The available information does not provide sufficient detail to establish a direct link between staffing and the incidents; therefore, it is difficult to determine whether these falls would have occurred had staffing levels been optimal.

The following impacts on patient and staff experience were identified in reports:

Impacts on patient experience included:

- Deferred care
- Temporary service closures or reduction in the service offered
- Temporary staff not familiar with care needs

Impacts on staff experience included

- Not having the required time for documentation
- Working when unwell
- Not taking rest breaks
- Unable to take time so working overtime or excess hours
- Reduced morale
- Higher workloads due to patient acuity, dependency needs, and reliance on temporary staff

2.5 Inpatient Nursing Staffing – National Return for August 2025

Fill Rate Analysis

Planned versus actual nursing hours (fill rates) for community hospital and mental health inpatient wards showed that average Registered Nurse fill rates remained within the agreed parameters for both day and night shifts. Mental Health Support Worker fill rates exceeded the KPI threshold of 120% during night shifts, reaching 125%. This increase was primarily due to the need for enhanced care and the substitution of second Registered Nurse duties with Mental Health Support Workers.

Hospital Site Details		Ward Name	Specialty 1	Day				Night			
Site code	Hospital Site name			Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nursing associates (%)	Average fill rate - non-registered nursing associates (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nursing associates (%)	Average fill rate - non-registered nursing associates (%)
RDYFY	WESTMINSTER MEMORIAL HOSPITAL	Ashmore/Shaston Ward	321 - REHABILITATION	95.3%	87.6%	N/A	N/A	99.0%	96.8%	-	-
RDYFC	YEATMAN HOSPITAL	Beech Ward	314 - REHABILITATION	94.9%	96.6%	-	N/A	98.5%	93.5%	-	-
RDYFJ	BRIDPORT COMMUNITY HOSPITAL	Colmers Ward	315 - REHABILITATION	135.1%	70.5%	-	N/A	103.3%	88.2%	-	N/A
RDY22	ALDERNEY HOSPITAL	Guernsey Ward	316 - REHABILITATION	90.3%	104.0%	-	N/A	100.0%	104.8%	-	-
RDYFE	VICTORIA HOSPITAL W'BORNE	Hanham Ward	317 - REHABILITATION	95.1%	92.5%	N/A	N/A	96.8%	112.8%	-	N/A
RDY22	ALDERNEY HOSPITAL	Jersey Ward	318 - REHABILITATION	92.6%	104.2%	-	N/A	100.0%	100.0%	-	-
RDYEG	WESTHAVEN HOSPITAL	Radipole Ward	319 - REHABILITATION	96.6%	80.8%	N/A	N/A	97.8%	89.2%	-	-
RDYFC	YEATMAN HOSPITAL	Rowan Ward	320 - REHABILITATION	91.8%	98.3%	N/A	-	95.2%	95.0%	-	-
RDYFD	SWANAGE COMMUNITY HOSPITAL	Stanley Purser Ward	322 - REHABILITATION	98.9%	90.5%	-	-	100.0%	100.0%	-	-
RDYFF	BLANDFORD COMMUNITY HOSPITAL	Tarrant Ward	323 - REHABILITATION	103.2%	98.2%	N/A	N/A	100.1%	98.4%	-	-
RDYFC	ST ANN'S HOSPITAL	AAU Seaview	710 - ADULT MENTAL ILLNESS	92.4%	101.4%	N/A	N/A	59.7%	126.5%	-	-
RDY10	ST ANN'S HOSPITAL	Alumhurst Ward	711 - ADULT MENTAL ILLNESS	105.6%	109.1%	-	N/A	85.5%	109.8%	-	-
RDY10	ST ANN'S HOSPITAL	Chine Ward	712 - ADULT MENTAL ILLNESS	75.3%	107.2%	-	N/A	72.6%	121.1%	-	-
RDY10	NIGHTINGALE HOUSE	Florence House	713 - ADULT MENTAL ILLNESS	81.4%	112.9%	-	N/A	103.3%	100.0%	-	-
RDYFX	MAIDEN CASTLE HOUSE	Glendinning Unit	714 - ADULT MENTAL ILLNESS	126.1%	109.9%	-	-	106.3%	104.5%	-	-
RDYFT	ST ANN'S HOSPITAL	Harbour Ward	715 - ADULT MENTAL ILLNESS	89.5%	135.6%	-	N/A	93.3%	176.3%	-	N/A
RDY10	ST ANN'S HOSPITAL	Haven Ward Female	928 - MENTAL HEALTH REHABILITATION	97.6%	97.5%	-	N/A	93.5%	148.1%	-	-
RDY10	ST ANN'S HOSPITAL	Haven Ward Male	929 - MENTAL HEALTH REHABILITATION	98.5%	108.1%	-	N/A	100.1%	97.8%	-	-
RDY10	ALDERNEY HOSPITAL	Herm Ward	715 - OLD AGE PSYCHIATRY	94.2%	116.3%	N/A	N/A	98.4%	140.6%	-	N/A
RDY22	KIMMERIDGE COURT	Kimmeridge Court	714 - ADULT MENTAL ILLNESS	60.2%	134.8%	N/A	N/A	68.8%	167.3%	-	-
RDYEG	FORSTON CLINIC	Melstock House	715 - ADULT MENTAL ILLNESS	107.2%	89.0%	N/A	N/A	161.9%	91.6%	-	-
RDYFX	NIGHTINGALE HOUSE	Nightingale House	716 - ADULT MENTAL ILLNESS	133.5%	88.2%	N/A	N/A	100.0%	100.0%	-	-
RDYFX	PEBBLE LODGE	Pebble Lodge	711 - CHILD AND ADOLESCENT PSYCHIATRY	90.3%	102.1%	N/A	N/A	100.0%	99.1%	-	-
RDYMR	ALDERNEY HOSPITAL	St Brelades Ward	715 - OLD AGE PSYCHIATRY	93.8%	98.3%	-	-	98.5%	116.6%	-	-
RDY22	ST ANN'S HOSPITAL	Twynham Ward	712 - FORENSIC PSYCHIATRY	77.3%	110.6%	-	N/A	84.0%	135.4%	-	-
RDY10	FORSTON CLINIC	Waterston AAU	710 - ADULT MENTAL ILLNESS	84.0%	150.1%	-	N/A	100.0%	191.9%	-	N/A

Community Hospital Wards

Colmers and Radipole’s daytime and night staffing for Health Care Support Workers fell below 90% (Comers 70% and 88%; Radipole 81% and 89%)
Shaston’s daytime staffing for HCSW fell below 90% (88%)

- Colmers: Although the Health Care Support Worker fill rate fell below 90%, the Registered Nurse fill rate exceeded 100% (135%) due to Registered Nurses backfilling Health Care Support Worker duties. The Ward Manager reports that, despite the higher skill mix, care felt compromised due to delays in meeting people’s needs. A data assurance check has confirmed the accuracy of the extracted data. A clinical visit with the Ward Manager, planned to explore this disconnect further, was postponed due to sickness and is now scheduled for 3rd October.

2.5 Inpatient Nursing Staffing – National Return for August 2025

Mental Health Inpatient Wards

- Alumhurst, Chine, and Seaview: Frequently rostered only one RN on night duty (instead of the planned two), mainly due to flexible working arrangements, which limit availability for night cover.
- Chine's actual RN hours during the day fell below 90% (75%). The Ward Manager attributes this to performance issues, long-term sickness, and occupational health requirements, all of which have impacted fill rates. The Ward Manager also raises concerns that prioritising two RNs on night shifts is creating a shortfall during the day, which in turn affects supervision, rest breaks, and attendance at patient reviews.
- Florence, Harbour, Herm, Kimmeridge, Melstock, Nightingale, Waterston and Twynham: Staffing shortfalls were attributed to a combination of vacancies, sickness, annual and other leave, and unfilled temporary shifts.
- Although fill rates were above 90%, Haven Male flagged due to high reliance on temporary staff.
- Registered Nurse block bookings are currently in place at Kimmeridge, Waterston, Haven Male, and Harbour to support continuity of care. These bookings are reviewed regularly through the Vacancy Control Panel to ensure they remain appropriate.

Escalations:

- Kimmeridge Court: The Safest Staffing Protocol remains in place due to vacancies and high temporary staff usage. A successful recruitment drive has filled all RN vacancies, though new staff will not start until October. Block-booked agency RN cover is in place in the interim. The ward remains in enhanced surveillance via the Provider Collaborative.
- Harbour and Waterston remain on the Watchful Waiting list and continue to be monitored by the safer staffing team.

Baker, Abi
06/10/2025 12:40:16

2.5 Inpatient Nursing Staffing – National Return for August 2025

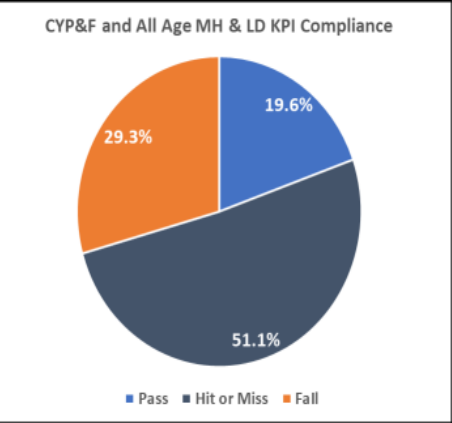
Hospital Site Details		Ward Name	Specialty 1	CHPPD				
Site code	Hospital Site name			Registered nurses/midwives	Care Staff	Registered nursing associates	Non-registered nursing associates	Overall
RDYFY	WESTMINSTER MEMORIAL HOSPITAL	Ashmore/Shaston Ward	321 - REHABILITATION	3.7	3.2	0.1	0.3	7.2
RDYFC	YEATMAN HOSPITAL	Beech Ward	314 - REHABILITATION	4.1	3.1	0.0	0.4	7.6
RDYFJ	BRIDPORT COMMUNITY HOSPITAL	Colmers Ward	315 - REHABILITATION	2.5	3.1	0.0	0.5	6.1
RDY22	ALDERNEY HOSPITAL	Guernsey Ward	316 - REHABILITATION	2.6	3.3	0.0	0.1	5.9
RDYFE	VICTORIA HOSPITAL W'BORNE	Hanham Ward	317 - REHABILITATION	2.6	3.3	0.2	0.3	6.5
RDY22	ALDERNEY HOSPITAL	Jersey Ward	318 - REHABILITATION	2.3	2.8	0.0	0.2	5.3
RDYEG	WESTHAVEN HOSPITAL	Radipole Ward	319 - REHABILITATION	2.6	2.7	0.1	0.1	5.5
RDYFC	YEATMAN HOSPITAL	Rowan Ward	320 - REHABILITATION	3.9	4.1	0.0	0.0	8.0
RDYFD	SWANAGE COMMUNITIY HOSPITAL	Stanley Purser Ward	322 - REHABILITATION	3.3	2.9	0.0	0.0	6.2
RDYFF	BLANDFORD COMMUNITY HOSPITAL	Tarrant Ward	323 - REHABILITATION	2.5	2.7	0.0	0.3	5.6
RDYFC	ST ANN'S HOSPITAL	AAU Seaview	710 - ADULT MENTAL ILLNESS	4.6	8.6	0.1	1.0	14.3
RDY10	ST ANN'S HOSPITAL	Alumhurst Ward	711 - ADULT MENTAL ILLNESS	2.7	4.3	0.0	0.4	7.3
RDY10	ST ANN'S HOSPITAL	Chine Ward	712 - ADULT MENTAL ILLNESS	3.9	7.0	0.0	0.5	11.4
RDY10	NIGHTINGALE HOUSE	Florence House	713 - ADULT MENTAL ILLNESS	10.4	8.4	0.0	0.1	19.0
RDYFX	MAIDEN CASTLE HOUSE	Glendinning Unit	714 - ADULT MENTAL ILLNESS	3.4	3.1	0.0	0.0	6.5
RDYFT	ST ANN'S HOSPITAL	Harbour Ward	715 - ADULT MENTAL ILLNESS	3.7	6.2	0.0	0.7	10.6
RDY10	ST ANN'S HOSPITAL	Haven Ward Female	928 - MENTAL HEALTH REHABILITATION	7.0	15.1	0.0	1.4	23.5
RDY10	ST ANN'S HOSPITAL	Haven Ward Male	929 - MENTAL HEALTH REHABILITATION	5.3	14.3	0.0	0.6	20.2
RDY10	ALDERNEY HOSPITAL	Herm Ward	715 - OLD AGE PSYCHIATRY	3.5	11.4	0.1	0.3	15.3
RDY22	KIMMERIDGE COURT	Kimmeridge Court	714 - ADULT MENTAL ILLNESS	8.7	16.3	0.5	0.1	25.7
RDYEG	FORSTON CLINIC	Melstock House	715 - ADULT MENTAL ILLNESS	11.2	12.3	0.9	2.9	27.2
RDYFX	NIGHTINGALE HOUSE	Nightingale House	716 - ADULT MENTAL ILLNESS	6.5	7.8	0.6	1.2	16.2
RDYFX	PEBBLE LODGE	Pebble Lodge	711 - CHILD AND ADOLESCENT PSYCHIATRY	8.1	13.9	0.3	0.9	23.1
RDYMR	ALDERNEY HOSPITAL	St Brelades Ward	715 - OLD AGE PSYCHIATRY	4.5	11.7	0.0	0.0	16.2
RDY22	ST ANN'S HOSPITAL	Twynham Ward	712 - FORENSIC PSYCHIATRY	5.6	10.1	0.0	0.5	16.2
RDY10	FORSTON CLINIC	Waterston AAU	710 - ADULT MENTAL ILLNESS	3.2	6.5	0.0	0.9	10.7

The above table show care hours per patient day (CHPPD). This is calculated by dividing actual staff hours by number of patients on the ward at 23.59.

Baker, Abi
06/10/2025 12:40:16

CYP, All Age Mental Health & Learning Disability Services – Operational Performance Summary August 2025 (M05)

Overview of Operational Performance/KPI Metric Summary



There are 182 reportable metrics across All Age MH&LD, CYP and S2W Services. 92 have a measurable target. In August 68.5% of reportable metrics are on target (63/92).

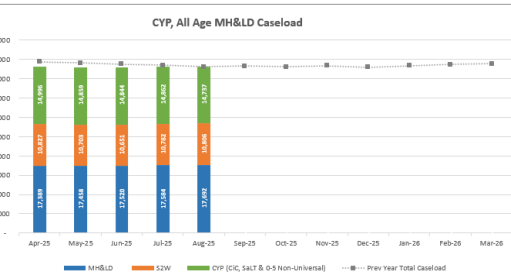
All Age MH&LD: 31/50
CYP: 26/30
S2W: 6/12

The rest are monitored monthly as agreed Operational priorities by the DMG/ICB. These are a mixture of activity based and non-targeted metrics.

Metrics specific to the NHS Long Term Plan (LTP) are also reported from Future NHSE reporting platform.

Exception summaries and action plans are in place for those off track some of which are part of longer-term transformation /development plans.

Caseload Summary



There are on average 43,143 people (including CYP) caseload each month, this is approx. 5.4% of the Dorset Population (779,770). On Av. 26% (8,002) of CYP caseload have additional needs and are on UP, UPP/UPPS pathways. The non-universal caseload is CiC & CYP SaLT.

Finance: (Brackets) = favourable variance

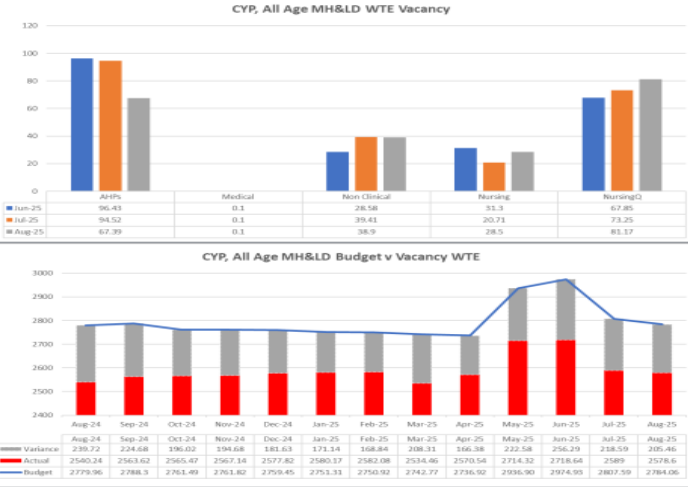
Financial Summary £m				
Annual Budget	YTD Budget	YTD Actual	YTD Variance	FOT Variance
122.9	50.5	54.0	3.1	3.1

The finance summary provides a combined overview of CYP, MH&LD

The YTD variance is attributable to

- 2.8 MH Services
- 0.3 CYP Services

Workforce



The vacancy rate is 7.38% (205.46 WTE) based on a contracted 2578.60 WTE.

CYP 0-19 PHS: 20.55 WTE
CYP SaLT: -5.37 WTE
CiC: 0.28 WTE
NHSP: 0 WTE
CAMHS: 14.96 WTE
Medical: 0 WTE
Prim & Psych: 48.77 WTE
LD & Pro Collab: 87.61 WTE
Secondary Comm: 60.71 WTE
High Acuity: 125.1 WTE

Activity Summary

Referrals	24/25 YTD	25/26 YTD	Growth Actual	Growth %
MH&LD	18,494	18,888	374	2%
Steps to Wellbeing	13,125	13,324	199	2%
CYP&F Referrals	1,450	1,933	483	33%
Total	33,069	34,125	1,056	3%

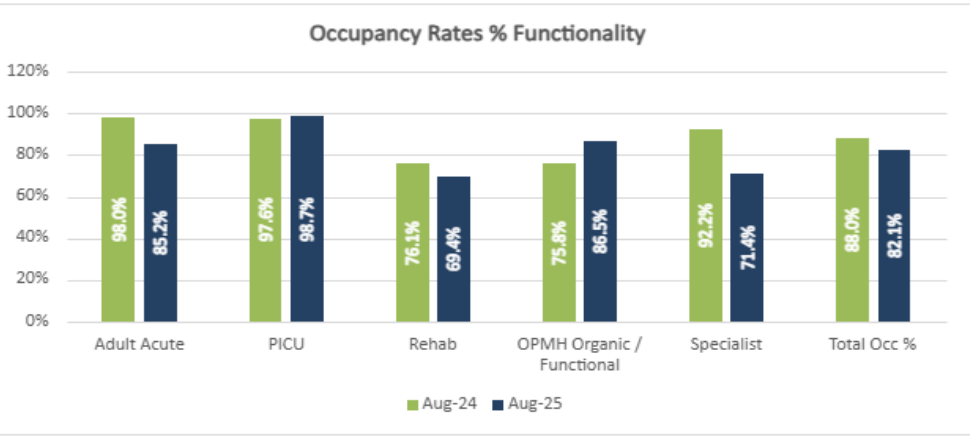
Contacts	24/25 YTD	25/26 YTD	Growth Actual	Growth %
MH&LD	148,748	157,964	9,216	6%
Steps to Wellbeing	88,874	88,941	67	0%
CYP&F	71,720	63,413	-8,307	-12%
Total	309,342	310,318	976	0%
MH Activity not Flowing	38,475	50,746	12,271	32%
Overall total	347,817	361,064	13,247	4%

YTD M5 activity is 0.3% (+976) growth in contacts compared to M5 24/25.
YTD M5 referrals 3.2% (+1,056) compared to M5 24/25

The services that do not use a viable system as their patient record or clinics with no associated referral that enables the data to be flowed is shown as "Activity not Flowing".

Service Director Commentary

- 68.5% of KPIs are compliant across Children, Young People, Families (CYPF) and All Age Mental Health & Learning Disabilities (MH & LD) services. Over 43,000 people are receiving care across all services.
- The OOA pressure has sustained a recovery plan which is being operationalised with revised trajectories, particularly focusing upon changing processes with executive support. OOA beds moved to 0 as per the plan at the end of August 2025.
- Staff vacancy rate is at 7.38% overall, with some areas (e.g., CYP In-patients) experiencing higher vacancies.
- Occupancy rates and average length of stay are closely monitored, showing trends in inpatient flow and service demand.
- Year-to-date activity is strong, with M5 activity at 94% and referrals at 92%.
- Financial performance is favourable, with positive variances for MH & LD services. Vacancies are actively being targeted to reduce expenditure on long-term bank use in addition to the agency burden, as achievement of the CIP reduction targets are a significant challenge against the performance metrics.



Occupancy Rates:

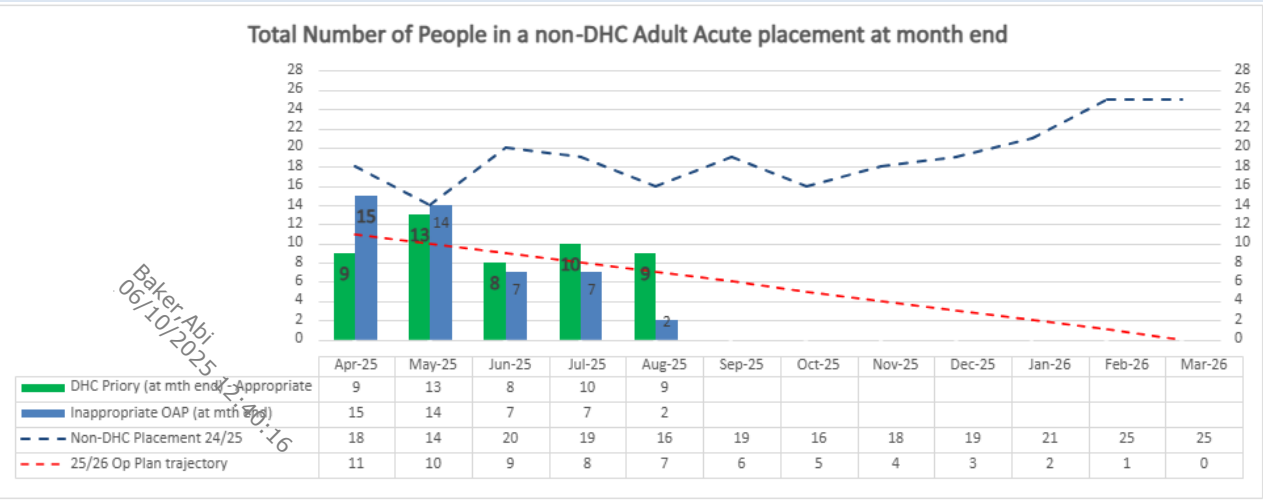
- There were 6253 bed days available in August 25, (excl. Marchwood Priory)
- 5136 were Occupied during the month for an overall Occupancy Rate of 82.1%
- Adult Acute Occ. Rates remain consistently high at 96.7% (excl. Melstock (Discharge Ward) which is now under Adult Acute and impacts on overall occ. rate for adult acute reducing it to 85.2%

Average Time Spent on a Ward:

- This differs to Length of Stay which is based on Hospital Episode (total time from admission to discharge irrespective of internal movement/transfers) compared to the same period in 24/25).
- 25/26 Operational Planning Adult Acute Average LOS (3-month rolling period) was 93 days in Aug against an in-month threshold of 91 days.

Av. Time On Ward (Days)	YTD Mean 24/25	YTD Mean 25/26	Growth (Days)	% Growth	25/26 YTD Median	25/26 YTD Mode
Adult Acute	67	62	-5	-7%	26	#N/A
AAU Seaview	26	20	-6	-22%	14	14
Chine Ward	42	50	9	21%	26	13
Harbour Ward	80	59	-21	-27%	25	2
Melstock House	100	101	1	1%	86	56
Waterston Acute Assessment Unit	88	80	-8	-9%	30	1
OPMH Organic/Functional	80	132	52	64%	83	#N/A
Alumhurst Ward	80	132	52	64%	83	77
Herm	172	86	-86	-50%	85	60
St Brelades	167	74	-94	-56%	74	2
PICU	41	39	-2	-5%	16	#N/A
Psychiatric Intensive Care Unit – F	40	43	3	6%	17	0
Psychiatric Intensive Care Unit - M	42	35	-7	-16%	16	14
Rehab	216	203	-13	-6%	182	#N/A
Glendinning Unit	192	148	-45	-23%	149	143
Nightingale House	241	259	18	8%	214	58
Specialist	84	198	114	136%	80	#N/A
Kimmeridge Court	99	146	47	48%	82	41
Pebble Lodge	70	151	81	117%	78	26
Perinatal In-Patient Mother's Ward	57	47	-10	-17%	40	14
Twynham Ward	111	449	339	306%	486	51
Total	100	117	17	17%	76	14

Out of Area Placements (OAP) No. of Patients Admitted



Supporting Commentary

Out of Area Placements:

- **Appropriate Placements:** As of 31 August, there were nine patients admitted to the Priory. There were eight admissions in month and nine discharges. A total of 275 Occupied Bed Days were utilised.
- **Inappropriate Placements:** As of 31 August, there were two patients admitted to other OAP providers. There were zero admissions in month and five discharges for 157 OBDs. This meets the directive to eliminate inappropriate out of area placements.
- The 10 block purchased beds at Southampton Priory are being appropriately and fully utilised.
- **CRfD:** In August a total of 54 patients were identified as being Clinically Ready for Discharge (CRfD) for a total of 565 OBDs. This was 21.6% of adult acute beds (104 beds). 49/54 were delays (539 OBDs).

Integrated Community Services – Operational Performance Board Summary – August 2025 (5)

Performance/KPI Metric Summary

CHS & IUCS KPI Compliance Monthly



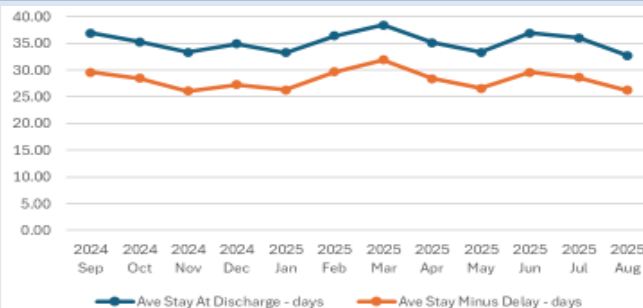
CHS & IUCS System KPI Compliance



47 KPIs included in month end reports
17 non-compliant KPIs of which:

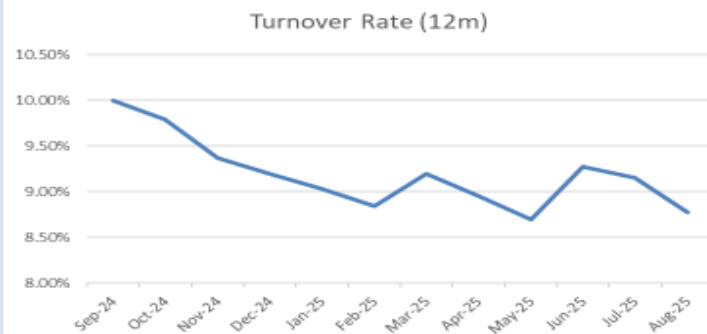
- 2 are system KPIs reported by DHC
- 2 are services still in recovery

Community Hospitals Average Length of Stay



In Aug '25 average length of stay (LoS) at discharge was 32.73 days. If delays in discharge had not occurred average LoS would have been 26.2 days. This represents a reduction in delay of 0.9 days on last month.

Staff Turnover Rate



The 12 month turnover rate for Community Services was 8.77% against a Trust total of 9.00%. This is within target of <10%.

Highlight on a Service

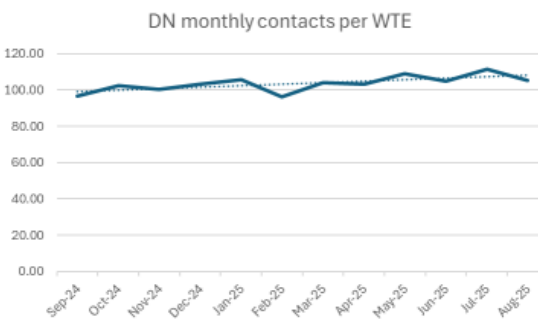
HIV Community Outreach Service

Following the allocation of additional funding from NHSE, the sexual health service has been able to embed an HIV community outreach service, led by non-medical clinical specialists within the service. This provides support patients living with HIV who find it challenging to attend mainstream services.

The team have managed to engage this diverse group in various ways, all unique to that individual which has resulted in maintaining and/or re-engaging patients in active treatment to receive the care they need. This includes- but is not limited to- administering injectable antiretrovirals (ARV), monitoring bloods and administering treatment for other conditions, as well as supporting patients with their mental health.

Our HIV outreach team strongly emphasises the value of the multidisciplinary team (MDT) by working collaboratively with consultants, sexual health clinicians, mental health services, housing teams, drug and alcohol services, social care and voluntary sector partners to deliver holistic, person-centred care. This integrated approach ensures that all aspects of a person's physical, emotional, and social needs are addressed, recognising that HIV care extends beyond medical treatment alone. Through regular MDT meetings, joint visits, and shared care planning, we have optimised the care pathway for people with HIV and those with complex sexual health needs - reducing fragmentation, improving continuity, and enabling earlier intervention. This collaborative model enhances trust, increases treatment adherence, and ultimately improves clinical outcomes and quality of life for those most at risk of falling through the gaps within standard care systems.

Contacts FTE in community nursing



In August 25 there was an average of 105.4 contacts per WTE for District Nursing staff. There has been an increase in contacts per wte over the last year. One of the major factors contributing to this is the continuing rise in insulin administration in the community setting. There has been an increase of 170 visits per day for insulin administration since Oct 24.

Service Director Commentary

We have seen an improvement in the number of patients on the DHC Community Waiting list in August after an increase in July. There are no patients waiting longer than 52 weeks.

DHC performance against the diagnostic standard is off plan and a recovery plan is being monitored through ICB planned care meetings. Significant work continues towards achieving the required new quality accreditation (IQUIPS) requiring considerable clinical resource, this will continue in Q3.

There is continues to be considerable resource across all our teams contributing towards major system transformation workstreams, including FutureCare and Integrated Neighbourhoods. These are key for service sustainability, but the size and scale of change is impacting on teams. Additional resource has now been received as recruitment is progressing towards increasing capacity to deliver these programmes of work.

Report to	Board in Common (DCH Board)	
Date of Meeting	7 th October 2025	
Report Title	DCH Finance Report – Month 5 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 five delivered a deficit of £3.2 million after technical adjustments, being £0.002 million better than the planned deficit. The year to date position sees the Trust £0.009 million ahead of its £14.3 million deficit planned position. Within this position, £0.264m relates to additional costs incurred as a direct result of the closure and support of the Yeovil maternity service, noting this has been offset by assumed income at this stage. August has seen increased operational pressures with front door activity up by 12.47% vs last year and 1,482 more attendances YTD than planned. This is reflected in the increase in pay costs (temporary workforce). Patients with no criteria to reside have also been above plan in month with an increase length of stay in August also seen (further detail in the Performance report). Pay expenditure overall is above plan by £1.2m, largely driven by bank expenditure offset by agency and noting costs supporting Industrial Action during July of £0.143 million are within this overspend. Corresponding offsets in non pay linked to drugs and stock levels under plan, and timing of income received has enabled the Trust to deliver to plan year to date. Agency expenditure in August has seen total month spend of £0.5 million being the first month worse than plan with a variance of £0.049m due to medical increases. Agency is still however £0.5 million better than plan year to date. In month challenges relate to medical agency with increased emergency activity seen in month and increased short term sickness levels.

Ongoing 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 ongoing high usage this month reflecting the increased operational pressures and levels of patients with no criteria to reside.

Enhanced workforce controls are in the process of being determined to support pressures in bank overspends, noting this is a key focus and recovery area for the Trust as bank spend is currently £1.8m overspend against plan (including expected phased CIP reductions) year to date.

Break glass Off Framework expenditure is being incurred each month, with £0.016 million incurred in month five taking the year to date expenditure to £0.072 million, with NHS England expecting nil Off Framework spend since last 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.

Year to date, the Trust has delivered £4.5 million against the £4.6 million plan, being 16% of total target delivered. The total schemes identified stand at £24.5 million with £4.5 million of unidentified schemes (16%), with a further £1.5 million of system transformation schemes at risk.

40% of schemes are classed as high risk at £11.5m, £5.9m as medium risk being 19% and the remaining £2.5 million classed as low risk at 9%.

Initial schemes relating to shared services (subsidiary) at the time of planning have since increased in delivery expectation to c.£11.6 million, however this figure is currently being externally validated noting recent HMRC updates.

Within the efficiency programme, £9m relates to pay schemes with 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. Currently NHSE Workforce leads are supporting the Trust with a detailed revised WTE recovery plan which is expected by mid/end September.

Weekly support meetings have been established for all areas delivery efficiencies off plan noting essential to remain on track for the year.

Efficiency delivery remains a significant challenge and key focus area for the Trust with actions being implemented linked to the detailed report presented to the Committee in July.

The cash position as at 31 August was £24.2 million, and remains ahead of the NHSE submitted plan. Improvement to cash levels are the result of funding received relating to 2024/25 M12 system transactions, a timing benefit for Health Education England income paid in April and timing benefit on capital payments. Cash remains a significant focus area for the Trust with daily monitoring in place for active mitigations where appropriate, noting modelling indicates a risk of cash shortfall in the last quarter of the financial year without the appropriate delivery of the Trusts efficiency programme, timing of capital payments made and suitable control of rates of expenditure.

The Trust is progressing with the capital programme for 2025/26 with month 5 spend totaling £2.5 million, which is ahead of plan by £0.8 million.

Externally funded projects are £2.6 million ahead of plan year to date 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 Risks (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 has received notification from NHSE of approval for the Critical Infrastructure Risk bids (CIR) totaling £2.7 million in June 2025.

Trust is awaiting the outcome of business cases submitted to NHSE for the Constitutional Standards Bids and has had to progress at risk to ensure the Stroke development is completed to required timescales. Mitigations are being planned for and are closely overseen by the Capital Space & Utilisation Group with regular lobbying of NHSE taking place.

Key Actions

Whilst the Trust remains within the planned position to month 5, there are a number of challenging areas which require significant focus and active delivery to ensure the Trust remains on plan throughout the year – these being efficiency recovery, delivery and full identification as well as pay variance control especially bank expenditure.

The Trust has established a Finance Recovery Board chaired by the Chief Executive and is in the process of implementing the recommendations from the recent David Moon report previously shared to the Committee.

Also included as part of recovery is a keen focus on assessing the Trusts grip and control with an exercise adopted across the Trust to determine areas of good practice and areas which require improvement. This exercise has been used formally by NHSE for a number of systems nationally with organisations in the Dorset system proactively driving this forward.

Collective interventions are required at all levels and disciplines across the Trust to ensure delivery of plans as the year progresses.

Recommendation

Members are recommended to:

Receive the month five financial position for the financial year 2025/26 for **assurance**.

Baker, Abi
06/10/2025 12:40:16



Dorset County Hospital
NHS Foundation Trust

Financial Position Update 2025/26

August 2025 - Month 5

Chris Hearn
Chief Financial Officer

 **Healthier lives**  **Empowered citizens**  **Thriving communities**

Baker, A
06/10/2025 12:40:16

Financial Position Update - August 2025

Executive Summary

A summary of progress is presented for the period of August 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 August 2025, Dorset County Hospital NHS Foundation Trust (DCHFT) has delivered a deficit of £3.2 million after technical adjustments, an adverse performance of £0.002 million against plan. Year to date, the Trust is £0.009 million favourable to a planned deficit of £14.3 million. Within this position, £264k relates to additional costs incurred as a direct result of the closure and support of the Yeovil maternity service, noting this has been offset by assumed income at this stage.

The Trust has achieved £4.5 million YTD of the planned £4.6 million efficiency target at month 5, with the remaining £0.1 million slippage driven by a number of areas largely relating to Estates & Facilities schemes and bank reduction CIP schemes behind plan.

The Trust wide efficiency target for the year stands at £29.1 million and is c.9% of expenditure budgets. While Exec led meetings are driving the efficiency schemes forward, £4.5 million remains unidentified, with a further £1.5m of system transformation plans at risk of delivery. Of the £24.6 million of identified schemes, £11.4 million are rated high risk and there is significant work being prioritised at pace to lower this risk.

Agency expenditure had a slight deviation from plan in M5 and is £49k above planned levels for August 2025 due to medical increases, however remains £0.5m under year to date. Medical agency reduction is a strong focus for the Trust alongside continued work on Nursing agency. Bank expenditure is now a key focus area with bank overspent by £1.8m YTD. Reduction in bank expenditure requires essential focus requiring enhanced controls across the Trust to manage the overspend in this area. Actions are taking place led by the Trusts Financial Recovery Board, including alignment as appropriate with Dorset HealthCare procedures.

The Trust is progressing with the capital programme for 2025/26 with month 5 YTD spend totalling £9.5 million, which is behind plan by £1.8 million. Externally funded projects are £2.6 million behind plan due to timing of expenditure in the New Hospital Programme (NHP) construction works with internally funded schemes, leased schemes and donated schemes ahead of plan by £0.9 million. Included in the capital plan are bids that the Trust has made to NHS England for Critical Infrastructure Risks (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 received approval of the Critical Infrastructure Risks bids from NHS England in June 2025 and is awaiting the outcome from NHS England of submitting business cases for the Constitutional Standard Bids. The Trust were notified of non-cash backed additional internally funded capital envelope of £1.0 million for Urgent & Elective Care in early July.

The cash position as at 31 August was £24.2 million, £3.6 million ahead of the adjusted plan forecast. The adjusted plan reflects the 2024/25 £13m Trust year-end surplus position and higher closing cash balance as a result of the surplus position. The variance of £3.6 million is due to timing of LVA income £1.8 million, net impact of timing of Q2 Health Education England £0.9 million, timing of HELP Charity Income for Helipad £0.5 million and funding for depreciation £0.4 million received from Dorset ICB. Cash remains a significant focus area for the Trust with daily monitoring in place for active mitigations where appropriate.

Baker, Abi
06/10/2025 12:40:16

 **Healthier lives**

 **Empowered citizens**

 **Thriving communities**

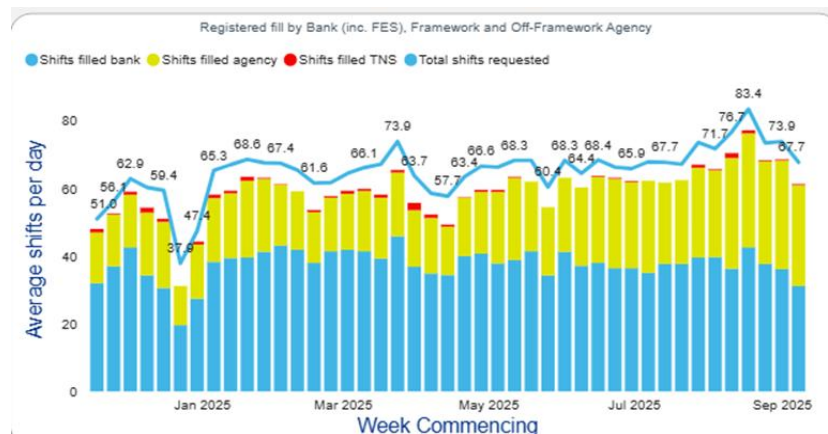
Key Risks

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 have increased the bank target to 20%. This equates to c.£2.4m agency reduction and c.£2.3m bank reduction for the financial year from 2024/25 levels incurred.

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 reduce year on year spend with the exception of safe staffing 'break glass' procedures and mental health escalation requirements. Active plans in place as part of the internal High Cost Agency Reduction group, which was primarily focused on nursing last financial year will now also focus on medical agency and is 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 however increasing bank usage whilst decreasing agency usage (maintaining patient and staff safety and quality levels). Agency notice has reduced to 48 hours in order for Bank Staff to access the shifts in the first instance.

Bank expenditure has deteriorated in month 5 due to the impact of Industrial Action, supporting operational pressures and continued approach to utilise bank before resorting to agency noting cover for vacancies, sickness, and maternity cover. Further workstreams have been requested to ensure bank is utilised under the appropriate circumstances, rosters are reviewed and managed accordingly, with effective Standing Operating Procedures 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

Red Risks: Financial Forecast Risk There is a risk of delivering the deficit position due to the challenging financial envelopes and significant efficiency plan levels. The Trust is actively deploying targeted support towards achievement, led by the CEO as part of the Financial Recovery Board (FRB) 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 planned deficits in the first 9 months of the year and challenging efficiency targets, which if not delivered will further negatively impact cast levels. 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. Risk of Cost Pressures re Yeovil Maternity closure On 19th May Yeovil District Hospital took the decision to close the Maternity and Special Care Baby Unit. Given 20% of activity in these units were the result of Dorset residents, plus many of the Somerset residents would rather travel to Dorchester than Taunton or Bath, significant increases in the number of mothers and babies needing care at DCH is evident. Whilst conversations with Somerset ICB re funding this activity is ongoing, DCH services have had to make urgent changes to staffing levels to accommodate the additional activity. At present, income has been included to offset all resulting expenditure incurred, however there is a risk final funding envelopes will leave a cost pressure - active discussions are taking place to mitigate and resolve appropriately. Awaited approval for capital constitutional bids The Trust submitted capital funding applications totalling £7m, drawing from the available Constitutional Standards (CS) and Critical Infrastructure Risk (CIR) funding streams, of this £2.7m of CIR bids and £0.6m of CS have been approved. The remaining amount is for equipment to support waiting list improvements and to support the Stroke and Urgent Treatment Centre development. Despite submission in May, the Trust awaits final approval from the National Team for these CS bids. To ensure full utilisation of funding, the Trust has committed £1.2m of these bids ahead of receipt largely relating to the Stroke development to ensure delivery within the 2025 required timescales. There is a risk of capital overspend against allowed envelopes if bids are not approved, while there is still currently unused internal envelope which could mitigate this risk in year, existing capital projects would have to be scaled back. Mitigation plans are underway as worse case overseen via Capital Planning & SSpace Utilisation Group (CPSUG).

Baker, Abi
06/10/2025 12:40:16

Key Risks

Amber Risk:

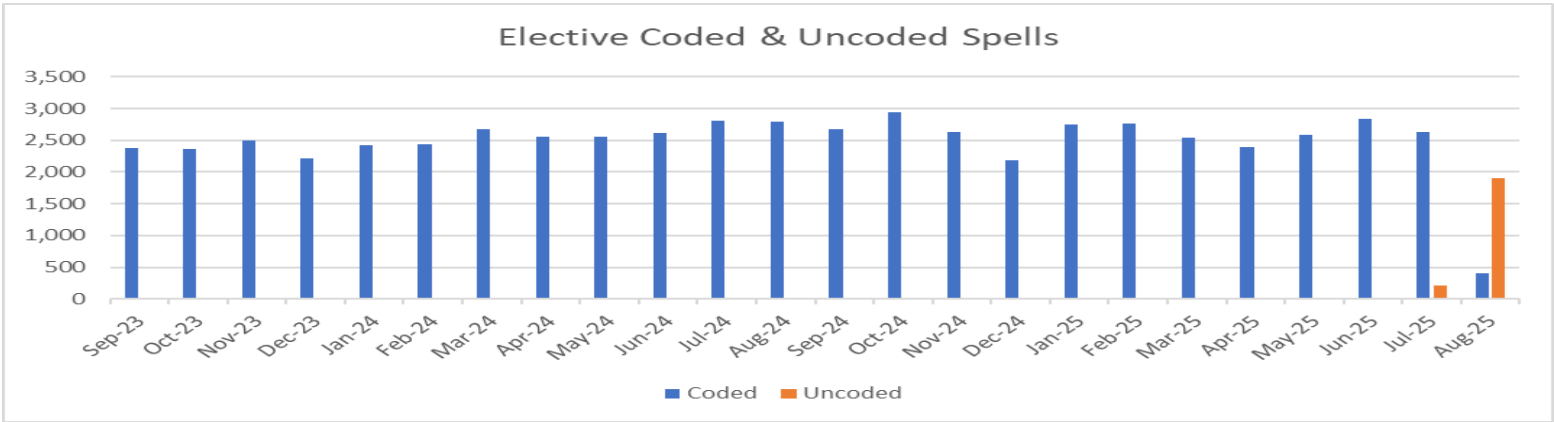
From 2023/24 NHS England introduced the Aligned Payment and Incentive (API) approach to all NHS standard contracts. This approach splits the payment mechanism for the majority of NHS contracts into two envelopes, Fixed and Variable.

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

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

The tariff for each patient is calculated based on their clinical coding assessment. Coding is operated on a flex/freeze model where final coding must be completed by the freeze date to qualify for payment. The freeze date is typically 7 weeks after the end of the month in which the activity occurred, the full timetable is included for information. Any elective activity that remains uncoded after the applicable freeze date represents a loss of income for the Trust.

As at August 2025, the Trust has 2,114 uncoded elective spells & 5,358 uncoded non-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.

Financial Position Update - August 2025

Key Focus Actions



Dorset County Hospital
NHS Foundation Trust

'Focus on delivery of existing plans – weekly focus and rigour

Independent initial efficiency review completed – David Moon & Mark Mansfield
Essential not to lose pace on non pay & income efficiency delivery with pay attention
Productivity schemes development and embedding
Interdependencies required for all schemes – support services etc requirement to enable delivery
EEQIA focus linked to all relevant schemes

Close unidentified gap, work up opportunity schemes

Revisit all system workstreams clarity & pace, including unpalatables
Bring forward schemes consideration at pace/acceleration – E&F in train
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

Non delivery impact risk cash shortfall H2/Q4 – essential Trust/system action required

Key KPIs for weekly reporting to JEMT/Delivery Group/ICB

Activity key performance against plan
Workforce performance against plan – WTE & £ reduction, focus on further controls implemented 2025/26
Efficiency delivery/unidentified – fully developed/plans in progress/opportunities/unidentified reporting
Monthly financial performance vs plan & forecast trajectory
Cash (noting daily cash reporting in place)

Baker, Abi
06/10/2025 12:40:16

Financial Position Update - August 2025

Income & Expenditure

Income and Expenditure
The overall revenue position of the Trust in Month 5 is a deficit of £3.192 million after technical adjustments, an adverse performance of £0.002 million against a plan of £3.190 million deficit. Year to date, the Trust is £0.009 favourable (£14.277 million deficit) to a planned deficit of £14.286 million.
The Trust has seen an increase in both emergency attendances and non elective admission in August, with high levels of no criteria to reside patients (see Performance report). Included within the substantive pay overspend (offset by vacancies) is c.£0.939m of overtime payments year to date across ED, Theatres, Renal and Trauma wards, Dialysis, Maternity and Pathology of note supporting activity increases, vacancies, sickness and maternity cover.
Bank expenditure continues to overspend against plan with ED, general medical staff, Maternity, theatres, Special Care Baby Unit, paediatrics, clinical coding and Estates & Facilities highest use. A detailed review is underway of workforce controls led by the Chief People Officer and supported by NHSE. This includes a safe staffing review of ward templates.
Non pay underspends are largely driven by drugs and stock underspends, however this is currently under review noting the ongoing implementation of the new Inventory Management System to ensure accurate recording and reporting is in place.
The Trust has a challenging plan for 2025/26, including current CIP plans of £29.1m (c.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.

Statement of comprehensive income	In Month			YTD		
	Current Plan £'000	Actual £'000	Variance £'000	Current Plan £'000	Actual £'000	Variance £'000
Operating income from patient care activities	23,135	23,497	(362)	116,316	116,850	(534)
Other operating income	2,130	2,690	(560)	10,700	10,634	66
Employee expenses:						
- Substantive	(16,548)	(16,018)	(530)	(83,307)	(83,076)	(231)
- Bank	(867)	(1,177)	310	(4,266)	(6,096)	1,830
- Agency	(464)	(513)	49	(2,419)	(1,972)	(447)
Operating expenses excluding employee expenses	(10,143)	(11,273)	1,130	(49,138)	(48,597)	(541)
OPERATING SURPLUS/(DEFICIT)	(2,757)	(2,794)	37	(12,114)	(12,257)	143
FINANCE COSTS						
Finance income	50	123	(73)	250	661	(411)
Finance expense	(60)	(59)	(1)	(303)	(302)	(1)
PDC dividend expense	(417)	(418)	1	(2,085)	(2,087)	2
NET FINANCE COSTS	(427)	(354)	(73)	(2,138)	(1,728)	(410)
Other gains/(losses) including disposal of assets	0	2	(2)	0	2	(2)
Share of profit/(loss) of associates/joint ventures	0	0	0	0	0	0
Gains/(losses) from transfers by absorption	0	0	0	0	0	0
Movements in fair value of investments, investment property, financial liabilities	0	0	0	0	0	0
Corporation tax expense	(2)	(5)	3	(12)	(14)	2
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	(3,186)	(3,151)	(35)	(14,264)	(13,997)	(267)
Adjusted financial performance	In Month			YTD		
	Current Plan £'000	Actual £'000	Variance £'000	Current Plan £'000	Actual £'000	Variance £'000
Surplus/(deficit) for the period/year	(3,186)	(3,151)	(35)	(14,264)	(13,997)	(267)
Add back all I&E impairments/(reversals)	0	0	0	0	0	0
Adjust (gains)/losses on transfers by absorption	0	0	0	0	0	0
Surplus/(deficit) before impairments and transfers	(3,186)	(3,151)	(35)	(14,264)	(13,997)	(267)
Retain impact of DEL I&E (impairments)/reversals	0	0	0	0	0	0
Remove capital donations/grants/peppercorn lease I&E impact	(4)	(41)	37	(22)	(280)	258
Add back PFI revenue costs on a UK GAAP basis	0	0	0	0	0	0
Adjusted financial performance surplus/(deficit) including PSF as per a	(3,190)	(3,192)	2	(14,286)	(14,277)	(9)
Adjusted financial performance surplus/(deficit)	(3,190)	(3,192)	2	(14,286)	(14,277)	(9)

Baker, Abi
06/10/2025 12:40:16

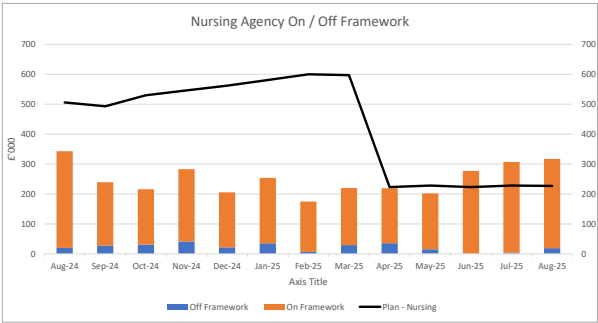
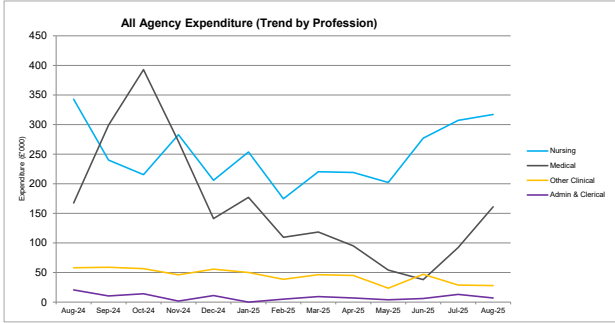
Financial Position Update - August 2025
Trust Wide Performance: Agency

Pay Analysis - Agency

Agency costs in month 5 were £0.513 million against a plan of £0.464 million. This is an improvement against spend in August last year (£589k) however a deterioration against prior months spend by £72k. Current year plans include a 30% reduction in agency spend from 2024/25 outturn (£6.5 million outturn), resulting in a reduction of c.£2.4 million across the year.

There was a deterioration against Medical agency spend compared to last month, there is ongoing focus to reduce spend in this area supported by a recently set up system working group.

Nursing agency spend deteriorated in month compared to July 2025, worsening by £10k linked to continued 1-2-1 staffing requirements for mental health patients and increased activity linked to ED attendances.



Agency Spend by Profession (£'000)	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
Nursing	343	240	215	283	208	254	175	220	219	202	277	307	317
Medical	167	299	393	271	141	177	110	118	95	54	38	92	161
Other Clinical	58	59	56	46	56	50	39	46	45	24	47	29	28
Admin & Clerical	21	10	14	2	11	0	5	9	7	4	6	13	7
Total	589	608	679	602	414	481	328	394	366	284	368	441	513
Plan - Total Agency	833	807	833	833	833	833	833	810	464	487	456	548	464
Variance to Plan	244	199	154	231	419	352	505	416	98	203	88	107	(49)

Nursing Agency Category	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
Off Framework	20	27	31	41	21	35	7	29	36	15	1	4	19
On Framework	323	212	185	242	184	219	168	191	184	187	276	303	298
Total	343	240	215	283	206	254	175	220	219	202	277	307	317
Plan - Nursing	506	493	530	546	562	581	600	597	223	228	223	228	227
Variance to Plan - Nursing	163	253	315	263	356	327	425	377	4	26	(54)	(79)	(90)

YTD Actual	YTD Plan	Variance
1,322	1,129	(193)
441	1,115	674
172	175	3
37	0	(37)
1,972	2,419	447

Pay Metrics	In Month Actual	YTD Actual
Agency expenditure as % of total pay	2.9%	2.2%
Off framework expenditure as % of total agency	3.7%	3.8%

Areas Using Nursing Agency Including Off Framework YTD (£'000)				
Area	On Framework	Off Framework	Total Nursing Agency	%
Emergency Dept Main Dept	272	2	274	21%
Purbeck Wd	172	1	173	13%
Moreton Ward - Respiratory	110	2	112	9%
Day Surgery Unit	105	-	105	8%
Ilchester Integrated Assessment	83	-	83	6%
Lulworth Ward	76	-	76	6%
Surge Area	73	-	73	6%
Fortuneswell Ward	57	-	57	4%
The Mary Anning Unit	50	1	51	4%
Stroke Unit	47	1	48	4%
Abbotsbury Ward	40	-	40	3%
Ridgeway Wd	30	-	30	2%
Crcu	30	19	49	4%
Kingfisher Ward	27	10	37	3%
Maternity Unit	19	-	19	1%
Prince Of Wales	18	-	18	1%
Frailty Sdec	15	-	15	1%
Cardiology Care Ward	13	-	13	1%
Sdec	7	-	7	1%
Discharge Team	-	-	-	0%
Scbu	-	40	40	3%
Evershot Ward	-	-	-	0%
Emergency Dept Nurse Practnrs	-	-	-	0%
Emergency Dept Medical Staff	-	-	-	0%
Nurse Bank	-	-	-	0%
Bank Nurses	-	-	-	0%
Total Nursing Agency YTD	1,246	75	1,321	

Baker,Abi
06/10/2025 12:40:16

Financial Position Update - August 2025
Trust Wide Performance: Bank

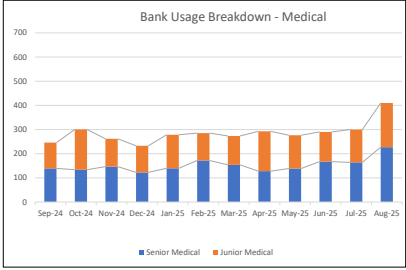
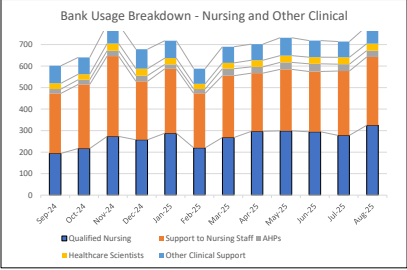
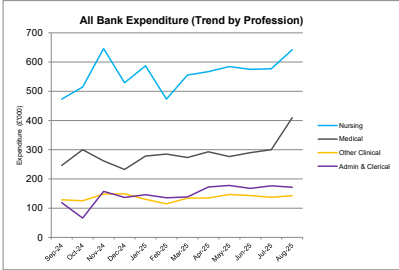
Pay Analysis - Bank

Bank costs in month 5 were £1.176 million against a plan of £0.867 million, similar to the levels seen in prior months, remaining relatively consistent across the past year.

Reduction in bank expenditure is a key focus area nationally, with a minimum of 10% cost reduction expected. As part of 2025/26 planning round, the Trust stretched this target to 20% equating to a cost reduction of c. £2.3m.

Workforce engagement is in place in this area to deliver enhanced booking controls across the Trust, and is being supported by NHSE to provide independent review and appropriate support.

This area requires key focus and will remain a strong area of scrutiny, requiring the same levels of rigour applied to the agency cost reduction programme.



Bank Spend by Profession (£'000)	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
Nursing	473	515	646	529	587	473	555	667	585	575	577	642	556
Medical	246	300	262	233	278	285	273	293	277	290	300	410	309
Other Clinical	128	128	148	149	130	115	134	135	147	143	137	143	137
Admin & Clerical	119	66	157	137	146	135	138	173	178	168	176	171	174
Total	967	1,007	1,213	1,048	1,142	1,009	1,101	1,167	1,186	1,176	1,190	1,366	1,176

Bank Category	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
Qualified Nursing	194	217	273	258	288	220	268	297	299	294	278	325	316
Support to Nursing Staff	279	297	373	272	300	253	288	270	286	281	299	318	240
AHPs	20	22	25	27	20	20	33	29	33	36	32	29	34
Healthcare Scientists	27	25	34	33	29	24	27	31	31	31	32	32	71
Other Clinical Support	81	78	90	90	81	71	75	75	83	77	73	81	149
Management / Admin	119	66	157	137	146	135	138	173	178	168	176	171	160
Senior Medical	139	134	147	123	140	172	154	128	139	167	164	227	174
Junior Medical	107	166	115	110	138	113	119	165	138	123	136	183	32
Total	967	1,007	1,213	1,048	1,142	1,009	1,101	1,167	1,186	1,176	1,190	1,366	1,176
Plan	876	862	826	776	724	669	611	594	630	651	801	917	867
Variance to Plan	(91)	(145)	(387)	(272)	(418)	(340)	(490)	(613)	(356)	(325)	(389)	(449)	(309)

YTD Actual	YTD Current Plan	Variance
2,935	2,717	(218)
1,585	977	(608)
707	248	(459)
867	324	(543)
6,095	4,266	(1,829)

Pay Metrics	In Month Actual	YTD Actual
Bank expenditure as % of total pay	6.6%	6.7%

Healthier lives Empowered citizens Thriving communities

Baker,Abi
06/10/2025 12:40:16

Financial Position Update - August 2025

Insourcing

Insourcing Narrative	Actual	Actual	Actual	Actual	Actual	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
The insourcing budget of £8.0 million is planned to deliver insourcing activity as presented to Committee during the 2025/26 planning round.	658	679	658	679	679	658	679	658	679	679	616	679	3,353	8,000
Year to date financial performance has delivered a £0.028m deterioration against year to date plan. The latest forecast trajectory as at month 4 shows total spend of £8.0m which is in line with plan to deliver 65 week wait activity and Elective Recovery activity. Activity performance will continue to be monitored throughout the year and current forecast underspend may need to be redistributed to underperforming specialties to address performance targets.														
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.														
Spend:														
Breast	13	13	26	15	26	0	13	0	0	13	0	0	93	119
Dermatology	144	126	128	116	145	118	118	118	118	118	118	118	658	1,487
Endoscopy/Gastro	131	107	48	118	105	107	107	107	107	107	107	107	508	1,259
ENT	91	48	11	64	46	50	50	50	50	50	50	50	260	611
General Surgery	6	6	(1)	12	0	6	6	6	6	6	6	6	23	63
Gynaecology	29	29	28	54	55	29	48	48	48	48	48	48	195	513
OMF	147	90	160	65	144	94	75	75	94	75	75	94	605	1,190
Ophthalmology	25	24	76	102	36	20	36	36	36	36	36	236	263	697
Orthopaedics	83	88	99	31	124	83	83	83	83	83	83	83	425	1,008
Urology	11	11	11	11	11	11	11	11	11	11	11	11	57	137
Theatre Staffing	0	122	57	57	56	89	89	89	89	89	89	89	292	912
Total spend	680	664	643	645	748	609	637	624	643	637	624	843	3,381	7,997
Surplus/(Deficit)	(23)	15	14	34	(69)	49	42	34	36	42	(9)	(164)	(28)	3

 Healthier lives  Empowered citizens  Thriving communities

Baker, Abi
06/10/2025 12:40:16

Financial Position Update - August 2025
Sustainability & Efficiency

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

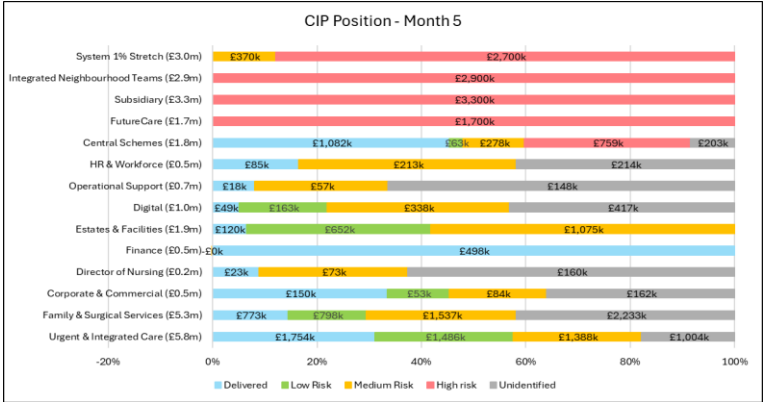
In month delivery of £0.9 million has been achieved, delivered from biosimilar drug savings, agency cost reduction of Off Framework and the remainder largely from finance income (bank interest) and workforce pay savings (vacancies). This is £0.105 million behind plan YTD, with YTD delivery being £4.540million.

Whilst £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 £11.5 million of the identified schemes are highlighted as high risk, bringing total high risk schemes to £16.1 million (56%). Further work is ongoing led by Exec's to progress at-risk schemes, find plans across the system to address the full £29.1 million requirement and complete development and delivery of identified projects. This includes identifying full potential of savings linked to the Subsidiary indicated in the Forecasts, work is still ongoing to provide evidence backed forecasts across the Cnetral and System Stretch schemes.

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.

Baker/Abi
06/10/2025 12:40:16

Area	5% of 2024/25 Operating Expenditure £'000	Corporate Stretch to 10% £'000	Total 2025/26 Efficiency Target £'000	Identified £'000	Pay specific Indicative Targets £'000	Total Identified - Plan Submission £'000	Unidentified £'000	Delivered £'000	YTD Plan £'000	Variance to Plan £'000
Core main - 5%										
Urgent & Integrated Care	5,757	-	5,757	1,996	2,757	4,753	1,004	1,743	1,503	(240)
Family & Surgical Services	5,347	-	5,347	724	2,390	3,114	2,233	785	942	157
Corporate & Commercial	277	183	460	-	298	298	162	150	9	(141)
Director of Nursing	117	117	234	-	74	74	160	22	2	(20)
Finance	244	244	488	267	220	487	-	498	220	(278)
Estates & Facilities	942	905	1,847	1,078	769	1,847	-	120	712	592
Digital	518	471	989	163	409	572	417	49	127	78
Operational Support	223	-	223	-	74	74	149	18	10	(8)
HR & Workforce	304	208	512	68	230	298	214	85	95	10
NR slippage	-	-	-	248	-	248	-	-	-	0
Central Schemes	-	-	2,246	1,796	-	1,796	203	1,070	1,024	(46)
			18,103	6,340	7,221	13,561	4,542	4,540	4,645	105
Central NR stretch - 3%										
FutureCare - detailed modelling underway			1,700	-	1,700	1,700	-	-	-	-
Subsidiary - INCREASE TO £11.6m - EXTERNAL VALIDATION PENDING			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 - RISK TO DELIVERY			100	100	-	100	-	-	-	-
System - WorkStream 4 - Commissioning for sustainability - RISK TO DELIVERY			600	600	-	600	-	-	-	-
System - WorkStream 4 - Virtual wards - RISK TO DELIVERY			200	200	-	200	-	-	-	-
System - WorkStream 4 - Balance sheet release			370	-	370	370	-	-	-	-
System - WorkStream 4 - system transformation/technical adjustments - RISK TO DELIVERY			500	500	-	500	-	-	-	-
			3,070	2,700	370	3,070	-	-	-	-
Totals			29,073	19,781	9,291	24,531	4,542	4,540	4,645	105



	Pay £'000	Non Pay £'000	Income £'000	Total £'000	R £'000
High Risk	1,700	14,102	100	15,902	8
Medium Risk	4,559	791	71	5,421	3
Low Risk	3,462	2,776	1,512	7,750	4
Total Efficiencies	9,721	17,669	1,683	29,073	15
Delivered	2,189	1,558	793	4,540	1
Fully Developed	1,480	1,633	574	3,686	2
Plans in Progress	6,053	2,219	216	8,487	6
Opportunity	0	7,718	100	7,818	5
Unidentified	0	4,542	0	4,542	
Total Efficiencies	9,721	17,669	1,683	29,073	15
% of Total Schemes (excl unidentified)	33%	61%	6%		

Financial Position Update - August 2025

Cash

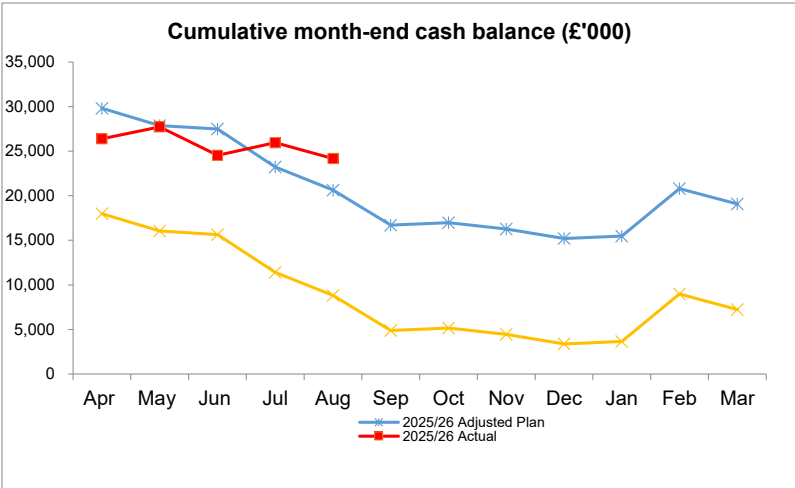
Cash Balance incl Forecast

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 shortfalls in cash. The cashflow forecast now includes a plan-adjusted forecast to reflect 2024/25 Trust surplus of £13 million and higher closing cash balance as a result of the surplus position.

The cash position is currently £24.2 million at end of August, which is ahead of the plan-adjusted forecasted position of £20.6 million. This is due to timing of LVA income £1.8 million received in August, net impact of the timing of Q2 Health Education England Income £0.9 million, timing of HELP Charity Income for Helipad £0.5 million and funding for depreciation £0.4 million received from Dorset ICB.

Whilst 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 noting any shortfall delivering monthly planned 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 and NHSE are being kept up to date and aware of the potential risk.



Working Capital Ratios	YTD Actual
Current Ratio (Net Current Assets / Current Liabilities)	0.90
Quick Ratio (As above excluding Inventories from current assets)	0.82
Creditor Days (Average days to pay creditors)	153
Debtor Days (Average days to receive payment for debtor invoices)	26
Inventory Holding Days (Average days inventory is held)	30

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 Submitted 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
2025/26 Adjusted Plan	29,815	27,876	27,483	23,225	20,639	16,703	16,982	16,280	15,202	15,486	20,797	19,067
2025/26 Actual	26,395	27,726	24,550	25,947	24,176							

Baker,Abi
06/10/2025 12:40:16

Baker, Abi
06/10/2025 12:40:16

Financial Position Update - August 2025

Capital

Capital Programme Narrative
Capital expenditure year to date to the end of August was £9.5 million and behind plan by £1.7 million.
Internally Funded schemes and donated schemes are overall ahead of plan at the end of August by £0.7 million.
Digital and Medical Equipment Schemes were ahead of plan year to date due to timing of EHR expenditure and the purchase of replacement items.
Estates schemes are ahead of plan year to date due to timings of expenditure on Chemotherapy Unit, Stroke Unit works design fees and timing of expenditure.
Externally Funded capital expenditure was £2.6 million behind plan due to timings of expenditure on New Hospital Programme (NHP) construction works.
Donated expenditure is ahead of plan by £0.3 million due to timing of expenditure on Chemotherapy Unit works but this is offset with donated asset income.
Leased expenditure is behind plan £0.1 million due to timing of lease remeasurement.
Included within the capital plan are bids that the Trust has submitted to NHS England for the following: - Critical Infrastructure Risk (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 Urgent & Emergency Care (UEC), including Stroke unit and ED walk-in/Urgent Treatment Centre configuration - external funding of £2.9 million.
The Trust has received notification from NHSE of approval for the Critical Infrastructure Risk bids (CIR) totaling £2.7 million in June 2025. The Trust were notified of non-cash backed additional internally funded capital envelope of £1.0 million for Urgent & Elective Care in early July.
The Trust is awaiting the outcome of business cases submitted to NHSE for the Constitutional Standards Bids, noting schemes linked to Stroke have progressed at risk in line with project timescales. CPSUG oversight in place.

CAPITAL	CURRENT MONTH			YEAR TO DATE			FULL YEAR 2025/26					
	Plan	Actual	Variance	Plan	Actual	Variance	Committed Spend	Forecast	Annual Plan	Variance		
<i>Estates</i>	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000		
Generator	-	4	-	4	-	25	-	128	800	800	-	
High Acute Stroke Unit (HASU)	50	178	-	128	250	408	-	757	757	757	-	
Other UEC Schemes	-	-	-	-	-	-	-	-	994	-	994	
Estates Schemes	72	113	-	41	355	678	-	323	1,111	1,111	-	
<i>Digital Services</i>												
EHR Matched Funding	-	56	-	56	-	216	-	216	512	1,781	1,781	-
IT Schemes	132	166	-	34	654	604	-	50	1,219	1,219	1,219	-
<i>Equipment</i>												
Other Equipment	122	99	-	23	222	257	-	35	349	1,557	1,557	-
Sub-Total Internally Funded Expenditure	376	616	-	240	1,481	2,187	-	706	4,076	8,219	7,225	- 994
<i>Donated</i>												
Other Donations	-	-	-	-	-	-	-	-	-	-	-	-
Chemotherapy Unit Refurbishment	40	-	-	40	200	462	-	262	462	480	480	-
Sub-Total Planned Donated Expenditure	40	-	-	40	200	462	-	262	462	480	480	-
<i>IFRS 16 Lease Additions</i>												
Admin Offices	-	-	-	-	-	-	-	-	-	1,500	1,500	-
MSCP Lease remeasurement	-	92	-	92	500	737	-	237	737	737	500	- 237
CEF Lease remeasurement	400	-	-	400	400	92	-	308	92	263	400	- 137
One Dorset Pathology	-	-	-	-	-	-	-	-	-	750	750	-
Other Leases	-	-	-	-	-	-	-	-	-	600	600	-
Accommodation & Vehicle Lease Additions	-	-	-	-	25	7	-	18	7	282	382	- 100
Sub-Total Planned IFRS 16 Expenditure	400	92	-	308	925	836	-	89	836	4,132	4,132	-
Total Internal & Leased Capital Expenditure	816	708	-	108	2,606	3,485	-	879	5,374	12,831	11,837	- 994
<i>Additional funded schemes</i>												
NHP Works	2,000	1,761	-	239	8,000	6,004	-	1,996	27,789	27,789	27,789	-
Digital EHR Funding	40	-	-	40	160	-	-	160	-	5,482	5,482	-
CIR Funding - Generator	200	-	-	200	200	-	-	200	-	1,800	1,800	-
CIR Funding - Renal OP Unit	-	-	-	-	-	-	-	-	-	600	600	-
CIR Funding - SSD Plant	-	-	-	-	-	-	-	-	-	302	302	-
Constitutional Standards - Diagnostics	-	-	-	-	-	-	-	-	177	550	550	-
Constitutional Standards - Elective	244	-	-	244	244	-	-	244	57	869	869	-
Constitutional Standards - UEC	-	-	-	-	-	-	-	-	1,122	2,850	2,850	-
LIMS Reach Programme	-	-	-	-	-	-	-	-	-	78	-	- 78
	2,484	1,761	-	723	8,604	6,004	-	2,600	29,145	40,320	40,242	- 78
Total Externally Funded Capital Expenditure												
Total Capital Expenditure	3,300	2,469	-	831	11,210	9,489	-	1,721	34,519	53,151	52,079	- 1,072
Expenditure as a % of Plan												
							</					

Report to	Board in Common (DHC Board)	
Date of Meeting	7 th October 2025	
Report Title	Trust Finance Report for Month 5, August 2025	
Report Author	Michele King – Head of Management Accounts	
Approved by Accountable Executive	Chris Hearn, Joint Chief Finance Officer	
Previously reviewed by	Senior Leaders' Group, 17 th September Finance and Performance Committee in Common, 24 th September	
Action Required	Approval	No
	Assurance	Yes
	Information	No

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? <i>Delete as required</i>	
Care	Yes	
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 and this will adversely impact our ability to provide safe sustainable services, and will impact upon the overall ICS position	
Financial	Value for money and financial sustainability addressed in the report	
Statutory & Regulatory	Underpins long term financial sustainability and delivery of operational plan	
Equality, Diversity & Inclusion	No implications arising from the report	
Co-production & Partnership	System financial plan delivery	

Executive Summary
Key messages for the five months ended August 2025 are as follows: - The Trust delivered an adjusted year-to-date deficit of £1.1m at month 5. This equates to a deficit of £0.06m against the plan submitted to NHSE for 2025/26. - With the exception of corporate services and finance and strategic development, all areas are overspent, with particular challenges around medical agency costs and unachieved savings. - The Trust has delivered savings of £4.2m against a month 5 ytd target of £3.5m. The Trust's full year efficiency target is £38.5m. - The forecast indicates an actual year-end deficit of £3.87m against a planned surplus of £9.77m. This assumes no further savings are found and spend continues at current rates. Actions: - Collectively work together to agree the actions to resolve the financial position at month 5. - Continue to identify recurrent savings.

Recommendation
Members are requested to: Receive the report for assurance

Trust Financial Performance Report

Month 5 2025/26 – August Summary

1. Summary

At the end of August half of the KPIs are rated green.

KPI	RAG
Current Month Break Even	
Year to Date Variance to Plan.	
Forecast Outturn	
Year to Date Capital Spend against Plan	
Delivery of Savings Programme	
Better Payment Policy	

Key messages

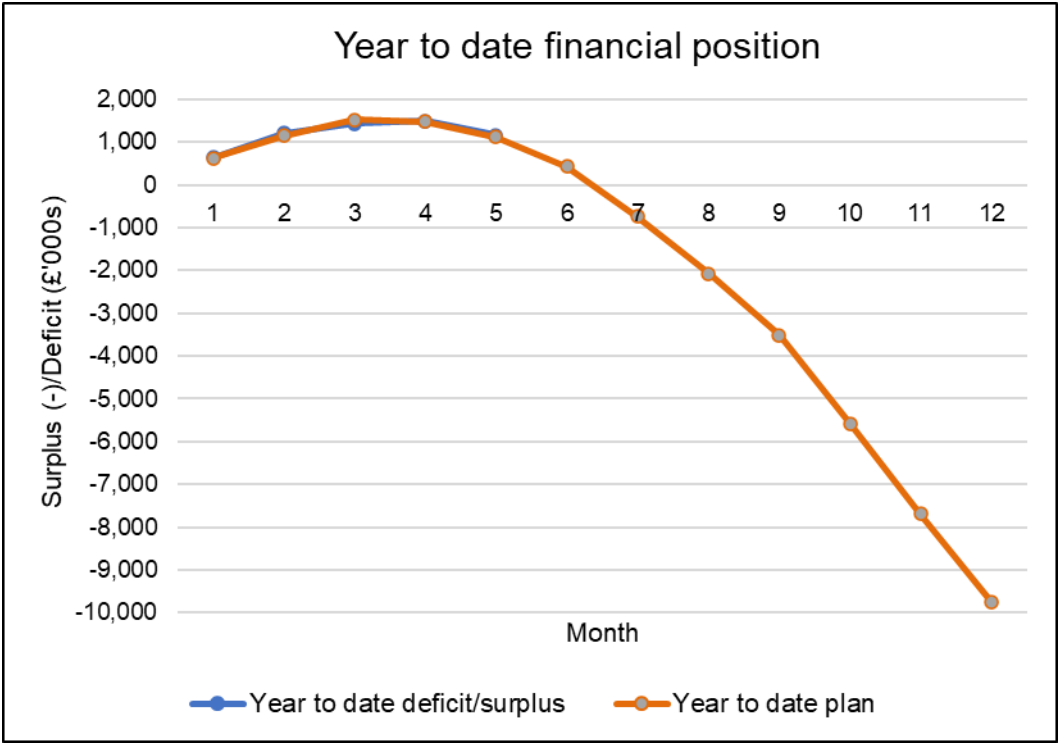
- The Trust has three measures of financial performance: Income over expenditure, performance against NHSE Plan and, due to phasing of budgets different from NHSE plan, the budget plan.
- The Trust delivered an adjusted year-to-date deficit of £1.1m at month 5. This equates to a deficit of £0.06m against the plan submitted to NHSE for 2025/26.
- With the exception of corporate services and finance and strategic development, all areas are overspent, with particular challenges around medical agency costs and unachieved savings.
- The Trust has delivered savings of £4.2m against a month 5 ytd target of £3.5m. The Trust’s full year efficiency target is £38.5m.
- The forecast indicates an actual year-end deficit of £3.87m against a planned surplus of £9.77m. This assumes no further savings are found and spend continues at current rates.

Baker, Abi
06/10/2025 12:40:16

2. Year to date performance

2.1 Summary

- The graph below shows that the Trust delivered an adjusted year-to-date deficit of £1.1m at month 5. This equates to a deficit of £0.06m against the plan submitted to NHSE for 2025/26.
- Appendix 1 includes the full detail of the Trust’s financial performance.



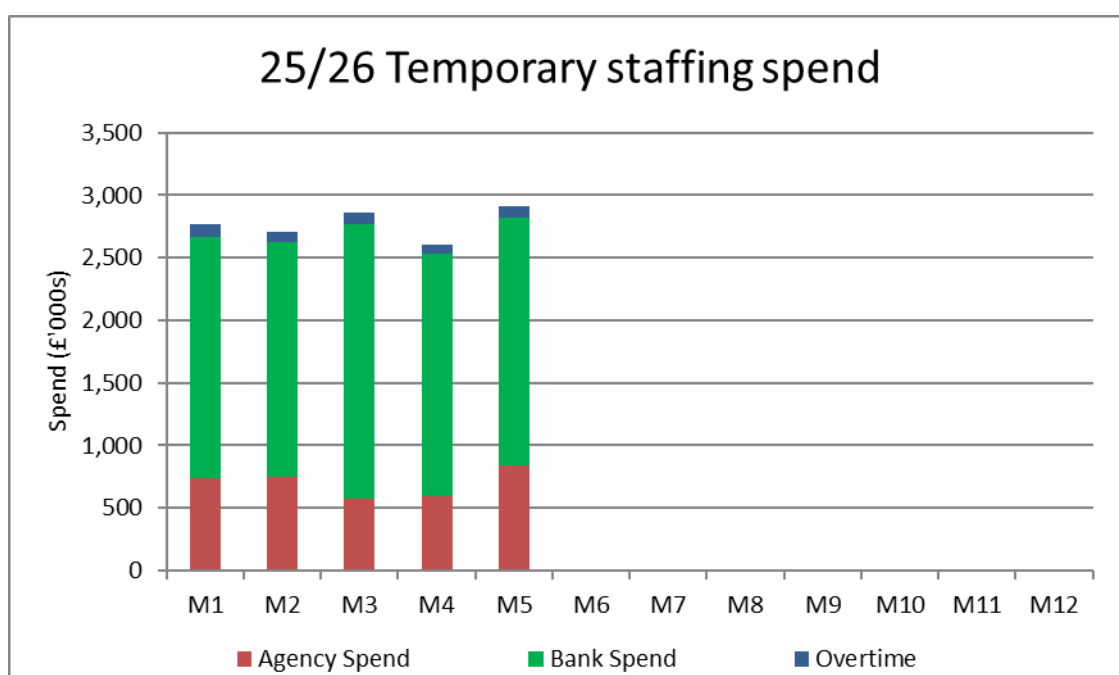
- The key drivers of the Trust’s position are set out in the table below.

Drivers of Financial Performance	£'000s
Temporary staffing	776
Out of area placements	1,970
Clinical non-pay (drugs, clinical supplies and services)	(1,777)
Efficiency savings	(707)
Interest received	(203)
Deficit against NHSE plan	59

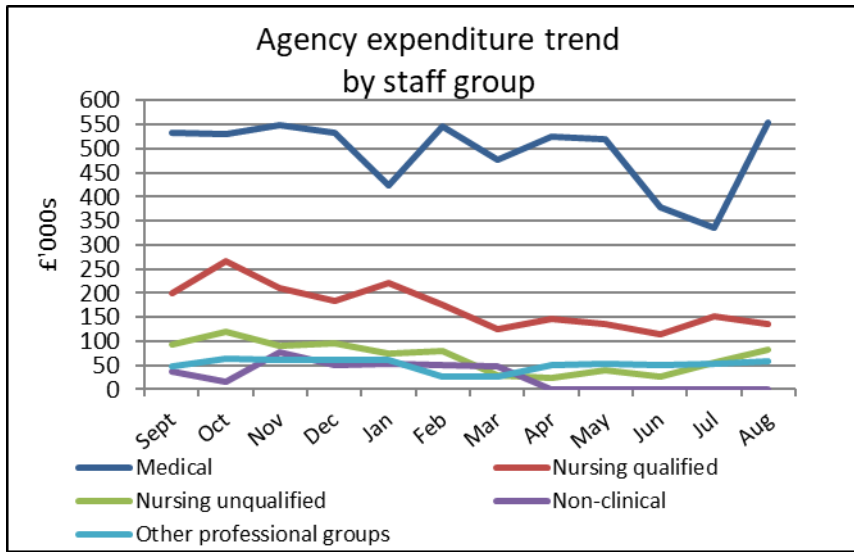
Baker, Abi
06/10/2025 12:40:16

2.2 Temporary staffing

- Temporary staffing costs increased by £308k in month 5.
- Agency costs increased by £243k, from £598k to £841k, however this increase may be due to change in calculation methodology, which is under investigation.
- Bank increased by £52k and overtime increased by £14k, noting that the back dated AfC pay award was paid in month 5, which will impact both bank and overtime costs.
- Year to date agency expenditure is £621k lower than the same period last year, bank £733k higher and overtime costs £19k higher.
- The largest area of agency spend is currently in the Medical directorate, which is £267k higher year to date, than the same period in 24/25, noting the review of methodology highlighted above.
- Year to date agency costs are below plan by £116k and are 2.56% of total pay costs.
- YTD bank costs are above plan by £891k.

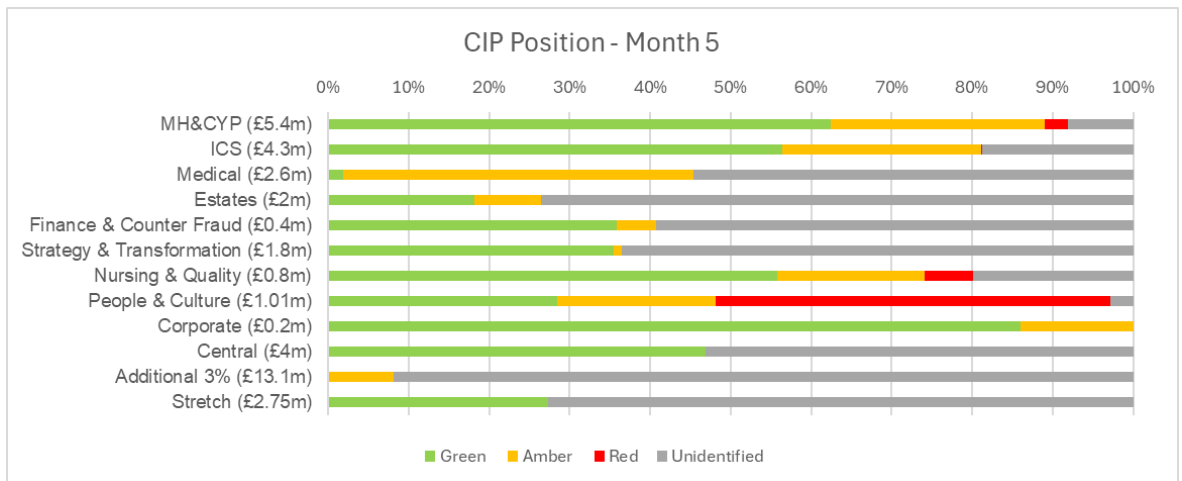


Baker, Abi
06/10/2025 12:40:16



2.3 Efficiency Programme

- The total target for 2025/26 is £38.5m. This is made up of £22.7m assigned to operational efficiencies and £15.8m transformational efficiencies.
- The graph below shows the position as at the end August.
- As at month 5, savings of £4.2m have been delivered against a plan of £3.5m, leading to a surplus against plan of £0.7m.



- Of the £38.5m target:
 - £10.6m (28%) of efficiency schemes are fully developed (green).
 - £5.3m (14%) of efficiency schemes are plans in progress (amber).
 - £0.7m (2%) of opportunities are currently being worked on.
 - £21.9m (57%) remains unidentified.
- Within the £21.9m unidentified:
 - £7.9m is within the core 5% efficiency that has been split across directorates

Baker, Abi
06/10/2025 12:40:16

- £12m is within the additional 3% requirement, which will be partly found through savings linked to the Dorset shared service.
- £2m is the additional CIP stretch target.
- Ongoing discussions with system partners to develop recovery plans in the second half of the year, across all organisations.

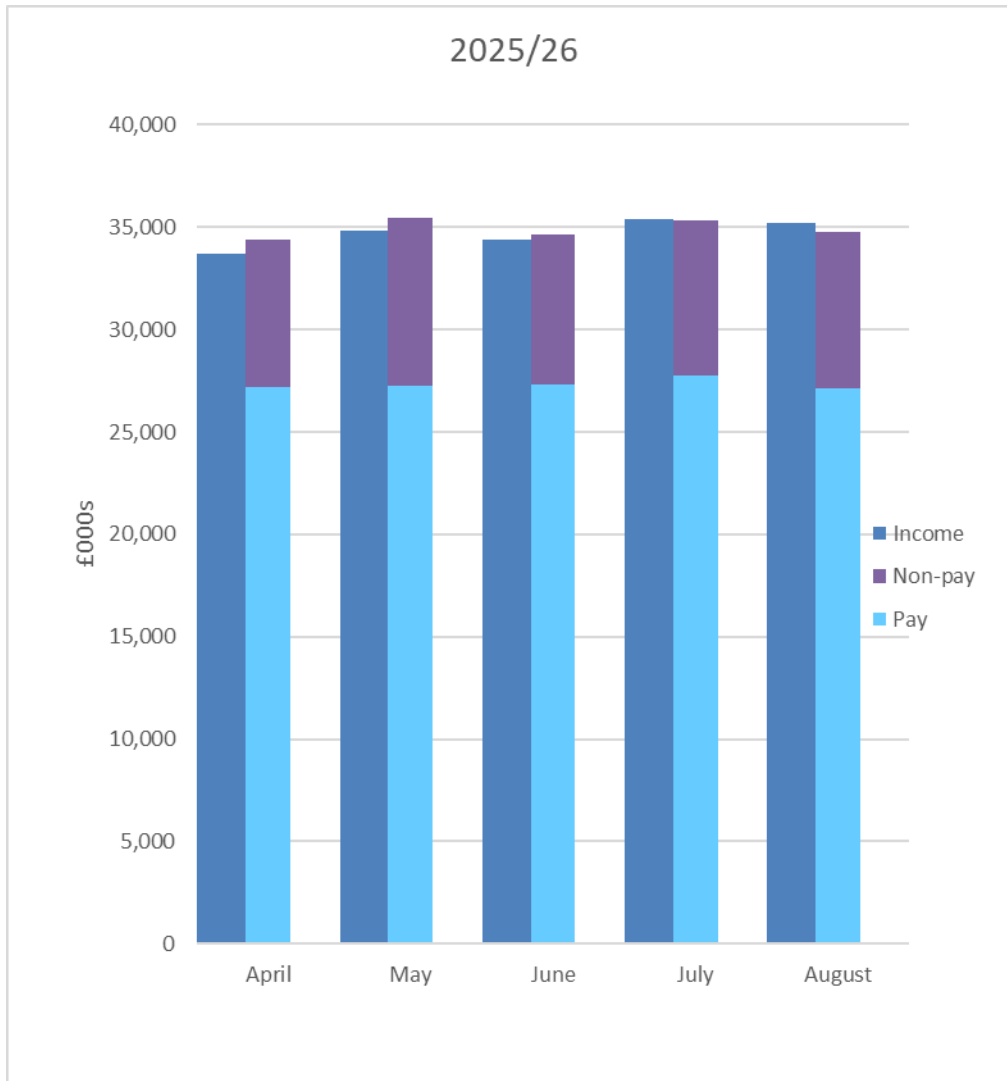
2.4 Out of area placements

- The mental health bed capacity in Dorset is currently below the modelled requirements, meaning that out of area placements will continue to be necessary until the new St Ann's hospital opens.
- Significant work has been undertaken to reduce the number of inappropriate out of area placements.
- With 1 patient remaining in a non-block booked bed at the end of August, the budget is overspent by £1.97m, reflecting the higher number of placements in months 1-4.
- Beds have been block booked at the Priory in Southampton to compensate for the lack of capacity. 10 beds have been block booked until the end of March 2026.

Baker, Abi
06/10/2025 12:40:16

3. Performance in month

- During the month of August, the Trust's income exceeded expenditure by £0.4m. This is before technical adjustments and impairments. The run rate is shown in the graph below.



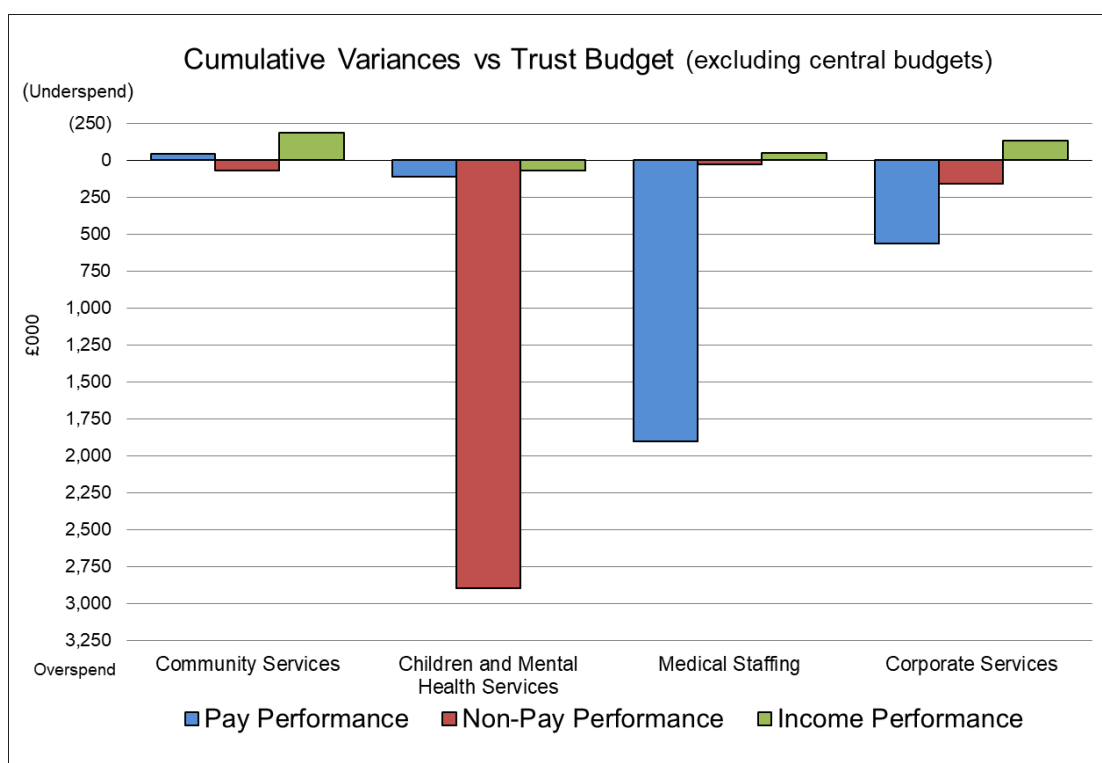
Baker, Abi
06/10/2025 12:40:16

4. Directorate performance

- The table below sets out the financial performance by directorate, with the majority of directorates facing financial challenges.
- Note that the variance to budget is a key internal control measure only and is a key indicator of individual directorate performance. It is not reported as the Trust's deficit externally as the budget phasing does not align with the plan submitted to NHSE.

	Full year budget	Month 5 spend	YTD spend	Variance to budget at Month 5
	£'000s	£'000s	£'000s	£'000s
Trust Wide Income	(339,708)	(28,364)	(141,881)	7
Central budgets	14,439	(3,591)	348	225
Integrated Community Services	108,844	10,070	44,995	(165)
Mental Health & Children's Service	122,906	11,767	53,977	3,075
Medical Staffing	26,098	3,022	12,770	1,883
Nurse Executive and Quality	9,599	832	3,926	(94)
Finance and Strategic Development	41,222	3,545	16,871	60
People & Culture	6,031	504	2,178	290
Strategy, Transformation & Partnerships	14,208	1,445	6,266	362
Corporate Services	3,859	359	1,678	(28)
Total	7,498	(410)	1,127	5,614
Capital donations/grants/peppercorn lease	(17,260)	45	45	
Adjusted total	(9,762)	(365)	1,172	

- The table above reflects the net position of each service.



Baker, Abi
06/10/2025 12:40:16

4.1 Integrated Community Services

	Full year budget	Month 5 spend	Year to date spend	Forecast Outturn	Forecast variance to budget
	£'000s	£'000s	£'000s	£'000s	£'000s
Income	(20,073)	(1,801)	(8,897)	(20,380)	(307)
Pay	107,000	10,033	44,721	106,956	(43)
Non-pay	21,917	1,838	9,171	22,301	383
Total	108,844	10,070	44,995	108,877	33

Drivers of year-to-date performance

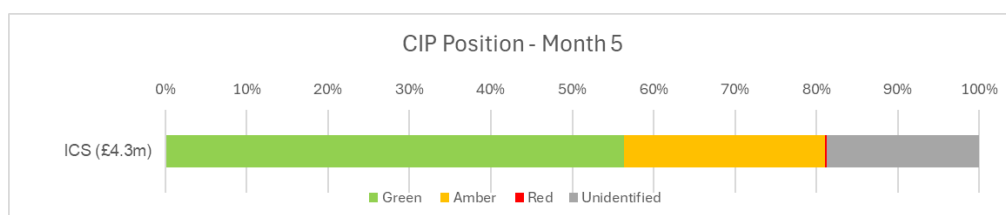
- Unachieved savings of £357k.
- High district nursing and MIU costs due to service demand and Nurse Apprentices working supernumerary, partly offset by vacancies in the Pain, Post COVID, Podiatry and Musculoskeletal services.
- High LVA income.

Key factors in outturn forecast position

- Assumed unachieved efficiency savings of £1.9m.
- Vacancies mainly in Integrated Community Rehabilitation teams, Pain, Podiatry, Musculoskeletal services and the wheelchair service.
- High hearing aid expenditure and contracted out pain costs below plan.

Performance against efficiency target

- The Integrated Community Services directorate's savings requirement is £4.38m.
- The chart below indicates the level of savings schemes that are fully developed (green) and the confidence in delivery.



Baker, Abi
06/10/2025 12:40:16

Actions to improve financial sustainability

- Ongoing scrutiny of vacancies.
- Review of all contracts to ensure best value for money and delivering services required.
- Engagement events with clinical teams to see where changes can be made to improve quality and reduce wastage and costs.
- Working with corporate teams to understand service cost base and benchmarking information to identify opportunities to learn from other service models.
- Fortnightly meetings of the management team to review progress towards schemes that improve quality, productivity and cost.

4.2 Mental Health and Children's Services

	Full year budget	Month 5 spend	Year to date spend	Forecast Outturn	Forecast variance to budget
	£'000s	£'000s	£'000s	£'000s	£'000s
Income	(32,008)	(3,173)	(13,571)	(31,649)	359
Pay	139,264	13,183	58,132	137,856	(1,408)
Non-pay	15,650	1,758	9,416	19,819	4,169
Total	122,906	11,767	53,977	126,025	3,120

Drivers of year-to-date performance

- Full year budget reduction actioned in month 5 to more clearly show the cost pressure relating to inappropriate out of area placements.
- Unachieved CIP savings.
- Vacancies in learning disabilities services, community mental health and rehab teams and primary and psychological services, partly offset by high agency usage to cover acuity, vacancies and sickness.
- With 1 patient remaining in a non-block booked bed at the end of August, the budget is overspent by £1.97m, reflecting the higher number of placements in months 1-4.

Key factors in outturn forecast position

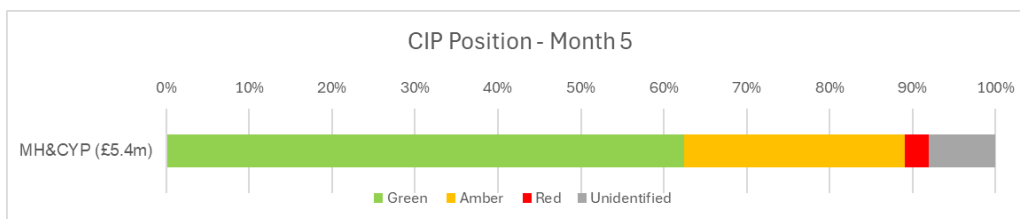
- Assumed unachieved savings of £2.1m.
- Vacancies partly offset by extra staffing on St Brelades ward and also high bank and agency on other wards.
- Assumption of 10 out of area patients in block booked beds with effect from September, plus 2 ad hoc beds.

Performance against efficiency target

- The Children's and Mental Health Services directorate's savings requirement is £5.47m.

Baker, Abi
06/10/2025 12:40:16

- The chart below indicates the level of savings schemes that are fully developed (green) and the confidence in delivery.



Actions to improve financial sustainability

- Working with the system to investigate alternative options to the use of out of area beds.
- Reviewing income received and identifying opportunities to support service cost pressures.

4.3 Medical Staffing

	Full year budget	Month 5 spend	Year to date spend	Forecast Outturn	Forecast variance to budget
	£'000s	£'000s	£'000s	£'000s	£'000s
Income	(2,948)	(260)	(1,257)	(2,983)	(35)
Pay	27,602	3,150	13,387	31,081	3,479
Non-pay	1,444	132	640	1,362	(82)
Total	26,098	3,022	12,770	29,460	3,362

Drivers of year-to-date performance

- The cost pressure in Medical staffing is driven by agency costs, which are higher than the same period in 2024/25 by £267k.

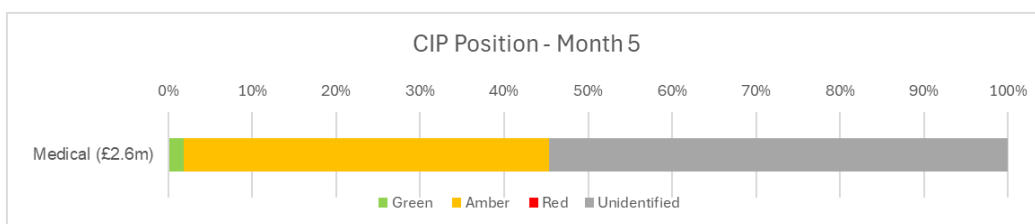
Key factors in outturn forecast position

- Assumed unachieved savings of £2.52m.
- High agency expenditure.

Performance against efficiency target.

- The Medical Staffing savings requirement is £2.56m.
- The chart below indicates the level of savings schemes that are fully developed (green) and the confidence in delivery.

Baker, Abi
06/10/2025 12:40:16



Actions to improve financial sustainability

- The use of agency staff is under review and alternative options are being reviewed to cover or change vacant posts, with a focus on specific high-cost staff.
- International recruitment to vacancies is progressing well.

4.4 Nursing Executive and Quality

	Full year budget	Month 5 spend	Year to date spend	Forecast Outturn	Forecast variance to budget
	£'000s	£'000s	£'000s	£'000s	£'000s
Income	(1,510)	(179)	(753)	(1,732)	(222)
Pay	9,868	913	4,125	9,746	(122)
Non-pay	1,241	98	554	1,314	73
Total	9,599	832	3,926	9,328	(271)

Drivers of year-to-date performance

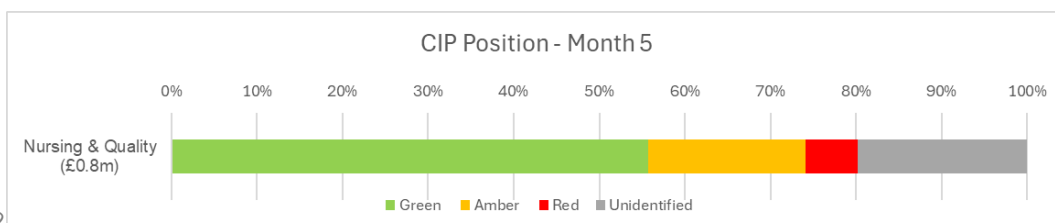
- Pharmacy, R&D and participation income ahead of target.
- Vacancies in the Mental Health Act team and Patient Safety.

Key factors in outturn forecast position

- Assumed unachieved savings of £364k.
- Pharmacy, R&D and participation income ahead of target.
- Vacancies.

Performance against efficiency target.

- The Nursing Executive and Quality directorate's savings requirement is £0.82m.
- The chart below indicates the level of savings schemes that are fully developed (green) and the confidence in delivery.



Baker, Abi
06/10/2025 12:40:16

4.5 Finance and Strategic Development

Finance and Strategic Development includes finance, estates and facilities, and counter fraud. The lead provider function for adult eating disorders is also within the directorate.

	Full year budget	Month 5 spend	Year to date spend	Forecast Outturn	Forecast variance to budget
	£'000s	£'000s	£'000s	£'000s	£'000s
Income	(4,639)	(393)	(1,967)	(4,596)	43
Pay	15,693	1,488	6,708	16,120	427
Non-pay	30,168	2,450	12,130	30,164	(4)
Total	41,222	3,545	16,871	41,687	465

Drivers of year-to-date performance

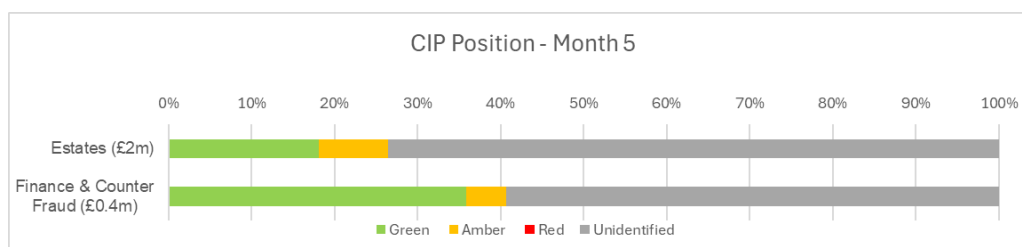
- Unachieved CIP savings.
- Facilities vacancies.
- Low gas and electric costs.

Key factors in outturn forecast position

- Assumed unachieved savings of £1.9m.
- Facilities vacancies.
- Low provisions, cleaning and transport costs.

Performance against efficiency target

- The Finance and Strategic Development directorate's savings requirement is £2.41m (Finance and Counter Fraud £0.413m and Estates £1.99m).
- The chart below indicates the level of savings schemes that are fully developed (green) and the confidence in delivery.



Actions to improve financial sustainability

- A review of leased estate is underway to identify where it may not be required or could be used more efficiently.
- Review of non-value added work.

4.6 Strategy, Transformation and Partnerships

The Strategy, Transformation and Partnerships directorate includes Information Management and Technology.

	Full year budget	Month 5 spend	Year to date spend	Forecast Outturn	Forecast variance to budget
	£'000s	£'000s	£'000s	£'000s	£'000s
Income	(51)	(9)	(37)	(90)	(39)
Pay	9,809	1,017	4,338	10,254	446
Non-pay	4,451	437	1,965	4,839	388
Total	14,208	1,445	6,266	15,004	795

Drivers of year-to-date performance

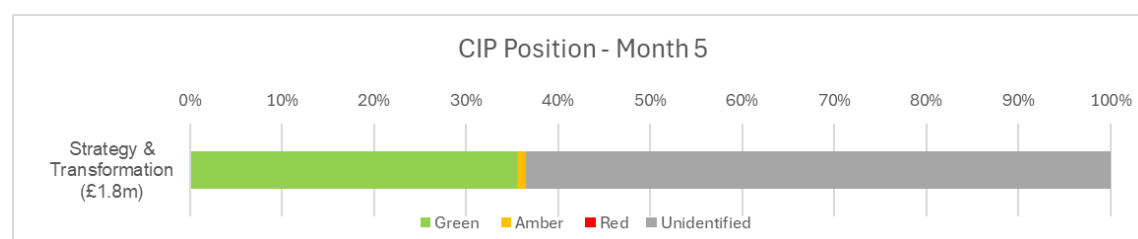
- Unachieved CIP savings.
- Vacancies.

Key factors in outturn position

- Assume unachieved savings of £1.16m.
- Vacancies.

Performance against efficiency target

- The Strategy & Transformation directorate's savings requirement is £1.797m.
- The chart below indicates the level of savings schemes that are fully developed (green) and the confidence in delivery.



Actions to improve financial sustainability

- Continued development of the One Transformation approach to support the Trust and DCH to deliver change.

4.7 People and Culture

	Full year budget	Month 5 spend	Year to date spend	Forecast Outturn	Forecast variance to budget
	£'000s	£'000s	£'000s	£'000s	£'000s
Income	(6,196)	(512)	(2,636)	(6,167)	29
Pay	9,574	891	4,066	9,993	419
Non-pay	2,653	124	747	2,797	145
Total	6,031	504	2,178	6,623	593

Drivers of year-to-date performance

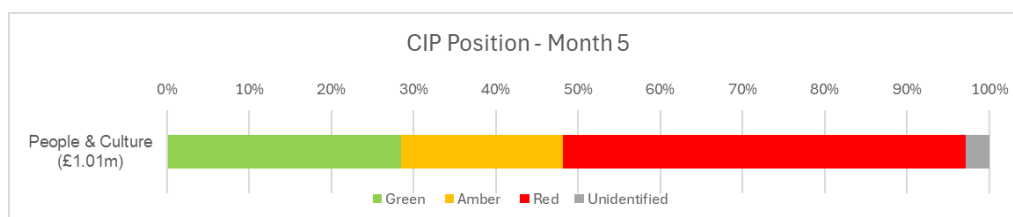
- Unachieved CIP savings..

Key factors in forecast outturn position

- Assumed unachieved savings of £0.73m.

Performance against efficiency target

- The People and Culture directorate's savings requirement is £1.015m.
- The chart below indicates the level of savings schemes that are fully developed (green) and the confidence in delivery.



4.8 Corporate Services

	Full year budget	Month 5 spend	Year to date spend	Forecast Outturn	Forecast variance to budget
	£'000s	£'000s	£'000s	£'000s	£'000s
Income	(480)	(40)	(197)	(476)	4
Pay	3,016	256	1,207	2,885	(131)
Non-pay	1,324	142	668	1,329	5
Total	3,859	359	1,678	3,739	(121)

Drivers of year-to-date performance

- Vacancies.

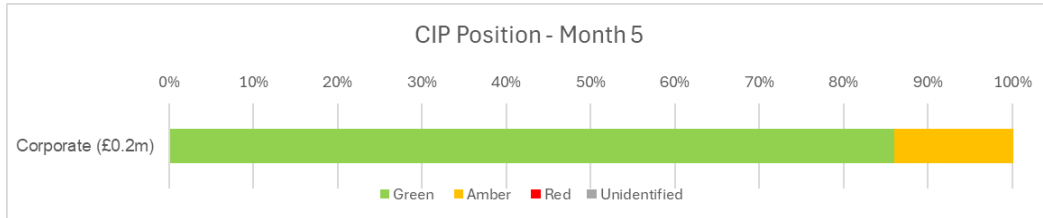
Key factors in forecast outturn position

- Assumed unachieved savings of £23k.
- Vacancies.

Baker Abi
06/10/2025 12:40:16

Performance against efficiency target

- The Corporate Services directorate's savings requirement is £0.166m.
- The chart below indicates the level of savings schemes that are fully developed (green) and the confidence in delivery.



Baker, Abi
06/10/2025 12:40:16

5. Year-end forecast outturn position

- The table below shows that the current year-end forecast is a potential deficit of £13.6m against the planned £9.77m surplus.

Forecast Outturn	Variance to budget at Month 5	Straight line year-end forecast	Known adjustments to Forecast	Revised forecast variance	Value of actions needed to breakeven
	£'000s	£'000s	£'000s	£'000s	£'000s
Community Services	(165)	(396)	430	33	(33)
Mental Health & Childrens Services	3,075	7,380	(4,260)	3,120	(3,120)
Medical Staffing	1,883	4,519	(1,157)	3,362	(3,362)
Nurse Executive & Quality	(94)	(225)	(46)	(271)	
Finance & Strategic Development	60	143	322	465	(465)
People & Culture	290	696	(103)	593	(593)
Strategy, Transformation & Partnerships	362	868	(73)	795	(795)
Corporate Services	(28)	(66)	(55)	(121)	
Trust Wide Income	7	16	(171)	(155)	
Central budgets	225	540	3,305	3,846	(3,846)
Total	5,614	13,473	(1,807)	11,667	(12,215)
Capital donations/grants/peppercorn lease				1,962	
Adjusted forecast - Variance to Plan				13,629	

- Current projections assume no further efficiency savings, only the fully developed schemes.
- The forecast has been adjusted for known service changes and one-off costs but highlights that action is required in most areas to mitigate the significant anticipated overspend.
- The central budgets line includes the central, stretched and additional 3% efficiency target, cost pressures, overheads, and capital charges. This funding is not allocated to individual services but contributes to the Trust's overall position.

Baker, Abi
06/10/2025 12:40:16

6. Provider Collaborative Financial Position

6.1 Dorset HealthCare as Provider

Dorset HealthCare provides a number of services through various provider collaboratives. The month 5 financial position is shown below.

Service	Provider Collaborative	Lead	Risk share	YTD expenditure variance to budget £000s	Forecast expenditure variance to budget £000s
Adult secure (low and medium) - For Me PC	Thames Valley and Wessex	Oxford Health	15.44%	(254)	(621)
Children & adolescent mental health services (CAMHS) Tier 4	South West	Devon Partnership	19%	24	(12)
Perinatal mental health	South West	Devon Partnership	14%	(17)	(52)
Adult eating disorders	Hampshire and Isle of Wight.	Dorset HealthCare	100%	(121)	(184)

Drivers of year-to-date performance

- Adult low secure – vacancies.
- CAMHS Tier 4 – Pebble Lodge high bank spend.
- Adult Eating Disorders - community team vacancies.

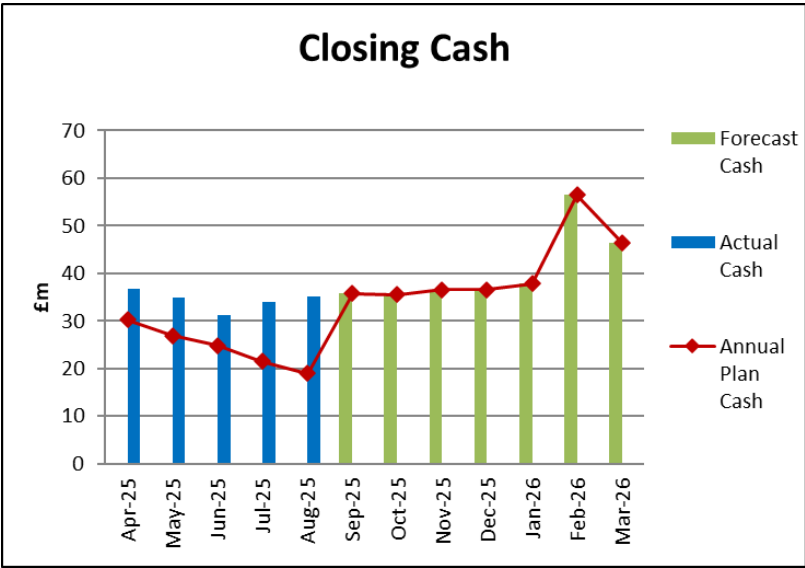
Key factors in the forecast outturn position

- As above but with recruitment in the adult eating disorders service.

7. Cashflow and Payments

- The cash balance at M5 was £35.04m, an increase of £0.93m from last month.
- Cash levels are currently above plan due to a difference in the phasing of the NHP funding.
- Overall debtors remain high with £11.42m of LA and NHS debt which is over 90 days old.

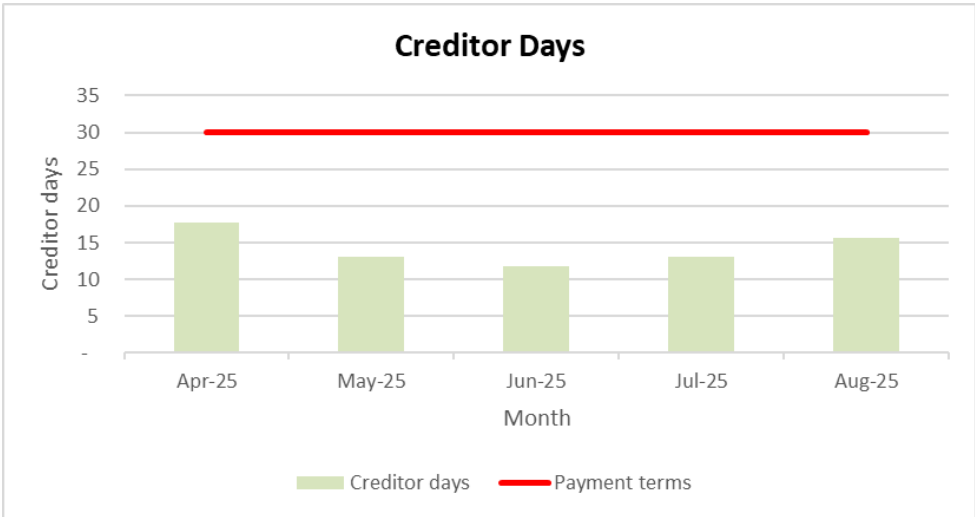
Baker, Abi
06/10/2025 12:40:16



- The YTD Better Payment Practice Code performance is shown below. The target is 95% and has been achieved again this month.

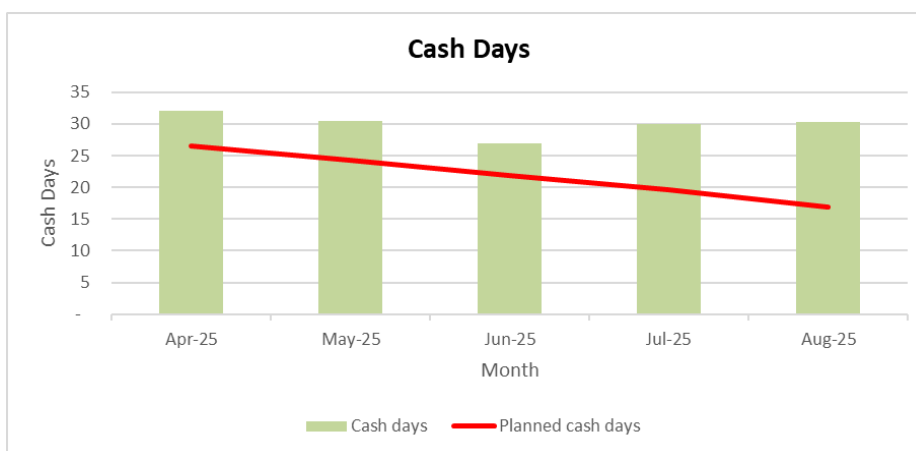
YTD					
Month	1	2	3	4	5
BPPC performance	96.49%	96.22%	95.67%	95.71%	95.30%

- Being above the 95% target is reflected in our favourable creditor days. This is the time it takes the Trust to pay its outstanding liabilities.

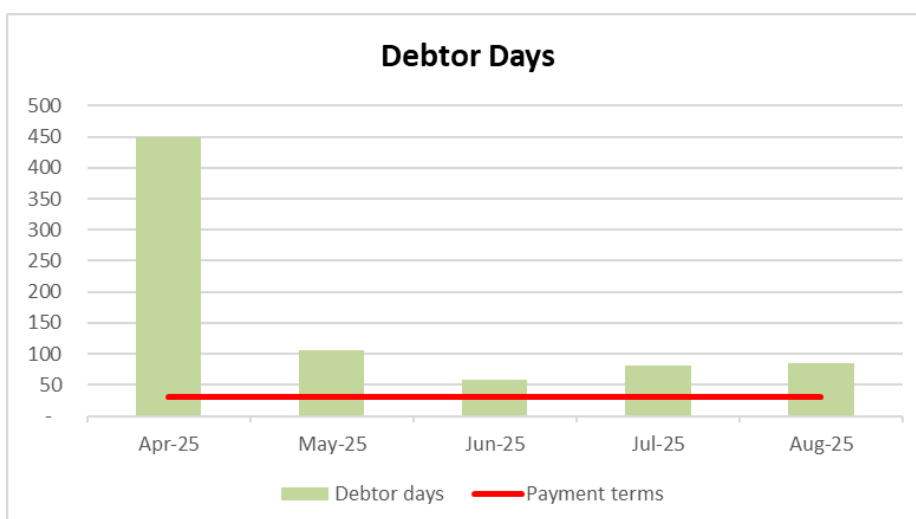


Baker, Abi
06/10/2025 12:40:16

- The cash days graph below shows the number of days that the Trust could sustain its current level of expenditure without any further income.



- The debtors day graph below shows the average time it takes the Trust to collect payment from its customers, To give a more accurate picture, the outstanding transactions with Dorset County Hospital have been excluded.
- April was high due to year end debtors including outstanding invoices of £3m with Bournemouth, Christchurch and Poole Council and Dorset of which £1.2m was over 91 days old.

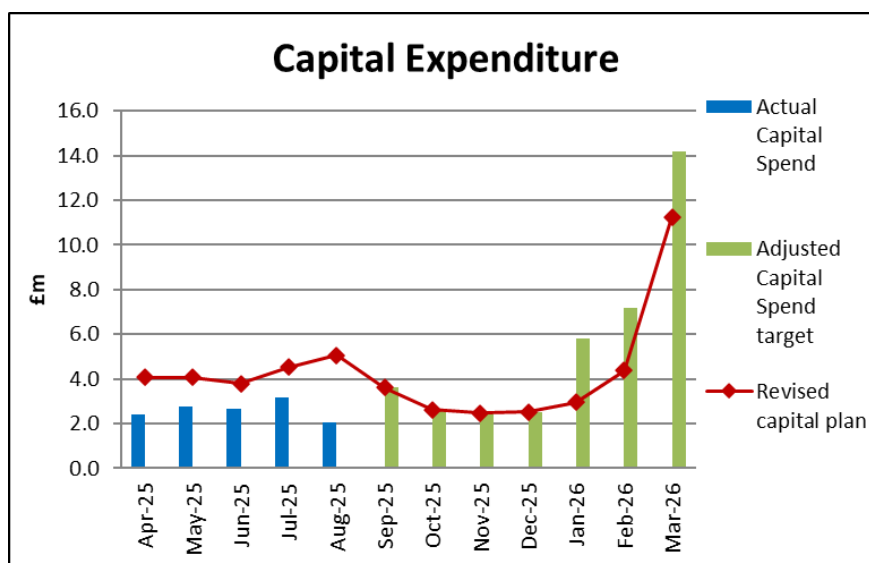


Baker, Abi
06/10/2025 12:40:16

6. Capital programme

- The capital expenditure target for 2025/26 is £51,404k including leases capitalised under IFRS16 of £2,544k and League of Friends' funded expenditure.
- Forecast spend in year on the continuing New Hospital Programme build remains at £36,437k, but currently has delays on the CAMHS build.
- Total capital spend year-to-date is £13,442k, of which £1,628k is internally funded against a YTD plan of £1,936k. The NHP programme spend was £1,644k in month against a plan of £4,608k.
- In previous years, the profile of spend has slipped into quarter four, creating pressures on delivering the capital programme. For 2025/26 a realistic capital spend profile based on previous years was used to create the planned profile spend. Effort will be made to bring capital forward and exceed the planned timescale of delivery where possible.
- The capital position is closely monitored by:
 - Regular meetings between the capital finance team and key capital budget managers.
 - Line by line review of larger capital project lines, such as the NHP project, backlog maintenance and IT projects.
 - The investigation of variances between plan and actual spend.
 - The accurate accruing to completion at the quarter months.
 - The identifying of internally funded capital slippage, and the reallocation to additional spends in year brought forward from future years.
 - Regular monthly meetings of the Capital Investment Meetings (CIM), where progress is reported, and adjustments agreed to the in-year programme to compensate for slippage.
- Key projects within the 2025/26 capital programme include:
 - St Ann's, CAMHS PICU, and HIP 2 – £36.1m (externally funded)
 - Backlog maintenance - £4.1m (internally funded)
 - Solar panels - £0.9m (externally funded)
 - Critical infrastructure risk - £0.7m (externally funded)
- Both NHP new builds are progressing well but issues with the delivery of the MEP (mechanical, electrical and plumbing works) for the CAMHS PICU has pushed the planned completion date back to the beginning of March. St Ann's Hospital is still due for completion by March 2026 and the further refurbishment works to complete by May 2027.
- Depreciation totalled £5.71m (plan £6.16m), for month 5, £0.45m below plan. Capitalisation of assets during the year will increase in month depreciation.

Baker, Abi
06/10/2025 12:40:16



7. Conclusion

- 2025/26 will be a challenging year for the NHS and Trust finances.
- Financial balance will only be achieved by individuals and directorates working hard to achieve a successful outcome and focus on achieving the efficiency target.
- There are a number of risks to financial balance which are being monitored closely across all areas of the Trust.

Baker, Abi
06/10/2025 12:40:16

Appendix 1 – Trust financial performance

INCOME & EXPENDITURE SUMMARY							
Month 5 2025/26	ANNUAL BUDGET	YTD			IN MONTH		
August		YTD Budget	YTD Actuals	YTD Variance	Budget	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
INCOME							
Baseline Income	(337,958)	(141,026)	(141,019)	7	(28,203)	(28,197)	7
Integrated Community Services	(20,073)	(8,709)	(8,897)	(188)	(1,743)	(1,801)	(58)
Children, Y.P. & Family Services, All Age Mental Health & L.D. Services	(32,008)	(13,638)	(13,571)	67	(3,194)	(3,173)	20
Medical Staffing	(2,948)	(1,210)	(1,257)	(47)	(249)	(260)	(11)
Nurse Executive & Quality	(1,510)	(637)	(753)	(115)	(138)	(179)	(42)
Finance & Strategic Development	(4,639)	(1,933)	(1,967)	(34)	(403)	(393)	10
People & Culture	(6,196)	(2,668)	(2,636)	32	(530)	(512)	19
Strategy, Transformation & Partnerships	(51)	(21)	(37)	(16)	(4)	(9)	(4)
Corporate	(480)	(200)	(197)	3	(40)	(40)	0
Interest Received	(1,750)	(862)	(862)	(0)	(167)	(167)	(0)
Central Budgets	(6,655)	(2,234)	(2,234)	(0)	(444)	(444)	(0)
Total Trust Income	(414,267)	(173,138)	(173,430)	(292)	(35,116)	(35,175)	(59)
EXPENDITURE							
Integrated Community Services	128,917	53,869	53,892	23	11,976	11,871	(105)
Children, Y.P. & Family Services, All Age Mental Health & L.D. Services	154,914	64,540	67,548	3,008	13,416	14,941	1,525
Medical Staffing	29,046	12,096	14,026	1,930	2,867	3,282	415
Nurse Executive & Quality	11,109	4,657	4,679	22	1,071	1,011	(60)
Finance & Strategic Development	45,861	18,744	18,838	93	3,868	3,938	70
People & Culture	12,226	4,555	4,813	258	1,039	1,015	(23)
Strategy, Transformation & Partnerships	14,259	5,926	6,304	378	1,322	1,454	132
Corporate	4,340	1,906	1,875	(30)	394	399	4
Central Budgets	(1,182)	0	225	225	(3,793)	(3,618)	175
Impairments	16,618	0	0	0	0	0	0
Total Trust Expenditure	416,108	166,294	172,199	5,906	32,161	34,293	2,132
NET INCOME & EXPENDITURE	1,841	(6,844)	(1,230)	5,614	(2,955)	(881)	2,073
PDCD	5,657	2,357	2,357	0	471	471	0
RETAINED SURPLUS/DEFICIT	7,498	(4,487)	1,127	5,614	(2,483)	(410)	2,073
EBITDA			3.9%				
Technical adjustments							
Capital donations/grants/peppercorn lease/PPE	(17,260)		45				
ADJUSTED SURPLUS/DEFICIT	(9,762)		1,172				

Baker, Abi
06/10/2025 12:40:16

Report to	Board of Directors, Part 1	
Date of Meeting	07 October 2025	
Report Title	Month 5 Dorset ICS Finance Summary	
Report Author	Dorset ICB	
Approved by Accountable Executive	Chris Hearn, Joint Chief Finance Officer	
Previously reviewed by	Finance and Performance Committee in Common, 24/09/2025	
Action Required	Approval	
	Assurance	
	Information	Yes

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? <i>Delete as required</i>	
Care	Yes	
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 and this will adversely. impact our ability to provide safe sustainable services, and will impact upon the overall ICS position	
Financial	Value for money and financial sustainability addressed in the report	
Statutory & Regulatory	Underpins long term financial sustainability and delivery of operational plan	
Equality, Diversity & Inclusion	No implications arising from the report	
Co-production & Partnership	System financial plan delivery	

Executive Summary
Month 5 finance summary for Dorset ICS, setting out individual and combined positions for DCH, DHC, UHD, SWASFT, and Dorset ICB. Report shows overall performance against plan, cash position, temporary staffing expenditure, and progress against combined system efficiency plans.

Recommendation
The Board is requested to: Receive the report for information

Month 5 Dorset ICS Finance Summary

£m Surplus/(Deficit)	Dorset County Hospital	Dorset Healthcare	University Hospitals Dorset	SWASFT	Dorset ICB	ICS
YTD Position - variance	0.0	(0.1)	0.0	0.6	0.0	0.6
Change from last month	(0.0)	(0.0)	(2.2)	0.1	0.0	(2.1)
Year End Outturn - variance	0.0	0.0	0.0	0.0	0.0	0.0

Dorset ICS is reporting a small surplus YTD in M5 due to a continued surplus position for SWASFT (£0.5m).

All providers continue to report adverse variances to plan for pay, mitigated by income overperformance and non pay savings within drug costs (Non HCDs) and clinical supplies and services savings. Additional finance income due to higher cash balances is also supporting the current positions of all Trusts.

YTD Efficiencies are ahead of plan (£1.8m), though recurrent savings are underperforming by £4.9m, across pay and non pay. Noting that after M6 in H2 planned efficiencies double overall.

Bank £m	M5 YTD Plan	M5 YTD Actual	M5 YTD Variance
DCH	(4.27)	(6.10)	(1.83)
DHC	(9.02)	(9.91)	(0.89)
SWASFT	(2.04)	(1.54)	0.50
UHD	(19.29)	(20.61)	(1.32)
	(34.61)	(38.15)	(3.54)
% of Bank Ceiling	45.7%	50.4%	

Agency £m	M5 YTD Plan	M5 YTD Actual	M5 YTD Variance
DCH	(2.42)	(1.97)	0.45
DHC	(3.61)	(3.50)	0.12
SWASFT	(0.06)	(0.06)	(0.00)
UHD	(4.82)	(2.84)	1.97
	(10.91)	(8.38)	2.53
% of Agency Ceiling	42.9%	32.9%	

M5 has seen a small reduction in the Bank run rate from M4. However, the run rate FOT is £16.0m higher than the M5 reported FOT and £17.2m above plan, indicating a material reduction in Bank spend required in H2 to achieve the Bank ceiling target, recognising that planned monthly bank costs are lower in H2 compared to H1.

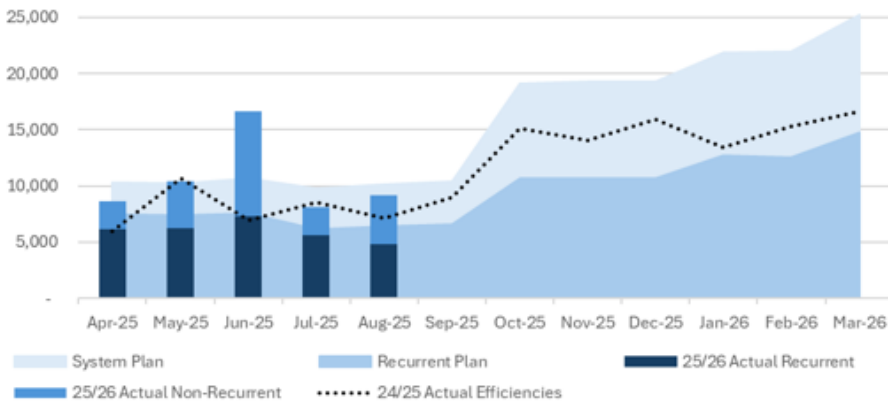
Agency remains on track to meet the national ceiling target, with a current forecast run rate underspend of £3.5m.

Provider - Cash and cash equivalents £'000	M4 Closing	M5 Planned Closing	M5 Closing Actual	M5 Closing Variance	Operating Expenditure Days		
					M3	M4	M5
DCH	25,947	8,809	24,177	15,368	28.4	29.3	26.9
DHC	34,111	19,014	35,043	16,029	28.3	31.4	32.7
SWASFT	23,520	17,176	26,913	9,737	20.3	20.9	25.0
UHD	80,017	70,055	105,932	35,877	31.6	33.8	43.2
System Total	163,595	115,053	192,065	77,012	28.14	29.92	34.93

System cash has again increased in M5 by c£28.5m, mainly within UHD but also with smaller increases for DHC and SWASFT. Operating expenditure days have also increased for all but DCH. All providers continue to remain above plan levels.

Cashflow forecasts report a drop in cash from M6 but remain above original plan levels, except for SWASFT who forecast below plan from M7 with a drop to 13 operating expenditure days. All of which are dependent on efficiency savings being achieved.

2025/26 Plan and YTD Actual Efficiencies Vs 2024/25 Actuals



Report to	DCH Board of Directors	
Date of Meeting	07 October 2025	
Report Title	Emergency Preparedness, Resilience & Response (EPRR) Annual Assurance 2024/2025	
Prepared By	Ian Kilroy – Head of Emergency Preparedness, Resilience & Response & Security Management	
Approved by Accountable Executive	Anita Thomas (Chief Operating Officer COO/Accountable Emergency Officer AEO)	
Previously Considered By	EPRG May, Jul and Sep 2025 Finance & Performance Committee, Sept 2025	
Action Required	Approval	Y
	Assurance	N
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? <i>Delete as required</i>	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework		
Financial	Not applicable	
Statutory & Regulatory	The Civil Contingencies Act 2004, Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005, NHS Act 2006 and Health and Care Act 2022 underpin EPRR within health. All acts place EPRR duties on NHS England and the NHS in England. Additionally, the NHS Standard Contract Service Conditions (SC30) require providers of NHS-funded services to comply with the NHS EPRR Framework and other NHS England guidance.	
Equality, Diversity & Inclusion	No impact	
Co-production & Partnership	No impact	

Executive Summary
NHS ENGLAND EMERGENCY PREPAREDNESS, RESILIENCE & RESPONSE (EPRR) ANNUAL ASSURANCE REPORT 2024/2025 Executive Summary - In May and Jul 2025, the Emergency Planning Resilience Group (EPRG) was presented with the latest update on Incident Response Plans (IRP), Action Cards, SharePoint improvement and explained the current position statement relating to NHS England Emergency Preparedness Resilience and Response (EPRR) Core Standards. No comments to challenge the changes to the updates. - In Sep 2025, the EPRG was presented with the update of the NHS England EPRR Core Standards (No Deep Dive required) to discuss, change and ratify the plans for the NHS England EPRR Core Standards and compliance report.

- Following internal meetings, work programme and targeting means, the Trust has been assessed as being **100% Full compliance** across all the 66 sections Emergency Preparedness, Resilience and Response (EPRR) Assurance Core Standards – Attached.
- These rational decisions to explain the compliance position are based upon evidence base examples, practical input and planned subjects to meet the criteria. Link to all evidence-based information (177 items) is available for review on the S Drive, Operations Directorate, Emergency Planning and uploaded to Future NHS framework, as required by NHS Dorset (ICB)
- This assessment will now be taken to the ICB’s ‘confirm and challenge’ meeting with NHSE on 10 Sep 2025 for further scrutiny and final confirmation as an element of the wider ICS EPRR Assurance process.
- Appended to this report is the EPRR Assurance Spreadsheet identifying the 66 EPRR Core standards and RAG rated compliance.

Recommendation

Board is requested to:

- **Approve** the report.

Emergency Preparedness, Resilience & Response (EPRR) Annual Assurance Report 2024/2025

1. Executive Summary

1.1 This report has been prepared to document the self-assessment outcomes of the Trust's Emergency Preparedness Resilience and Response (EPRR) compliance standards, in accordance with NHS England's EPRR Core Assurance Standards.

1.2 All NHS-funded organisations must meet the requirements of

- the Civil Contingencies Act 2004,
- the NHS Act 2006,
- the Health and Care Act 2022,
- the NHS standard contract,
- the NHS Core Standards for EPRR and;
- NHS England business continuity management framework

2. Main narrative

2.1 The annual NHS Core Standards are published annually, normally in early summer in line with the EPRR framework. The standards cover all NHS providers, with most completing 66 standards.

2.2 As an internal process, the Head of EPRR & Security completed the draft core standards along with their essential evidence for presentation to the Trusts Accountable Emergency Officer (AEO) and Deputy Accountable Emergency Officer (Dep AEO) where an internal self-assessment standard is then agreed and confirmed at the DCHFT Emergency Preparedness Resilience Group (EPRG).

2.3 Trusts are required to provide a paper for their Trust Board on the outcome of their Annual NHS England EPRR Core Standards Assurance Self-Assessment.

2.4 Following the internal self-assessment, a 'confirm and challenge' meeting is arranged (10 Sep 2025) with NHS Dorset AEO and Head of EPRR/Operations & DCHFT Deputy AEO and Head of EPRR & Security, to present their submitted evidence for review and if there are any challenges, are able to provide clarity as and where required.

2.4 Both NHS Dorset and NHS England assess and review the evidence submitted against the NHS Core Standards before agreeing and awarding any grading or outcome, which is formally sent to the AEO.

3. Assurances 2025

3.1 The NHS Core Standards set for 2025 has 66 standards. 66 with relevance for Acute Trusts contained within. These are sub-divided into 10 key domains:

- Governance (Domain 1)
- Duty to Risk Assess (Domain 2)
- Duty to Maintain Plans (Domain 3)
- Command and Control (Domain 4)
- Training and Exercising (Domain 5)
- Response (Domain 6)
- Warning and Informing (Domain 7)
- Cooperation (Domain 8)
- Business Continuity (Domain 9)
- Chemical, Biological, Radiological & Nuclear (CBRN) (Domain 10)

3.2 The Trust is assessed against the criteria shown in the below table:

Organisational Rating	Criteria
Fully	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards
*Substantial	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non- Compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

4. Deep Dive

4.1 Traditionally within the NHS England EPRR Core Standards, there is a Deep Dive Section, with a focus on a specific topic. Last year was Cyber Security. For clarity; this year NHSE have removed this element.

5 Summary

5.1 The Head of EPRR & Security has continued to strive and improve over the last years through preparing and responding to the ever-changing operational delivery of key services whilst preparing and dealing with emergency situations and incidents. Continuity to work closely with our EPRR colleagues within the ICB and support others as and when required.

6. Recommendations

- a. The Board /is recommended to:
 - i. **Approve** the report

7. Appendices – NHS England EPRR Core Standards 2025

Name and Title of Author: Ian Kilroy, Head of EPRR & Security Management

Date: Sep 2025

NHS England EPRR Core Standards August 2025 – Submission

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
Domain 1 - Governance								
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description	Evidence • Name and role of appointed individual AEO (Anita Thomas - Chief Operating Officer) • Name and role of appointed individual Deputy AEO (Adam Savin - • AEO responsibilities included in role/job description (YES) • AEO & Dep AEO JD Requested and Uploaded • http://sharepoint/departments/emergencyplanning/SitePages/Home.aspx	Fully compliant	EPRG Governance Additional evidence link - Future NHS Domains 1	IK

Baker, Abi
06/10/2025 12:40:16

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	Evidence The policy should: • Have a review schedule and version control (YES) • Use unambiguous terminology (YES) • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised (YES - p. 9 para. 7.4 / 7.5) • Include references to other sources of information and supporting documentation. (YES - p.7 para. 6.0) Evidence • Up to date EPRR policy or statement of intent (Reviewed at	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
					EPRG in May 2025 and implemented Apr 2023) that includes: • Resourcing commitment (YES, p. 8. para 7.1 - revised EPRR Policy doc) • Access to funds (YES, p. 8. para 7.1 - revised EPRR Policy doc) • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc. (YES. p. 9 etc)			

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
3	Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activities.	Evidence • Emergency Planning Resilience Group (EPRG) meets every 3 months. • Terms of Reference defined and ratified at EPRG • Sources are escalated to the Finance & Performance Committee (FPC) Report and Assurance Reports • Annually EPRR Core Standards are completed and an EPRR Core Standards Annual Report submitted to EPRG	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan	Evidence • Reporting process explicitly described within the EPRR policy statement (YES - 14.6 - 16.0) • EPRR & SRM work programme developed for EPRG	Fully compliant	EPRG Governance	IK
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group	Evidence • Revised EPRR Policy (v. 1.4) 2022 • Head of EPRR and Security Management Role Profile established with reviewed JD • Operational Business Manager available	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations	Evidence • Revised EPRR Policy (v. 1.4) 2022. • Lessons learnt process initially established through EPRG Agenda and meeting minutes • On Call Management working Group established. • Structured debrief process designed • Post Incident Tracker established and monitored through EPRG • Escalation Reports issued from EPRG to FPC	Fully compliant	EPRG Governance	IK
Domain 2 - Duty to risk assess								
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather	Evidence • Corporate Risk Register - DATIX Risk Management software system - references all known EPRR Risks.	Fully compliant	EPRG Governance Additional evidence submitted to link - Future NHS Domain 2	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Evidence - EPRR risks are considered in the organisation's risk management policy - Reference to EPRR risk management in the organisation's EPRR policy document	Evidence - EPRR Risks considered in Trust Risk Management Policy and reports update at the EPRG http://sharepoint/departments/emergencyplanning/EPRR%20Risk%20Register/Forms/AllItems.aspx	Fully compliant	EPRG Governance	IK
Domain 3 - Duty to maintain Plans								
9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence - Consultation process in place for plans and arrangements - Changes to arrangements as a result of consultation are recorded	Evidence Engagement with ICB/NHS England and LHRP new group and planning agenda agreed and implemented. http://sharepoint/departments/emergencyplanning/Specific%20Response%20Plans/Forms/AllItems.aspx	Fully compliant	EPRG Governance Additional evidence submitted to link - Future NHS Domain 3	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
10	Duty to maintain plans	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Evidence • Current Major Incident Response Plan (MIRP) currently reviewed, ratified and governed from the EPRG May 2025. Attached	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
11	Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.	Evidence • Heatwave Plan / Cold Weather Plan reviewed, ratified and governed from the EPRG in May 2025. (Reference of NHS England Adverse weather included) • Implemented the Beat the Heat & Severe Weather SharePoint. Attached	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
12	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles. https://www.england.nhs.uk/coronavirus/secondary-care/infection-control/ppe/ffp3-fit-testing/ffp3-resilience-principles-in-acute-settings/	Evidence • IPC Plans - Various on Sharepoint e.g. Infection Prevent focussed Plans. • Updated HCID Policy and Action Cards. Attached • Designed new SharePoint • Planned TTE 8 Jul 2025 with Post Exercise Report for EPRG • http://sharepointapps/clinguide/Pages/index.aspx?View={DEBF5C00-FCDD-410F-AD87-1A4F7BF4CB47}&SelectedID=36. • https://staffnet.dchft.nhs.uk/clinical-departments/IPC/Pages/Infection%20Prevention%20and%20Control.aspx	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
13	Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Evidence • Pandemic Plan (Influenza) reviewed, ratified and governed from the EPRG in May 2025 (Changed to Pandemic Plan with IPC input) Attached	Fully compliant	EPRG Governance	IK

Baker, Abi
06/10/2025 12:40:16

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
14	Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during	Evidence • Countermeasures Plan - reviewed, ratified and governed from the EPRG in May 2025. Attached	Fully compliant	EPRG Governance	IK

Baker, Abi
06/10/2025 12:40:16

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
				activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.				

Baker, Abi
06/10/2025 12:40:16

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
15	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.	Evidence • Mass Casualties Plan reviewed and ratified at EPRG in May 2025. Attached	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
16	Duty to maintain plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Evidence • Evacuation & Shelter Plan - Updated and ratified in the EPRG May 2025. Attached	Fully compliant	EPRG Governance	IK
17	Duty to maintain plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment	Evidence • Lockdown Plan reviewed and governed from the EPRG in May 2025 . Also shared, reviewed and updated at the DCH H&S, Fire and Security Committee in Mar 2025. Attached	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
				requirements • outline any staff training required				
18	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs), high profile patients and visitors to the site.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Evidence • VIP Plan reviewed/updated, via the EPRG in May 2025. Attached	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
19	Duty to maintain plans	Excess fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Arrangements should be: • current • in line with current national guidance • in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Evidence • Dorset LRF Mass Fatalities Plan • Link to RD connection	Fully compliant	EPRG Governance	IK
Domain 4 - Command and control								

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
20	Command and control	On-call mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners	Evidence • EPRR Policy / On Call Manager & Executive Rota SOP reviewed • On Call Manager & Executive Handbook reviewed and expressed the difference of Operations Lead and EPRR Lead for DCHFT. • On Call Management Working Group established with TOR/Agenda/Share point resources improved. • https://teams.microsoft.com/l/team/19%3ATUoHOpYzHQVgb0Lakjnqv3PzU4DPNciteOT8Vjyya201%40thread.tacv2/conversations?groupId=1de974eb-d732-4b74-a747-4740629eea07&tenantId=b7a39383-db28-44ff-8bd3-e97190987af9 • http://sharepoint/departments/emergencyplanning/Training%20Materials/Forms/AllItems.aspx	Fully compliant	EPRG Governance Additional evidence submitted to link - Future NHS Domain 4	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
21	Command and control	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.	Evidence • Updated EPRR Policy document /all staff issued with & briefed on OCM / OCE handbook (See previous for copy of decision log book / JDM • Resilience Staff App launched and developed • E Learning On Call Management launched. Attached • PoHC and Loggist Training Record	Fully compliant	EPRG Governance	IK
Domain 5 - Training and exercising								

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
22	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Evidence • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	Evidence • Updated EPRR Policy document /all staff issued with & briefed on OCM / OCE handbook. • Proposed TNA for On Call Management Group agreed at EPRG. • Dorset LRF accessible for On Call Management Group. • PDP issued to all OCE/OCM. Survey completed • E Learning of On Call Management & Business Continuity issued to all OCE/OCM and monitored on monthly basis • PoHC Training published through Education Centre and monitored at the EPRG • On Call Training Record Developed - Attached	Fully compliant	EPRG Governance Additional evidence submitted to link - Future NHS Domain 5	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. Evidence • Exercising Schedule which includes as a minimum one Business Continuity exercise	Evidence • Comms Test completed through OCM Group - Whats App • Developing the new On Call System - Multitone • Completed and Planned (TTE) - E&F, Education, CSM, HCID Lulworth and RCRP • Post Incident Tracker details coverage • OCM Group Media Training Programme in place	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
				• Post exercise reports and embedding learning				

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Evidence • Training records • Evidence of personal training and exercising portfolios for key staff	Evidence • Training Records of PRPS trained staff / loggists / OCM's / new Portfolio's of evidence.	Fully compliant	EPRG Governance	IK
25	Training and exercising	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	As part of mandatory training Exercise and Training attendance records reported to Board	Evidence • EPRG - Training Record	Fully compliant	EPRG Governance	IK
Domain 6 – Response								

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
26	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.	Evidence • ICC Plan - Reviewed, assessed and verified, via the EPRG in Aug 2023, Jul 2024 and May 2025	Fully compliant	EPRG Governance Additional evidence submitted to link - Future NHS Domain 6	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
27	Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Planning arrangements are easily accessible - both electronically and local copies	Evidence • Sharepoint / hard copies - ICC / Mini ICC	Fully compliant	EPRG Governance	IK
28	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes	Evidence • Process for maintenance and review of Business Impact Analysis (BIA) and Business Recovery Plans (BRP) over covered by Business Continuity Policy are governed by the EPRG	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	• Documented processes for accessing and utilising loggists • Training records	Evidence • Loggists Database developed and awareness training package available • http://sharepoint/departments/emergencyplanning/Training%20Materials/Forms/AllItems.aspx?RootFolder=%2Fdepartments%2Femergencyplanning%2FTraining%20Materials%2FOn%20Call%20Management%5FLoggist%20Training%20Resources&FolderCTID=0x0120006AD6B1DFE0A4C0448D2170E4E7E3AEB0&View={6EF76331-AB15-43ED-AA07-3E4F9F748B8A} • Loggist Training sessions implemented	Fully compliant	EPRG Governance	IK
30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template	Evidence • Revised ICC Plan and evidence based Sit Reps through SCC routinely covering IA, Bronze, Systems Resilience network. • Resilience Alerts issued	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
31	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Guidance is available to appropriate staff either electronically or hard copies	Evidence • Issued to ED Facilitator • Copy in ED and issued to share point	Fully compliant	EPRG Governance	IK
32	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	Guidance is available to appropriate staff either electronically or hard copies	Evidence • Issued to ED Facilitator • Copy in ED and issued to share point	Fully compliant	EPRG Governance	IK
Domain 7 - Warning and informing								

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	- Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. - Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. - Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. - Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.	Evidence Media & Comms Strategy Document & current Major Incident Response Plan - details incident types / 24/7 comms call out via switchboard / ICC administrative processes in place for tracking actions / incoming requests / information etc.	Fully compliant	EPRG Governance Additional evidence submitted to link - Future NHS Domain 7	IK

Baker, Abi
06/10/2025 12:40:16

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).	Evidence • Action Cards and Response Plans, via share point review	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
35	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	- Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications - A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. - A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident - Appropriate channels for communicating with members of the public that can be used 24/7 if required - Identified sites within the	Evidence Action Card and Response Plan	Fully compliant	EPRG Governance	IK

Baker, Abi
06/10/2025 12:40:16

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
				organisation for displaying of important public information (such as main points of access) • Have in place a means of communicating with patients who have appointments booked or are receiving treatment. • Have in place a plan to communicate with inpatients and their families or care givers. • The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements				

Baker, Abi
06/10/2025 12:40:16

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response	Evidence • Media & Comms Strategy Document & current Major Incident Response Plan - details incident types / 24/7 comms call out via switchboard / ICC administrative processes in place for tracking actions / incoming requests / information etc. • WhatsApp Test completed - OCE/OCM • Liaising with DTI to develop the Mina tone System	Fully compliant	EPRG Governance	IK
Domain 8 - Cooperation								

Baker, Abi
06/10/2025 12:40:16

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	- Minutes of meetings - Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.	Evidence Minutes from LHRP BMG/Execs meeting in situ between Nov 2024-Jul 2025.	Fully compliant	EPRG Governance Additional evidence submitted to link - Future NHS Domain 8	IK
38	Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	- Minutes of meetings - A governance agreement is in place if the organisation is represented and feeds back across the system	Evidence - Dorset LRF Training & Exercising Capability Group - Action & Decision Log - Access for LRF training packages to DCH OCE/OCM staff to assist decision making and awareness qualifications	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
39	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	- Detailed documentation on the process for requesting, receiving and managing mutual aid requests - Templates and other required documentation is available in ICC or as appendices to IRP - Signed mutual aid agreements where appropriate	Evidence DCHFT Mutual Aid access points through LHRP/LA/SWASFT/Police/FRS/PHE connections	Fully compliant	EPRG Governance	IK
43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	- Documented and signed information sharing protocol - Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004	Evidence DCHFT Mutual Aid access points through LHRP/LA/SWASFT/Police/FRS/PHE connections	Fully compliant	EPRG Governance	IK
Domain 9 - Business Continuity								

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
44	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning	Evidence • Reviewed and updated BC Management Policy Document in May 2025 • http://sharepoint/departments/emergencyplanning/BCM/Forms/AllItems.aspx	Fully compliant	EPRG Governance Additional evidence submitted to link - Future NHS Domain 9	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers.	Evidence • See BC Policy - 3.0 BCMS - Scope & Objectives / 5.0 Roles & Responsibilities / 1.1 Requirements for BC / 15.1 Risk Assessment	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
				how the understanding of BC will be increased in the organisation				

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: - the method to be used - the frequency of review - how the information will be used to inform planning - how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: - Determining impacts over time should demonstrate to top	Evidence - EPRR policy document - 12.2 - BIA Process; Strategic & Tactical BC / CI focussed Plan - Appendix B - Identifies prioritised Critical Services; Operational (Ward/Departmental) BIA's http://sharepoint/departments/emergencyplanning/BCM/Forms/AllItems.aspx?RootFolder=%2Fdepartments%2Femergencyplanning%2FBCM%2FBusiness%20Impact%20Analysis%20Documents&FolderCTID=0x01200012B827809D69B54792ECA96BF2547B66&View={CCE096E4-E4D0-4833-A816-84C5395E4667}	Fully compliant	EPRG Governance	IK

Baker, Abi
06/10/2025 12:40:16

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
				management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.				

Baker, Abi
06/10/2025 12:40:16

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
47	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies.	Evidence • Governed through the EPRG • http://sharepoint/departments/emergencyplanning/BCM/Forms/AllItems.aspx	Fully compliant	EPRG Governance	IK

Baker, Abi
06/10/2025 12:40:16

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
				• Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices				

Baker, Abi
06/10/2025 12:40:16

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
48	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief Evidence Post exercise/ testing reports and action plans	Evidence • Between Feb 2024 - Jun 2025; Industrial Actions, ICC responses involving JD, HC, RCN, SWASFT, ED water spillage, Bed Management BAU events have been routinely active live exercises and testing the processes of EPRR covering ICC, OCM/OCE responsibilities, BC Plans, MIRP, Communications and Liaison with external health groups. • Business Continuity Exercises activated have been CSM Fire and Evacuation Exercises, Education Centre - Mass Casualties and E&F BC Exercises	Fully compliant	EPRG Governance	IK
49	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Evidence • Statement of compliance • Action plan to obtain compliance if not achieved	Evidence • Certification of full compliance in email from Information Governance	Fully compliant	EPRG Governance	IK

Baker, Abi
06/10/2025 12:40:16

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	• Business continuity policy • BCMS • performance reporting • Board papers	Evidence • BCMS Internal Audit Checklist adhered to at EPRG. Significant improvement of raising awareness to BIA and BRP (Total of 57 Services with 50+ updates completed) • BC approach, delivery and monitoring governed at the EPRG. • Direction issued, updates completed (57), support offered to service managers. • EPRR Drop in sessions issued. • Attending the BCI Course in Oct 2025 for Head of EPRR raising knowledge base	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme	Evidence • BOD Audit completed during 23-25, recognised and response plan implemented through EPRG	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
52	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing • Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal	Evidence • Governed, compliance checked and managed through EPRG • Improvements of BIA/BC Plans, Audit, Tests, EPRG governance and PDCA approach • Post Exercise Report for E&F presented at EPRG • BC Master Document is monitored and presented at the EPRG • BIA improved (57) • BRP improved (57) • Awareness sessions implemented - BC Awareness • BCMS Share point improved • E Learning Package - Developed and Implemented	Fully compliant	EPRG Governance	IK

Baker, Abi
06/10/2025 12:40:16

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
				• Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents				

Baker, Abi
06/10/2025 12:40:16

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers	Evidence • Liaison with Procurement and Logistics, DCHFT	Fully compliant	EPRG Governance	IK
Domain 10 - CBRN								

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
55	Hazmat/CBRN	Governance	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	Details of accountability/responsibility are clearly documented in the organisation's Hazmat/CBRN plan and/or Emergency Planning policy as related to the identified risk and role of the organisation	Evidence • HAZMAT CBRNe reviewed through the EPRG in May 2025 • EPRR Policy available and updated • BCMS Policy available and updated • CBRN Initial Operational Response Aide Memoir practically issued to ED Staff • IOR Guidance issued to ED Staff	Fully compliant	EPRG Governance Additional evidence submitted to link - Future NHS Domain 10	IK
56	Hazmat/CBRN	Hazmat/CBRN risk assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Evidence of the risk assessment process undertaken - including - i) governance for risk assessment process ii) assessment of impacts on staff iii) impact assessment(s) on estates and infrastructure - including access and egress iv) management of potentially hazardous waste v) impact assessments of Hazmat/CBRN decontamination on critical facilities and services	Evidence • EPRR Risk Register updated	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
57	Hazmat/CBRN	Specialist advice for Hazmat/CBRN exposure	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements. These should include ECOSA, TOXBASE, NPIS, UKHSA Arrangements should include how clinicians would access specialist clinical advice for the on-going treatment of a patient	Evidence • ED Facilitator Staff (Trainers) • Head of EPRR • Medical Engineering - RAMGENE specialist areas • Links to SWASFT Specialist CBRNe • Link to CBRNe Police/FRS/PHE/LA	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
58	Hazmat/CBRN	Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders	Documented plans include evidence of the following: • command and control structures • Collaboration with the NHS Ambulance Trust to ensure Hazmat/CBRN plans and procedures are consistent with the Ambulance Trust's Hazmat/CBRN capability • Procedures to manage and coordinate communications with other key stakeholders and other responders • Effective and tested processes for activating and deploying Hazmat/CBRN staff and Clinical Decontamination Units (CDUs) (or equivalent) • Pre-determined decontamination locations with a clear distinction between clean and dirty areas and demarcation of safe clean access for patients, including for the off-loading of non-decontaminated patients from ambulances, and safe cordon control • Distinction between dry and wet decontamination and the decision making process for the appropriate	Evidence • HAZMAT CBRNe reviewed through EPRG • EPRR Policy available and updated • BCMS Policy available and updated • CBRN Initial Operation Response Aide Memoir practically issued to ED Staff • IOR Guidance issued to ED Staff	Fully compliant	EPRG Governance	IK

Baker, Abi
06/10/2025 12:40:16

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
				deployment • Identification of lockdown/isolation procedures for patients waiting for decontamination • Management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • Arrangements for staff decontamination and access to staff welfare • Business continuity plans that ensure the trust can continue to accept patients not related/affected by the Hazmat/CBRN incident, whilst simultaneously providing the decontamination capability, through designated clean entry routes • Plans for the management of hazardous waste • Hazmat/CBRN plans and procedures include sufficient provisions to manage the stand-down and transition from response to recovery and a return to business as usual activities • Description of process for obtaining replacement PPE/PRPS - both during				

Baker, Abi
06/10/2025 12:40:16

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
				a protracted incident and in the aftermath of an incident				

Baker, Abi
06/10/2025 12:40:16

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
59	Hazmat/CBRN	Decontamination capability availability 24 / 7	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	Documented roles for people forming the decontamination team - including Entry Control/Safety Officer Hazmat/CBRN trained staff are clearly identified on staff rotas and scheduling pro-actively considers sufficient cover for each shift Hazmat/CBRN trained staff working on shift are identified on shift board Collaboration with local NHS ambulance trust and local fire service - to ensure Hazmat/CBRN plans and procedures are consistent with local area plans Assessment of local area needs and resource	Evidence • HAZMAT CBRNe reviewed through the EPRG • EPRR Policy available and updated • BCMS Policy available and updated • CBRN Initial Operation Response Aide Memoir practically issued to ED Staff • IOR Guidance issued to ED Staff • EPRR CBRNe specialist Action Cards in place	Fully compliant	EPRG Governance	IK

Baker, Abi
06/10/2025 12:40:16

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
60	Hazmat/CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients - Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/epr-decontamination-equipment-checklist.xlsx - Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2018/07/epr-decontamination-equipment-checklist.xlsx	This inventory should include individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment). There are appropriate risk assessments and SOPs for any specialist equipment Acute and ambulance trusts must maintain the minimum number of PRPS suits specified by NHS England (24/240). These suits must be maintained in accordance with the manufacturer's guidance. NHS Ambulance Trusts can provide support and advice on the maintenance of PRPS suits as required. Designated hospitals must ensure they have a financial replacement	Evidence - Suits - Portakabin - Maintenance	Fully compliant	EPRG Governance	IK

Baker, Abi
06/10/2025 12:40:16

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
			content/uploads/2015/04/epr-chemical-incidents.pdf	plan in place to ensure that they are able to adequately account for depreciation in the life of equipment and ensure funding is available for replacement at the end of its shelf life. This includes for PPE/PRPS suits, decontamination facilities etc.				

Baker, Abi
06/10/2025 12:40:16

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
61	Hazmat/CBRN	Equipment - Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include where applicable: - PRPS Suits - Decontamination structures - Disrobe and robe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes	Documented process for equipment maintenance checks included within organisational Hazmat/CBRN plan - including frequency required proportionate to the risk assessment • Record of regular equipment checks, including date completed and by whom • Report of any missing equipment Organisations using PPE and specialist equipment should document the method for it's disposal when required Process for oversight of equipment in place for EPRR committee in multisite organisations/central register available to EPRR Organisation Business Continuity arrangements to ensure the continuation of the decontamination services in the event of use or damage to primary equipment Records of maintenance and annual servicing	Evidence • Suits • Portakabin • Maintenance	Fully compliant	EPRG Governance	IK

Baker, Abi
06/10/2025 12:40:16

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
			There is a named individual (or role) responsible for completing these checks	Third party providers of PPM must provide the organisations with assurance of their own Business Continuity arrangements as a commissioned supplier/provider under Core Standard 53				

Baker, Abi
06/10/2025 12:40:16

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
62	Hazmat/CBRN	Waste disposal arrangements	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans	Documented arrangements for the safe storage (and potential secure holding) of waste Documented arrangements - in consultation with other emergency services for the eventual disposal of: - Waste water used during decontamination - Used or expired PPE - Used equipment - including unit liners Any organisation chosen for waste disposal must be included in the supplier audit conducted under Core Standard 53	Evidence • HAZMAT Plan	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
63	Hazmat/CBRN	Hazmat/CBRN training resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy) Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination Documented evidence of training records for Hazmat/CBRN training - including for: - trust trainers - with dates of their attendance at an appropriate 'train the trainer' session (or update) - trust staff - with dates of the training that that they have undertaken Developed training programme to deliver capability against the risk assessment	Evidence • Training Records of PRPS trained staff - Excel spreadsheet	Fully compliant	EPRG Governance	IK

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
64	Hazmat/CBRN	Staff training - recognition and decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Evidence of trust training slides/programme and designated audience Evidence that the trust training includes reference to the relevant current guidance (where necessary) Staff competency records	Evidence • Training Package - EPRR, IOR Suits, MIRP, Threats • Annual and refresher package managed and co-ordinated from ED, DCH	Fully compliant	EPRG Governance	IK

Baker, Abi
06/10/2025 12:40:16

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self-assessment RAG	Action to be taken	Lead
65	Hazmat/CBRN	PPE Access	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS available for immediate deployment to safely undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	Completed equipment inventories; including completion date Fit testing schedule and records should be maintained for all staff who may come into contact with confirmed respiratory contamination Emergency Departments at Acute Trusts are required to maintain 24 Operational PRPS	Evidence • Accessible via ED	Fully compliant	EPRG Governance	IK
66	Hazmat/CBRN	Exercising	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Evidence • Exercising Schedule which includes Hazmat/CBRN exercise • Post exercise reports and embedding learning	Evidence • As part of the EPRG Training work programme - DCH	Fully compliant	EPRG Governance	IK

Report to	DHC Board of Directors	
Date of Meeting	Tuesday 7th October	
Report Title	EPRR Annual Core Standards Assurance Self-Assessment Report September 2025	
Prepared By	Sandra Hodgkyns Head of Emergency Planning / Deputy AEO	
Approved by Accountable Executive	Rachel Small Chief Operating Officer and Accountable Emergency Officer (AEO)	
Previously Considered By	Finance and Performance Committee.	
Action Required	Approval	N
	Assurance	Y
	Information	Y

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? <i>Delete as required</i>	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework		
Financial	no implication	
Statutory & Regulatory	The Civil Contingencies Act 2004, Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005, NHS Act 2006 and Health and Care Act 2022 underpin EPRR within health. All acts place EPRR duties on NHS England and the NHS in England. Additionally, the NHS Standard Contract Service Conditions (SC30) require providers of NHS-funded services to comply with the NHS EPRR Framework and other NHS England guidance.	
Equality, Diversity & Inclusion	no implication	
Co-production & Partnership	no implication	

Executive Summary
The purpose of the report is to update on the outcome of the Trusts Self-Assessment of NHS England's EPRR Core Assurance Standards for 2025. This report is submitted following the Head of Emergency Planning Response and Resilience (EPRR) and Accountable Emergency Officer (AEO) Self-Assessment of the Trusts positions of the annual assessment for NHS England's EPRR Core Assurance Standards 2025 prior to review and confirm and challenge process by NHS Dorset. This is provided as a review of the Self-Assessment only. All NHS-funded organisations must meet the requirements of: - the Civil Contingencies Act 2004, - the NHS Act 2006, - the Health and Care Act 2022, - the NHS standard contract, - the NHS Core Standards for EPRR and; - NHS England business continuity management framework.

In 2024 the Trust achieved full compliance in the Core Standard Assurance for the third year consecutively.

The EPRR team continues to plan, prepare, respond and recover to the ever-changing ways of supporting the Trusts operational delivery of key services whilst dealing with incidents, events or emergencies as and when they arise.

Following almost 7 months of gathering evidence and completing the self-assessment requirement primary stages, the EPRR Team and AEO believe that we have met our core standard compliance and are Fully Compliant again this year (2025) for the fourth consecutive year.

The Trusts Chief Operating Officer/ Accountable Emergency Officer and Head of Emergency Planning / Deputy Accountable Emergency Officer will meet with NHS Dorset in October, for a 'confirm and challenge' meeting. Once this has concluded, the outcomes of the assurance will be included in the annual EPRR system assurance summary letter which is submitted to NHS England and Improvement South West.

An EPRR annual report will be submitted to the Audit Committee and Trust Board in the early part of 2026, once the summary letter has been provided.

Recommendation

Members are requested to:

- Receive the report for information
- Receive the report for assurance

Baker, Abi
06/10/2025 12:40:16

Trust Board

1 Executive Summary

- 1.1 This report has been prepared to document the self-assessment outcomes of the Trust's Emergency Preparedness Resilience and Response (EPRR) compliance standards, in accordance with NHS England's EPRR Core Assurance Standards.
- 1.2 All NHS-funded organisations must meet the requirements of
- the Civil Contingencies Act 2004,
 - the NHS Act 2006,
 - the Health and Care Act 2022,
 - the NHS standard contract,
 - the NHS Core Standards for EPRR and;
 - NHS England business continuity management framework

2 NHS Core Standards

- 2.1 The annual NHS Core Standards are published annually, normally in early summer in line with the EPRR framework. The standards cover all NHS providers, with most completing approx. 50+ standards.
- 2.2 As an internal process, the EPRR Team complete their draft core standards along with their essential evidence for presentation to the Trusts Accountable Emergency Officer (AEO) where an internal self-assessment standard is then agreed and confirmed.
- 2.3 Trusts are required to provide a paper for their Trust Board on the outcome of their Annual EPRR Core Standards Assurance Self – assessment outcome.
- 2.4 Following the internal self- assessment, a 'confirm and challenge' meeting is arranged with NHS Dorset where the AEO and Head of EPRR, present their submitted evidence for review and if there are any challenges, are able to provide clarity as and where required.
- 2.4 Both NHS Dorset and NHS England assess and review the evidence submitted against the NHS Core Standards before agreeing and awarding any grading or outcome, which is formally sent to the AEO.

3 Assurances 2025

- 3.1 The NHS Core Standards set for 2025 has 67 standards. 58 with relevance for Community & Mental Health Trusts contained within. These are sub-divided into 10 key domains:
- Governance (Standards 1 – 6)
 - Duty to Risk Assess (NHS Core Standards 7 – 8)
 - Duty to Maintain Plans (NHS Core Standards 9 – 19)
 - Command and Control (NHS Core Standards 20 - 21)
 - Training and Exercising (NHS Core Standards 22 - 25)
 - Response (NHS Core Standards 26 – 30)
 - Warning and Informing (NHS Core Standards 33 – 36)

Baker, Abi
06/10/2025 12:40:16

- Cooperation (NHS Core Standards 37 – 39 & 43)
 - Business Continuity (NHS Core Standards 44 – 53)
 - Chemical, Biological, Radiological & Nuclear (CBRN) (NHS Core Standards 55, 56, 57, 58, 60, 61, 63, 64, 65 and 66)
- 3.2 Other standards outside of these numbers are not applicable for DHC and are based upon other NHS organisations criteria e.g. Acute Hospitals or Ambulance Trusts.
- 3.3 The Trust is assessed against the criteria shown in the below table:

Organisational Rating	Criteria
Fully	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards
*Substantial	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non- Compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

4 Deep Dive

- 4.1 Traditionally within the NHS Core Standards, there is a Deep Dive Section, with a focus on a specific topic. However, this year NHSE have removed this element.

5 Summary

- 5.1 The EPRR team have continued to strive and improve over the last year through preparing and responding to the ever-changing operational delivery of key services whilst preparing and dealing with emergency situations and incidents. We continue to work closely with our EPRR Colleagues within the ICB and support others as and when required.

6 Recommendations

- 6.1 The Board is recommended to:
- a. Receive the report for information
 - b. Receive the report for assurance

Name and Title of Author: Sandra Hodgkyns Head of EPRR / Deputy AEO
Date 30.09.25

Baker, Abi
06/10/2025 12:40:16

People and Culture Committee in Common Assurance Report
for the meeting held on Monday 22 September 2025

Chair	Frances West, NED
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	- Request for the Board to receive the whole-time equivalent reduction/financial implications paper - WRES and WDES reports for DCH and DHC - Recommendation for the Board to approve the mutually agreed resignation scheme (MARS) - Recommendation for the Board to approve the DHC Medical Appraisal and Revalidation – Statement of Compliance

Key issues / matters discussed at the meeting	The committee received, discussed and noted the following reports: Chief People Officer Update (incl. SubCo position) noting: - The ongoing, complex discussions within the system about the financial and operational position - An update on the proposed development of a subsidiary company, with continued engagement with the unions and those individuals affected and recognising the uncertainty the proposal caused for staff. - Upcoming programmes of work for the directorate include staff vaccinations, staff survey, and staff recognition scheme - A positive first meeting of the Joint Culture and Improvement Group with good representation from both trusts. - That morale was a challenge at present, given the high level of pressures in the two trusts. Workforce KPI Dashboard (Joint) DHC, noting: - Largely static key performance indicators with minor positive movements in turnover, employee relation cases, and appraisals. Areas for improvement include mandatory training rates, sickness rates, and vacancies. - Comprehensive discussions around mandatory training compliance for both trusts, noting that work was ongoing to improve this, with compliance in the medical and dental staff group noted to be particularly low. DCH noting: - Strong focus on improving mandatory training rates, with the education team offering ‘get me green’ days to support this. Compliance stood at 89%

Baker, Abi
06/10/2025 12:40:16

- Stable metrics in relation to sickness, slight spike in informal disciplinary cases, and reduction in turnover.

Progress against the Joint People plan (Joint) noting the progress and challenges in relation to the four overarching goals. The organisational change within the people directorate was noted, as was the increase in health and wellbeing champions. Work was needed to ensure the plan was well known across both organisations.

Workforce Equality Reports DCH WRES and WDES

- WRES: Five scores had improved but there continued to be a disparity in the experiences of staff from black and minority ethnicity backgrounds, compared to white staff, for example in relation to experience of harassment and likelihood of being appointed to a role. Three actions had been identified to address these concerns and were detailed in the report.
- WDES: Improvements in eight metrics, with five actions identified to promote further improvements.
- Discussion around the current anti-immigrant narrative in the media and society and rise of the far right, and the impact on staff. As much support as possible was being provided to staff but it was a challenging and unsettling time for staff.

DHC WRES and WDES

- WRES: Six scores had improved, with an increase in representation of ethnically diverse staff, but those members of staff are more likely to experience harassment, bullying or abuse, and experience higher disciplinary rates than white colleagues.
- WDES: Five scores had declined, with disabled staff two times more likely to go through a capability process, but high levels of satisfaction with workforce adjustments.
- Achievements to date and next steps include the launch of the inclusion and belonging strategy, launching diverse recruitment panels for band 8a+, and promoting active bystander training.

For both Trusts, a recognition that Board representation metrics were incomplete as they only included Board members directly employed by each Trust, so joint roles were not reflected in both Trust's reports.

Staffing Gaps / Safety Concerns (DCH/DHC)

- Robust processes in place both in- and out-of-hours to support safer staffing and support escalation and management of safer staffing concerns, with safer staffing leads in post in both trusts. Policies and procedures were in place and were well-understood by staff.
- Recognition of the impact on patients and staff if safe staffing levels are not managed appropriately.
- Risks in specific areas of the trusts were detailed. The risks well sighted and regularly reviewed at groups and Quality Committee in Common.
- The seriousness of the risks was highlighted, and the Board should be aware of this, with some of the risks scoring 20.

Whole Time Equivalent (WTE) Reduction and Financial Implications (Joint)

DCH:

- Overall, the Trust was behind plan but the biggest proportion of WTE reduction had been identified. Reduction of substantive posts was on plan, but fluctuations were being seen in bank staff.
- 161.5 WTE identified of the 232 required.
- All plans underwent a quality impact assessment to consider the impact on patient safety.

DHC:

- Ahead of plan by 34.7 WTE. 31% of the reduction had already been realised, but there was a need to further reduce temporary staffing levels.
- 401 WTE identified of the 411 required

Mutually Agreed Resignation Scheme (Joint) noting there was no material change to the scheme compared to the last time it was run, although learning from the implementation of the scheme had been taken on board. Approved by both committees.

Quarterly Guardian of Safe Working Report (DCH/DHC)

DCH:

- The process for raising exception reports had moved to HealthRota which was proving tricky initially but would provide better data in the long run. No particular concerns about the nature or number of reports raised.

DHC:

- No significant changes compared to the last report with all figures within acceptable ranges.

Medical Appraisal and Revalidation – Statement of Compliance (DHC)

- The report was considered at the last committee meeting, but the statement of compliance was now presented for approval and was approved by the committee.

10 Point Plan to Improve Resident Doctors' Working Lives (DCH/DHC)

This was a national initiative to improve resident doctors experience at work. Both trusts had completed the survey element of the task and a three-month task and finish process was underway to meet the requirements. There were many areas rated 'green'; some of those that were 'red' or 'amber' were outside of the trusts' control.

Maternity Multiprofessional Training Report (DCH) noting that it would be discussed in greater detail at Quality Committee in Common. It was important to ensure that doctors and midwives had the right support to meet training compliance.

Policies (DHC) noting that six policies were overdue for review, with the longest overdue by five months. Four of the policies were due to be presented to the Trade Union Partnership Forum for approval imminently.

Assurance reports from below sub-groups of the People and Culture Committee in Common

DCH:

Baker, Abi
06/10/2025 12:40:16



- Partnership Forum
 - Equality, Diversity, Inclusion and Belonging Steering Group
 - Local Negotiating Committee
- DHC:
- Equality, Diversity, and Inclusion Steering Group
 - Trade Union Partnership Forum
 - Workforce Wellbeing Group
- Governance Structure (Joint)** outlining the structure of groups that report in to the committee, and detailing trust leads for statutory or regulatory roles. Committee members noted the usefulness of the document and that it should be shared widely across the organisation.

Decisions made at the meeting

- Approval by the DCH and DHC committees of the Mutually Agreed Resignation Scheme
- Approval by the DHC committee of the Medical Appraisal and Revalidation – Statement of Compliance

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	Y	Y			
Frances West	A	Y	Y			
Suresh Ariaratnam	Y	Y	Y			
Margaret Blankson	Y	Y	Y			
Dawn Dawson	Y	Y	A			
Eiri Jones	Y	Y	Y			
Lucy Knight	Y	Y	Y			
Nicola Plumb	A	Y	Y			
Rachel Wharton	A	A	A			

Baker, Abi
06/10/2025 12:40:16

Report to	Board of Directors, Part 1 (DCH Board)	
Date of Meeting	07 October 2025	
Report Title	Quarterly Guardian Report of Safe Working report: Doctors in Training (1 st April 2025 – 30 th June 2025)	
Prepared By	Dr Jill McCormick, Guardian of Safe Working (GoSW) - outgoing Dr Andy Macklin, Guardian of Safe Working (GoSW) - incoming	
Accountable Executive	Dr Rachel Wharton, Interim Chief Medical Officer, DCH	
Previously Considered By	People and Culture Committee in Common – 22/09/2025	
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	
Financial	The guardian of safe working ensures that issues of compliance with safe working hours are addressed by the doctor and the employer or host organisation as appropriate. It provides assurance to the board of the employing organisation that doctors' working hours are safe.	
Statutory & Regulatory	Adhering to requirements of the Junior Doctor Contract 2016	
Equality, Diversity & Inclusion	People Plan Principle – we will improve safety and care by creating a culture of openness, innovation, and learning, where staff feel safe themselves	
Co-production & Partnership	The report is also shared with the Local Negotiating Committee for Medical and Dental staff once seen by PCCiC.	

Executive Summary
1. This is the Q1 Report submitted to the Trust Board by the outgoing Guardian of Safe working (Dr Jill McCormick) and the incoming Gurdian of Safe Working (Dr Andy Macklin). Dates from 1st April 2025 to 30th June 2025. 2. First report using the Healthrota IT system for Exception Reporting (from the 1st April 2025) with challenges to collating data. 3. During this period of time there were 106 Exception reports received, 14 were Immediate Safety Concerns (ISCs). 4. Areas with the highest number of ERs were Cardiology, Gastroenterology and General Medicine (including Fortuneswell medical outliers), and T&O (however this mostly includes the on call with ENT/Orthopaedics).

Baker, Abi
06/10/2025 12:40



Healthier lives



Empowered citizens



Thriving communities

Recommendation

The Board is requested to:

- Receive the report for **assurance**

Baker, Abi
06/10/2025 12:40



Healthier lives



Empowered citizens



Thriving communities

**Quarterly Guardian Report of Safe Working report: Doctors in Training (1st April 2025
– 30th June 2025)**

Executive Summary

5. This is the Q1 Report submitted to the Trust Board by the outgoing Guardian of Safe working (Dr Jill McCormick) and the incoming Gurdian of Safe Working (Dr Andy Macklin). Dates from 1st April 2025 to 30th June 2025.
6. First report using the Healthrota IT system for Exception Reporting (from the 1st April 2025) with challenges to collating data.
7. During this period of time there were 106 Exception reports received, 14 were Immediate Safety Concerns (ISCs).
8. Areas with the highest number of ERs were Cardiology, Gastroenterology and General Medicine (including Fortuneswell medical outliers), and T&O (however this mostly includes the on call with ENT/Orthopaedics).

Introduction

All eligible doctors in training between April and June 2025 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 2025 complied with contractual commitments under the 2016 Contract.

The provision of three quarterly reports and one annual report from the Guardian of Safe Working is a contractual requirement outline in the T&CS of the 2016 Contract.

High level data for Dorset County Hospital NHS trust

Number of training post (total): 201

Number of doctors in training post (total): 177.3

Annual average vacancy rate among this staff group: 19.2

Amount of time available in job plan for Guardian of Safe Working 1 PA

Amount of job planned time for educational supervisor 0.25 PA per trainee

Baker, Abi
06/10/2025 12:40



Healthier lives



Empowered citizens



Thriving communities

Exception reports

Specialty	No. exceptions carried over from last report (2024 Q4)	No. exceptions raised	No. exceptions closed
Acute Medicine (Including Medical On-call)	0	6	6
Anaesthetics	0	0	0
Cardiology	0	17	17
Clinical Oncology	0	0	0
Dermatology	0	0	0
D&E	0	1	1
Emergency Dept	0	0	0
ENT	0	4	4
Gastroenterology	0	10	10
General Medicine / Including Fortuneswell Medical outliers	0	16	16
General Practice	0	0	0
General Surgery	0	13	13
Geriatric Medicine (Medical On-call included)	0	7	7
Haematology	0	3	3
Obstetrics & Gynaecology	0	0	0
Orthogeriatrics	0	3	3
Paediatrics	0	0	0
Renal	0	2	2
Respiratory Medicine	0	2	2
Stroke	0	6	6
Trauma & Orthopaedics	0	16	16
Urology	0	0	0
Total	0	106	106

Baker, Abi
06/10/2025 12:40:33



Healthier lives



Empowered citizens



Thriving communities

Exception reports by grade				
Grade	No. exceptions carried over from last report (2024 Q4)	No. exceptions raised	No. exceptions closed	No. exceptions outstanding (from JUN '25)
F1	0	56	57	0
F2	0	18	18	0
CT1	0	0	0	0
CT2	0	6	0	0
CT3	0	7	0	0
ST1	0	17	17	0
ST2	0	0	0	0
ST3	0	1	0	0
ST4	0	0	0	0
ST5	0	1	0	0
ST6	0	0	0	0
ST7	0	0	0	0
ST8	0	0	0	0
MT01	0	0	0	0
MT02	0	0	0	0
MT03	0	0	0	0
MT04	0	0	0	0
MT05	0	0	0	0
Total	0	106	106	0

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	F2	LED ST1 EQUIV (MT03)
General Medicine		2
T&O	1	
Total	1	2

Baker
06/10/2025 12:40



Healthier lives



Empowered citizens



Thriving communities

Vacancies

Appendix 1 Details all vacancies among the medical training grades during the Q1 of this year, split by specialty and grade.

Appendix 2 – Exception report submission since 2023/4 until Q1 2025/26

Appendix 3 – Exception report submission since 2016 – 2023/2024

Fines

There were no fines levied during this period.

Qualitative information

Part of overseeing the Exception Reporting mechanism involves constant awareness of under reporting and a constant effort to promote appropriate engagement with the mechanism via the Medical Director, DME, GMC regional officer and the local BMA representatives.

Data for the Q1 Report has been more challenging with a move to the new Healthrota IT system, completed on 31st March 2025. It has been more difficult to ascertain which Exception report is coming from which department. There is a utility to create a report for the quarter period and then go through each individual exception report. There is more training and development to improve data collection from the Healthrota planned. However, the information I have obtained is to the best of my knowledge.

It has also been noted from the last report that any numbers of reporting less than 5 are not disclosed, to prevent any risk of identifiability moving forward.

The areas that have generated the most reports are Gastroenterology, Cardiology and General Medicine (which includes the Fortuneswell medical patients). These have all generated Exception Reports due to overwhelming workload, patient numbers, and acutely unwell patients, which meant staying late. It may be an area to discuss with the Medical Workforce Lead and medical Rota coordinator to support more, but my understanding is that more Resident Doctors have been assigned to this team since August 2025.

Within the Immediate safety concerns were General medicine; T&O and General surgery related to volume of work and staffing levels. T&O it was related to the difficulties of managing Orthopaedic and ENT patients within an on-call. T&O appears to have less overall Exception Reports which is an improved trajectory.

Within Acute medicine / Geriatrics there were less Exception Reports for on-call work, which is an improvement from the last quarter.

It is important to appreciate there has been a significant increase in ERs this quarter; related possibly to the new Healthrota System. It has also changed that HR will approve the majority of ERs; exception being any over 2 hours; Immediate Safety Concerns (For GOSW) or Educational Concerns



Healthier lives



Empowered citizens



Thriving communities

(For DME), therefore no longer involving directly Educational Supervisors – we may again see an increase in reports in the forthcoming year.

The Guardian acknowledges the Trust's compliance with the safeguarding aspects of the 2016 contract; recognizes good practice within the Trust and a concerted effort to support Resident Doctor's as much as possible.

1. Recommendations

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

Baker, Abi
06/10/2025 12:40



Healthier lives



Empowered citizens



Thriving communities

APPENDICES

QUARTERLY GUARDIAN REPORT ON SAFE WORKING HOURS: DOCTORS IN TRAINING

APRIL 2025 – JUNE 2025

Appendix 1 – Trainee Vacancies within the Trust

Department	Grade	Rotation Dates	Apr 25	May 25	Jun 25	Average Q1
Paediatrics	ST3	Sept	1	1	1	1.0
Paediatrics	ST4+	Sept	0.8	1.4	1.4	1.2
O&G	ST1	Oct	0	0	0	0.0
O&G	ST3+	Oct	0	0.4	0.4	0.3
ED	ST3+	Sept and Feb	1	1	1	1.0
Surgery	CT1	Aug	0	0	0	0.0
Surgery	CT2	Aug	0	0	0	0.0
Surgery	ST3+	Oct	0	0	0	0.0
Orthopaedics	ST3+	Sept	0	0	0	0.0
Anaesthetics	CT1/2	Aug	1.4	1.4	1.4	1.4
Anaesthetics	ST3+	Aug and Feb	1.2	1.2	1.2	1.2
Clinical Radiology	ST1/2	Aug and Feb	1	1	1	1.0
Medicine	CT1/2	Aug	4.1	4.1	4.1	4.1
Medicine COE	ST3+	March	0.2	0.4	0.4	0.3
Medicine Diab/Endo	ST3+	Aug	1	1	1	1.0
Medicine Gastro	ST3+	Sept	0	0	0	0.0
Medicine Resp	ST3+	Aug	0	0	0	0.0
Medicine Cardio	ST3+	Feb	0.2	0.2	0.2	0.2
Medicine Acute Internal	ST3+	Sept	1	1	1	1.0
Medicine Renal	ST3+	Aug	1	1	1	1.0
Haematology	ST3+	Sept	1	1	1	1.0
Med/Surg	FY1	Aug	2	2	2	2.0
Med/Surg	FY2	Aug	1.3	1.3	1.3	1.3
GPST	ST1	Aug & Feb	0.2	0.2	0.2	0.2
GPST	ST2	Aug & Feb	0	0	0	0.0
GPST	ST3	Aug & Feb	0	0	0	0.0
Orthodontics	ST3+	March	0	0	0	0.0
Ophthalmology	ST3	Aug	0	0	0	0.0
Total			18.4	19.6	19.6	19.2

Baker:Adi
06/10/2025 12:40



Healthier lives

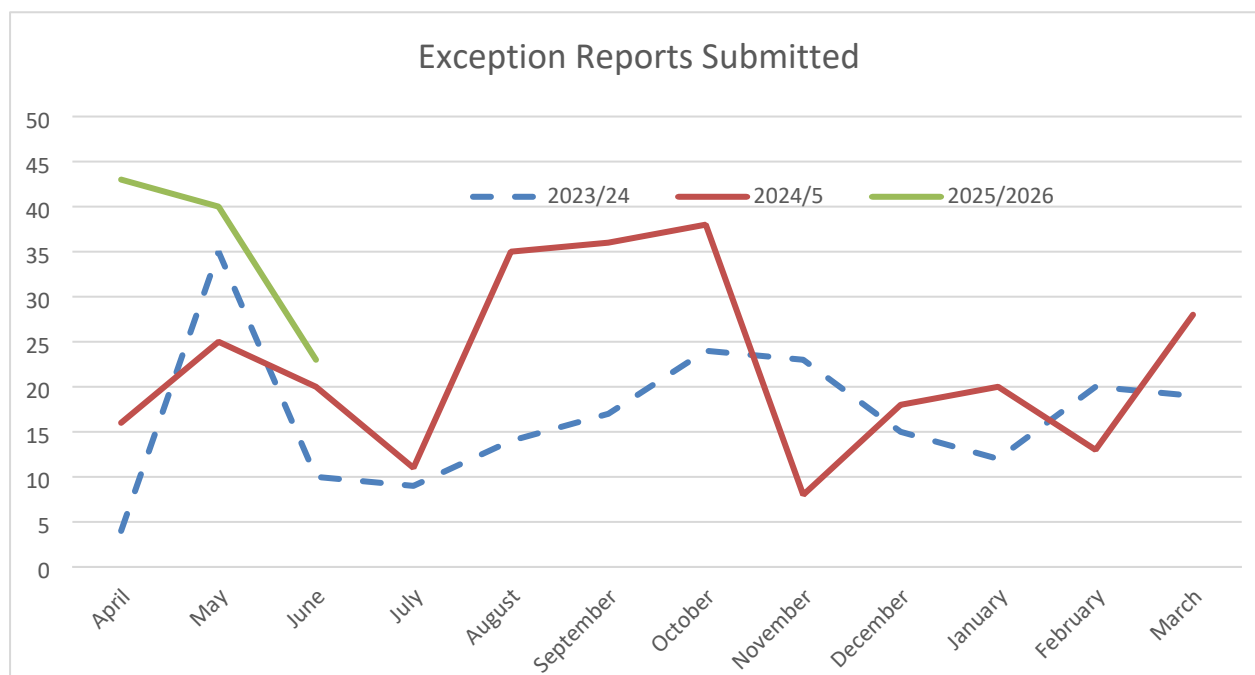


Empowered citizens



Thriving communities

Appendix 2 – Exception Report submission since 2023/24 to Q1 2025/26



Baker, Abi
06/10/2025 12:40



Healthier lives

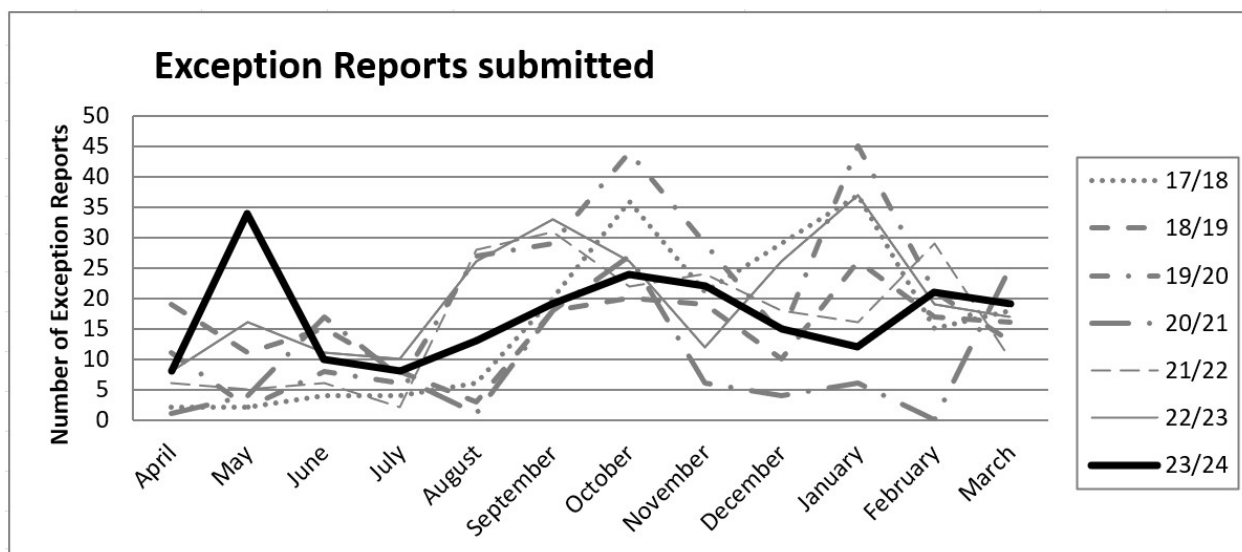


Empowered citizens



Thriving communities

Appendix 3 – Exception Report submission introduction of the 2016 Contract to 2023/2024



Baker, Abi
06/10/2025 12:40



Healthier lives



Empowered citizens



Thriving communities

Report to	Board of Directors, Part 1 (DHC)	
Date of Meeting	7 October 2025	
Report Title	Guardian of Safe Working Report of Safe Working Hours of Doctors in Training Q1 (Feb-Apr 2025)	
Prepared By	Dr Ian Rodin (Director of Medical Education), in the absence of Claire Vick (Guardian of Safe Working Hours)	
Approved by Accountable Executive	Dr Lucy Knight Chief Medical Officer	
Previously Considered By	People & Culture Committee in Common, 22 September 2025	
Action Required	Approval	N
	Assurance	Y
	Information	N
Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? <i>Delete as required</i>	
Care	Yes	
Colleagues	Yes	
Communities		No
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 Safety & Quality. If we are not able to deliver the fundamental standards of care we will not be providing consistently safe, effective and compassionate care.	
Financial	Fines are incurred for breaches of safe working	
Statutory & Regulatory	NA	
Equality, Diversity & Inclusion	Adherence to the GOSW provisions helps us treat resident doctors fairly and consistently.	
Co-production & Partnership	NA	
Executive Summary		
The introduction of the 2016 contract for resident doctors established the role of the Guardian of Safe Working Hours, who is required to provide assurances to the Trust Board in relation to the compliance with these hours on a quarterly basis. • This report covers the period 05/02/2025 – 01/05/2025, in-line with the rotation of resident doctors • There were 28 exception reports raised during this period • Ten of the exception reports raised were in relation to breaches of working times during on-call shifts and incurred a fine to the Trust - nine of these involved residents having less than five hours of continuous rest between 10pm and 7am, and one related to a resident working more than 13 hours during a weekend shift. • Sixteen of the reports related to one resident's work during normal office hours - 14 of these related to them working beyond these hours and two related to missed education sessions. • There were no other reports relating to missed educational opportunities. • No reports raised an immediate safety concern. • No reports required an escalation. The Director of Medical Education is assured that Resident Doctors working hours are safe and the Guardian of Safe Working has raised no safety concerns		
Recommendation		
Members are requested to: Receive the report for assurance		

1. Background

- 1.1 Following the introduction of the 2016 resident doctor contract, the role of guardian of safe working hours (GOSWH) was created to provide assurances to both the board and resident doctors that their working hours would be safe (in line with the new contract.) These reports are intended to provide an overview and assurance of the Trust's compliance with safe working hours for doctors in training and to detail any areas of concern.
- 1.2 All doctors in training are issued with a work schedule (which details hours to be worked and educational opportunities expected in each job) and a proposed Rota (detailing frequency as well as Rota dates) prior to the start of each rotation. The Trust currently operates a normal intensity Rota which is compliant in terms of weekend frequency and number of consecutive days worked.
- 1.3 Deviations from the work schedule that result in additional hours worked or inability to take appropriate rest periods during a scheduled workday should result in the resident raising an exception report. Residents should also raise an exception report if they do not achieve the required 5 hours continuous rest between 10pm and 7am and or 8 hours total rest during a 24 hour on-call period. These exception reports are overseen by the Guardian of Safe Working Hours.
- 1.4 The amendments to the contract also require residents to raise an exception report when they have been unable to attend training related activities due to clinical commitments. These are discussed with their educational or clinical supervisor in the first instance as above and are passed to the Director of Medical Education for information. Exception reports raised in relation to education are beyond the remit of the Guardian of Safe Working Hours but the number of reports raised will however be added to this report for completeness.
- 1.5 All the doctors in training in this Trust are on the new contract.
- 1.6 Exception reports raised by Foundation Doctors are dealt with by the GOSW in the acute trusts and are therefore beyond the remit of this report.

2 Information for consideration

2.1 Exception reports relating to working hours from 01/11/2024- 04/02/2025

Training programme	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
CT/ GPVTS	25	25	0
ST	3	3	0
Total	28	28	0

Baker, Abi
06/10/2025 12:40:16

2.2 Outcomes of exception reports

- 2.2.1 Ten of the exception reports related to breaches of the 5-hour continuous rest period between 10pm and 7am.
- 2.2.2 Two reports were for breaches of the maximum 13-hour shift length during on-call shifts at weekends or public holidays.
- 2.2.3 Sixteen reports related to the work and training of one resident doctor during normal working hours – 14 concerned the doctor working more than eight hours during the day, two concerned them missing protected education time. The doctor worked with their clinical supervisor to reduce their daytime work.
- 2.2.4 All reports were from resident doctors placed in psychiatry posts. There were no issues raised by residents in community hospital or sexual health posts, which do not entail on-call work with the Trust.
- 2.2.5 There have been no instances of exception report outcomes not being agreed by a trainee and therefore needing a level 2 or 3 resolution.

2.3 Exception report raising immediate safety concern

- 2.3.1 There were no exceptions raised as an immediate safety concern.

2.4 B: Exception reports related to missed education/ training

- 2.4.1 No exception reports were raised in relation to inadequate clinical experience or exposure. One resident reported missing a protected education session and being interrupted during another.

2.5 C: Work schedule reviews

- 2.5.1 There have been no new work schedule reviews required over the last period

2.6 D: Vacancies and locum bookings

- 2.6.1 The core resident and specialty resident posts on Alumhurst Ward at St Anns were both vacant during this quarter and a full-time locum doctor and a peripatetic Trust core resident were deployed on the ward. There were four other vacant specialty psychiatry resident posts, all in community teams, and one vacant sexual health specialty resident post.

2.7 E: Fines

- 2.7.1 The amendments to the contract which have been rolled out since September 2019 have introduced stricter adherence to aspects of the contract, which has increased the number of fines.

Baker, Abi
06/10/2019 12:40:18

2.7.2 Fines are payable in two parts with one part going directly to the doctor and the remainder going to the Guardian of Safe Working Hours to be spent on training and education in agreement with the Resident Doctors Forum.

2.7.3 Ten of the exception reports registered relate to true breaches of working times and incurred a Guardian of Safe Working Hours fine – nine for less than five hours continuous rest hour, one for exceeding 13 hours worked at a weekend .

2.7.4 Monies raised through the fines process are to be used to improve the education, training and working environment for trainees. Disbursement of these funds are discussed at each quarterly Resident Doctors Forum.

2.7.5 Fines by Rota:

Fines by Rota		
Rota	Number of fines levied	Value of fines levied against department
CT/ GPVTS	8	£1057.30
ST	3	£377.86
Total	7	£1435.16

2.7.6 Cumulative Balance in Guardian Cost Centre

Cumulative fines in Guardian Cost Centre (Total fines less payment to Trainee)			
Balance at end of last quarter	Fines this quarter	Disbursements this quarter	Balance at end of this quarter
-£181.16	£1435.16	0	£1235.00

2.8 F: Additional Information

2.8.1 The Resident Doctors Forum continues to meet quarterly and is well attended.

3 Guardian of Safe Working Hours Safety Statement

3.1 As Director of Medical Education, I am assured that the working hours for doctors in training are safe. The Guardian of Safe Working carried out her usual duties during the reporting period and has not raised safety concerns with me.

Contact for further information:

Dr Ian Rodin

Director of Medical Education

Exmouth Hospital 01308 426281, i.rodin@nhs.net

Dr Claire Vick

Consultant Psychiatrist and Guardian of Safe Working Hours for the Trust

Shelley Clinic 01202 646 300

Report to	Board in Common, part 1 (DCH and DHC Boards)	
Date of Meeting	7th October 2025	
Report Title	DCH and DHC Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES) Reports 24-25	
Prepared By	Jan Wagner and Manpreet Aujla-Gudgeon – EDI Leads	
Accountable Executive	Nicola Plumb – Joint Chief People Officer	
Previously Considered By	People and Culture Committee in Common	
Action Required	Approval	X
	Assurance	
	Information	

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below	
Board Assurance Framework	SR2: Culture The reports demonstrate development of fair and inclusive leadership, practice and culture & contributes to the 'Well Led' CQC Domain. Inclusive workplaces report better staff health and wellbeing, which is linked to markedly higher patient satisfaction and better patient outcomes, meaning that there is potential for progress in EDI work to positively contribute to all CQC Domains.	
Financial	Non-compliance with EDI legislation would create risks for the organisation in terms of reputation and potential fines.	
Statutory & Regulatory	The general equality duty is set out in section 149 of the Equality Act 2010. Public organisations including NHS Trusts are subject to the general duty and must have due regard to the need to: eliminate unlawful discrimination, harassment and victimisation. The Public Sector Equality Duty (PSED) requires public bodies to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between different people when carrying out their activities.	
Equality, Diversity & Inclusion	The reports signal our intention to truly value our disabled staff and those from minority ethnic communities. Our people are our most important asset, and we want them to feel valued, welcomed, respected, they belong and matter. We recognise the link between high levels of staff satisfaction and improving patient experience and outcomes.	
Co-production & Partnership	Championing Equality, Diversity and Inclusion is a key ambition of the Trust's Social Value pledge. It also supports delivery of equitable services that are informed by engagement and involvement.	

Executive Summary
The Workforce Disability Equality Standard (WDES) and the Workforce Race Equality Standard (WRES) are mandated by the NHS Standard Contract and applies to all NHS Trusts and Foundation Trusts. Following approval, the data and narrative will be published on our public websites along with our action plans, in line with regulatory requirements.

The WRES is a data-based standard and uses a series of nine indicators (measures) as a strategic framework for NHS Trusts to address racial inequality. The measures aim to improve the representation and experiences of BME staff across all levels in the NHS, with a key focus on improving representation at senior levels. The nine indicators encompass workforce data (Indicators 1-4), Staff Survey data (Indicators 5-8) and Board representation (Indicator 9).

The WDES is also a data-based standard and uses a series of ten measures (metrics) to improve the experiences of disabled staff in the NHS. The ten key metrics comprise workforce metrics (1-3), Staff Survey metrics (4-9a), narrative evidence of actions taken (9b) and a metric based on Board representation (10).

The WRES results for Dorset County Hospital are included in appendix A.

Overall, there were improvements in FIVE measures (1, 2, 4, 7 and 8), declines in THREE measures (3, 5 and 6) which relate to likelihood of formal disciplinary processes and to staff experiencing bullying and harassment.

The WRES results for Dorset HealthCare are included in appendix B.

Overall, we have seen **improvements in six indicators** (1, 2, 5, 6, 7 and 8) and **declines in three indicators** (3, 4 and 9) compared to 2023/24, showing progress in representation, recruitment and staff experience but continued challenges in disciplinary processes, training access and board-level diversity.

The WDES results for Dorset County Hospital are included in appendix C.

Overall, there were improvements in EIGHT metrics (1-4 and 6-9). and a decline in ONE metric (5) relating to career development.

The WDES results for Dorset HealthCare are included in appendix D.

Overall, **three metrics** (1, 5, 6) **improved** this year, **five** (2, 3, 7, 8, 9) **declined**, and **two** (4, 10) **remained largely unchanged**, showing progress in workforce representation and reduced pressure to work when unwell but continued challenges in recruitment, capability processes, workplace culture and board diversity.

There are metrics in both standards relating to the difference between the organisation's Board voting membership and the overall workforce, but as each Trust is only permitted to report the data of those Board members that they employ, these metrics are incomplete. A complete overview of this element will be provided in the joint annual EDIB Report.

Action is already underway to target areas of concern identified in these reports. New actions identified through this process will be added to the overarching Inclusion and Belonging Strategy Action Plans in both organisations.

Recommendation

The Board in common is recommended to approve the reports.

Dorset County Hospital

Workforce Race Equality Standard Report

2024-25

Baker, Abi
06/10/2025 12:40:16

1.0 Introduction

This report provides an analysis of our annual performance against the Workforce Race Equality Standard (WRES) metrics for **2024-25**. The data, along with our action plan, will be publicly available on our website in compliance with regulatory requirements.

The WRES was established by the NHS Equality and Diversity Council (EDC) as a strategic framework for NHS Trusts to address racial equality. Its introduction followed Roger Kline's influential 2014 report, 'The Snowy White Peaks of the NHS', which highlighted the connection between high-quality patient care and a workforce that mirrors the diversity of the local community.

Dorset's Black and Minority Ethnic (BME) population remains at approximately 5%, yet BME staff at Dorset County Hospital Foundation Trust make up **21.65%** of the workforce, a rise of **2.91%** from last year. This figure is likely to continue to grow in the coming years due to increased international recruitment to fill critical roles.

Launched on 1 April 2015, the WRES aims to improve the representation and experience of BME staff across all levels of NHS organisations, with a focus on scrutinising and improving BME representation at senior levels. Within the WRES framework, White staff are defined as those identifying as White British, White Irish, or White Other (Ethnic codes A, B, and C), while BME staff include all other ethnic categories, excluding 'not stated'.

The WRES is comprised of nine indicators, encompassing workforce data (Indicators 1-4), Staff Survey data (Indicators 5-8), and Board representation (Indicator 9):

1. Percentage of BME staff.
2. Relative likelihood of White candidates compared to BME candidates being appointed from shortlisting across all posts.
3. Relative likelihood of BME staff compared to White staff entering the formal disciplinary process.
4. Relative likelihood of White staff compared to BME staff accessing non-mandatory training and CPD.
5. Percentage of staff experiencing harassment, bullying, or abuse from patients, relatives, or the public in the last 12 months.
6. Percentage of staff experiencing harassment, bullying, or abuse from colleagues in the last 12 months.
7. Percentage of staff believing that their trust provides equal opportunities for career progression or promotion.
8. Percentage of staff personally experiencing discrimination from a manager, team leader, or other colleagues.
9. BME board membership.

The data for Dorset County Hospital's **2024-25** WRES submission is based on staff with recorded ethnicity in the Trust's Electronic Staff Records (ESR), with ethnicity data available for **98%** of our workforce.

Baker
06/10/2024
10:16

- **Indicator 1** is drawn from ESR data as of **31 March 2025**.
- **Indicator 2** is drawn from TRAC data as of **31 March 2025**
- **Indicator 3** is based on HR records from **1 April 2024 to 31 March 2025**.
- **Indicator 4** reflects ESR data from **1 April 2024 to 31 March 2025**.
- **Indicators 5-8** are derived from the national NHS Staff Survey conducted between early October and end November 2024, with results published in **March 2025**.
- **Indicator 9** is based on ESR data as of **31 March 2025**.

The average response rate for BME staff on survey indicators (5–8) was **20.8%**, representing **188 respondents**. This is **4.5% below** the national average of **25.3%**.

As part of the NHS standard contract, compliance with WRES is mandatory, ensuring accountability in our efforts to improve racial equality. Non-compliance poses significant risks, not only to the Trust's reputation but, more importantly, to the wellbeing of our workforce.

2.0 Overview of changes since 2023/24 data

Over the past year, Dorset County Hospital (DCH) has deepened its commitment to creating an inclusive workplace, guided by our joint Inclusion and Belonging Strategy with Dorset Healthcare (DHC). This approach enables us to align priorities across the federated alliance while tailoring actions to the needs of our own workforce.

Investment in capability building has remained a priority. Conscious inclusion and inclusive leadership programmes have been delivered collaboratively across all NHS Trusts in Dorset, ensuring that leaders and managers at every level have access to the tools needed to foster equitable and respectful teams.

Staff networks continue to play a vital role in creating belonging. The Overseas Staff Network now provides peer support to over 400 members, helping colleagues settle into new roles and communities. The Ethnic Diversity Network is relaunching under new leadership, with a renewed focus on advocacy and visibility.

This year's data tells a more complex story. The proportion of BME staff in our workforce has grown to its highest level to date, reflecting successful recruitment and retention. However, several experience indicators – particularly recruitment outcomes, reports of harassment, and senior representation – continue to show disparities. These results underline the importance of coupling diversity growth with systemic changes that improve equity of experience and opportunity.

Closing these gaps will be a core focus for 2025/26. Our action plan prioritises fair recruitment practices, stronger anti-bullying measures, leadership accountability for inclusion, and more robust pathways for BME staff to progress into senior roles.

3.0 Summary of Results

The data submitted to the national WRES team is included in Annex A.

Key Indicator 1: *Percentage of staff in each of the AfC Bands 1-9 or Medical & Dental subgroups and VSM (including Executive Board members) compared with the % of staff in the overall workforce*

The proportion of ethnically diverse staff at Dorset County Hospital has grown from 905 in 2023/24 to 1,033 in March 2025 – an **increase** of 3.91 percentage points, bringing overall representation to 21.65 %. This continues a consistent four-year upward trend and reflects sustained recruitment from a broad range of backgrounds, particularly through international recruitment into critical roles.

This progress strengthens the diversity profile of our workforce, but the data also shows that representation remains heavily concentrated in certain staff groups and lower pay bands. BME presence at senior levels is still limited, meaning that the benefits of diversity are not yet fully realised in all decision-making spaces.

The challenge now is to convert representation into equity of experience and opportunity. This requires targeted mentoring, clear and transparent promotion processes, leadership development pathways, and active sponsorship to support BME colleagues into senior and strategic roles.

Key Indicator 2: *Relative likelihood of White staff being appointed from shortlisting compared to BME staff*

The recruitment data shows a continuing disparity between White and BME applicants. In 2024/25, the likelihood of White applicants being appointed from shortlisting was 3.06 times higher than for BME applicants. While this represents an **improvement** compared to last year's figure, the difference remains significant, with appointment rates of 33.7% for White applicants compared to 11% for BME applicants.

This persistent gap highlights the need to strengthen inclusive recruitment practices, particularly in shortlisting and final appointment decisions. Work is underway through the Inclusive Recruitment project to ensure greater fairness and consistency in how candidates are assessed and selected.

Key Indicator 3: *Relative likelihood of BME staff entering the formal disciplinary process compared to White staff (Note: This Indicator will be based on data from a two-year rolling average of the current year and the previous year)*

BME staff are now 1.38 times more likely than White staff to enter the formal disciplinary process, compared with no measurable difference in the previous year. While the overall numbers involved remain small, the **proportional impact is significant**, and the data shows that disparities in the experience of formal procedures persist.

This shift underlines the need to examine our processes in detail. We will carry out a full review of disciplinary cases over the past two years to identify any patterns of bias or inconsistency, working in partnership with staff networks and drawing on feedback from managers involved in these processes.

Key Indicator 4: *Relative likelihood of White staff accessing non-mandatory training & CPD compared to BME staff*

The likelihood ratio for accessing non-mandatory training and CPD has **increased** from 0.81 in the previous year to 0.93, indicating that BME staff now take up these opportunities at a slightly higher rate than their White colleagues. This represents a positive shift and suggests

Baker
06/10/2025 11:40:16

that recent measures to improve awareness and accessibility of professional development are beginning to deliver results.

To maintain and strengthen this progress, we will continue to ensure that CPD opportunities are well-publicised, easy to apply for, and open to all staff on an equitable basis. This will include targeted promotion through staff networks, proactive encouragement from managers during appraisals, and the use of simple, transparent application processes. Regular monitoring will help us to identify any emerging gaps and address them promptly.

Key Indicator 5: *Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months*

The proportion of BME staff reporting harassment, bullying, or abuse from patients, relatives, or the public has **risen** from 22% in the previous year to 28%, **increasing the gap** with White staff to 9.2 %. This change reverses last year's improvement and shows that existing measures have not yet delivered consistent or sustained reductions in such incidents.

Addressing this requires a renewed and visible commitment. We will strengthen anti-bullying and anti-abuse campaigns aimed at both staff and the public, improve the accessibility and visibility of reporting mechanisms, and ensure timely, tailored support for anyone affected. In addition, we will review incident data more frequently to identify emerging patterns and take prompt action, working closely with frontline teams to implement practical prevention measures.

Key Indicator 6: *Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months*

Reports of harassment, bullying, or abuse from colleagues among BME staff have **increased** slightly, from 25.8% to 26.4%, **widening the gap** with White staff to 5.2%. While the overall rate has not shifted significantly, the persistence of this disparity indicates that more needs to be done to embed a consistently respectful and inclusive workplace culture.

We will continue to roll out inclusive leadership training, so that managers have the skills and confidence to address issues promptly and fairly. We will also improve communication about reporting routes and reinforce assurances that all concerns will be handled sensitively, confidentially, and without risk of retaliation. This approach aims to build trust that unacceptable behaviour will be challenged and resolved effectively.

Key Indicator 7: *Percentage of staff believing that the Trust provides equal opportunities for career progression and promotion*

The proportion of BME staff who believe the Trust provides equal opportunities for career progression and promotion has decreased from 59.3 % to 56.6 %. White staff show a similar decline, from 58.1 % to 56.2 %, resulting in a **disparity gap of just 0.4 %** – the smallest recorded to date. While this closer alignment may suggest more consistent perceptions across groups, the overall drop in confidence for both will be monitored.

Key Indicator 8: *In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/Team Leader or other colleagues.*

Baker
06/10/2023
12:40:16

16.0 % of BME staff reported experiencing discrimination from managers, team leaders, or colleagues – a **reduction** from 18.0 % last year. The disparity gap **also reduced** to 9.4%. While this improvement is welcome, it shows that discriminatory experiences continue to affect a significant proportion of our ethnically diverse workforce.

Closing this gap will require both stronger prevention and clearer accountability. We will reinforce bias awareness and inclusive leadership training for all managers, ensure that reporting routes are straightforward, accessible, and trusted, and act promptly and visibly when concerns are raised. Our aim is to build a culture in which discriminatory behaviour is consistently identified, challenged, and addressed, so that all staff can work in an environment of fairness and respect.

Key Indicator 9: *Percentage difference between the organisation's Board voting membership & its overall workforce*

The national WRES team has advised that we are only permitted to report on Board members who are directly employed by us. As a result, joint roles and Board members employed via Dorset HealthCare are excluded, which limits the completeness of the data. A complete overview of this element will be provided in the joint annual EDIB Report.

4.0 Conclusion and Actions

This year's WRES results present a mixed picture. While the proportion of ethnically diverse staff has continued to rise for the fourth consecutive year, disparities between BME and White colleagues remain in several indicators. While harassment from both patients and colleagues has increased, the recruitment gap following shortlisting has narrowed compared to last year, though it remains significant.

These findings reinforce that representation alone is not enough. We must take more targeted and sustained action to remove structural barriers, embed fair and transparent processes across all people practices, and create a working environment in which all staff feel safe, respected, and supported to develop.

The following actions set out focused, measurable steps, rooted in the latest data, to address the most pressing challenges. It aligns directly with the WRES indicators, our joint Inclusion and Belonging Strategy, and the priorities in the Trust People Plan. Progress will be tracked against clear metrics and reviewed regularly to ensure that improvements are not only initiated but embedded for the long term.

Action 1 – Recruitment and Selection

Aim: Eliminate the post-shortlisting appointment gap between White and BME candidates (WRES Indicator 2) and ensure fairness at every recruitment stage.

Key Actions:

- Full review of end-to-end recruitment – job descriptions, essential criteria, advertising channels, and interview formats – to identify and remove structural barriers.
- Mandatory inclusive recruitment training for all recruiting managers, covering bias mitigation, reasonable adjustments, and cultural competence.

- Diverse recruitment panels as standard for all Band 7+ posts and high-volume recruitment, with panel diversity recorded in ESR.
- Live recruitment monitoring dashboard – monthly tracking of shortlisting and appointment rates by ethnicity, reported to the Workforce Committee and staff networks.
- Post-interview candidate feedback loop to identify recurring barriers and improve applicant experience.

Timeframe: These actions are already in the Inclusion and Belonging Strategy Action Plan with the aim to implement all by early 2026.

Action 2 – Bullying, Harassment and Discrimination

Aim: Reduce disparity in experiences of harassment, bullying, or discrimination from both patients/public (WRES 5) and staff (WRES 6 & 8).

Key Actions:

- Trust-wide zero tolerance campaign, visible to staff, patients, and visitors, with clear behavioural expectations and senior leadership endorsement.
- Streamlined reporting system with improved accessibility, confidentiality, and follow-up for reporters.
- Quarterly trend analysis of incidents by protected characteristic to enable early, targeted interventions.

Timeframe: These actions are already in the Inclusion and Belonging Strategy Action Plan with the aim to implement all by early 2026.

Action 3 – Career Progression and Professional Development

Aim: Increase BME staff confidence in career progression opportunities (WRES 7) and ensure equitable access to CPD (WRES 4).

Key Actions:

- Structured career conversations embedded in annual appraisals, with prompts to explore aspirations, barriers, and targeted support.
- Mentoring and sponsorship programmes for BME staff, including senior leader shadowing and Board observation opportunities.
- Clear promotion criteria for every band, with application guidance and examples of successful progression pathways.

Timeframe: These actions will be added to the Inclusion and Belonging Strategy Action Plan and will be completed by the end of March 2026.

Baker, Abi
06/10/2025 12:40:16

Annex A

WRES Indicator	2021/22	2022/23	2023/24	2024/25
Indicator 1 Percentage of staff in each of the AfC Bands 1-9 or Medical & Dental subgroups and VSM (including Executive Board members) compared with the % of staff in the overall workforce	White: 3486 BME: 564 Unknown: 199 Total staff: 4249 Overall BME %: 13.27	White: 3564 BME: 679 Unknown: 186 Total staff: 4429 Overall BME %: 15.33	White: 3693 BME: 905 Unknown: 231 Total staff: 4829 Overall BME %: 18.74	White: 3664 BME: 1033 Unknown: 72 Total staff: 4769 Overall BME %: 21.65
Indicator 2 Relative likelihood of being appointed from shortlisting across all posts <i>Relative likelihood of White staff being appointed from shortlisting compared to BME staff</i>	White: 1324 (69%) BME: 427 (68%) Difference: 1% Likelihood ratio: 1.01	White: 1122 (44%) BME: 263 (29%) Difference: 15% Likelihood ratio: 1.51	White: 928 (25%) BME: 384 (4%) Difference: 21% Likelihood ratio: 5.57	White: 1325/446 (33.7%) BME: 1119/123 (11%) Difference: 22.7% Likelihood ratio: 3.06
Indicator 3 The relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation <i>Relative likelihood of BME staff entering the formal disciplinary process compared to White staff</i>	White: 17 (1%) BME: 3 (1%) Difference: 0% Likelihood ratio: 1	White: 17 (0.4%) BME: 6(0.8%) Difference: 0% Likelihood ratio: 0	White: 17 (0.46%) BME: 5 (0.55%) Difference: 0.09% Likelihood ratio: 1.2	White: 8 (0.22%) BME: 3 (0.30%) Difference: 0.08% Likelihood ratio: 1.38
Indicator 4	White: 1573 (57%)	White: 2779 (77%)	White: 2156 (58.38%)	White: 2167 (59.14%)

Relative likelihood of staff accessing non-mandatory training and CPD Relative likelihood of White staff accessing non-mandatory training & CPD compared to BME staff	BME: 316 (60%) Difference: 3% Likelihood ratio: 0.95	BME: 503 (74%) Difference: 3% Likelihood ratio: 1.05	BME: 651 (71.93%) Difference: 13.55% Likelihood ratio: 0.81	BME: 693 (67.06%) Difference: 7.92% Likelihood ratio: 0.93
Indicator 5 % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	White: 24.5% BME: 34% Difference: 9.5%	White: 25% BME: 29.8% Difference: 4.8%	White: 18% BME: 22% Difference: 4%	White: 18.8% BME: 28% Difference: 9.2%
Indicator 6 % of staff experiencing harassment, bullying or abuse from staff in the last 12 months	White: 26.0% BME: 29.1% Difference: 3.1%	White: 24.9% BME: 32.4% Difference: 7.5%	White: 22.6% BME: 25.8% Difference: 3.2%	White: 21.2% BME: 26.4% Difference: 5.2%
Indicator 7 % of staff believing that the Trust provides equal opportunities for career progression and promotion	White: 62.6% BME: 55% Difference: 7.6%	White: 60.7% BME: 47% Difference: 13.7%	White: 58.1% BME: 59.3% Difference: 1.2%	White: 56.2% BME: 56.6% Difference: 0.4%
Indicator 8 In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/Team Leader or other colleagues	White: 5.6% BME: 18.7% Difference: 13.1%	White: 6.1% BME: 16.6% Difference: 10.5%	White: 7.8% BME: 18% Difference: 10.2%	White: 6.6% BME: 16% Difference: 9.4%
Indicator 9 % difference between the organisation's Board	White: 93% Difference: 13%	White: 91% Difference: 10%	White: 71.43% Difference: -5%	White: 92.9% Difference: -7.0%

voting membership & its overall workforce	BME: 7% Difference: -8%	BME: 8.3% Difference: - 4.2%	BME: 7.14% Difference: - 12%	BME: 7.10% Difference: - 14.9%

Baker, Abi
06/10/2025 12:40:16

Dorset HealthCare

Workforce Race Equality Standard Report

2024-25

Baker, Abi
06/10/2025 12:40:16

Author	Manpreet Aujla-Gudgeon (Equality, Diversity and Inclusion Lead)
Purpose of Report	This report sets out our 2024/2025 data and action plan against the Workforce Race Equality Standard (WRES) metrics.

Executive Summary

This report sets out Dorset HealthCare’s annual performance against the WRES metrics for 2024/2025. The WRES sets out a national framework through which Trusts are required to measure their performance against nine key indicators for staff representation and experience regarding race. These include workforce indicators (1-4), Staff Survey indicators (5-8) and an indicator based on Board representation (9):

Indicator	Description	2022/23 result	2023/24 result	2024/25 result
1	Percentage of black and minority ethnic (BME) staff	7.8%	8.56%	9.53%
2	Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants	White applicants are 3.08 times more likely	White applicants are 5.95 times more likely	White applicants are 3.01 times more likely
3	Relative likelihood of BME staff entering the formal disciplinary process compared to white staff	BME staff are 2.16 times more likely	BME staff are 2.14 times more likely	BME staff are 2.16 times more likely
4	Relative likelihood of white staff accessing non-mandatory training and continuous professional development (CPD) compared to BME staff	White staff are 1.03 times more likely	White staff are 0.91 times less likely	White staff are 0.98 times less likely
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White: 22.7% BME: 25.6%	White: 18.4% BME: 29.9%	White: 17.5% BME: 27.8%
6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White: 14.7% BME: 16.8%	White: 14.6% BME: 21.3%	White: 14.2% BME: 15.6%
7	Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion	White: 60.6% BME: 52.7%	White: 59.6% BME: 49.3%	White: 61.0% BME: 54.5%
8	Percentage of staff personally experiencing discrimination at work from	White: 4.5% BME: 8.4%	White: 4.2% BME: 16.1%	White: 4.2% BME: 10.9%

	a manager/team leader or other colleagues			
9	BME board membership	13.3%	18.2%	6.7%

Key findings

Overall, we have seen improvements in **six indicators** and negative movement in **three indicators** compared to 2023/24.

Background

The [NHS Equality and Diversity Council](#) announced on 31 July 2014 that it had agreed action to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. This was in response to the 2014 study by Roger Kline titled ‘The snowy white peaks of the NHS’, which highlighted the link between good patient care and an NHS workforce that is representative of the local population it serves. The WRES came into effect on 1 April 2015 and is now mandated as part of the standard NHS Contract – it supports closer scrutiny of the progress we make and outcomes we achieve, but more importantly, supports the wellbeing of the overall workforce. The data will be published on our public website, along with our action plan, in line with regulatory requirements. Please note, the WRES uses the term ‘BME’, however, we prefer the use of the term ethnic minority at Dorset HealthCare because BME or BAME emphasises certain ethnic minority groups and excludes others. For the purposes of this report, our narrative will use the term ethnic minority, but the indicators used by the WRES will still refer to BME as per the WRES technical guidance.

Data sources

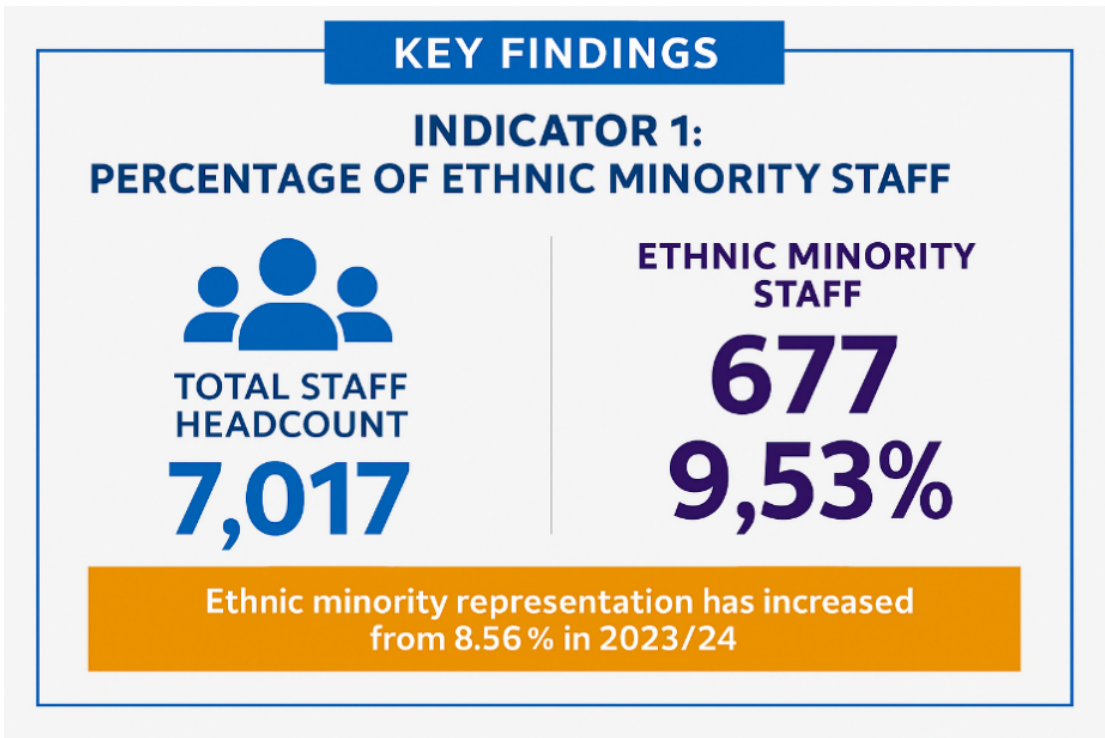
- Indicator 1 is based on data recorded on ESR on snapshot date: 31 March 2025
- Indicator 2 is based on known data TRAC for the period 1 April 2024 to 31 March 2025
- Indicator 3 is based on known data from HR records for the period 1 April 2024 to 31 March 2025
- Indicator 4 to 9 are based on the NHS Survey data which was collected over a two-month period from early October to early December 2024 (the NHS Staff Survey Results were released on 13 March 2025)
- Indicator 10 is based on data recorded on ESR on snapshot date: 31 March 2025

Baker, Abi
06/10/2025 12:40:16

Analysis of data

Indicator 1: Percentage of black and minority ethnic (BME) staff

The data in 2024/25 shows our total staff headcount is 7017. We currently employ 677 staff from an ethnic minority background, and they represent **9.53%** of our workforce. Our ethnic minority representation has increased from **8.56%** in 2023/24. According to the 2021 Census, the ethnic minority community comprises of around 8.7%¹ of the population in Bournemouth, Christchurch and Poole (BCP), compared to approximately 2.9%² in the wider Dorset Council area. This highlights the varying levels of diversity across the county and underscores the importance of tailored approaches to representation, leadership development and progression pathways for underrepresented groups.

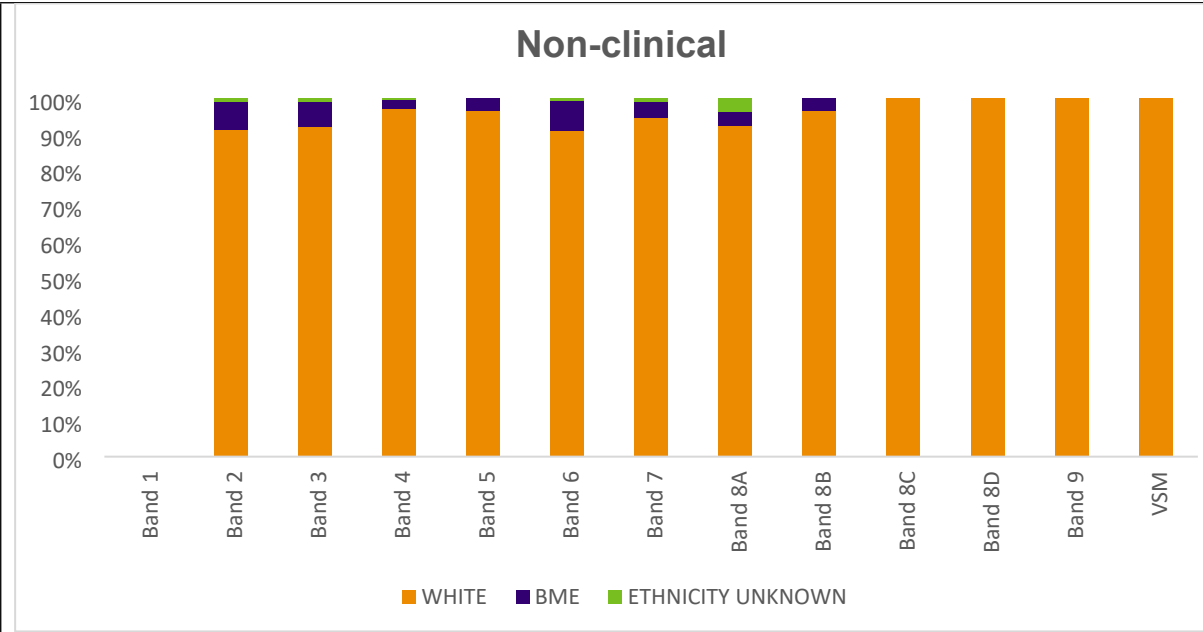


When looking at representation across all levels, greater representation of ethnic minority staff can be seen across bands in the clinical workforce, compared with the non-clinical workforce. Ethnic minority staff make up only **6.0%** of the non-clinical workforce, significantly below the organisational average (9.53%), whereas representation in clinical areas is stronger at **11.01%**, above the organisational average.

Baker, Abi
06/10/2024
13:36

¹ <https://www.ons.gov.uk/visualisations/censusareachanges/E06000058/>; [Regional ethnic diversity - GOV.UK Ethnicity facts and figures](#)

² [How life has changed in Dorset: Census 2021](#)



According to workforce data, individuals from ethnic minority backgrounds make up 9.53% of the overall workforce. When comparing this benchmark to the distribution of ethnic minority staff across non-clinical bands, the following patterns emerge:

Proportional Representation

- Bands 2 (8.0%), Band 3 (6.9%), and Band 6 (8.4%) show ethnic minority representation that is broadly in line with or approaching the overall workforce figure.
- These bands reflect reasonable inclusivity at the lower to mid-range levels.

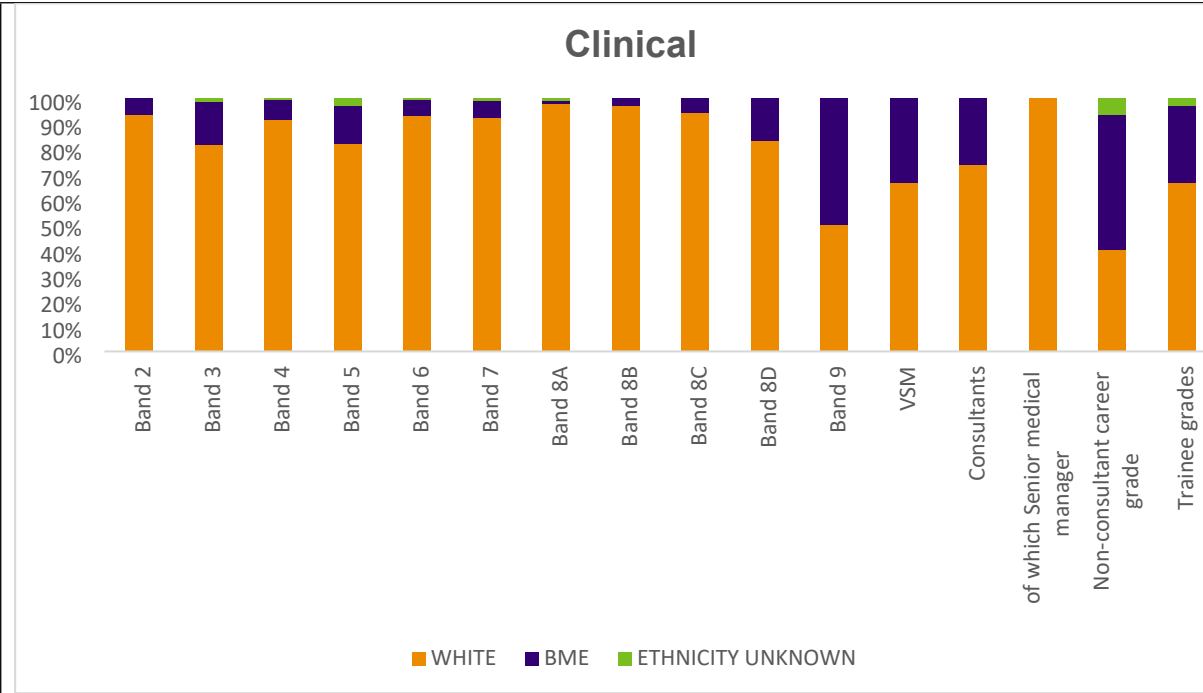
Underrepresentation in Progression Bands

- Bands 4, 5, 7, 8a, and 8b display notably lower ethnic minority representation, ranging from 2.7% to 4.3%, suggesting reduced representation as roles become more senior.
- This drop may indicate barriers to progression or gaps in career development support for minority ethnic staff.

Zero Representation at Senior Levels

- At Bands 8c and above (including V/SM), ethnic minority representation is 0%, highlighting a complete absence of ethnic diversity at the most senior levels of the non-clinical workforce.
- These figures suggest a need for targeted leadership development, sponsorship, and succession planning to support greater inclusion at the top.

Baker, Abi
06/10/2025 12:40:16



Proportional Representation

- As of 31st March 2025, clinical roles account for 5,001 staff across the organisation.
- 551 of these (11.01%) are from ethnic minority backgrounds – higher than the overall workforce average of 9.53%.
- This suggests a stronger level of ethnically diverse staff within clinical roles compared to non-clinical areas.
- Key areas of high diversity include:
- Band 5: 182 staff from ethnic minority backgrounds (17.27%), significantly above average; reflects strong diversity in frontline clinical roles.
- Medical & Dental Career Grade: 130 ethnic minority staff (39.88%) – very high representation.
- Medical & Dental Trainees: 80 ethnic minority staff (36.20%) – strong early-career diversity in medical professions.

Underrepresentation in Progression Bands

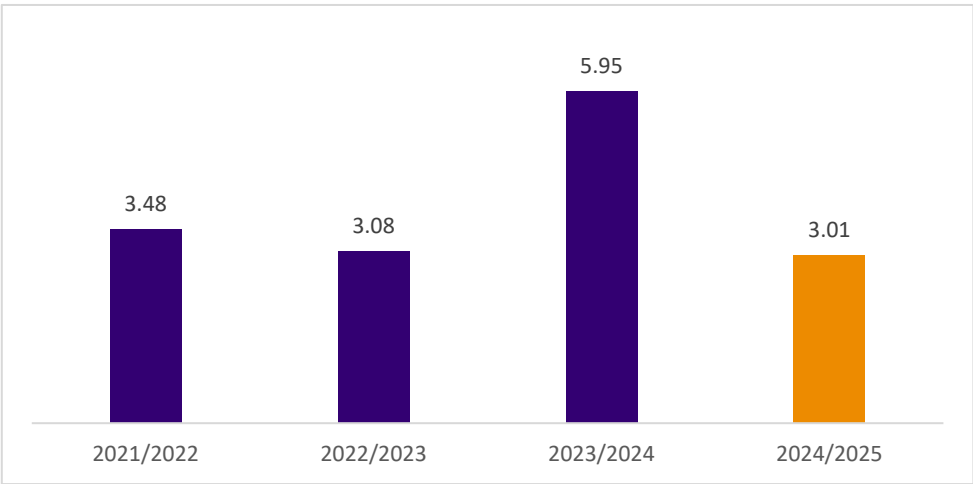
- Despite strong diversity at entry and early-career levels, staff from ethnic minority backgrounds are underrepresented as pay bands increase.
- Representation starts to decline after Band 6, with lower proportions observed in Bands 7 and above.
- In Bands 8a–8b, the proportion of staff from ethnic minority backgrounds falls closer to or below the organisational average.
- By Bands 8c and 8d, only two staff from ethnic minority backgrounds are present in each – a significant drop from earlier career stages.
- These trends indicate possible barriers to progression and highlights the need for focused support and fair access to leadership development.

Representation at Senior Levels

- At the VSM level, there are currently no staff from ethnic minority backgrounds, reflecting a lack of ethnic diversity at the executive level.
- Among Consultants, 16 out of 159 (10.06%) are from ethnic minority backgrounds – roughly aligned with the overall workforce average.

- However, this does not reflect the high levels of ethnic diversity seen among trainees and medical career grades.
- This suggests that although ethnically diverse staff are entering clinical professions in strong numbers, they are not progressing into senior roles at the same rate.
- Addressing this disparity is key to creating a more inclusive leadership pipeline and improving representation at decision-making levels.

Indicator 2: Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants



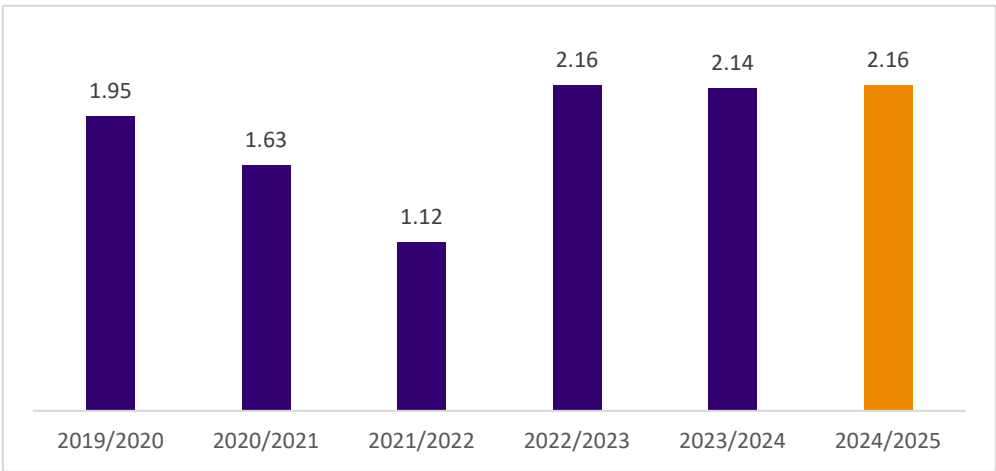
In 2024/2025, the relative likelihood of white applicants being appointed from shortlisting compared to ethnic minority applicants was **3.01**. This represents a significant improvement from **5.95** in 2023/24, although it remains slightly lower than the **3.08** recorded in 2022/23. While the disparity persists, the decrease suggests that early interventions are beginning to have an impact. Reducing this gap continues to be a key priority for the Trust. In response to last year's sharp increase, we implemented a number of interventions aimed at promoting fairness and inclusivity in recruitment.

These include:

- The recent launch of Inclusive Recruitment Training aimed at hiring managers, designed to raise awareness of bias, improve equitable decision-making, and ensure consistent, inclusive recruitment practice. To date, 56 managers have completed the training, although limited capacity remains a challenge for scaling it across the organisation.
- We will introduce a process to ensure Diverse Interview Panels, starting with Band 8+ roles, with plans to extend to Band 6+ by Year 3 of the intervention.
- We will continue to monitor recruitment data via TRAC and ESR and remain committed to creating fair and equitable processes for all applicants.

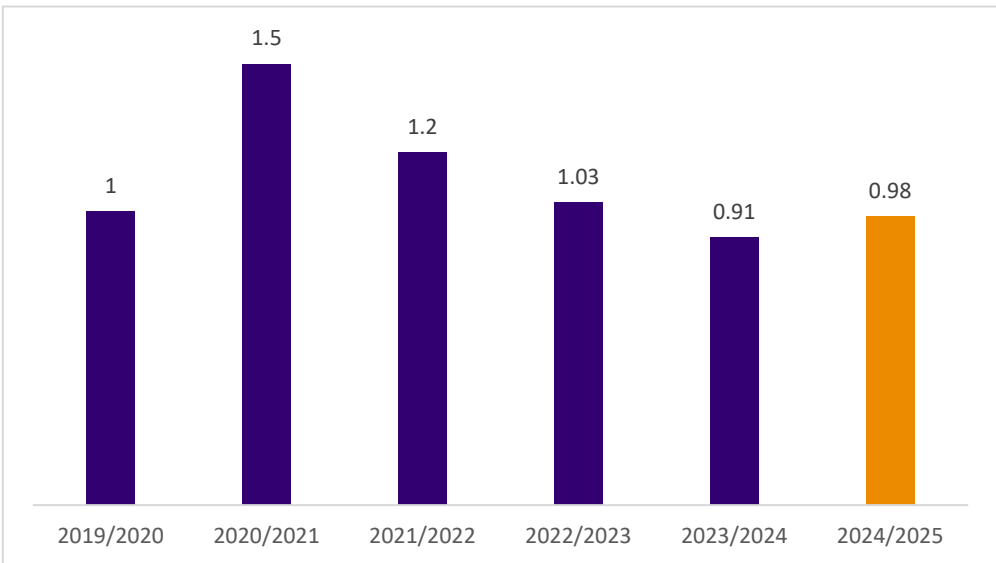
While we can't yet assess longer-term trends due to the accuracy of the data before 2021/22, our recent progress shows our commitment to a transparent, fair, and inclusive recruitment process. We will continue refining our approach, engaging with staff networks, and closely reviewing data to further reduce disparities in the coming year.

Indicator 3: Relative likelihood of BME staff entering the formal disciplinary process compared to white staff



The relative likelihood of ethnic minority staff entering the formal disciplinary process has increased slightly to **2.16** in 2024/25, up from **2.14** in 2023/24. While the overall number of cases remains small, we have seen a rise in total disciplinary cases this year. Our HR team continues to use the Employee Relations tracker to strengthen data capture across both informal and formal cases, supporting better monitoring and analysis. We are also working with our Multicultural Staff Network and Freedom to Speak Up Guardians to better understand the factors contributing to these outcomes. To help mitigate potential bias, Conscious Inclusion and Inclusive Leadership training is now mandatory for all line managers. In addition, we have recently piloted a new triage form to support the initial assessment of potential conduct concerns. This tool is designed to promote a fair, transparent, and consistent approach to decision-making, aligned with our commitment to a Just and Learning Culture and informed by the Mersey Care Decision Tree.

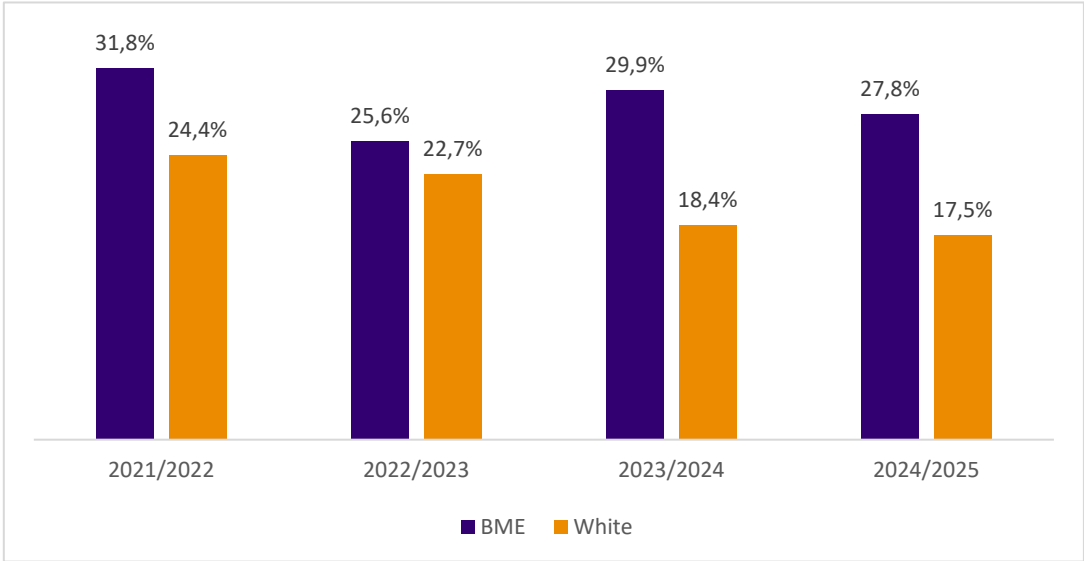
Indicator 4: Relative likelihood of white staff accessing non-mandatory training and continuous professional development (CPD) compared to BME staff



Baker, Abi
06/10/2025 12:40:16

The relative likelihood moved closer to parity, with White staff **0.98** times less likely than ethnic minority staff to access non-mandatory training and CPD, compared to **0.91** times less likely in 2023/24. While this suggests improved equity, higher uptake among ethnic minority staff may reflect targeted development initiatives, proactive engagement, or a perceived need to upskill to progress. We remain focused on ensuring equal access and outcomes for all staff and will continue to monitor this data and engage with staff to understand their experiences

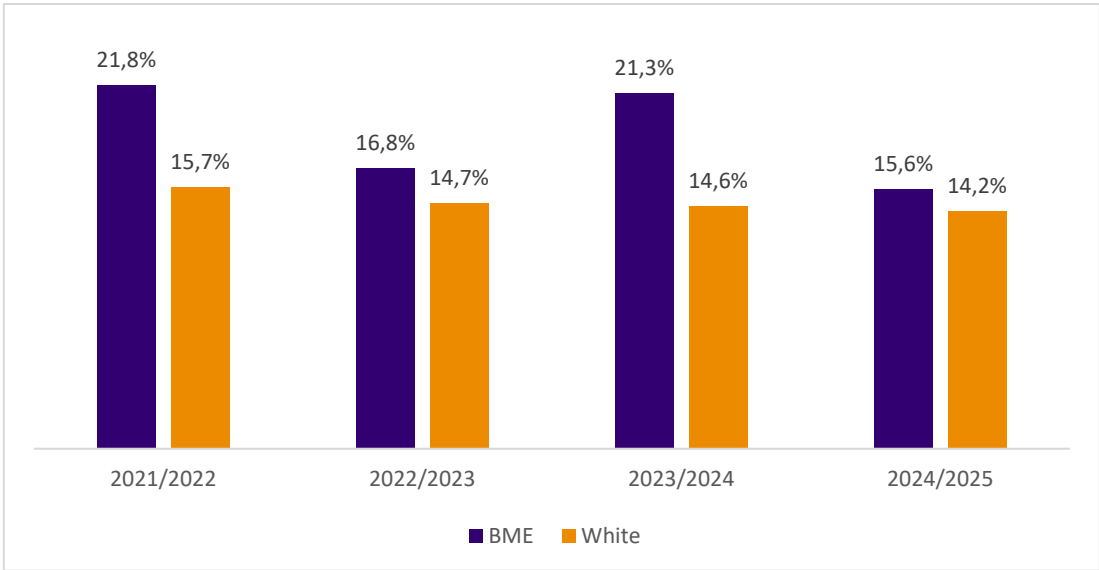
Indicator 5: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months



In 2024/25, **27.8%** of staff from ethnic minority backgrounds reported experiencing harassment, bullying or abuse from patients, relatives or the public, a slight improvement from **29.9%** in 2023/24. This remains notably higher than the **17.5%** reported by white staff (down from **18.4%**). While these changes represent a positive trajectory, the 10.3 percentage point gap between ethnic minority and white staff remains significant, reinforcing the need for continued focus and accountability. In response, we launched a Violence, Aggression and Discrimination Task and Finish Group in October 2023 to analyse data, improve reporting, and ensure support for affected staff. Key actions have included mandating Conscious Inclusion and Inclusive Leadership training for managers and developing guidance for managers on supporting staff facing these unacceptable behaviours, developed in collaboration with the Nursing and Quality and SAFE teams. We will be launching this guidance in September 2025 through listening events, marking one year since the race-related incidents in the UK last year and reinforcing our commitment to a respectful, inclusive working environment.

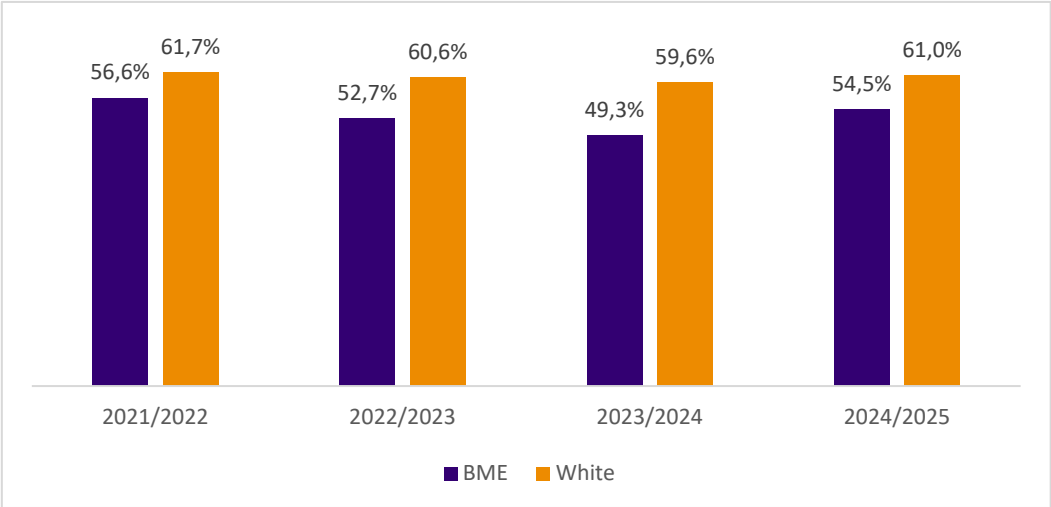
Our SAFE (Security and Fraud Experts) Team continues to play a critical role in responding to significant incidents. Their actions include engaging directly with service users to address inappropriate behaviour, helping them understand the impact of their actions, issuing formal warnings, and, when necessary, involving the Police where the criminal threshold has been met.

Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months



In 2024/25, **15.6%** of staff from ethnic minority backgrounds reported experiencing harassment, bullying or abuse from other staff, a notable decrease from **21.3%** in 2023/24. For white staff, the figure remained relatively stable at **14.2%**, down slightly from **14.6%**. Although the disparity between ethnic minority and white staff has narrowed, the overall prevalence for all staff remains a concern. This issue has been a focus of the Trust's Violence, Aggression and Discrimination Task and Finish Group, which also addressed staff-on-staff behaviour. Key actions include establishing clearer consequences for staff who engage in such behaviour, reinforced by a public zero-acceptance statement from the Chief Executive, as outlined in our Joint Inclusion and Belonging Strategy. We also are embedding the Respect and Resolution Policy, which offers clearer guidance on how to report incidents and how allegations will be managed. These measures aim to embed a culture of inclusion, accountability and psychological safety across all teams.

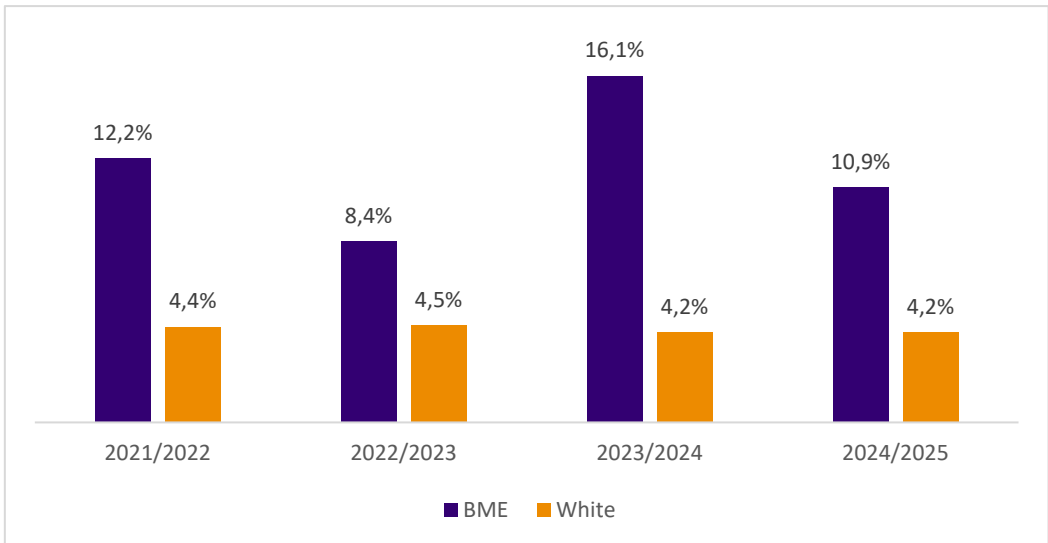
Indicator 7: Percentage of staff believing that trust provides equal opportunities for career progression or promotion



In 2024/25, **54.5%** of staff from ethnic minority backgrounds believed there are equal opportunities for career progression, up from **49.3%** in 2023/24. For white staff, the figure

also increased from **59.6%** to **61.0%**. While the gap has narrowed slightly, a disparity remains. To address this, we recently completed our third cohort of the Reciprocal Mentoring Programme, aimed at increasing senior leaders' awareness of the barriers faced by underrepresented groups. This is supported by mandated Conscious Inclusion and Inclusive Leadership training for line managers, promoting fair and unbiased decision-making around progression. We continue to celebrate success stories, including visible role models from ethnically diverse backgrounds, to build aspiration and trust. Future talent interventions, including upcoming mentoring cohorts, will be monitored to ensure they remain effective and inclusive.

Indicator 8: Percentage of staff personally experiencing discrimination at work from a manager/team leader or other colleagues



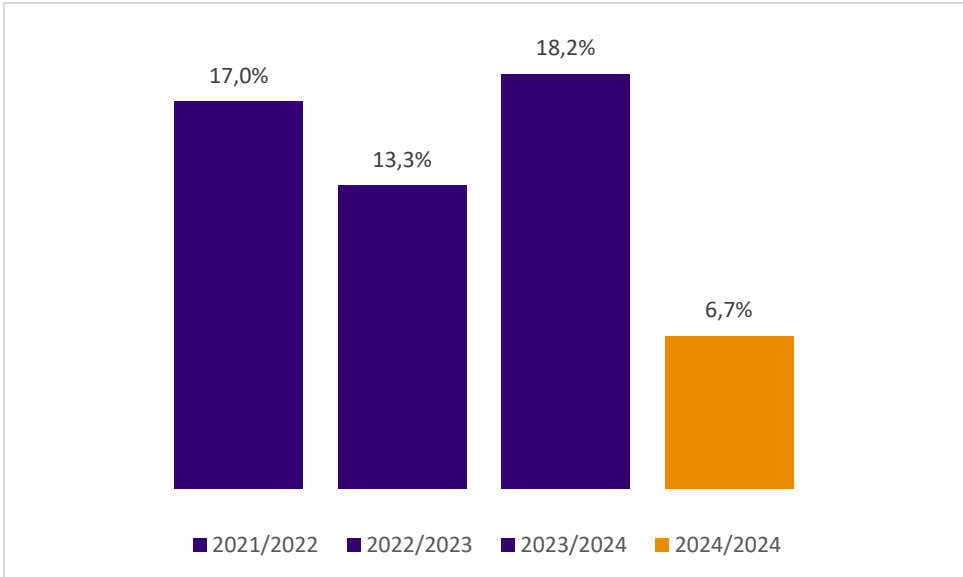
In 2024/25, **10.9%** of staff from ethnic minority backgrounds reported experiencing discrimination at work from a manager, team leader, or colleague, a reduction from **16.0%** in 2023/24. For white staff, the figure remains unchanged at **4.2%**. While the decrease is welcome, the disparity between ethnic minority and white staff remains a concern. To address this, we have implemented system-wide Conscious Inclusion and Inclusive Leadership training for line managers to tackle bias and support inclusive team cultures. We are also promoting the use of mediation services, Freedom to Speak Up Guardians, and Staff Networks, while embedding our Respect and Resolution Policy to ensure clear, fair processes for raising and addressing concerns. Additionally, we continue to support internationally recruited staff and their managers, ensuring respectful induction and integration into the workforce, with a focus on professionalism and cultural inclusion.

Indicator 9: BME board membership

As of 31st March 2025, ethnic minority representation on the organisation's voting Board is **6.7%**, compared to 9.5% in the overall workforce – a 2.8-percentage point shortfall which highlights underrepresentation at the most senior level. This represents a decrease from **18.2%** in 2023/24, due to one ethnically diverse Board member leaving (reducing

representation from 2 members to 1, and based on the number of board members employed directly by Dorset HealthCare each person represents 7.7%).

While interventions such as diverse recruitment panels for Board appointments have been introduced, this change highlights the importance of maintaining focus on inclusive senior leadership recruitment and retention. Going forward, we will continue to strengthen our talent pipelines for senior and Board-level roles, with an emphasis on progression, succession planning, and ensuring sustained representation of underrepresented groups.



Next steps

A key priority this year has been embedding our first joint Inclusion and Belonging Strategy in partnership with Dorset County Hospital. This strategy includes an overarching action plan that consolidates all our activity under NHS England’s statutory EDI reporting obligations, including the WRES.

- **Leadership and Training:** Dorset HealthCare has taken the lead in designing and implementing system-wide Conscious Inclusion and Inclusive Leadership training for line managers. This training is now mandatory for all line managers, with 304 of our staff trained to date and a further 311 booked on to our remaining 2025 dates.
- **Respect & Resolution Policy:** We continue to embed our Respect & Resolution Policy for staff-on-staff incidents. This policy marks a significant step in fostering a culture of psychological safety, encouraging colleagues to speak up, and reinforcing our zero-acceptance approach to unwanted behaviours.
- **Guidance on Unacceptable Behaviours:** In collaboration with our Nursing and Quality and SAFE Team, we have developed guidance for managers on how to support staff experiencing unacceptable behaviour from patients or visitors.
- **Reciprocal Mentoring:** We concluded our third Reciprocal Mentoring Programme in July 2025, continuing our commitment to shared learning and leadership development. We will consider suggestions put forward by participants to ensure their voices have been heard.
- **Staff Networks:** We continue to support our Multicultural Staff Network with their activity (e.g., relaunch event, attendance at Dorset Mela and plans for Black History Month in October 2025. As well as the invaluable peer support they provide to staff from ethnically diverse backgrounds).

Baker, Abi
06/10/2025 12:40:16

- **Inclusive Recruitment:** We have reviewed the recruitment and induction processes to ensure equality and diversity are embedded. This has included the launch of Inclusive Recruitment training for hiring managers.

Key actions for 2025/26 will include:

- **Inclusive Recruitment:** we will launch the Diverse Recruitment Panels intervention starting with all roles Band 8+, with plans for Band 6+ by year 3 at the start of 2026.
- **Guidance on Unacceptable Behaviours:** the guidance has now been approved by senior leaders with plans to launch and socialise the guidance in September 2025 through listening events and communications including a statement from our Chief Executive.
- **Zero Acceptance Culture:** Continued promotion of zero-acceptance of behaviours that undermine inclusion and respect.
- **Staff Education:** Ongoing focus on embedding compassionate, inclusive, professional and respectful behaviour towards all colleagues is not only expected, but essential.
- **Public engagement:** Strengthening communication with patients, visitors, and the community to promote respectful behaviour towards staff.
- **Talent development:** Establishing career progression pathways for underrepresented groups.
- **Training:** We have designed Active Bystander eLearning, with plans to launch it in collaboration with our Sexual Safety work in late 2025.
- **New Appraisal Process:** Embedding the new process, which includes a more flexible approach within a defined framework, with enhanced objective setting and dedicated career/development conversations, ensuring individual strengths and aspirations are recognised. Supports fairer access to progression planning and development opportunities, which will support underrepresented staff groups.

Conclusion

This year's WRES data shows some positive movement, including improved perceptions of equal opportunity and reduced reports of discrimination from colleagues and patients. However, it also highlights a persistent disparity between ethnic minority and white staff, particularly in relation to workplace treatment, progression, and overall experience. Significant challenges remain, especially around ethnic minority representation at senior levels and continued inequalities in experiences of discrimination and harassment.

Key interventions such as Reciprocal Mentoring, Conscious Inclusion and Inclusive Leadership training and the Respect and Resolution Policy are beginning to make an impact. However, the sharp decline in board-level diversity highlights the need for renewed focus on leadership pipelines and accountability.

We remain committed to creating a fair, inclusive, and respectful workplace. Sustained cultural and structural action will be essential to achieving long-term change and ensuring all staff feel included, valued and supported.

Recommendation	The Board and Joint People & Culture Committee in Common are asked to note the Workforce Race Equality Standard data, action plan, and next steps.

Baker, Abi
06/10/2025 12:40:16

Indicator 5 % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	White: 21% BME: 32% Difference: 11%	White: 23% BME: 29% Difference: 6%	White: 24% BME: 32% Difference: 28%	White: 23% BME: 26% Difference: 3%	White: 18% BME: 30% Difference: 12%	White: 18% BME: 28% Difference: 10%
Indicator 6 % of staff experiencing harassment, bullying or abuse from staff in the last 12 months	White: 17% BME: 24% Difference: 7%	White: 13% BME: 13% Difference: 0%	White: 17% BME: 15% Difference: 2%	White: 15% BME: 17% Difference: 2%	White: 15% BME: 21% Difference: 6%	White: 14% BME: 16% Difference: 2%
Indicator 7 % of staff believing that the Trust provides equal opportunities for career progression and promotion	White: 91% BME: 87% Difference: 4%	White: 91% BME: 85% Difference: 6%	White: 57% BME: 62% Difference: 5%	White: 61% BME: 53% Difference: 8%	White: 60% BME: 49% Difference: 11%	White: 61% BME: 55% Difference: 6%
Indicator 8 In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/Team Leader or other colleagues	White: 4% BME: 9% Difference: 5%	White: 5% BME: 12% Difference: 7%	White: 4% BME: 12% Difference: 8%	White: 4% BME: 8% Difference: 4%	White: 4% BME: 16% Difference: 12%	White: 4% BME: 11% Difference: 7%
Indicator 9 % difference between the organisation's Board voting membership & its overall workforce	White: 95% BME: 5%	White: 87% BME: 13%	White: 83% BME: 17%	White: 82% BME: 18%	White: 93% BME: 7%	White Voting board: 93.3% Overall workforce: 90.5% BME: Voting board: 6.7% Overall workforce: 9.5%

Baker, Abi
06/10/2025 12:40:16

Appendix 2: DHC's Workforce Metrics (Indicator 1)

	MEASURE	WHITE	BME	UNKNOWN/NULL
1a) Non-Clinical workforce		Verified figures	Verified figures	Verified figures
Under Band 1	Headcount	0	0	0
Band 1	Headcount	0	0	0
Band 2	Headcount	420	37	4
Band 3	Headcount	716	54	8
Band 4	Headcount	322	9	1
Band 5	Headcount	189	7	0
Band 6	Headcount	130	12	1
Band 7	Headcount	89	4	1
Band 8A	Headcount	48	2	2
Band 8B	Headcount	27	1	0
Band 8C	Headcount	11	0	0
Band 8D	Headcount	3	0	0
Band 9	Headcount	4	0	0
VSM	Headcount	4	0	0
1b) Clinical workforce of which Non-Medical				
Under Band 1	Headcount	0	0	0
Band 1	Headcount	0	0	0
Band 2	Headcount	28	2	0
Band 3	Headcount	859	182	13
Band 4	Headcount	411	35	3

Band 5	Headcount	750	141	26
Band 6	Headcount	1195	77	8
Band 7	Headcount	693	49	7
Band 8A	Headcount	250	3	3
Band 8B	Headcount	66	2	0
Band 8C	Headcount	16	1	0
Band 8D	Headcount	5	1	0
Band 9	Headcount	2	2	0
VSM	Headcount	2	1	0
<i>Of which Medical & Dental</i>				
Consultants	Headcount	53	19	0
<i>of which Senior medical manager</i>	Headcount	1	0	0
Non-consultant career grade	Headcount	12	16	2
Trainee grades	Headcount	44	20	2
Other	Headcount	0	0	0
Number of staff in overall workforce	Headcount	6349	677	81
Overall workforce - % by Ethnicity	Headcount	89.33%	9.53%	1.14%

Baker, Abi
06/10/2025 12:40:16

Appendix 3: 2025-2026 WRES Action Plan

Trust	Dorset HealthCare University NHS Foundation Trust	
Year	2025	
Primary author of the action plan	Manpreet Aujla-Gudgeon (Equality, Diversity and Inclusion Lead)	
Sources of information underpinning the plan	WRES data, Staff Survey, National reports, NHS equality, diversity, and inclusion improvement plan	
WRES Indicator	Actions 2025/26	Owner(s)
Indicator 2 Likelihood of being appointed from shortlisting across all posts	• Improve diverse panel compositions and interview questions through collaboration with staff networks to ensure ethnic minority perspectives are embedded in recruitment and selection processes, supporting fairer outcomes • Deliver new Inclusive Recruitment training to all recruiting Managers including focusing on eliminating bias and improving equitable outcomes for candidates from ethnic minority backgrounds • Review advertising and shortlisting processes for all Board appointments including advertising and shortlisting practices, to ensure fairness, transparency, and improved representation of ethnic minority candidates • EDI question at every interview to assess candidates' understanding and commitment to inclusion, helping to build a leadership culture that values diversity.	Recruitment Staff Network Chairs EDI
Indicator 3 Staff entering formal disciplinary process	• Year on year reduction in the percentage of ethnic minority staff involved in disciplinary procedures • Continue roll out of Conscious inclusion and Inclusive Leadership training for line managers • Monitor data following launch of our Respect and Resolution Policy	Human Resources EDI

Indicator 4 Staff accessing non-mandatory training and CPD	• Review and measure success of third cohort of our Reciprocal Mentoring Programme • Promote all opportunities across the workforce, with a particular focus on the take up of development opportunities by females, ethnic minority staff and staff with a disclosed disability to ensure an equitable workforce. • Embed career conversations as part of the annual performance appraisal process	EDI
Indicator 5 Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	• Embed Zero Acceptance: Promote zero acceptance of bullying, harassment, discrimination, and violence, supported by a Chief Executive statement and staff guidance • Maintain Partnerships: Continue collaboration with the SAFE Team and Dorset Police • Encourage Reporting: Work with Freedom to Speak Up Guardians to support staff in raising concerns. • Deliver Action Plan: Complete and implement actions from the Task and Finish Group to improve reporting and staff support (e.g. Launch managers guidance for supporting staff who experience unacceptable behaviours) • Monitor Data: Continue reviewing Ulysses data to identify trends and guide improvement	Human Resources EDI SAFE Team Nursing and Quality
Indicator 6 Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	• Embed zero acceptance approach to reduce bullying, harassment, discrimination and violence to ensure staff feel safe to come to work • Identify themes and hotspots for colleague-on-colleague • Complete action plan following Task and Finish Group to ensure incidents are reported and staff are supported • Continue to monitor data to identify themes and hotspots for colleague-on-colleague harassment, bullying or abuse • Continue to embed Respect and Resolution policy	Human Resources EDI FTSUG

Baker, Abi
06/10/2025 12:40:16

Indicator 7 Percentage believing that trust provides equal opportunities for career progression or promotion	• Review and measure success of third cohort of our Reciprocal Mentoring Programme • Embed career conversations as part of the annual performance appraisal process • Deliver mandated Conscious Inclusion and Inclusive Leadership training for line managers • Deliver EDI content in the manager's induction programme • Promote all opportunities across the workforce, with a particular focus on the take up of development opportunities by females, ethnic minority staff and staff with a disclosed disability to ensure an equitable workforce.	EDI Organisational Development
Indicator 8 In the last 12 months have you personally experienced discrimination at work from any of the following: Manager/team leader or other colleagues	• Include an EDI objective in yearly appraisals to ensure every leader demonstrates their commitment to inclusion and fairness • Launch Active bystander eLearning	FTSUG Human Resources EDI
Indicator 9 Percentage difference between the organisations' board voting membership and its overall workforce	• Increase in staffing levels more reflective of diversity of local communication and regional/national labour markets • Use of diverse panels for all senior appointments, starting with all roles Band 8+	Recruitment

Baker, Abi
06/10/2025 12:40:16

Dorset County Hospital

Workforce Disability Equality Standard

Report

2024-25

Baker, Abi
06/10/2025 12:40:16

1.0 Introduction

The Workforce Disability Equality Standard (WDES) Report for 2024–25 sets out Dorset County Hospital’s progress and priorities in building a truly inclusive and equitable workplace for colleagues with disabilities. It reflects our ongoing commitment to transparency, accountability, and meaningful action, in line with the WDES framework mandated by the NHS Standard Contract.

The WDES provides a clear structure for understanding and improving the workplace experiences and career prospects of disabled staff across the NHS. Its ten metrics draw on a range of sources, including recruitment and HR data, Electronic Staff Record (ESR) workforce information, and the annual NHS Staff Survey. In addition, metric 9b captures the narrative actions taken by the Trust to strengthen the voice and representation of disabled colleagues. Together, these measures enable us to track progress, identify challenges, and take targeted, evidence-based action.

This year’s data, covering the period from 1 April 2024 to 31 March 2025, offers valuable insight into both where we have made gains and where further work is required. We have approached this analysis with a clear aim: to ensure every member of our workforce, regardless of disability status, feels supported, valued, and able to thrive. The findings and actions set out in this report will be published alongside our action plan on the Trust’s public website, in line with our statutory obligations and our wider commitment to openness.

The ten WDES metrics comprise workforce metrics (1-3), Staff Survey metrics (4-9a) and a metric based on Board representation (10), as follows;

1	Percentage of staff in each of the AfC Bands 1-9 or Medical & Dental subgroups and VSM (including Executive Board members) compared with the % of staff in the overall workforce
2	Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts
3	Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.
4	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse I. From patients/service users, their relatives or other members of the public II. From Managers III. From other colleagues
5	Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression and promotion
6	Percentage of Disabled staff compared to non-disabled staff saying they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties
7	Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work

8	Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work
9	NHS Staff Survey and the engagement of Disabled staff <i>Part (a): The engagement score for Disabled staff, compared to non-disabled staff</i> <i>Part (b): Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?</i>
10	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated: <i>(a) By Voting Membership of the Board</i> <i>(b) By Executive membership of the Board</i>

The 2024–25 WDES data for Dorset County Hospital is drawn from disability information recorded in the Trust's Electronic Staff Record (ESR), supported by HR and Staff Survey data. This year, **6.56%** of our workforce have disclosed a disability—continuing the steady upward trend in declaration rates from previous years. While this is encouraging, we recognise that disclosure remains below the true prevalence. Increasing confidence in, and understanding of, self-declaration will remain a focus, so that we can build the clearest possible picture of our workforce and target our actions where they will have the greatest impact.

- **Indicator 1** is based on ESR data as at 31 March 2025.
- **Indicator 2** is based on TRAC recruitment data as at 31 March 2025.
- **Indicator 3** draws on HR records from 1 April 2024 to 31 March 2025.
- **Indicators 4 to 9** are based on the NHS Staff Survey, conducted from early October to November 2024, with results published in March 2025.
- **Indicator 10** is drawn from ESR data as at 31 March 2025.

2.0 Overview of changes since 2023/24 data

Creating an inclusive culture at Dorset County Hospital (DCH) remains central to our joint Inclusion and Belonging Strategy with Dorset HealthCare, developed under our federated alliance. Over the past year, we have seen tangible progress, driven in large part by the work of our *Without Limits* disability staff support network. The network has been instrumental in raising awareness of disability inclusion, shaping and launching the Health Passport and Reasonable Adjustment Policy, and supporting targeted training for line managers, including autism awareness.

3.0 Summary of Results

The data submitted to the national WDES team is included in Annex A.

Metric 1: *Percentage of staff in each of the AfC Bands 1-9 or Medical & Dental subgroups and VSM (including Executive Board members) compared with the % of staff in the overall workforce*

The proportion of staff identifying as having a disability has **risen** from 4.88% in 2023/24 to 6.56% in 2024/25, marking an increase of 1.68 percentage points. Among clinical staff, the

percentage identifying as having a disability has increased from 5.2% in 2023/24 to 7.2% in 2024/25. For non-clinical staff, the figure is now 7.3%, and for Medical & Dental staff, 2.06% have disclosed a disability. These figures reflect a steady improvement in disclosure rates, although they remain below the estimated prevalence of disability in the wider NHS workforce.

Metric 2: *Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts*

The relative likelihood ratio of non-disabled staff being appointed from shortlisting compared to disabled staff has **decreased** further from 0.56 in 2023/24 to 0.41 in 2024/25. This means that disabled applicants are now, on average, more likely to be appointed than their non-disabled counterparts when shortlisted.

Metric 3: *Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.*

The relative likelihood of disabled staff entering the formal capability process has **decreased** from 2.83 in 2023/24 to 0.00 in 2024/25. This means there were no recorded cases during the reporting year involving a member of staff who had disclosed a disability—an encouraging development that suggests improvements in early intervention, support, and performance management processes.

It is important to note that in previous years, high relative likelihoods could be influenced by the small proportion of the workforce who have declared a disability. With very low case numbers, percentage changes can appear large and may not indicate systemic issues.

Note on Metrics 4a- 9a

While ESR records show that **6.56%** of staff have disclosed a disability, Metrics 4–9a are derived from our 2024 NHS Staff Survey, where **30.44%** of respondents identified themselves as disabled or having a long-term condition. These figures represent a significant portion of our staff who took part in the 2024 survey.

Metric 4a: *Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse*

(i) From patients/service users, their relatives or other members of the public

The data shows **a reduction** in the percentage of disabled staff reporting harassment, bullying, or abuse from patients, their relatives, or the public, with 20.5% affected in 2024/25 compared to the previous year's figure. However, the disparity between disabled and non-disabled staff has **increased** slightly, standing at 6.1 percentage points (14.4% for non-disabled staff). This remains a key area of concern, as both staff groups continue to experience unacceptable levels of such behaviour.

(ii) From Managers

The data shows **a reduction** in staff reported experiencing harassment, bullying, or abuse from managers, and **a reduction** in disparity between disabled and non-disabled staff. While the overall proportion of disabled staff affected has decreased compared to the previous year, the gap between disabled and non-disabled colleagues remains significant and warrants

continued focus.

(iii) From other colleagues

In 2024/25, 20.7% of disabled staff reported experiencing harassment, bullying, or abuse from other colleagues — **down** from 24.2% in 2023/24. Among non-disabled staff, the figure was 13.9% (previously 14.3%), resulting in a **disparity of 6.8** percentage points between the two groups (slightly higher than the 6.2 percentage points recorded last year). While the reduction in reports among disabled staff is encouraging, the persistence — and slight widening — of the gap, alongside the still considerable proportion of staff affected, indicates that workplace culture, peer-to-peer respect, and early intervention remain key priorities for the Trust.

Metric 4b: *Percentage of Disabled staff compared to non-disabled staff saying the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it*

In 2024/25, 54.1% of disabled staff said that they or a colleague reported the last incident of harassment, bullying, or abuse at work — **an increase** on the 53.6% recorded in 2023/24, marking the third consecutive year of stable or improving results. Among non-disabled staff, the figure was 58.8% (previously 50.0%), resulting in a disparity of 4.7 percentage points, indicating that disabled staff are less likely to report such incidents than their non-disabled colleagues.

While the stability in reporting rates among disabled staff is positive, the renewed widening of the disparity highlights the need for targeted action to ensure all staff feel equally empowered and supported to raise concerns about inappropriate behaviour.

Metric 5: *Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression and promotion*

In 2024/25, 54.0% of disabled staff said they believe the Trust provides equal opportunities for career progression and promotion — a slight **decrease** from 55.3% in 2023/24. Among non-disabled staff, the figure was 59.1% (previously 59.3%), resulting in a **disparity of 5.1** percentage points, compared with 4.0 percentage points last year.

While both figures remain above the national average for Acute Trusts, the widening gap signals a need for renewed focus on ensuring equitable access to career development, mentoring, and promotion pathways for disabled colleagues. Strengthening inclusive talent management and targeted leadership development opportunities will be key to closing this disparity.

Metric 6: *Percentage of Disabled staff compared to non-disabled staff saying they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties*

In 2024/25, 21% of disabled staff said they had felt pressure from their manager to come to work despite not feeling well enough — **down** from 24.5% in 2023/24. Among non-disabled staff, the figure was 15.8% (previously 14.0%), resulting in a **disparity of 5.2** percentage points (down from 6.5 percentage points last year).

Baker
06/10/2025 12:40:16

The reduction in both the absolute percentage and the disparity is encouraging, suggesting some improvement in sickness management practices. However, continued emphasis on supportive line management, proactive wellbeing conversations, and a culture that prioritises staff health will be essential to sustain and build on this progress.

Metric 7: Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work

In 2024/25, 37.0% of disabled staff said they were satisfied with the extent to which their organisation values their work — **up** slightly from 36.8% in 2023/24. However, among non-disabled staff, the figure was 49.9% (previously 48.4%), resulting in a **disparity of 12.9** percentage points (up from 11.6 percentage points last year).

While satisfaction among disabled staff has improved marginally, the widening gap compared to non-disabled colleagues underscores the importance of targeted initiatives to ensure all staff feel equally valued and recognised for their contributions. Enhancing visibility of achievements, creating inclusive recognition programmes, and strengthening staff engagement activities will be key to closing this gap.

Metric 8: Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work

In 2024/25, 73.7% of disabled staff said that their employer had made adequate adjustments to enable them to carry out their work — **an increase** from 71.4% in 2023/24. This represents an improvement of 2.3 percentage points, in line with the national average for Acute Trusts, which stands at 74%.

The continued upward trend locally is encouraging and reflects the impact of initiatives such as the Health Passport, Reasonable Adjustment Policy, and targeted line manager training. To sustain this progress, we will continue to focus on the timely provision, consistency, and quality of workplace adjustments, alongside improving awareness among managers and staff of available support.

Metric 9: NHS Staff Survey and the engagement of Disabled staff

Part (a): The engagement score for Disabled staff, compared to non-disabled staff

In 2024/25, the engagement score for disabled staff was **6.77**, **up** slightly from 6.71 in 2023/24. For non-disabled staff, the score was **7.25** (previously 7.19), resulting in a disparity of **0.48 points**, unchanged from last year

While the stability in the engagement gap is positive in the sense that it has not widened, the fact that it has not narrowed highlights the need for continued, targeted action to ensure that disabled staff feel equally connected, supported, and involved in organisational life.

Part (b): Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?

Yes. The *Without Limits* Staff Support Network continues to play a pivotal role in advocating for disabled colleagues, promoting awareness, and ensuring members receive the necessary workplace adjustments and a supportive environment. The network chair holds a standing

agenda item on the Equality, Diversity, Inclusion and Belonging (EDIB) Steering Group, enabling direct influence on organisational decision-making.

In 2024/25, the network has also contributed to the development and rollout of the Health Passport, Reasonable Adjustment Policy, and targeted manager training, further strengthening its role as a key voice for disabled staff across the Trust.

Metric 10: *Percentage difference between the organisation's Board voting membership and its organisation's overall workforce.*

The national team has advised that we are only permitted to report on Board members who are directly employed by us. As a result, joint roles and Board members employed via Dorset HealthCare are excluded, which limits the completeness of the data. A complete overview of this element will be provided in the joint annual EDIB Report.

4.0 Conclusion and Actions

The data tells a clear story of improvement in several key areas: the proportion of staff declaring a disability has risen from 4.88% to 6.56%; disabled applicants are now slightly more likely to be appointed from shortlisting than non-disabled applicants; and, for the first time, there were no recorded cases of disabled staff entering the formal capability process. Satisfaction with workplace adjustments has also increased to 73.7%, and the engagement score gap between disabled and non-disabled colleagues has narrowed.

However, progress is not uniform. The disparity in career progression opportunities has widened to 5.1 percentage points, and a gap of 12.9 percentage points remains in how valued disabled and non-disabled colleagues feel. While some harassment and bullying disparities have reduced, these experiences remain too frequent. Board-level representation of disabled colleagues continues to be absent, underlining the need for targeted leadership development and succession planning.

This actions below respond directly to the 2024/25 WDES findings, aligning with our Joint Inclusion and Belonging Strategy and supporting delivery against the NHS Long-Term Workforce Plan. Each action is linked to specific WDES metrics and will be added to the Inclusion and Belonging Strategy Action Plan to ensure measurable progress.

1. Centralised Reasonable Adjustment Process (Metrics 8, 5)

Progress the proposal for a centralised Trust-wide process for workplace adjustments to remove local funding barriers and ensure timely, consistent, and equitable provision. The pilot will run from April 2026 to April 2027 and will include KPIs relating to delivery times, colleague satisfaction, and Access to Work reclaim rates.

2. Reasonable Adjustment Policy & Health Passport (Metrics 8, 5, 6)

Continue embedding the Health Passport and Reasonable Adjustment Policy across all divisions. Include mandatory awareness for all new line managers as part of induction and refresher sessions for existing managers as highlighted in the Inclusion and Belonging Strategy Action Plan.

3. Disability Confident Scheme – Leader Status (Metrics 5, 10)

Advance from Level 2 to Level 3 accreditation to signal sector leadership in disability inclusion, including a focus on representation in leadership roles and succession planning for Board diversity. We are aiming to achieve this by the end of 2026.

4. Tackling Harassment, Bullying & Abuse *(Metrics 4a, 4b)*

Expand early intervention and bystander training, with targeted action on patient/public-related incidents and peer-to-peer respect. Promote reporting channels and close feedback loops to sustain the rise in reporting confidence. DHC has already designed a suitable e-learning package and we intend to introduce it at DCH by the end of the year.

Baker, Abi
06/10/2025 12:40:16

Annex A

Detailed below is the organisation’s WDES data which was submitted in May 2025 covering the period 1 April 2024 – 31 March 2025. Where data is available, year-on-year comparisons have been made.

Metric 1: Percentage of staff in AfC pay bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.

NON-CLINICAL				
	DISABLED	NON-DISABLED	UNSPECIFIED	TOTAL
Below Band 1	0	0	0	0
Band 1	0	2	3	5
Band 2	14	181	27	222
Band 3	15	169	12	196
Band 4	14	115	18	147
Band 5	6	81	9	96
Band 6	4	58	7	69
Band 7	6	48	5	59
Band 8 - Range A	1	44	3	48
Band 8 - Range B	1	18	2	21
Band 8 - Range C	1	9	1	11
Band 8 - Range D	0	1	0	1
Band 9	2	6	1	9
VSM	0	3	0	3
All other	2	5	5	12
Total	66	740	93	899

CLINICAL

	DISABLED	NON- DISABLED	UNSPECIFIED	TOTAL
Below Band 1	0	0	0	0
Band 1	0	0	0	0
Band 2	26	142	10	178
Band 3	40	509	33	582
Band 4	10	101	8	119
Band 5	35	558	29	622
Band 6	41	419	41	501
Band 7	18	274	27	319
Band 8 - Range A	3	68	10	81
Band 8 - Range B	0	18	1	19
Band 8 - Range C	1	6	1	8
Band 8 - Range D	0	1	0	1
Band 9	0	3	0	3
VSM	0	2	0	2
All other	1	4	0	5
Total	175	2105	160	2440

CLINICAL				
	DISABLED	NON- DISABLED	UNSPECIFIED	TOTAL
Consultant	3	149	35	187
Non-Consultant Career Grade	2	51	4	57
Trainee Grade	5	218	18	241
Total	10	418	57	485

Baker, Nbj
06/10/2023 12:40:16

WORKFORCE TOTAL	251	3263	310	3824

Metric 2: Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts

Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting	Relative likelihood in 2023-24	Relative likelihood in 2024-25	A figure below 1.00 indicates that Disabled staff are more likely than non-disabled staff to be appointed from shortlisting
	0.56	0.41	

Metric 3: Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

Relative likelihood of Disabled staff compared to non-disabled staff entering	Relative likelihood in 2023-24	Relative likelihood in 2024-25	A figure above 1.00 indicates that Disabled staff are more likely than non-disabled staff to enter the formal capability process
	2.83	0.00	

Metric 4: Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse

4a: % of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:	2022			2023			2024		
	Disabled staff	Non-disabled staff	% points difference (+/-)	Disabled staff	Non-disabled staff	% points difference (+/-)	Disabled staff	Non-disabled staff	% points difference (+/-)
(i) Patients/service users, their relatives or other members of the public	28.8	24.5	-4.3	22.8	17.1	-5.7	20.5	14.4	-6.1
(ii) Managers	16.0	9.9	-6.1	14.5	7.5	-7	12.3	6.5	-5.8

(iii) Other colleagues	28.8	18.9	-9.9	24.2	18.0	-6.1	20.7	13.9	-6.8
4b: % of Disabled staff compared to non-disabled staff saying the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	52.0	42.0	-10.0	53.6	51.6	-2	54.1	58.8	-4.7

Metric 5: Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression and promotion.

2022			2023				2024	
Disabl ed staff	Non-disabl ed staff	Differen ce (+/-)	Disabl ed staff	Non-disabl ed staff	Differen ce (+/-)	Disabl ed staff	Non-disabl ed staff	Differen ce (+/-)
59.1	58.6	0.5	55.3	59.3	-4	54.0	59.1	-5.1

Metric 6: Percentage of Disabled staff compared to non-disabled staff saying they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

2022			2023				2024	
Disabl ed staff	Non-disabl ed staff	Differen ce (+/-)	Disabl ed staff	Non-disabl ed staff	Differen ce (+/-)	Disabl ed staff	Non-disabl ed staff	Differen ce (+/-)
28.6	18.0	-10.6	24.5	18.0	-6.5	21	15.8	-5.2

Metric 7: Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.

2022			2023				2024	
Disabl ed staff	Non- disabl ed staff	Differen ce (+/-)	Disabl ed staff	Non- disabl ed staff	Differen ce (+/-)	Disabl ed staff	Non- disabl ed staff	Differen ce (+/-)
36.5	46.4	-9.9	36.8	48.4	-11.6	37	49.9	-12.9

Metric 8: Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.

2022	2023	2024
71.9	70.3	73.7

Metric 9: NHS Staff Survey and the engagement of Disabled staff

Part (a): *The engagement score for Disabled staff, compared to non-disabled staff*

2022			2023				2024	
Disabl ed staff	Non- disabl ed staff	Differen ce (+/-)	Disabl ed staff	Non- disabl ed staff	Differen ce (+/-)	Disabl ed staff	Non- disabl ed staff	Differen ce (+/-)
6.6	7.1	-0.5	6.7	7.2	-0.5	6.77	7.25	-0.48

Part (b): Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? **Yes.**

In 2024/25 the ‘Without Limits’ Staff Support Network continued to play a pivotal role in ensuring the voices of disabled colleagues are represented and acted upon. The network provides a safe and constructive space for discussion, advocacy, and peer support, and its Chair maintains a standing agenda item at the Equality, Diversity, Inclusion & Belonging (EDIB) Steering Group.

Over the past year, the network has contributed directly to policy development, including the Reasonable Adjustment Policy and Health Passport, and has advised on practical improvements to workplace accessibility. Engagement between the network, senior leadership, and HR has strengthened, ensuring that issues raised by disabled colleagues are considered in decision-making and feed directly into the Trust’s Inclusion & Belonging Action Plan.

Metric 10: Percentage difference between the organisation’s Board voting membership and its organisation’s overall workforce, disaggregated).

The national team has advised that we are only permitted to report on Board members who are directly employed by us. As a result, joint roles and Board members employed via Dorset HealthCare are excluded, which limits the completeness of the data. A complete overview of this element will be provided in the joint annual EDIB Report.

Snapshot as at 31/3/25	Disabled	Non-disabled	Disability unknown
Total Board members	11,11%	88,89%	0,00%
By Voting Membership of the Board	25,00%	75,00%	0,00%
By Non-Voting Membership of the Board	0,00%	100,00%	0,00%
By Executive Membership of the Board	0,00%	100,00%	0,00%
By Non-Executive Membership of the Board	16,67%	83,33%	0,00%
Difference (Total Board – Overall Workforce)	5%	4%	-8%
Difference (Voting membership – Overall Workforce)	18%	-10%	-8%
Difference (Executive membership – Overall workforce)	-7%	15%	-8%

Baker, Abi
06/10/2025 12:40:16

Dorset HealthCare

Workforce Disability Equality Standard

Report

2024-25

Baker, Abi
06/10/2025 12:40:16

Author	Manpreet Aujla-Gudgeon (Equality, Diversity and Inclusion Lead)			
Purpose of Report	This report sets out our 2023/2024 data and action plan against the Workforce Disability Equality Standard (WDES) metrics.			
Executive Summary				
This report sets out Dorset HealthCare’s annual performance against the WDES metrics for 2024/2025. The WDES sets out a national framework through which Trusts are required to measure their performance against ten key measures (metrics). This enables NHS organisations to compare the workplace and career experiences of Disabled and non-disabled staff.				
Metric	Description	2022/23 result	2023/24 result	2024/25 result
1	Percentage of staff in each of the AfC Bands 1-9 or Medical & Dental subgroups and VSM (including Executive Board members) compared with the % of staff in the overall workforce	6.05%	6.76%	7.72%
2	Relative likelihood of non-Disabled staff compared to Disabled staff being appointed from shortlisting across all posts	0.98 (A figure below 1.00 indicates that Disabled staff are more likely than Non-disabled staff to be appointed from shortlisting)	0.63 (A figure below 1.00 indicates that Disabled staff are more likely than Non-disabled staff to be appointed from shortlisting)	1.08 (A figure above 1.00 indicates that Disabled staff are less likely than Non-disabled staff to be appointed from shortlisting)
3	Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure	1.07 (A figure above 1.00 indicates that Disabled staff are less likely than Non-disabled staff to enter the formal capability process)	1.02 (A figure above 1.00 indicates that Disabled staff are more likely than Non-disabled staff to enter the formal capability process)	2.03 (A figure above 1.00 indicates that Disabled staff are more likely than Non-disabled staff to enter the formal capability process)
4	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public	Disabled: 30.2% Non-Disabled: 20.3%	Disabled: 24.6% Non-Disabled: 16.9%	Disabled: 23.3% Non-Disabled: 16.0%
	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Managers	Disabled: 9.7% Non-Disabled: 5.5%	Disabled: 9% Non-Disabled: 5.1%	Disabled: 9.5% Non-Disabled: 4.6%

	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from other colleagues	Disabled: 15.5% Non-Disabled: 10.1%	Disabled: 15.1% Non-Disabled: 10.3%	Disabled: 15.7% Non-Disabled: 9.32%
	Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	Disabled: 54.5% Non-Disabled: 55.2%	Disabled: 57.7% Non-Disabled: 56.1%	Disabled: 55.7% Non-Disabled: 62.5%
5	Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression and promotion	Disabled: 56.5% Non-Disabled: 61.5%	Disabled: 53.3% Non-Disabled: 60.8%	Disabled: 56.3% Non-Disabled: 61.9%
6	Percentage of Disabled staff compared to non-disabled staff saying they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	Disabled: 13.9% Non-Disabled: 12.6%	Disabled: 17.7% Non-Disabled: 12.9%	Disabled: 16.2% Non-Disabled: 10.7%
7	Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work	Disabled: 47.0% Non-Disabled: 53.2%	Disabled: 47.8% Non-Disabled: 54.8%	Disabled: 47.1% Non-Disabled: 54.5%
8	Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work	84.5%	87.1%	86.6%
9	NHS Staff Survey and the engagement of Disabled Staff: The engagement score for Disabled staff, compared to non-disabled staff	Disabled: 6.8 Non-Disabled: 7.2	Disabled: 7.0 Non-Disabled: 7.3	Disabled: 6.9 Non-Disabled: 7.3
10	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:	0%	0%	0% (The percentage difference between the organisation's Board voting membership and its

Baker Abi
06/10/2025 12:40:16

	a) By Voting Membership of the Board			overall workforce is: -7.72%)
	b) By Executive membership of the Board	0%	0%	0% (The percentage difference between the organisation's Board voting membership and its overall workforce is: -7.72%)

Key findings

Overall, we have seen improvements from last year in **three metrics**, negative movement in **five metrics**, and **two metrics** remaining the same. Metric 4 presents a largely unchanged picture. There has been a small reduction in harassment, bullying, or abuse from patients and service users towards both Disabled and non-Disabled staff. However, experiences of harassment from colleagues and managers have remained static or shown slight increases, and reporting by Disabled staff has dipped. This indicates that while some progress has been made in reducing abuse from the public, workplace culture continues to require focused attention.

Background

The WDES launched in 2019 with the aim of enabling NHS organisations to better understand the experiences of Disabled staff and support positive change for all staff by creating a more inclusive environment for Disabled people working and seeking employment in the NHS. Research shows that a motivated, included and valued workforce helps to deliver high quality patient care, increased patient satisfaction and improved patient safety. WDES is mandated for all trusts in England with the aim of furthering equality and inclusion for Disabled staff in the NHS. The data will be published on our public website, along with our action plan, in line with regulatory requirements.

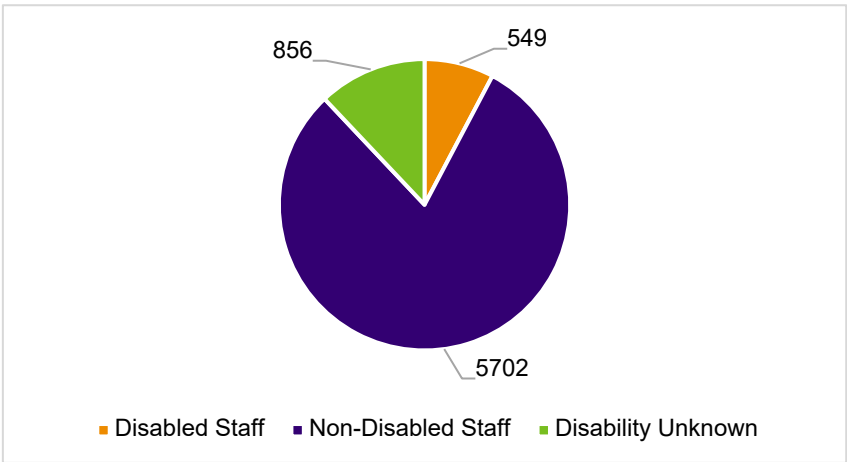
Data sources

- Metric 1 is based on data recorded on ESR on snapshot date: 31 March 2025
- Metric 2 is based on known data TRAC for the period 1 April 2024 to 31 March 2025
- Metric 3 is based on known data from HR records for the period April 2022 to March 2025 (to get 2-year rolling average)
- Metric 4 to 9 are based on the NHS Survey data which was collected over a two-month period from early October to early December 2024 (the NHS Staff Survey Results were released on 13 March 2025)
- Metric 10 is based on data recorded on ESR on snapshot date: 31 March 2025

Baker, Abi
06/10/2025 12:40:16

Analysis of data

Metric 1: Percentage of disabled staff – Disability Disclosure

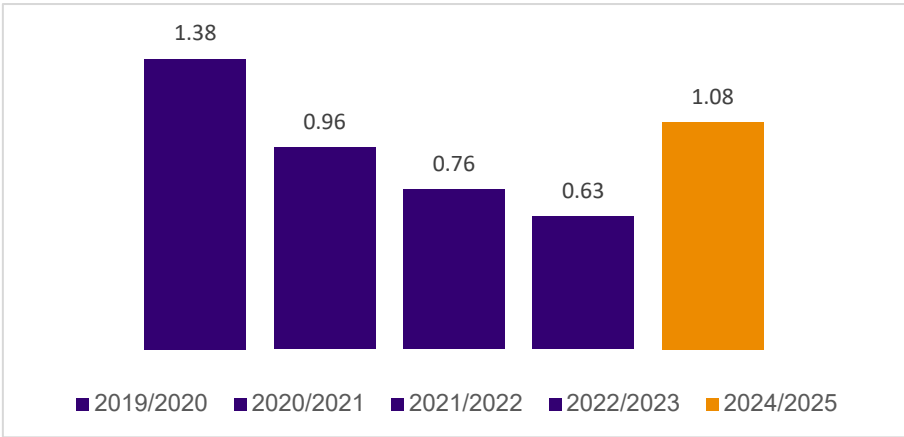


Our data in 2024/25 shows our total staff headcount is **7,107**. We currently employ **549** Disabled staff, who represent **7.72%** of our workforce. In 2023/24, our Disabled staff represented **6.76%** of our organisation. Whilst this demonstrates a positive increase, we recognise there is still work to do in order to better reflect the wider population. Nationally, 17.7% of people reported being disabled under the Equality Act 2010 (Census 2021, ONS³). In the combined Dorset and Bournemouth, Christchurch and Poole (BCP) area, approximately 19.3% of residents are classified as disabled (Census 2021⁴). It is also important to note that we may have higher numbers of staff with a disability who have not disclosed, as **12.04%** of our workforce have not indicated their disability status (down from 14.04% last year). This will be an area for continued investigation. We have seen a year-on-year decrease in the 'disability unknown' category, which we attribute to staff feeling more comfortable disclosing their status. We will continue our communications on the importance of disability declaration on ESR and provide clear instructions on how to update this information.

³ [Disability, England and Wales - Office for National Statistics](#)

⁴ [How life has changed in Dorset: Census 2021](#) and [How life has changed in Bournemouth, Christchurch and Poole: Census 2021](#)

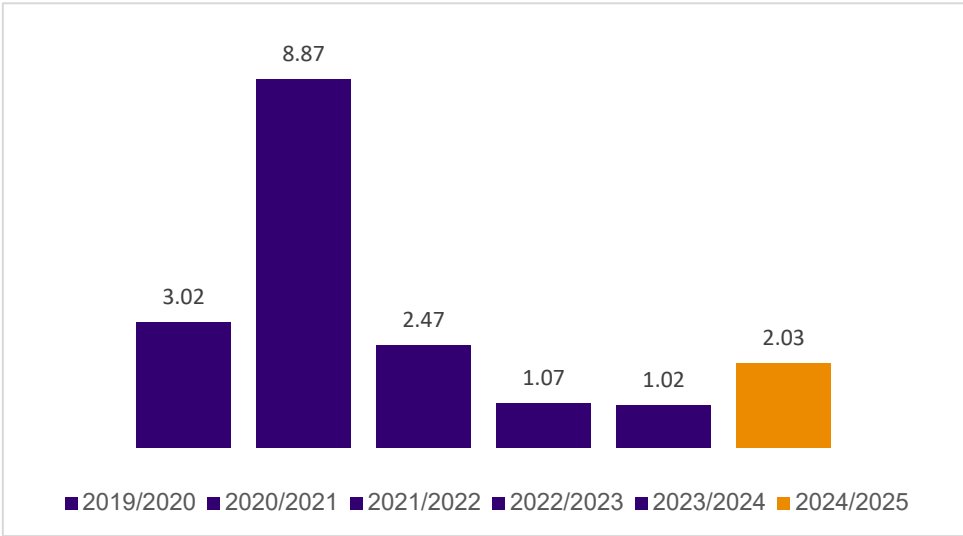
Metric 2: Relative likelihood of non-Disabled staff compared to Disabled staff being appointed from shortlisting across all posts



The data for 2024/25 shows a relative likelihood of **1.08**, indicating that Disabled applicants were slightly less likely to be appointed from shortlisting compared to non-disabled applicants. This represents a reversal from the 2023/24 figure of **0.63**, where Disabled applicants were more likely to be appointed. A relative likelihood of **1.00** would indicate no difference between groups, so the current figure suggests a slight disparity that we will continue to monitor closely. While this year's data does not indicate a significant gap, we remain committed to ensuring equity in our recruitment practices.

We have recently launched Inclusive Recruitment training for hiring managers and are planning to introduce the use of Diverse Panels. We will start at roles Band 8 and above, with plans to extend this to Band 6 and above by Year 3 of the intervention. We will continue to monitor recruitment data via TRAC and ESR and build on our inclusive recruitment efforts to ensure that our processes support fair outcomes for all applicants, including those with disabilities.

Metric 3: Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure



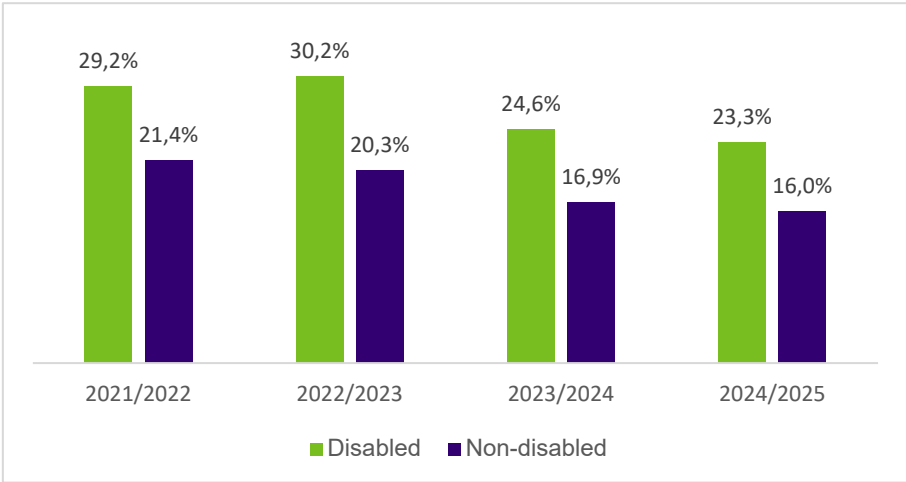
Baker, Abi
06/10/2025 12:40:16

The data for 2024/25 shows a relative likelihood of **2.03**, indicating that Disabled staff are more than twice as likely to enter the formal capability process compared to their non-disabled colleagues. This represents a notable increase from last year (**1.02**) and highlights a disparity that requires close attention. Several factors may be contributing to this trend. Notably, recent changes to our sickness absence management processes have introduced earlier formal recording of cases. Previously, many cases remained in a protracted informal stage and were not captured in reporting. Now, cases are recorded from Stage One onwards, which has likely led to an increase in the number of formally documented cases, including those involving Disabled staff.

Additionally, anecdotal evidence suggests that staff are increasingly joining the organisation with, or developing, more complex health conditions during the course of their employment. While we have robust policies and processes in place to provide support, the nature and complexity of these conditions – whether or not they meet the legal definition of a disability – can sometimes limit our ability to identify or implement reasonable adjustments sufficient to maintain attendance or performance in current roles. We are reviewing our approach to reasonable adjustments to improve clarity around the process and ensure staff and managers fully understand what support is available and how to access it. This work aims to strengthen early intervention and reduce the likelihood of escalation to formal capability processes.

We have also seen an increase in capability cases during probationary periods, which fall under this metric. This trend may continue, particularly in light of anticipated legislative changes such as day-one rights for unfair dismissal. We remain committed to ensuring fair and supportive processes and will continue to review both capability and sickness management procedures, recognising these are distinct. Our focus is on strengthening early interventions and investing in training for managers to support staff with disabilities or long-term health conditions appropriately and equitably. The formal sickness process should not be viewed negatively, as it provides structured support. Tracking dismissals on grounds of capability will give a clearer picture of outcomes.

Metric 4a: Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public

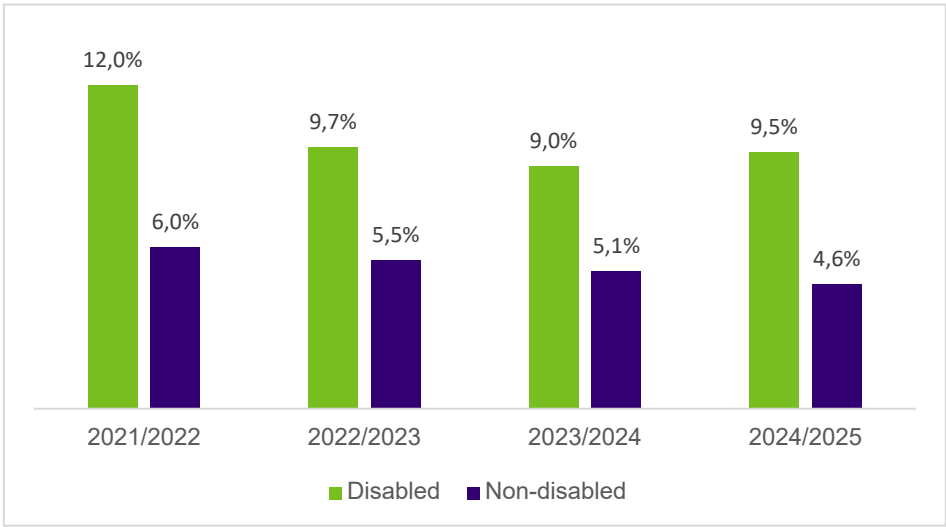


Baker, Abi
06/10/2025 12:40:16

The percentage of Disabled staff reporting harassment, bullying, or abuse from patients, service users, relatives, or the public has decreased to **23.3%** in 2024/25, compared to **24.6%** in 2023/24. While this reduction is encouraging, the figure remains a concern and continues to be a priority area for action. In response to this issue, we established a Task and Finish Group in October 2023 focused on violence, aggression, and discrimination. The group has worked to better understand how such incidents are reported and how staff are supported following them. This research has informed a series of actions to address and reduce instances of discriminatory behaviour. Key measures include the rollout of mandated Conscious Inclusion and Inclusive Leadership training for line managers, as well as the upcoming introduction of guidance for line managers on how to support staff who experience unacceptable behaviours from patients and visitors.

Our SAFE (Security and Fraud Experts) Team continues to play a critical role in responding to significant incidents. Their actions include engaging directly with service users to address inappropriate behaviour, helping them understand the impact of their actions, issuing formal warnings, and, when necessary, involving the Police where the criminal threshold has been met.

Metric 4b: Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Managers



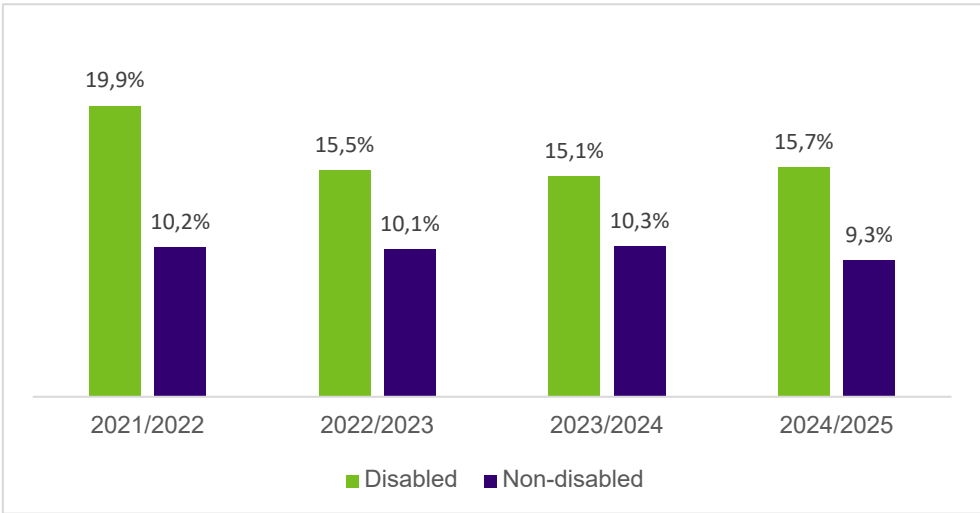
In 2024/25, **9.5%** of Disabled staff reported experiencing harassment, bullying or abuse from managers, up slightly from **9%** in 2023/24. While progress has been made in recent years, this increase highlights that we have not yet achieved parity of experience between Disabled and non-disabled staff.

To address this, we are continuing the rollout of mandated Conscious Inclusion and Inclusive Leadership training for all line managers. We are also implementing actions from our Task and Finish Group on violence, aggression and discrimination.

Baker, Abi
06/10/2025 12:40:16

Staff are encouraged to raise concerns through multiple routes, including our Disability Staff Network, Navigating Neurodiversity Staff Network, Freedom to Speak Up Guardians, and Staff Side Chairs, to ensure they feel supported and heard.

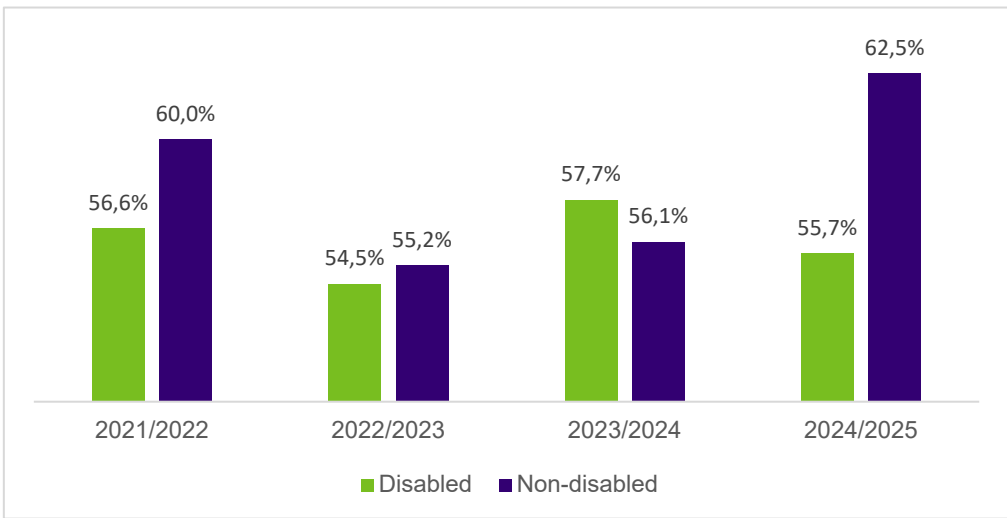
Metric 4c: Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from other colleagues



In 2024/25, **15.7%** of Disabled staff reported experiencing harassment, bullying or abuse from colleagues, up from **15.1%** the previous year. This remains higher than for non-disabled staff and highlights a persistent disparity in workplace experience.

We continue to encourage staff to speak up through routes such as our Freedom to Speak Up Guardians, EDI Team, Disability Staff Network and Navigating Neurodiversity Staff Network. To support culture change, all line managers are required to complete mandated Conscious Inclusion and Inclusive Leadership training to build inclusive, respectful teams.

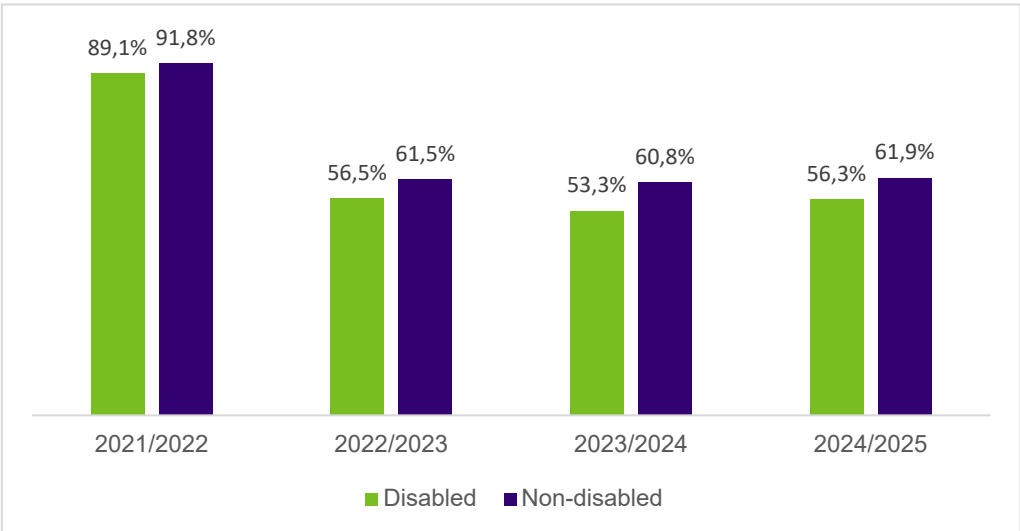
Metric 4d: Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it



Baker, Abi
06/10/2025 12:40:16

In 2024/25, **55.7%** of Disabled staff and **62.5%** of non-disabled staff said they or a colleague reported the last incident of harassment, bullying or abuse at work. This reflects a slight decrease for Disabled staff (down from **57.7%** in 2023/24) and a notable increase for non-disabled staff (up from **56.1%**). The growing gap suggests a need to strengthen psychological safety and trust among Disabled staff to encourage more consistent reporting. We remain committed to fostering a culture where all staff feel safe, supported, and confident to speak up when unacceptable behaviour occurs.

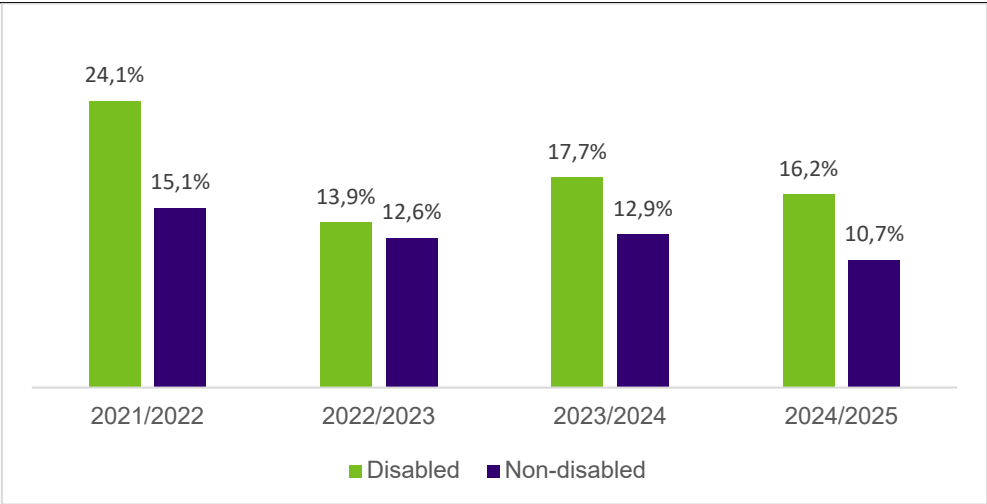
Metric 5: Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression and promotion



In 2024/25, **56.3%** of Disabled staff and **61.9%** of non-disabled staff felt the Trust provides equal opportunities for career progression and promotion. While this reflects a slight improvement for Disabled staff from **53.3%** in 2023/24, a gap remains when compared with non-disabled staff. We have recently completed our third cohort of the Reciprocal Mentoring programme, aimed at increasing awareness among senior leaders of the barriers faced by underrepresented groups. In addition, mandated Conscious Inclusion and Inclusive Leadership training for line managers continues to support fair and unbiased decision-making around development and progression.

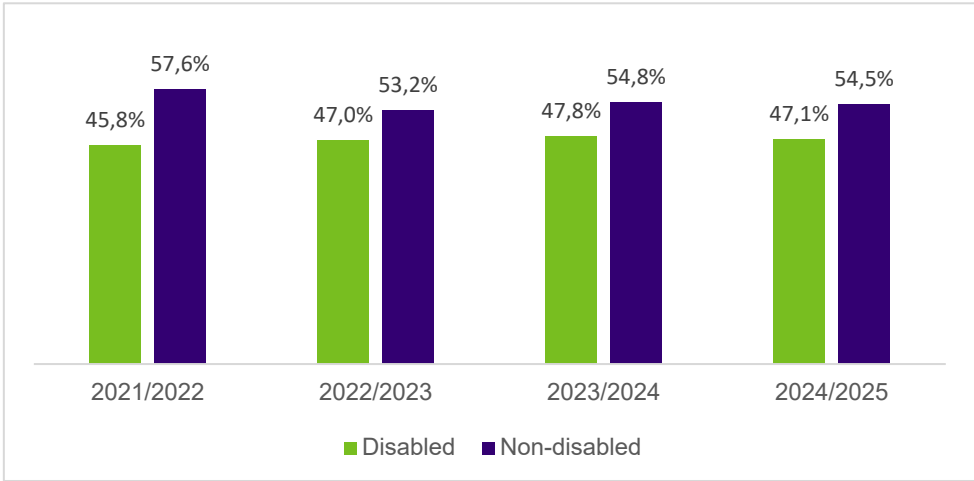
Metric 6: Percentage of Disabled staff compared to non-disabled staff saying they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties

Baker, Abi
06/10/2025 12:40:16



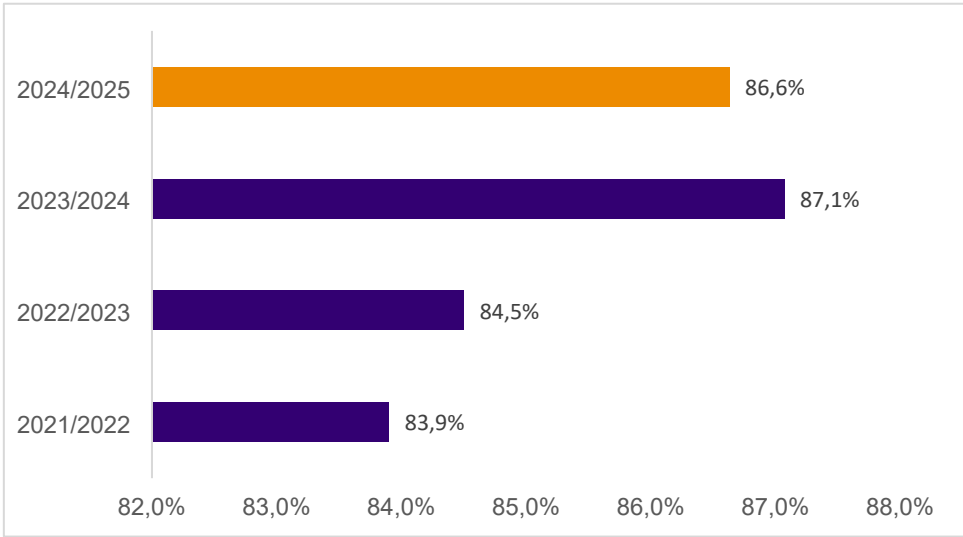
In 2024/25, **16.2%** of Disabled staff and **10.7%** of non-disabled staff reported feeling pressure from their manager to attend work despite not feeling well enough to perform their duties. While this is a slight improvement for Disabled staff compared to **17.7%** in 2023/24, the disparity between Disabled and non-disabled staff remains significant. Our Health and Wellbeing Champions and maturing Staff Networks continue to raise awareness of the support available to help staff stay well at work. Since their introduction in late 2021/22, Wellbeing Plans, structured conversations between employees and line managers, have supported better understanding of individual health needs. We will continue to promote these resources and work with managers to embed inclusive and compassionate leadership, aiming to reduce this figure further and improve the experience for all staff, particularly those with long-term health conditions or disabilities.

Metric 7: Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work



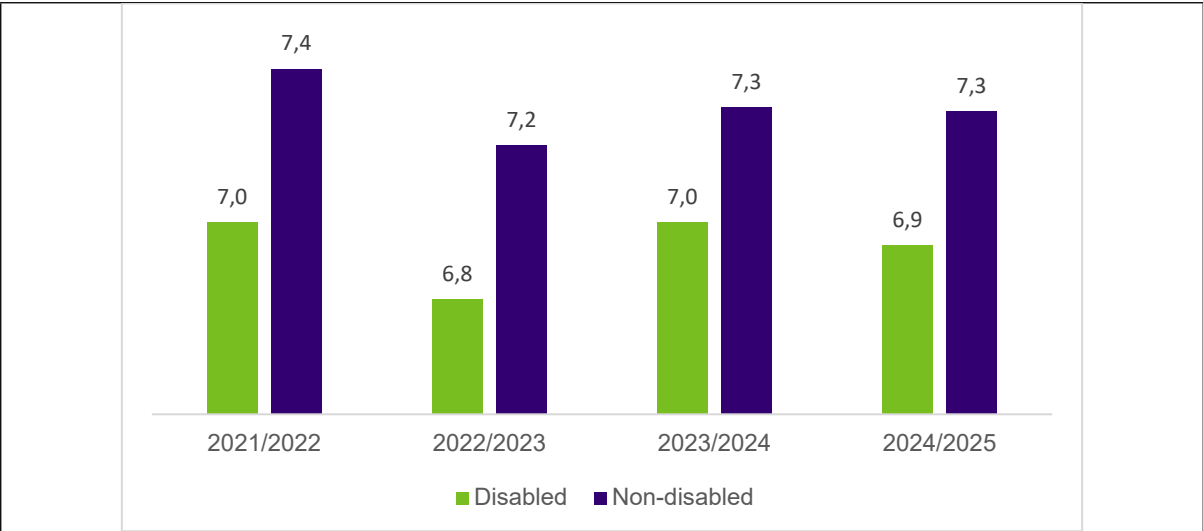
In 2024/25, **47.1%** of Disabled staff and **54.5%** of non-disabled staff reported feeling satisfied with how much the Trust values their work. This reflects a slight decrease for Disabled staff from **47.8%** in 2023/24, and the gap between Disabled and non-disabled staff remains. We will continue to review career development opportunities through the lens of disability inclusion and monitor progression through detailed data analysis to better understand and address this disparity.

Metric 8: Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work



In 2024/25, **86.6%** of Disabled staff said the Trust has made adequate adjustments to support them at work, a slight decrease from **87.1%** in 2023/24. While overall satisfaction remains high, we recognise the need to continually improve the consistency and quality of support provided. We are reviewing our reasonable adjustments process to ensure it reflects the social model of disability and provides clarity for both staff and managers. Our refreshed Sickness Absence Policy includes updated guidance on reasonable adjustments to support staff with health conditions or disabilities. We are also developing Access to Work guidance for line managers to ensure they are equipped to provide timely and effective support. We remain committed to improving the experience of Disabled staff and will continue working to raise this figure further in the year ahead.

Metric 9: NHS Staff Survey and the engagement of Disabled Staff



We have seen a slight decrease in this metric, with the Disabled staff engagement score moving from **7.0** in 2023/24 to **6.9** this year. In contrast, the engagement score for non-Disabled staff has remained consistent at **7.3** for the second consecutive year. While our score remains comparatively positive – particularly when considering that some regions report scores as low as 0 – it is clear that more needs to be done to close the engagement gap between Disabled and non-Disabled staff. Addressing this disparity is essential to ensuring a more inclusive and equitable workplace. Our action plan (Appendix 3) outlines the steps we will take to drive improvement. All interventions will be tracked and evaluated to ensure meaningful progress is made in supporting the engagement and experience of our Disabled workforce.

Metric 10: Board representation

As of March 2025, there are no disabled voting members on the Trust Board, resulting in a **-7.72% disparity** when compared to the overall workforce disability representation of 7.72%.

We have taken action to ensure that our Board update any disability status that is currently marked as 'Unknown' on ESR. This will support role-modelling throughout the organisation to ensure that Equality Data is updated. Talent management pathways for Disabled staff will also be a key area of focus as this will ensure that Board diversity improves in the future. We will look at ways in which we can widen diversity in our senior leadership talent pool to ensure future diversity in succession planning.

Next steps

A key priority this year has been embedding our first joint Inclusion and Belonging Strategy in partnership with Dorset County Hospital. This strategy includes an overarching action plan that consolidates all our activity under NHS England's statutory EDI reporting obligations, including the WDES.

- **Leadership and Training:** Dorset HealthCare has taken the lead in designing and implementing system-wide Conscious Inclusion and Inclusive Leadership training for line managers. This training is now mandatory for all line managers, with 304 of our staff trained to date and a further 311 booked on to our remaining 2025 dates.

Baker, Abi
06/10/2025 12:40:16

- **Respect & Resolution Policy:** We continue to embed our Respect & Resolution Policy for staff-on-staff incidents. This policy marks a significant step in fostering a culture of psychological safety, encouraging colleagues to speak up, and reinforcing our zero-acceptance approach to unwanted behaviours.
- **Guidance on Unacceptable Behaviours:** In collaboration with our Nursing and Quality and SAFE Team, we have developed guidance for managers on how to support staff experiencing unacceptable behaviour from patients or visitors.
- **Reciprocal Mentoring:** We concluded our third Reciprocal Mentoring Programme in July 2025, continuing our commitment to shared learning and leadership development. We will consider suggestions put forward by participants to ensure their voices have been heard.
- **Staff Networks:** We continue to support our Helping Disabilities Staff Network and the newly formed Navigating Neurodiversity Staff Network in delivering peer support and raising awareness of lived experiences within the organisation.
- **Inclusive Recruitment:** We have Reviewed the recruitment and induction processes to ensure equality and diversity are embedded. This has included the launch of Inclusive Recruitment training for hiring managers.

Key actions for 2025/26 will include:

- **Inclusive Recruitment:** we will launch the Diverse Recruitment Panels intervention starting with all roles Band 8+, with plans for Band 6+ by year 3.
- **Guidance on Unacceptable Behaviours:** the guidance has now been approved by senior leaders with plans to launch and socialise the guidance in September 2025 through listening events and communications including a statement from our Chief Executive.
- **Zero Acceptance Culture:** Continued promotion of zero-acceptance of behaviours that undermine inclusion and respect.
- **Staff Education:** Ongoing focus on embedding compassionate, inclusive, professional and respectful behaviour towards all colleagues is not only expected, but essential.
- **Public engagement:** Strengthening communication with patients, visitors, and the community to promote respectful behaviour towards staff.
- **Talent development:** Establishing career progression pathways for underrepresented groups.
- **Reasonable Adjustments:** Review and improvement of the process to ensure it is clear, accessible, and responsive for both staff and managers.
- **Training:** We have designed Active Bystander eLearning, with plans to launch it in collaboration with our Sexual Safety work in late 2025.
- **New Appraisal Process:** Embedding the new process, which includes a more flexible approach within a defined framework, with enhanced objective setting and dedicated career/development conversations, ensuring individual strengths and aspirations are recognised. Supports fairer access to progression planning and development opportunities, which will support underrepresented staff groups.

Conclusion

The data indicates that we are making slow but steady progress in improving the experiences of Disabled staff and fostering a more inclusive environment at Dorset HealthCare for all.

Baker
06/10/2025 12:40:16

Qualitative feedback highlights the need to review and strengthen our reasonable adjustments process, which will be a key focus for the year ahead to ensure Disabled staff are better supported at work.	
Recommendation	The Board is asked to note the Workforce Disability Equality Standard data and action plan, and next steps.

Baker, Abi
06/10/2025 12:40:16

Appendix 1: Comparison

	Disabled staff in 2019/2020	Disabled staff in 2020/21	Disabled staff in 2021/22	Disabled staff in 2022/23	Disabled staff in 2023/24	Disabled staff in 2024/25
1a. Non-clinical Workforce	%	%	%	%	%	%
Cluster 1 (Bands 1-4)	3.5%	5.20%	5.20%	6.30%	7.0%	7.9%
Cluster 2 (Band 5 - 7)	5.5%	5.80%	5.60%	6.40%	7.9%	7.9%
Cluster 3 (Bands 8a - 8b)	7.0%	4.80%	5.50%	6.80%	7.7%	7.5%
Cluster 4 (Bands 8c - 9 + VSM)	6.7%	3.60%	0.00%	0.00%	0.00%	0.00%
	Disabled staff in 2019/2020	Disabled staff in 2020/21	Disabled staff in 2021/22	Disabled staff in 2022/23	Disabled staff in 2023/24	Disabled staff in 2024/25
1b. Clinical Workforce	%	%	%	%	%	%
Cluster 1 (Bands 1 - 4)	3.35%	3.80%	3.50%	4.10%	5.1%	5.9%
Cluster 2 (Band 5 - 7)	4.91%	5.30%	6.30%	7.30%	7.7%	9.1%
Cluster 3 (Bands 8a - 8b)	3.13%	3.90%	4.60%	5.60%	5.7%	6.8%
Cluster 4 (Bands 8c – 9 & VSM)	0%	0.00%	0.00%	0.00%	0.00%	3.3%
Cluster 5 (Medical, Dental staff and Consultants)	0%	2.53%	1.33%	3.95%	3.95%	1.39%
Cluster 6 (Medical and Dental staff, Non-consultant career grade)	1.31%	0.74%	0.00%	0.00%	1.45%	4.55%
Cluster 7 (Medical and Dental staff, Medical and Dental trainee grades)	4.76%	3.45%	3.45%	2.38%	3.70%	3.33%

	Non-disabled staff in 2019/2020	Non-disabled staff in 2020/21	Non-Disabled staff in 2021/22	Non-Disabled staff in 2022/23	Non-Disabled staff in 2023/24	Non-Disabled staff in 2024/25
1a. Non-clinical Workforce	%	%	%	%	%	%
Cluster 1 (Bands 1-4)	71.0%	94.7%	77.30%	78.50%	79.3%	79.5%
Cluster 2 (Band 5 - 7)	68.4%	72.3%	75.10%	77.60%	78.7%	79.4%
Cluster 3 (Bands 8a - 8b)	60.5%	66.3%	68.50%	73.00%	73.1%	76.3%
Cluster 4 (Bands 8c - 9 + VSM)	60.0%	71.4%	73.10%	66.70%	63.6%	68.2%
	Non-disabled staff in 2019/2020	Non-disabled staff in 2020/21	Non-Disabled staff in 2021/22	Non-Disabled staff in 2022/23	Non-Disabled staff in 2023/24	Non-Disabled staff in 2024/25
1b. Clinical Workforce	%	%	%	%	%	%
Cluster 1 (Bands 1 - 4)	72.74%	75.30%	75.70%	78.70%	80.6%	82.1%
Cluster 2 (Band 5 - 7)	72.86%	76.90%	77.70%	78.60%	79.4%	80.6%
Cluster 3 (Bands 8a - 8b)	71.43%	72.90%	77.40%	77.90%	80.7%	80.9%
Cluster 4 (Bands 8c – 9 & VSM)	21.74%	28.00%	30.40%	44.00%	47.8%	56.7%
Cluster 5 (Medical, Dental staff and Consultants)	54.79%	63.29%	62.67%	63.16%	63.16%	68.06%
Cluster 6 (Medical and Dental staff, Non- consultant career grade)	75.16%	74.26%	63.79%	100.00%	75.36%	72.73%
Cluster 7 (Medical and Dental staff, Medical and Dental trainee grades)	80.95%	82.76%	75.86%	54.76%	74.07%	83.33%

Baker Abi
06/10/2024
14:40:16

	Relative likelihood in 2019/20	Relative likelihood in 2020/21	Relative likelihood in 2021/22	Relative likelihood in 2022/23	Relative likelihood in 2023/24	Relative likelihood in 2024/25	Comments
2. Relative likelihood of non-disabled staff being appointed from shortlisting compared to Disabled staff	1.38	0.96	0.76	0.98	0.63	1.08	A figure below 1.00 indicates that Disabled staff are more likely than Non-disabled staff to be appointed from shortlisting.
	Relative likelihood in 2019/20	Relative likelihood in 2020/21	Relative likelihood in 2021/22	Relative likelihood in 2022/23	Relative likelihood in 2023/24	Relative likelihood in 2024/25	Comments
3. Relative likelihood of Disabled staff entering formal capability process compared to non-disabled staff	3.02	8.87	2.47	1.07	1.02	2.03	A figure above 1.00 indicates that Disabled staff are more likely than Non-disabled staff to enter the formal capability process.

Baker, Abi
06/10/2025 12:40:16

	Unknown/ null staff in 2019/20	Unknown/ null staff in 2020/21	Unknown/ null staff in 2021/22	Unknown/ null staff in 2022/23	Unknown/ null staff in 2023/24	Unknown/ null staff in 2024/25	Total staff in 2019/20	Total staff in 2020/21	Total staff in 2021/22	Total staff in 2022/23	Total staff in 2023/24	Total staff in 2024/25
1a. Non-clinical Workforce	%	%	%	%	%	%	Headcount	Headcount	Headcount	Headcount	Headcount	Headcount
Cluster 1 (Bands 1-4)	25.50%	0.10%	17.50%	15.30%	13.7%	12.6%	1687	1484	1581	1584	1601	1571
Cluster 2 (Band 5 - 7)	26.20%	21.80%	19.30%	16.00%	13.4%	12.7%	275	394	393	424	456	433
Cluster 3 (Bands 8a - 8b)	36.20%	28.90%	26.00%	20.30%	19.2%	16.3%	43	83	73	74	78	80
Cluster 4 (Bands 8c - 9 + VSM)	33.30%	25.00%	26.90%	33.30%	36.4%	31.8%	30	28	26	33	22	22

Baker, Abi
06/10/2025 12:40:16

	Unknown/null staff in 2019/20	Unknown/null staff in 2020/21	Unknown/null staff in 2021/22	Unknown/null staff in 2022/23	Unknown/null staff in 2023/24	Unknown/ null staff in 2024/25	Total staff in 2019/20	Total staff in 2020/21	Total staff in 2021/22	Total staff in 2022/23	Total staff in 2023/24	Total staff in 2024/25
1b. Clinical Workforce	%	%	%	%	%	%	Headcount	Headcount	Headcount	Headcount	Headcount	Headcount
Cluster 1 (Bands 1 - 4)	23.91%	20.80%	20.80%	17.20%	14.3%	12.1%	1761	1876	1377	1450	1507	1533
Cluster 2 (Band 5 - 7)	22.23%	17.80%	16.00%	14.10%	12.9%	10.4%	2973	3312	2756	2790	2922	2946
Cluster 3 (Bands 8a - 8b)	25.45%	23.10%	18.00%	16.50%	13.5%	12.3%	224	255	239	267	296	324
Cluster 4 (Bands 8c – 9 & VSM)	78.26%	72.00%	69.60%	56.00%	52.2%	40.0%	23	25	23	25	23	30
Cluster 5 (Medical, Dental staff and Consultants)	45.21%	34.18%	36.00%	32.89%	32.89%	30.56%	73	79	75	76	76	72
Cluster 6 (Medical and Dental staff, Non- consultant career grade)	23.53%	25.00%	36.21%	0.00%	23.19%	22.73%	153	136	58	39	69	66
Cluster 7 (Medical and Dental staff, Medical and Dental trainee grades)	14.29%	13.79%	20.69%	42.86%	22.22%	13.33%	21	29	29	42	27	30

WDES metric		2019	2020	2021	2022	2023	2024
4(a) I Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Patients/service users, their relatives or other members of the public	Disabled	27.6%	29.2%	32.5%	30.2%	24.62%	23.27%
	Non-Disabled	21.4%	21.4%	22.1%	20.3%	16.88%	15.99%
4a ii. Managers	Disabled	12.6%	12.0%	11.5%	9.7%	8.95%	9.53%
	Non-Disabled	6.0%	5.5%	5.5%	5.5%	5.06%	4.61%
4a iii. Other colleagues	Disabled	19.9%	19.8%	17.5%	15.5%	15.14%	15.70%
	Non-Disabled	11.4%	10.2%	10.1%	10.1%	10.32%	9.32%
4(b) Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.	Disabled	57.7%	56.6%	53.7%	54.5%	57.65%	57.65%
	Non-Disabled	56.7%	60.0%	57.4%	55.2%	56.07%	56.07%
5. Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.	Disabled	58.7%	57.8%	56.6%	56.5%	53.28%	56.34%
	Non-Disabled	64.2%	61.1%	63.1%	61.5%	60.82%	61.34%
6. Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	Disabled	26.2%	24.1%	21.6%	13.9%	17.69%	16.22%
	Non-Disabled	12.9%	15.1%	12.4%	12.6%	12.89%	10.73%

Baker
06/10/2025 12:40:16

7. Staff Survey Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	Disabled	43.9%	45.8%	44.2%	47.0%	47.75%	47.12%
	Non-Disabled	57.9%	57.6%	54.1%	53.2%	54.81%	54.54%
8. Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.		83.0%	83.9%	83.3%	84.5%	87.06%	86.63%
9(a) The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.	Disabled	7.18	7.01	6.90	6.84	7.0	6.9
	Non-Disabled	7.51	7.43	7.28	7.23	7.3	7.3

Baker, Abi
06/10/2025 12:40:16

Appendix 2: 2025-2026 WDES Action Plan

Trust	Dorset HealthCare University NHS Foundation Trust	
Year	2025	
Primary author of the action plan	Manpreet Aujla-Gudgeon (Equality, Diversity and Inclusion Lead)	
Sources of information underpinning the plan	WDES data, Staff Survey, National reports, NHS equality, diversity, and inclusion improvement plan	
WDES Metric	Actions 2025/26	Owner
2. Relative likelihood of non-disabled staff being appointed from shortlisting compared to Disabled staff	• Improve diverse panel compositions and interview questions through collaboration with staff networks • Deliver new Inclusive Recruitment training to all recruiting Managers including knowledge of reasonable adjustments • Review advertising and shortlisting processes for all Board appointments and explore any disability-related inequalities • EDI question at every interview to assess candidates' understanding and commitment to inclusion, helping to build a leadership culture that values diversity.	Recruitment EDI Staff Network Chairs
3. Relative likelihood of Disabled staff entering formal capability process compared to non-disabled staff	• Year on year reduction in number of disabled staff involved in a formal capability procedure for performance management • Continue roll out of Conscious inclusion and Inclusive Leadership training for line managers • Monitor data following launch of our Respect and Resolution Policy	Human Resources EDI
4a) Staff experiencing harassment, bullying or abuse from patients/ service users, their relatives or other members of the public in the last 12 months	• Embed Zero Acceptance: Promote zero acceptance of bullying, harassment, discrimination, and violence, supported by a Chief Executive statement and staff guidance • Maintain Partnerships: Continue collaboration with the SAFE Team and Dorset Police • Encourage Reporting: Work with Freedom to Speak Up Guardians to support staff in raising concerns	Human Resources EDI SAFE Team Nursing and Quality

	• Deliver Action Plan: Complete and implement actions from the Task and Finish Group to improve reporting and staff support (e.g. Launch managers guidance for supporting staff who experience unacceptable behaviours) • Monitor Data: Continue reviewing Ulysses data to identify trends and guide improvement.	
4b) Staff experiencing harassment, bullying or abuse from managers in the last 12 months	• Include an EDI objective in yearly appraisals to ensure every leader demonstrates their commitment to inclusion and fairness • Launch Active bystander eLearning	Human Resources EDI FTSUG
4c) Staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	• Embed zero acceptance approach to reduce bullying, harassment, discrimination and violence to ensure staff feel safe to come to work • Identify themes and hotspots for colleague-on-colleague • Complete action plan following Task and Finish Group to ensure incidents are reported and staff are supported • Continue to monitor data to identify themes and hotspots for colleague-on-colleague harassment, bullying or abuse • Continue to embed Respect and Resolution policy	Human Resources EDI FTSUG
4d) Staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months	• Embed zero acceptance approach to reduce bullying, harassment, discrimination and violence to ensure staff feel safe to come to work • Continue work with the SAFE Team and Dorset Police • Continue to work with FTSUG for reporting • Complete action plan following Task and Finish Group to ensure incidents are reported and staff are supported • Continue review of Ulysses data and HR data	Human Resources EDI FTSUG
5. Percentage of Disabled staff compared to non-disabled staff believing that the trust provides	• Review and measure success of third cohort of our Reciprocal Mentoring Programme	Human Resources EDI

equal opportunities for career progression or promotion.	• Embed career conversations as part of the annual performance appraisal process • Deliver mandated Conscious Inclusion and Inclusive Leadership training for line managers • Deliver EDI content in the manager's induction programme • Promote all opportunities across the workforce, with a particular focus on the take up of development opportunities by females, ethnic minority staff and staff with a disclosed disability to ensure an equitable workforce.	
6. Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	• Promote the Wellbeing Service to all staff • Promote uptake of Wellbeing Plans for all staff	Human Resources Wellbeing
7. Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work	• Work closely with the Disability Staff Networks to engage with staff and understand needs and implement suggestions, where possible	Organisational Development EDI
8. Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work	• Promote Access to Work on DORIS – including developing catalogue, process maps and guidance documents for both line managers and staff • Occupational Health to support staff who have a disability and require reasonable adjustments • Raise awareness of supporting colleagues with a disability and reasonable adjustments as part of the new manager induction process	EDI Human Resources Occupational Health

Baker, Abi
06/10/2025 12:40:16

9a) The staff engagement score for Disabled staff, compared to non-disabled staff	• Senior management team to engage with Disability staff networks through senior sponsorship of staff networks • EDI team to manage and feedback themes from networks and review of scores by Directorate	Organisational Development EDI
b) Has your trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?	• Continue work with Staff Networks • Senior Management and Board to engage with Staff Networks on a more formal basis through our newly formed Joint Culture and Belonging Reference Group with DCH • Representation of Disabled staff on Task and Finish Groups related to inclusion and belonging and workforce needs	EDI
10. Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated by Exec/non-exec and Voting/non-voting.	• Increase in staffing levels more reflective of diversity of local community and regional/national labour markets • Use of diverse panels for all senior appointments, starting with all roles Band 8+	Recruitment

Baker, Abi
06/10/2025 12:40:16

Report to	Board in Common, part 1 (DCH and DHC Boards)	
Date of Meeting	7th October 2025	
Report Title	Reintroduction of Mutually Agreed Resignation Scheme (MARS)	
Prepared By	Catherine Granville - Service Director People and Culture (DHC)	
Approved by Accountable Executive	Nicola Plumb, Joint Chief People Officer	
Previously Considered By	People and Culture Committee in Common, 22/09/2025	
Action Required	Approval	Y
	Assurance	N
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives	
Care		No
Colleagues	Yes	
Communities		No
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 and this will adversely impact our ability to provide safe sustainable services, and will impact upon the overall ICS position	
Financial	The aim of the scheme is to reduce pay costs.	
Statutory & Regulatory	NHSE Regulations allow Foundation Trusts to implement a MARS with Board approval.	
Equality, Diversity & Inclusion	An EIA has been completed as part of the Dorset system MARS policy developed in November 2024	
Co-production & Partnership	The first MARS was a system wide approach with shared policy and guidelines which will be re-used for the second round if approved.	

Executive Summary
Due to system wide financial pressures, a Mutually Agreed Resignation Scheme (MARS) was implemented across all NHS organisations within Dorset as a means to reduce staff numbers and the pay bill. The scheme was approved by individual Trust Boards and NHSE approval was also obtained. The scheme opened to applications 6th January and closed 24th January 2025. That round of MARS resulted in reoccurring savings as follows: DCH; £95k DHC approximately £590k This paper proposes the reintroduction of MARS at both DHC and DCH. It is proposed that the scheme is run for a three-month duration (maximum time allowed) up to end of December 2025 as a strategic approach to reduce overall WTE, support directorate/divisional reorganisation and transformation schemes and reduce financial pressure. It is important to note that a potential NHS wide voluntary redundancy scheme may be publicised soon, however, with no allocated funding MARS remains a more cost effective and viable option. The scheme will need to be supported with Board approval at both Trusts before being presented to NHS for final approval. We are advised that NHSE approval will be a quick process.
Recommendation
Board in common is requested to approve the reintroduction of MARS.

1.0 Introduction

- 1.1 A mutually agreed resignation scheme (MARS) is a form of voluntary severance and has been developed with the aim of increasing the flexibility to organisations as they address periods of change and service redesign, in the light of the financial circumstances in which they operate.
- 1.2 The very difficult financial situation both nationally and locally and the scale of challenge facing all NHS and social care services is well understood. In order to secure its long-term future, both DHC and DCH must reduce its overall operating costs, by becoming more efficient in the way that patient services are provided and by scrutinising every area of expenditure.
- 1.3 MARS is viewed as being a voluntary resignation on the part of the individual employee, in return for a severance payment. As there may be significant financial implications for the employee, employers can support the decision-making process by assisting individuals with understanding these implications. Successful applicants will be required to sign a formal Settlement Agreement. The employing Trust will make a financial contribution towards the legal costs associated with such Agreements, up to an agreed maximum.
- 1.4 Should we wish to run our own local scheme, we are required to follow the principles agreed by the NHS Staff Council and set out in section 20 of the NHS terms and conditions of service handbook.
- 1.5 HM Treasury has extended delegated authority to NHS foundation trusts to implement local MARS' up to 31 March 2026 subject to the following conditions:
- Each scheme is appropriately considered and authorised by the trust board.
 - Each scheme should be on the terms of the past national NHS MARS including the payment rate.
 - Individual payments must not be greater than £80,000 in respect of any individual.
 - Each scheme applies a salary cap of £80,000 for staff with total earnings of more than £80,000, the figures used for calculating a MARS payment will be £80,000 (pro rata for part time workers).
 - Each scheme will not operate for more than three months in duration.
 - Each scheme, including full scheme details, to be notified to NHS England and HM Treasury, in advance.
 - Each scheme is a re-run of a previous scheme based on the above criteria and for which HM Treasury approval had been obtained.
- 1.6 The severance payment is not subject to normal tax and N.I. deductions up to the first £30k
- 1.7 The scheme can be attractive to staff as it offers a range of opportunities for individuals, including:
- retraining, or change of career direction
 - embarking upon a new business venture
 - reducing mortgage commitments
 - opportunity to re-assess work-life balance
 - travel

- 1.8 The opportunity may also be of interest to staff who:

- simply wish to leave the organisation
- have limited service with the NHS and are concerned about the level of compensation they would receive if made redundant at some future date
- have less than two years' service and are thus not entitled to a redundancy payment
- may wish to leave/retire earlier than planned, but do not believe that they will meet future redundancy criteria

2.0 Previous MARS outcome

2.1 A MARS was approved by individual Trust Boards and NHSE approval was also obtained. The scheme opened to applications 6th January 25 and closed 24th January 25.

2.2 DCH Received 22 applications:

- 13 were unsupported by line managers due to service need
- 6 were considered by a check and consistency panel
- 3 were withdrawn by applicant during approval process

This check and consistency panel consisted of Director of Nursing, Deputy Chief Finance Officer, and Head of People Services. Two applications were rejected by panel and one was held pending further information.

The savings made by the three supported applications are;

- WTE reduction of 2.56 WTE
- Recurrent saving of £95k (Y2)

2.3 DHC Received over 65 applications:

- 38 were unsupported by line managers due to service need
- 27 were considered by a check and consistency panel

This check and consistency panel consisted of Service Directors of People & Culture and Finance, Director of Nursing and a Consultant in Public Health, the Trusts lead for Health Inequalities.

Due to the complexity and nature of some of the queries it is not possible to provide an accurate WTE reduction or recurrent savings, however the approximate figures are:

- WTE reduction of 12.41 WTE
- Recurrent savings are of £590,000

3.0 Proposal

3.1 The proposal to re-run the MARS will be based on the following core principles:

- MARS is entirely voluntary from the employer's and employee's perspective and there is no legal obligation on the part of either organisation to accept any individual application.

Regardless of staff group, individuals will be ineligible to apply for MAR if they:

Baker, Abi
06/10/2025 12:40:16

- have already formally given notice of their intention to resign/retire, prior to the date when applications are formally being sought
 - have already secured employment with another employer
 - have been notified of the date of the termination of their contract of employment for any other reason
 - are currently in a selection pool identifying them for potential redundancy
 - are being managed under the Trust's Capability Policy; or
 - are subject to the application of the Trust's Disciplinary Procedures
- If approved by Board the scheme will be time-limited for a maximum of three months. Options are
 - Run for a defined period of time say one month
 - Keep open for the whole three months and hold several panels.
 - There are pros and cons of each approach. A defined period will make it easier to administer. Keeping the scheme open for three months may attract more applicants.
 - Each application made in accordance with MARS will be considered on its own merits and the Trust will reserve the right to determine whether or not an application will be approved and there will be no right of appeal on the part of those employees whose applications are not successful.
 - Prior to scrutiny by an appointed panel, applications for MARS will require line manager and Service Director discussion and information of how recurrent cost savings can be made, for example:
 - Impact on the service.
 - The cost of voluntary severance against the level of savings to be delivered if MARS agreed (recurrent and non-recurrent) and the calculated payback period.
 - Whether the application creates an opportunity for another displaced member of staff.
 - Employees who leave the NHS under MARS would not be re-engaged under normal circumstances by the NHS in England, in the same or a different post before a period of one month has elapsed. If an individual does return to the NHS within one month, they would be required to repay any MARS payment in full.
 - Where an employee returns to work for the NHS in England within six months and before the expiry date of the period for which they have been compensated, then an employee would be required to repay any un-expired element of their compensation.
 - Employees who decide to proceed with a MAR will be issued with a settlement agreement to sign, which will set out the financial and other terms under which the employment relationship will end.

MARS payments will be calculated using the model below. There is no flexibility to adjust this payment scale.

Reckonable Service (complete years)	Scale of Payment
1 year's continuous service (organisation/NHS)	3 months' basic salary
2 years' continuous service (organisation/NHS)	3 months' basic salary
3 years' continuous service (organisation/NHS)	3 months' basic salary

Baker, Abi
06/10/2025 12:40:16

4 years' continuous service (organisation/NHS)	3 months' basic salary
5 years' continuous service (organisation/NHS)	3 months' basic salary
6 years' continuous service (organisation/NHS)	3 months' basic salary
7 years' continuous service (organisation/NHS)	3 ½ months' basic salary
8 years' continuous service (organisation/NHS)	4 months' basic salary
9 years' continuous service (organisation/NHS)	4 ½ months' basic salary
10 years' continuous service (organisation/NHS)	5 months' basic salary
11 years' continuous service (organisation/NHS)	5 ½ months' basic salary
12 years' continuous service (organisation/NHS)	6 months' basic salary
13 years' continuous service (organisation/NHS)	6 ½ months' basic salary
14 years' continuous service (organisation/NHS)	7 months' basic salary
15 years' continuous service (organisation/NHS)	7 ½ months' basic salary
16 years' continuous service (organisation/NHS)	8 months' basic salary
17 years' continuous service (organisation/NHS)	8 ½ months' basic salary
18 years' continuous service (organisation/NHS)	9 months' basic salary
19 years' continuous service (organisation/NHS)	9 ½ months' basic salary
20 years' continuous service (organisation/NHS)	10 months' basic salary
21 years' continuous service (organisation/NHS)	10 ½ months' basic salary
22 years' continuous service (organisation/NHS)	11 months' basic salary
23 years' continuous service (organisation/NHS)	11 ½ months' basic salary
24 years' + continuous service (organisation/NHS)	12 months' basic salary

4 Considerations

4.1 NHS guidance states that it is for employers working in partnership with local staff side to determine the eligibility criteria for the MARS over and above the nationally required exclusions detailed in section 2.1. It is not proposed that there would be additional eligibility criteria applied.

4.2 It is proposed that applications for the MARS would be open to individuals who are employed by either organisation in a substantive post, either on a full-time or part-time contract, but whose employment is not fixed-term. The Scheme will also apply to staff who are on maternity leave, or on an extended career break. Applications from anyone who is on long-term sick leave will be considered, but on a case-by-case basis. The Scheme would not apply to doctors in training and bank-only staff.

4.3 A review of the process using lessons learnt from the previous round has been undertaken to ensure it is more streamlined. The suggestion is that all requests go to a panel (separate panels for each Trust) made up of a Service Directors from each Directorate or Division. Each Trust would run its own panel. The panel would make a recommendation to the Executive Director for final sign off. Prior to applications being presented to panel the line manager and the Service Director will discuss the application.

Baker, Abi
06/10/2025 12:40:16

5 Financial Implications

- 5.1 The payback timeframe for MARS in terms of how long it takes for the costs associated with the severance payment to be recovered through cost savings or other financial benefits will be no more than two years.
- 5.2 As a general guide, the payback timeframe for a MARS severance payment will be calculated as follows:

Payback Period =
$$\frac{\text{Total Costs}}{\text{Recurrent Annual Savings achieved within two years}}$$

6 Recommendation

- 6.1 That the Board approve the implementation of MARS
- 6.2 That the Trust applies the scheme cap of a maximum of £80k.

Baker, Abi
06/10/2025 12:40:16

Strategy Transformation and Partnerships Committee Assurance Report
for the meeting held on Monday 22 September 2025

Chair	David Clayton-Smith, Chair
Executive Lead	Dawn Dawson Nicola Plumb
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	- Challenges remain in the development and production of a strategy delivery dashboard to measure, monitor and demonstrate real tangible difference and improvement. - A multi-organisation/agency event is planned for the end of September to focus on Integrated Neighbourhood teams to showcase all the positive work that is underway.

Key issues / matters discussed at the meeting	The committee received, discussed and noted the following reports: Strategy in Action Received a presentation on the pilot of a Children and Young People Mental Health and Neurodiversity Training Programme. The pilot training course was delivered in partnership with Dorset Healthcare colleagues, Dorset Mental Health Forum and people with lived experience. The aim was to build staff confidence and improve collaborative working between teams. Feedback from staff has been very positive. The course continues to be reviewed through PDSA cycles and there will be a further pilot followed by agreement and implementation of a final training course. Strategy Delivery Dashboard including implementation An update was provided on progress against the joint strategy plan in its first year of delivery, recognising the challenge of competing priorities, an everchanging national NHS landscape and capacity within the teams to deliver. The federation has built strong foundations and achieved notable successes. Continued efforts are required to overcome barriers, manage risk and realise the clinical integration benefits. Challenges remain in the development and production of a dashboard to measure, monitor and demonstrate real tangible difference and improvement. There was recognition by the committee that further work is needed to connect enabling plans, transformation programmes, and system priorities into a coherent 'whole'.

Baker, Abi
06/10/2025 12:40:16

One Transformation Approach Highlight Report and Improvement Activity Update including Peer Open Dialogue Dorset – Early-stage analysis of Pilot Sites

A comprehensive update was provided on the One Transformation Approach Place & Neighbourhood programmes and Mental Health and Working Together Portfolios. A multi-organisation/agency event is planned for the end of September to focus on Integrated Neighbourhood teams to showcase all the positive work that is underway, reduce duplication, help understand the National agenda, network and share ideas. Dorset council has been successful in the first round of applications for the National Neighbourhood Health Implementation Programme which is recognition of all the positive work that is underway.

Joint Improvement Framework

An update was provided on the 'Improving together programme' which is progressing well with engagement at its core to deliver outcomes which are meaningful for colleagues. The programme team have utilised multiple opportunities to listen to colleagues through celebration events such as conferences and QI Week including ward walks, poster competitions, information stands and certificate handouts. This approach and culture supports working across departmental boundaries and helps teams to understand what each other does and how they can benefit each other and the patient. Further work is planned on how to encourage senior leaders not to be recipients of information but proactive leads and role models for improvement, recognising the challenge of the operational environment and capacity to deliver.

Access Well-being – Focussed Review

A presentation was given on the Access Wellbeing Programme detailing its background, principles, progress and ongoing evaluation of outcomes and challenges. Dorset HealthCare has been able to increase support within community mental health services by 27% as part of the total Access Wellbeing model. There have been over 9,500 contacts in the last year compared to 7,500 in the previous year. Over 60 partner organisations have been based in the Universal hubs across Dorset providing a holistic approach. Positive feedback has been received from service users.

Systems Strategic Partnership

A verbal summary was provided on plans for DCH, DHC and UHD to undertake a clinical services review with a particular focus on acute services. This will be discussed in more detail at the next Board to Board to Board meeting at the end of September which will help inform the plan further for the remainder of the year.

Provider collaborative

An update was provided on the current strategic programmes of the Our Dorset Provider Collaborative Board highlighting the progress around

centralised management of Interventional Radiology services in Dorset, reviewing care pathways for gynaecology patients and developing a Women's Health Hub.

Dorset Innovation Hub

An update was provided on Dorset Innovation Hub's partnership work, highlighting two main schemes: the review of Fractional Exhaled Nitric Oxide Implementation and the development of a Nutrition in Ageing People Collaborative lunch club. The placement of the Innovation Hub will be impacted by the ICB reconfigurations, the outcome of which is still to be determined.

Digital Risks

Assurance was provided that the digital risks at DHC and DCH are identified, reviewed and mitigated, and management processes are in place. Further refinement of risk management systems and processes will occur through the alignment of digital services across Dorset. An initiative to move to a single risk management solution is underway for the three healthcare providers across Dorset. The committee recognised that significant challenges remain to manage and mitigate digital-related risks and acknowledged everything that can be done is being done within the current resources and financial climate. Many risks can be resolved with the implementation of a new EHR across Dorset but this will not occur for some time; therefore, some additional mitigation prioritisation will be required.

Electronic Health Record Programme

An update was provided on the joint procurement and planned implementation of a new EHR across Dorset and Somerset. The programme has been split into six stages, and is currently in the 'procure' stage (stage 2). Tenders have been received by suppliers and evaluations are nearly complete. The DHC outline business case has successfully attracted £10.5million of funding. The draft full business case is expected to be complete in mid-October with full Board approvals expected in November 2025. Implementation is planned from 2026 with 'go-live' in 2028/29. Recognition by the committee that clinical leadership and engagement are critical in this programme.

Green Plan Guidance Refresh

An update was provided on producing the Green plan to align with the new refreshed NHS England guidance. Work is being progressed against the actions for DCH and DHC to produce the plan. Indicative costs for the resources required to develop a full plan in line with the guidance will be proposed, but the Committee could not approve additional costs without further details.

Policies Update – DHC

An update was provided on the policy status at DHC relevant to the Strategy, transformation and partnership portfolio. There are two applicable policies. The Registration Authority policy is 15 months overdue for review and the digital change and release management policy is 3 months overdue. Confirmation is awaited if these have now been superseded. Updates on DCH policies will be brought to future committee meetings to align with this report.

The following escalation reports from subgroups were received for assurance by the committee members:

Joint

- System Executive Group Assurance Report
- New Hospitals Programme Board Assurance Report

DCH

- Sustainability Working Group Assurance Report
- Digital Transformation and Assurance Group Assurance Report

Consent Items

Committee Governance Structures received for assurance

Decisions made at the meeting

- None

Issues / actions referred to other committees / groups

- Prioritisation of mitigation to address Digital Risks, particularly those dependent on implementation of a new HER (see 'Digital Risks' above)

Quoracy and Attendance

	28/05/2025	28/07/2025	22/09/2025		
Quorate?	Y	Y	Y		
David Clayton-Smith	Y	Y	Y		
Frances West	Y	Y	Y		
Dave Underwood	Y	Y	Y		
Andreas HAIMBOCK-TICHY	Y	Y	N		
Claire Lehman	Y	Y	Y		
Nick Johnson	Y	Apols	N/A		
Chris Hearn	Y	Y	Y		
Dawn Dawson	Y	Y	N		
Nicola Plumb	N	Y til 11	Y		



Report to	Board in Common, part 1 (DCH and DHC Boards)	
Date of Meeting	07 October 2025	
Report Title	Green Plan Guidance Refresh – September 2025	
Prepared By	Bev Lagden – Sustainability Manager - DCH Patrick McDermott – Head of Sustainability & Fleet – DHC	
Approved by Accountable Executive	David McLaughlin Director of Estates & Facilities	
Previously Considered By	Strategy, Transformation and Partnership Committee in Common 22/09/2025	
Action Required	Approval	Y
	Assurance	N
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? <i>Delete as required</i>	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR5 Estates SR7 Collaboration SR8 Transformation and Improvement	
Financial	£28,132.50 per trust	
Statutory & Regulatory	Climate Change Act 2008 Health & Care Act 2022 Environment Act 2021	
Equality, Diversity & Inclusion	To be completed as part of Green Plan rewrite Quality Impact Assessment.	
Co-production & Partnership	DCH, DHC and UHD and external delivery partners e.g. Dorset Council	

Executive Summary
The NHS England Green Plan Guidance came out late with an informal extension to produce from 31 July to October 2025 as advised by the Dorset ICB. Work has taken place to develop a 12 month Greener and Sustainable update to the Annual Social Value Programme. Initially the 3 Dorset trusts began work on a joint Green Plan, but this was postponed pending a move to a wholly owned subsidiary company. At the last update, the Federation of DHC and DCH Sustainability Leads began work on individual 12-month action lists with an overarching 'light' refresh. UHD have since done a light refresh of their Green Plan The Federated Trusts anticipate a light refresh Green Plan to the Board by 30 October 2025. This report update is what is needed to deliver a fuller refresh in line with guidance. The Committee are recommended to approve costs around a Green Travel Plan, Climate Change Risk Assessment, Adaptation Plan, Biodiversity Action Plan and Carbon Literacy training, further a Soil Association accreditation process will inform the plan and is included within DCH Sustainability Materials budget for 2025/6. This approach will inform a 3–5-year plan of either a trust with shared services or as federation and in collaboration with the ICB and respond to recent criticism of NHS trusts and preparedness for Climate Change. The paper is regarding the production not delivery of a Green Plan although some groundwork on engagement and green kitchen awards forms a dual development and delivery role.

Recommendation
Members are requested to:

1. **Note** the Green Plan light refresh with a 12-month SMART Objectives and KPIs by end of October for governance and approval by the Board of Directors.
2. **Note** the intention to develop a Dorset wide Green Plan in discussion with Dorset ICB and meeting NHS England guidance once shared services outcome known.
3. **Approve** the additional costs and resources, indicative at this stage, to develop a Green Plan, Green Travel Plan by December 2026.

Green Plan Guidance Refresh – September 2025

Introduction

In 2021, NHS England guidance on [how to produce a green plan](#) asked systems and trusts to develop green plans spanning 3 years (2022/23 to 2024/25). Significant progress towards achieving net zero. The updated guidance in May 2025 gave [guidance](#) to trusts and systems to refresh their green plans for the next 3 year cycle.

The Dorset trusts' requested an extension in the context of significant organisational change and requested to NHS England the option to prepare a joint plan going forward. NHS Dorset report the requirement to refresh the green plans of DCHFT and DHC was extended to October 2025 to all trusts as the NHS England came out later than expected. [DCH Green Plan](#) mirrors the artwork and layout of the [UHD Green Plan](#) who took a recent decision to refresh theirs.

Green Plan Light 2025/6

It was agreed by Sustainability leads across the Federation with the Joint Director of Estates and Facilities' and in the last update to the board and with NHS Dorset ICB Dorset system to develop a 'Green Plan Light Refresh' that would set 12 months of actions and short updates on progress across the guided themes that are regarded as material to the operations of the trusts by NHS England. This would then leave the opportunity to undertake a more detailed stakeholder engagement and working with the potential Dorset Shared Services changes.

The KPIs approved at DCH and now mirrored with DHC will continue for the Green Plan Lite

KPIs, DCH & DHC

1. Compliant Green Plan Targets Achieved %, include NZC Procurement
2. Carbon Footprint – decreasing in line with NHSE targets (annual)
3. National Target for waste 60:20:20 (annual)
4. Eco Earn activity – increasing (quarterly)
5. Sustainable Development Assessment Tool 2 – maintain and improve score DHC, develop, DCH.

Requirements of the Green Plan Refresh

The requirements include Board approval and publicly accessible on a website, with a focus on SMART actions. KPIs, stakeholder engagement and alignment with the national net zero targets and guidance, covering 3-5 years with annual reviews and governance to measure progress and legal duties such as reducing inequalities.

Since the guidance was published there have been 3 Dorset trust Green leads meetings with the ICB covering Approach to meet the encouragement of a collaborative approach with the ICBs.

Joint GP explored and notified to NHSE, drafted structure to each have an action list with some commonality, joint initiatives, such as Dorset NHS Lift share, EcoEarn and overview with specific actions tailored to each trust.

DCH and DHC have agreed to produce a 12-month plan with an action list (drafts Appendix 1 & 2). This will satisfy criteria while allowing for reframing and longer plan once there is a decision on Dorset shared services. The shared services will create further requirement and opportunity for a shared Green Plan as at 1 and potential to enrapture innovation and further shared initiatives while reflected the local distinctiveness of service delivery, estates, clinical and environmental landscape of each trust and their clinical and support operations.

Adjoining trusts - UHD

Shared services having been paused that is now lifted, UHD have reprinted their green plan with minor updates.

Indicative costs

The following costs are for the design, consultation, and preparation of a Green Plan, not to deliver the costed action list that would form part of the new plan. Please refer to Table 1 – as below.

Baker, Abi
06/10/2025 12:40:16

Indicative costs

The following costs are for the design, consultation, and preparation of a Green Plan, not to deliver the costed action list that would form part of the new plan. Please refer to Table 1.

Item Part of Green Plan	Notes	Per trust
Climate Change Risk Assessment	£29,887.50 (excluding VAT) quote for UHD, DHC and DCH or same for 1 trust or 3.	9,962.50
Carbon Literacy training	Trainers free until Oct 2026 then £15pp for certification	15*150 people per trust = £2,250 in DCH met by sustainability budget
Soil Association Award	Catering Manager at DCH interested and potentially at DHC	£1,980 per trust in DCH met by Sustainability budget
Green Travel Plan	Estimate, degree of pre-work and plans available	£10640
Biodiversity Action Plan	Use of the Nature Recovery Ranger and Sustainability Manager at DCH with Phase 1 habitat training and for specialist ecological surveys	3000
Green Plan engagement	Sustainability pack, artwork, survey raffle prizes	£300 per trust in DCH met by Sustainability budget
	TOTAL	£28,132.50

Please note deadline of December 2026 for Green Travel Plan, Time to find and work with consultants and engage staff with green plan this is requested over 2 financial years, divided into year 1 CCRA, engagement, year 2 GTP.

DCH requested Soil Association, Carbon Literacy and Engagement last fiscal year so the Sustainability budget includes, £2,250, £300 and £1980 with the opportunity of the HealthybyNature project and Biodiversity tasks, reducing the overall to **£23,602**

Baker, Abi
06/10/2025 12:40:16

Table 1: Indicative Consultation or Expertise Costs

Applies to	Green Plan Production Cost	Owned by	Resources	Opportunities	Threats	Indicative Costs
UHD, DHC and DCH	Climate Change Risk Assessment and Adaptation Plan across the Dorset system					
	Consultant contract management	Sustainability leads Head of Emergency Planning & Security Management	Sustainability teams	Opportunity for joint climate adaptation support	competing priorities potential lack of engagement and understanding	£29,887.50 (excluding VAT).
	- Solar gain mapping - Hot/cold/flood reports on MICAD	Not yet undertaken	Sustainability teams	Anecdotal reports, identified potential. Deadline Weds 10 Workshop support of flood and heat in incident reporting and effective adaptation plans	not yet undertaken	Support tool workshop during Sep 2025
	RFI from trusts likely to include. - ERIC data - NIFE Asset survey - Flood risk (Dorset Council) - Tree maps (site map of 2021)	Sustainability team Compliance managers	Shared Consultancy	Up to date information and systems to interrogate	Estates information and competing priorities causes delay or missing information and increases cost of producing the plan	Within existing resources across teams
	CCRA data on topography, flood risk, (fluvial, groundwater), tree canopy, land use, drainage.	Sustainability team Estates	Dorset Explorer and DC GIS	Public Sector Decarbonisation and Ecology Group, (PSDEG) led by Dorset Council		Admin support

Applies to	Green Plan Production Cost	Owned by	Resources	Opportunities	Threats	
Trust level	Carbon literacy training					
Trust level	Delivered to Green Leads, Board of Directors, Procurement.	Sustainability team, decision makers and r green plan leads		Green theme leads		Sustainability teams undertaken training and cascade. £15pp certification, currently subsidised by NHS England 150 first wave x £15=
	Centre for Sustainable Health Care		Centre for Sustainable Healthcare Carbon Literacy https://sustainablehealthcare.org.uk/courses/	Review this		
	HFMA		HFMA https://www.hefma.co.uk/news/new-environmental-sustainability-e-learning-session-from-hee	Managers		
	Carbon Literacy for Health Care leadership		there is a licence to use the toolkit) https://carbonliteracy.com/healthcare/	Train team to be facilitators training is free		
Federation	Soil Association Award process for Catering function	Catering Manager, Sustainability Manager	DCH has begun baselining food waste for around 12 months. Local sourced food is recorded and reported in past Annual reports, contributing to local economy, farming and social value, and may contribute to reducing health inequalities	This process gives support enabling engagement in the green plan		<u>£1,980</u>
				Potential for staff, patients and visitors to feel positive about food sourcing		
				across DCH and DHC a recognised accreditation system of local and low pesticide food sourcing that could be reported in a GP and Annual report.		

Baker, Abi
06/10/2025 12:40:16

Applies to	Green Plan Production Cost	Owned by	Resources	Opportunities	Threats	
Trust Jointly and Specific	Green Travel Plan (overarching joint with tailored local information)					
Trust Jointly and Specific	Green Travel Plan for Main site, Charlton Down and update actions in GTP for South Walks House		Consultants for a generic Green Travel Plan and localised to specific trust	Scope drafted and circulated to STWG		Sustainability teams
			RFI by consultants A Consultants vary 200-2000/day, average/Mid Range consultants estimate 532/ day / person, estimate team of 2 for 10 days £10,640.	Some work undertaken by both trusts. Joint NHS Dorset Lift Share with UHD, DCH, DHC Maybe opportunity for joint procurement		£10, 640+VAT
			South Walks House (BREEAM Very Good ()) DCH has a bike users' group. VIVUP Staff bikes and accessories benefits Information on staff net and website Annual Staff Travel Survey (DCH) (2024 & 2025)	EcoEarn Cycle to work day. Dorset Council e-bikes between sites DC Works to improve cycling to site (2025)	Cycle facilities conditions and opportunities at main site. Different administration practice across appointment letters	Within Existing Resources and budgets
Consultation on preparing a Green Plan 3-5 years	Staff Green Plan Survey		Sustainability teams, administrative support, online surveys		Online	Sundries of £300 costs to be met within the Sustainability budget at DCH
	Workshops and drop ins		Room bookings, refreshments – costs met in house		Consider admin support	
	Green stories design, photos, printing		Printing costs for display panels £2-300 jointly produced			
	Green Champion sign up prizes		Raffle prizes £50 per trust			

Table 2: Stakeholder Mapping and Engagement Plan Draft

Stakeholder	Relevance, Contribution. Willing to engage, involvement, Interest, Power	Engagement Method	Costs
Sustainability Champions	Delivery partner, interested, varied engagement	Online survey and drop ins. Refresh ways to engage	Sustainability team time Communication materials design and printing costs, project management training, carbon literacy training
Green Plan theme leads	Delivery partner, theme focus, often engaged – but clinical and some non-clinical timing issues – refreshments? Go to them?	Sustainability and Travel Working Group; subgroup workshops online and if possible, on site	Sustainability team time, clinical staff time, support services, carbon literacy, administration potential room bookings
Green Plan theme staff	Not necessarily engaged although IPC example, variable interest, involved in day-to-day operations of this theme	Workshops, drop ins	Room booking, artwork, engagement tools
Board and executives	Direct and significant impact and high influence, legitimate responsibilities, variable ability, time or willingness to engage	Carbon literacy training and presentation	Board specific or cascade carbon literacy, from free after sustainability team complete up to £200pp
Staff	Not necessarily engaged although variable interest, involved in day-to-day operations	Consultation pop events across the estate and online teams drop ins	Within existing resources with pressure on other work areas and admin support would be useful
Visitors and patients	Optional engagement, may value projects, people we serve	Pop =events, consider climate change anxiety picnic with HealthybyNature Recovery Ranger	Small sundries for survey incentive prizes and artwork
HR	Specific role in consultation and development of plan	Teams meeting and briefing	Within existing resources
Equality and diversity	Specific role in consultation and development of plan	EDI Meeting	Within existing resources
Health and Wellbeing	Specific role in consultation and development of plan	Health and wellbeing coaches	Wellbeing Coaches undertake training
Greenspaces group	Specific role in consultation and development of plan	Teams meeting	Within existing resources
EcoEarn participants	Pro-environmental decisions and actions	Survey link	Within existing subscription and resource

Baker, Abi
06/10/2025 12:40:16

Conclusion

The Dorset Green Leads have sought NHS England guidance on joint Green Plans, taken part in meetings with the ICB, and the Federated trusts are working on a Green Plan Light and draft action list, this was first developed at DCH for the Social Value Action Plan 2025/26. And DHC has a draft action list for 2025/6.

To develop a full Green Plan in line with the guidance indicative costs are proposed for consideration and approval. This would enable greater stakeholder engagement, an update for the Adaption plan that at DCH expires in 2026, working collaboratively to reduce costs and where there is commonality of challenges and impact. The required Green Travel Plan by December 2026 has already benefitted from the learnings of the South Walks House Green Plan and the Sustainability Managers experience on Green Travel Plans in local councils, and for DHC the Sustainability lead's experience in fleet management for their Green Plans, alongside developing the Dorset NHS Lift share Scheme across the 3 trusts. This would be supplemented by consultants work on specific provisions, funding opportunities and transport options with generic information shared and tailored actions focused per trust.

Recommendations

1. **Note** Green Plan light refresh with a 12-month SMART Objectives and KPIs by end of October for governance and approval by the Board of Directors.
2. **Note** the intention to develop a Dorset wide Green Plan in discussion with Dorset ICB and meeting NHS England guidance once shared services outcome known.
3. **Approve** the additional costs and resources, indicative at this stage, to develop a Green Plan, Green Travel Plan by December 2026.

Baker, Abi
06/10/2025 12:40:16

DCH Charitable Funds Committee Assurance Report for the meeting held on 30.9.2025

Chair	Name Dave Underwood
Executive Lead	Name Chris Hearn
Quoracy met?	Yes
Purpose of the report	To provide assurance on the main items discussed and, if necessary, escalate any matter(s) of concern or urgent business.
Recommendation	To receive the report for assurance

Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework	• Nil

Key issues / matters discussed at the meeting	The committee received, discussed and noted the following reports: • CFC Minutes (22.7.25) – approved as an accurate record. • CFC Actions (22.7.25) – All actions completed or in progress. • DCH Charity Financial Reports 25/26 (M5) – reports were received. Total income as of end Aug 2025 £179,930. Unrestricted funds were £404,451 providing a surplus of £131,451 against the approved reserves target of £273,000. • £2.5M Capital Appeal (ED/CrCU) report (Aug 2025) – report received. £1.165M income and pledges received to date. • Fundraising & Communications report – overview of current key fundraising activities and communications. • Lillian Martin legacy – Advised to support submission of representation to Local Plan re-potential future commercial development of land. Knight Frank to submit on behalf of the beneficiaries. Committee agreed. • AOB – Extreme Sport fundraising guidance and Donation Acceptance/Refusal Policy to be brought to next meeting for review/approval.

Decisions made at the meeting	• Lillian Martin legacy: Advised to support submission of representation to Local Plan re-potential future commercial development of land. Knight Frank to submit on behalf of the beneficiaries. Committee agreed.

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	Date 22.7.25	Date 30.9.25
Quorate?	Y	Y	Y	Y	Y	Y
Committee member name	Y Dave Underwood	Y Dave Underwood	Y Dave Underwood	Y Dave Underwood	Y Dave Underwood	Y Dave Underwood
Committee member name	Y Chris Hearn	Y Chris Hearn	N Chris Hearn	Y Chris Hearn	N Chris Hearn	Y Chris Hearn
Committee member name	Y Jo Howarth	Y Jo Howarth	N Jo Howarth	Y Jo Howarth	Y Jo Howarth	N Jo Howarth
Committee member name	Y Anita Thomas	Y Anita Thomas	Y Anita Thomas	Y Anita Thomas	Y Anita Thomas	N Anita Thomas
Committee member name	Y Margaret Blankson	Y Margaret Blankson	Y Margaret Blankson	Y Margaret Blankson	Y Margaret Blankson	Y Margaret Blankson
Committee member name	Y Stephen Tilton	N Stephen Tilton	Y Stephen Tilton	Y Stephen Tilton	N Stephen Tilton	Y Stephen Tilton

Baker, Abi
06/10/2025 12:40:16

DCH SubCo Ltd Assurance Report for the meeting held on 06 August 2025

Chair	Stephen Tilton
Executive Lead	Nick Johnson, Claire Abraham (DCH SubCo Directors)
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	• The need for a replacement director for NJ (i.e. a third director), in addition to previous discussions about the need for a fourth director • Approval of the Annual Report and Accounts subject to final contract reviews, impacting the going concern position • The pharmacy had moved in to the new expanded footprint • Reform of VAT rules and the impact this is likely to have on the NHS • Approval of the capital costs linked to the expansion (totalling £107,603) • Proposal to extend the contract to 10 years • KPIs to be updated as workforce expands in the new footprint

Key issues / matters discussed at the meeting Baker, Abi 06/10/2025 12:40:16	The DCH SubCo board received, discussed and noted the following reports: • Finance report, noting the position at the end of June of a surplus of £21,000, slightly behind the planned surplus of £24,000. Cash balance was slightly behind plan, but this was due to the timing of payment to suppliers and was not a cause for concern. • Q1 Performance Report noting: ○ All KPIs remain green. The KPIs were being revised in line with the new footprint. ○ A risk relating to the reform of VAT rules was noted; this was expected to have a big impact on the NHS and the company. • Review of Risk Register, Incidents and Complaints and Mitigating Actions noting ○ One dispensing error which had been addressed. The low number of incidents in the company was noted. ○ Risks relating to the footprint had been largely mitigated due to the recent move in to the new space. • Contract Review Feedback • Annual Report and Accounts, noting: ○ Clean accounts prepared in accordance with regulatory requirements and UK generally accepted accounting practices. Audited by KPMG. ○ Ongoing contract discussions meant that the auditors were not yet able to finalise their report as the contract impacted the



- going concern assessment; authority to sign off the Annual Report and Accounts was delegated to CA once this process had been finalised.
- Approval of the management letter of representation
- Approval of the capital costs linked to the expansion (totalling £107,603)
- Receipt of the tax provision report and computations, and transmittal letter/report
- Discussion re contract and lease, noting the need to annually review the disaster recovery and business plan, and the proposal to have a ten-year lease due to incoming leasing standards. Activity levels would be reviewed, and any changes would be managed via the change control notice once in place.
- Proposed Remuneration Packages – Workforce Expansion
 - Approval of the proposal which detailed remuneration packages for new roles within the previously approved expanded workforce. This included progression routes and additional training offers. The package was in line with the previously approved business case.
 - Discussion around recruitment and the associated risks.
- Governance items:
 - Submission of Confirmation Statement to Companies House
 - Review of DCH SubCo Officers and Directors' Liability Insurance
- AOB:
 - Receipt of NJ's resignation from DCH SubCo Ltd Board. Thanks were extended to NJ for his contribution to the company, as this was his last meeting.

Decisions made at the meeting

- Authority to sign the Annual Report and Accounts was delegated to CA, pending ongoing work to renew the contract between the trust and the company.
- Approval of the management letter of representation
- Approval of the capital costs linked to the expansion (totalling £107,603)
- Approval of the Proposed Remuneration Packages – Workforce Expansion
- Approval to notify the GPhC of the move to the new footprint (under AOB)

Issues / actions referred to other committees / groups

- Nil

Performance Report

Andrew Harris

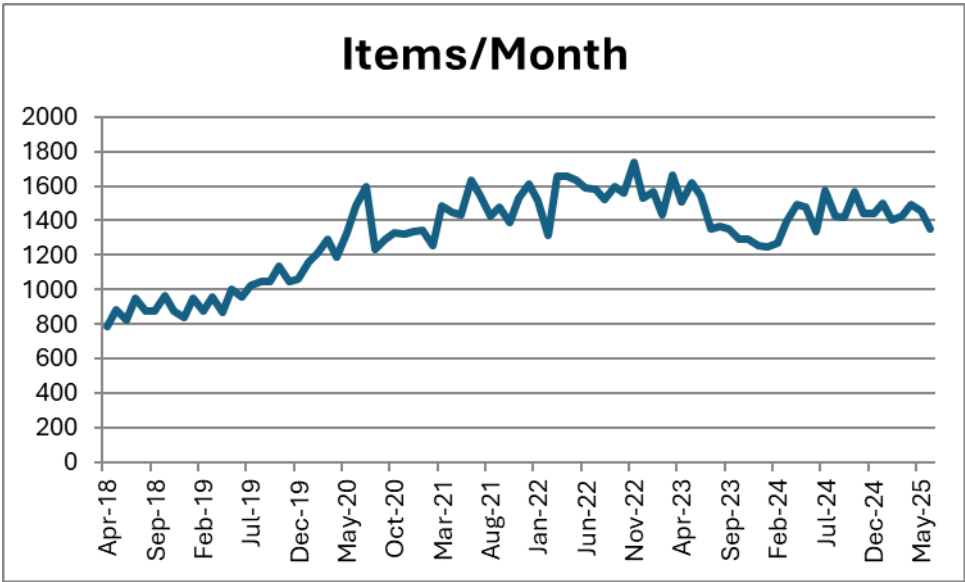
Superintendent Pharmacist

July 2025

Key Performance Indicators (KPIs)

	Apr-25	May-25	Jun-25
Total Number of Customers per Month	179	137	141
Total Items Dispensed	1493	1452	1353
Average Items/day	74.7	72.6	61.5
No. of same day Prescriptions	194	202	137
No. of Advance Prescriptions	501	424	505

Activity levels from April 2018 to current:



Fortuneswell Pharmacy has returned to cancer only related activity which is reflected in the reduced activity from August 2020, though cancer related activity is now climbing.

A review of dispensing activity was undertaken in June 2023 in conjunction with the Chief Pharmacist and Lead Cancer Nurse to identify activity that could be relocated elsewhere (main hospital pharmacy or community pharmacy) to manage the increasing workload.

Baker, Abi
06/10/2025 12:40:16

All contractual KPIs year to date are green:

Performance measure	Key Performance Indicator	Target performance	Green	Amber	Red	Apr-25	May-25	Jun-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%	0.22%
Near Miss Monitoring	Number of errors made per total volume of prescriptions dispensed that have NOT LEFT the department	<2.0%				0.94%	1.10%	1.03%
Availability of service	Responsible Pharmacist Availability	0	0 to 45 mins	45 to 90 mins	> 90 mins	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%	99.73 %	99.59 %	99.93 %
MHRA Recall Assurance	100% of all SABs alerts, MHRA and Company-Led recalls are managed in accordance with Class status	100%				100%	100%	100%
All Mosaik advance prescription prepared the day in advance of collection	The completion time should be the day in advance of collection/ delivery to chemotherapy nurses.	>90%	100% - 90%	89.9% - 80%	<80%	93.4%	91.0%	97.4%
The waiting time for dispensing prescriptions, during a monthly period shall be: (i) 30 minutes or less in respect of 95% of all prescriptions; and (ii) 20 minutes or less in respect of 80% of all prescriptions	The time taken for a patient to wait for their prescription from the time they present it to the Pharmacy.	(i) 30 minutes or less in respect of 95% of all prescriptions (ii) 20 minutes or less in respect of 80% of all prescriptions	For (i) Greater than or equal to 95% For (ii) Greater than or equal to 80%	For (i) 80% - 94.9% For (ii) 65% - 79.9%	For (i) Less than 80% For (ii) Less than 65%	(i) 100% (ii) 95.2%	(i) 99.2 % (ii) 95.3%	(i) 99.0% (ii) 98.0%
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%
Number of complaints	The number of upheld complaints		1 or fewer complaints per quarter	0	0	0	0	0

Baker Abi
06/10/2025 12:40:16

Number of non-agreed non-formulary items supplied	Number of items that appear on total non-formulary supply report	0%	0% - 0.049%	0	0	0	0	0
Controlled drug management	Correct procedure against SOPs followed at all times	100%	No Tolerance			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%
Waste/Expiry management*	Waste Costs below £200 per month - Stock waste to be managed	<£200	<£200			£5.87	£0.00	£39.46

	Apr-25	May-25	Jun-25
Month End Stock Value £k	363	446	384

Incidents

1 dispensing error left the department on 17th June. No harm to patient. £3,600 of stock had to be written off.

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. **Some of this should be resolved with moving into the new build Fortuneswell Pharmacy on Thursday 10th July.**
- 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.

Baker, Abi
06/10/2025 12:40:16

Report to	Board of Directors, Part 1 (DHC Board)	
Date of Meeting	07 October 2025	
Report Title	Medical Staff Revalidation – Annual Update and Statement Of Compliance	
Prepared By	Dr John Stephens, Associate Medical Director & Lead for Revalidation and Medical Appraisal Helen Young, Medical Appraisal, Revalidation & Job Plan Coordinator	
Approved by Accountable Executive	Dr Lucy Knight Chief Medical Officer & Responsible Officer	
Previously Considered By	People and Culture Committee in Common 22/09/2025	
Action Required	Approval	Y
	Assurance	N
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? <i>Delete as required</i>	
Care	Yes	
Colleagues	Yes	
Communities		No
Sustainability		No
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 Safety and Quality SR2 Culture SR3 Workforce Capacity	
Financial	No implication	
Statutory & Regulatory	No implication	
Equality, Diversity & Inclusion	No implication	
Co-production & Partnership	No implication	

Executive Summary
The purpose of the report is to update the Board on the Trust's arrangements to enable revalidation of medical staff. The report sets out the Medical Appraisal and Revalidation process the Trust has in place in line with GMC guidelines. It provides the Board with the following updates: - The number of prescribed connections to the Trust and number of doctors who have had an appraisal for the 2024/2025 appraisal year - The number of Trust Appraisers and how their learning and development is supported - The systems in place to support the appraisal and revalidation process and provide quality assurance - The number of doctors who have revalidated in 2024/2025 and the number of doctors who were deferred - Recruitment and Background checks - Responding to concerns and remediation At the end of the 2024/2025 appraisal year there were 120 doctors with a prescribed connection to Dorset HealthCare University NHS Foundation Trust. All doctors with a prescribed connection were allocated a trained appraiser and have had an appraisal meeting or a valid reason for exception for the 2024/2025 appraisal year. I continue to be assured that the Trust has a well-run medical appraisal and revalidation system with no risks or issues.

Recommendation

Members are requested to:

- **Approve the report**

Baker, Abi
06/10/2025 12:40:16



MEDICAL STAFF REVALIDATION – UPDATE

07 October 2025

1 PURPOSE OF REPORT

- 1.1 To provide assurance the Trust has a system that meets GMC requirements for appraisal and revalidation of medical staff with a connection to the Trust.
- 1.2 Revalidation of doctors is an established national process. The enhanced appraisal which supports the revalidation process within Dorset HealthCare University NHS Foundation Trust, has been in place since 2011.
- 1.3 This update report covers the calendar year April 2024-April 2025.

2 BACKGROUND

- 2.1 Medical Revalidation was launched in 2012 to strengthen regulation of doctors, develop the quality of care provided to patients, improve patient safety and increase public trust in the medical system.
- 2.2 Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations. It is expected that provider boards will oversee compliance by:
 - monitoring the frequency and quality of medical appraisals in their organisations
 - checking there are effective systems in place for monitoring the conduct and performance of their doctors
 - confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
 - ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

3 GOVERNANCE ARRANGEMENTS

- 3.1 The Trust has in place the following key personnel to support the appraisal and revalidation process:
 - Responsible Officer – Lucy Knight
 - Deputy Responsible Officer – Andy Dean
 - Medical Appraisal and Revalidation Lead – John Stephens
 - Medical Appraisal and Revalidation Co-ordinator – Helen Young
- 3.2 Progress of the appraisal and revalidation process during 2024/2025 was monitored via regular reporting as follows:

Baker
06/10/2025 12:40:16

- Bi-monthly reports are provided for the Responsible Officer and discussed at bi-monthly meetings by the Responsible Officer, Deputy Responsible Officer, Medical Appraisal & Revalidation Lead and Medical Appraisal Revalidation Co-ordinator
- Annual Organisational Audit (AOA) has been stood down since 2020. Compliance is now achieved through completion of the table within the NHS England Framework for Quality Assurance.

3.3 The Trust plans to submit the Responsible Officers Framework for Quality Assurance including the Statement of Compliance to NHS England. This is included for Board approval as Appendix A.

4 MEDICAL APPRAISAL

4.1 Doctors with a prescribed connection

4.1.2 As of 31 March 2025, there were 120 doctors with a prescribed connection to the Trust. In the 2024/2025 appraisal year, 112 doctors had an appraisal meeting with the Trust.

Eight doctors connected with the Trust as of 31 March 2025 did not require appraisals. One appraisal was an approved miss due to maternity leave. One appraisal was an approved miss due to sickness absence. Two doctors who were appraised were no longer connected by 31 March 2025.

In the 2024/2025 appraisal year, 15 Appraisals were defined as postponed; 97 were completed within the required time. All postponements were agreed for appropriate reasons, including sickness, planned absence and workload.

4.1.3 All doctors have access to funded multi-source feedback, once within a five year revalidation cycle to meet minimum revalidation requirements. Infrequently, there are circumstances that require additional multi-source feedback to be undertaken, and this is carefully considered on a case-by-case basis. The 360° feedback from colleagues and patients is discussed, with reflection forming an important part of the appraisal process. The uptake of multi-source feedback and the output from this process is monitored and assured at the time of a revalidation recommendation.

4.1.4 In the 2024/2025 appraisal year, all doctors were required to submit their appraisal data on the online toolkit Strengthened Appraisal and Revalidation Database (SARD). This enables monitoring, audit and quality assurance of appraisal outputs and revalidation recommendations.

4.2 Appraisers

4.2.1 The Trust had 20 trained medical appraisers at the end of 2024/2025 year.

4.2.2 Appraisers are supported in their role in the following ways:

- access to support and guidance from Medical Appraisal and Revalidation Lead as required
- allocated peer group of appraisers

- individual meetings with Appraisal and Revalidation Lead to receive feedback on review of appraisal outputs using the NHS E & I Appraisal Summary and PDP Audit Tool form (ASPAT) and feedback received from appraisees. This is used as an opportunity to plan any personal development, including peer review process of appraisal outputs.
- Bi-annual Appraiser Support and Development Forum half days.

4.3 Quality Assurance

- 4.3.1 An internal audit of the appraisal and revalidation system was not deemed necessary in 2024 or 2025 as an NHS England Higher Level Responsible Officer review took place in July 2024.
- 4.3.2 It has been decided by the RO that we will not collect annual declaration forms for doctors with another responsible officer.
- 4.3.3 Under the Framework of Quality Assurance, an Independent Verification Review by NHS England took place on 23 July 2024.
- 4.3.4 The HLRO Review made eight recommendations. Two of these 'must' be implemented and six are for our consideration.
- 4.3.5 The Trust Board 'must' be aware that it is a key responsibility of the Board to ensure adequate resources for provision of a Trust Appraisal service for doctors. The HLRO Review report is available on request.
- 4.3.6 The Trust 'must' ensure that there are no single points of failure within the Trust Appraisal and Revalidation processes and systems. This will be achieved by agreement of adequate resource and capacity within the Revalidation team.
- 4.3.7 Individual qualitative feedback on the value of appraisal has been collated for sharing with appraisers to focus development. This also enables the Trust to identify the broader benefits of the medical appraisal system. Overall feedback was very positive. A summary report outlining the full audit of the 2024/2025 feedback, Audit of Medical Appraisal Feedback 2024/2025 is available on request.
- 4.3.8 The Trust Lead for Medical Appraisal and Revalidation meets individually with Trust appraisers annually to reflect on the role, receive feedback and consider further areas for development.

4.3 Access, Security and Confidentiality

- 4.4.1 All staff appraisal information and evidence is stored on the Trust's Medical Revalidation drive, the Trust's Business and Performance drive and the SARD online toolkit. Access is limited to staff involved in the co-ordination and delivery of the appraisal and revalidation process.
- 4.4.2 The Revalidation Team work closely with the Trust Information Governance Team and have improved and developed the link with the Revalidation Team.

Baker-Allen
06/10/2025 12:40:16

4.4 Clinical Governance

4.5.1 The following data is provided to doctors and their appraisers to facilitate their appraisal and revalidation:

- individual complaint data is forwarded to all involved doctors
- Serious Untoward Incident data and reports are forwarded to individual medical staff for inclusion in their appraisal documentation.
- it is expected that doctors will reflect on the data provided and include this in their annual appraisal documentation.

4.5.2 Collated information on numbers of complaints and Serious Untoward Incidents for individual doctors is shared with their appraiser to enable triangulation and ensure appropriate reflection occurs.

4.5.3 Doctors are also supported to complete mandatory training.

5 REVALIDATION RECOMMENDATIONS

5.1 Between 1 April 2024 and 31 March 2025 the Responsible Officer made revalidation recommendations for 36 doctors. 31 doctors were successfully revalidated. 3 doctors were deferred due to an ongoing process and 2 were deferred due to insufficient evidence.

6 RECRUITMENT AND ENGAGEMENT BACKGROUND CHECKS

6.1 Medical HR has a robust process in place to verify ID and qualifications and obtain references for all medical staff employed by Dorset HealthCare. The Trust uses the NHSE process for Transfer of Information to ensure we have complete information when doctors are employed.

6.2 Locums are recruited using Government Procurement Service agencies. The locum agency is required to provide the Trust with the following information:

- GMC confirmation that the doctor has a licence to practice (inclusion on the Specialist Register for all consultant posts).
- up-to-date CV
- name of the doctor's Responsible Officer
- date of last appraisal (must be within 12 months)
- two references to be provided, which would include 1 from the most recent assignment
- Section 12 approval (Psychiatry only)
- enhanced DBS disclosure

Baker, Abi
06/10/2025 12:40:16

- photographic ID and right to work documentation.
- up to date Basic Life Support Certificate
- Occupational Health Fitness to Practice Certificate with full immunisation details
- must be able to drive with own vehicle (if applicable for the role)
- Approved Clinician status (if required for the role).

6.3 The locum doctor is given a 'Welcome Pack' on commencement of employment. The pack contains the following:

- induction checklist for locum doctors.
- Fitness to Practice Form
- Confidentiality declaration
- DBS declaration and form for completion
- Prescription Signature
- Day 1 Agency Worker's letter.

6.4 At the end of the locum's assignment an end of assignment form is completed by the appropriate medical manager.

7 RESPONDING TO CONCERNS AND REMEDIATION

7.1 Only one formal investigation of medical staff took place during 2024/2025. While this progressed to a formal capability hearing it did not result in a formal sanction.

7.2 A Responsible Officer Advisory Group (ROAG) has been established to provide independent oversight and professional advice to support the Responsible Officer in fulfilling their statutory duties under the Medical Profession (Responsible Officers) Regulations 2010. The group ensures that decisions related to medical revalidation are consistent, evidence-based, and subject to appropriate scrutiny. Acting as a source of professional challenge and assurance, the ROAG helps maintain high standards of governance, promotes fairness and transparency, and supports the Responsible Officer in managing complex or sensitive cases effectively.

7.3 A Fitness to Practise Group has also been established to provide a structured, multidisciplinary forum for reviewing and managing concerns about a doctor's ability to practise safely and effectively. This group supports the organisation's duty to protect patients and maintain professional standards by identifying, assessing, and overseeing concerns related to conduct, capability, health, or performance. It typically advises on appropriate actions such as investigation, support, remediation, or referral to the regulatory body, and ensures concerns are managed fairly, consistently, and in line with relevant policies and legal frameworks. The group may also monitor ongoing cases and identify themes to inform learning and system improvement.

7.4 The Trust has the following relevant policies in place:

- Handling of Concerns and Disciplinary Procedures for Medical Staff (IN-768)
- Medical Staff Return to Practice Policy (IN-187)

- Medical Staff Appraisal to Support Revalidation (IN-122)
- Policy for the Management of Medical Locums (IN-153)

8 RISKS AND ISSUES

8.1 No risks identified in relation to the appraisal and revalidation process.

Dr Lucy Knight, Responsible Officer & Chief Medical Officer 2025

Baker, Abi
06/10/2025 12:40:16

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative

Section 2 – Metrics

Section 3 - Summary and conclusion

Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2024 – 31 March 2025

1A – General

The board/executive management team of: Dorset HealthCare

can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Y
Action from last year:	No changes planned
Comments:	Dr Lucy Knight became Chief Medical Officer and Responsible Officer October 2024.

Action for next year:	No changes planned

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Y
Action from last year:	Continue
Comments:	Nil
Action for next year:	Continue

1A(iii) An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Y
Action from last year:	Continue to maintain up to date records
Comments:	Since April 2021 there has been a full-time Medical Appraisal, Revalidation & Job Plan Coordinator in place within the organisation. This reflects the expansion in the number of doctors for whom Dorset HealthCare is the Designated Body. The Medical Appraisal, Revalidation and Job Plan Coordinator keeps an accurate record of all licensed registered medical practitioners with a prescribed connection to Dorset HealthCare. This record is subject to continual updates as circumstances change. The SARD electronic toolkit has been used for this for the last three years.
Action for next year:	Continue to maintain up to date records

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Y
Action from last year:	IN-153 due for review March 2025, IN-187 due for review May 2025, IN-768 due for review February 2026
Comments:	IN-153 due for review July 2025, IN-187 due for review July 2025, IN-768 due for review February 2026
Action for next year	IN-768 due for review February 2026 IN-122 due for review July 2027

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	Y
Action from last year:	Ensure completion of all actions arising from the HLRO Review. Continue to send annual appraisal self-declaration form.
Comments:	The HLRO visit took place on 23 July 2024. The following recommendations were made: 1. The RO must secure additional resources for appraisal in order to have adequately deliver effective appraisal 2. To bring the newly configured model of operating Revalidation and Appraisal in line for both organisations in the federated group 3. To formalise a Responsible Officer Advisory Group (ROAG) 4. It is recommended to outsource Appraisal externally for the Appraisal & Revalidation Lead to ensure there is no Conflict of Interest within the organisation 5. To undertake a review of doctors on the Performers List and explain that they no longer need to be on the Performers List if not undertaking any general medical services so can align to your organisation's Responsible Officer to Appraise and Revalidate 6. To review the 'make up' of Appraisers, ensuring there is an equal, diverse and balanced team and a wider range of disciplines. Review number of Appraisals undertaken and set a minimum to 5-6 per year. 7. Ensure any retired and returned doctors are suitable to undertake Appraisal; ensuring they remain trained and up to date.

Baker, Abi
06/10/2025 12:40:16

8. To ensure there is no single point of failure by establishing cross cover of those tasks within the appraisal system, there is a potential to link with DCH to help mitigate these risks

The report received concluded with the following:

Dr Michael Marsh, and his team, would like to thank you for your engagement in this process and for providing written evidence/information and discussion with regards to systems in place, this has assured Dr Marsh, as your Higher-Level Responsible Officer and he has no concerns regarding the performance of Responsible Officer functions. The recommendations made above, previously informed verbally at the meeting, are intended to be supportive and developmental.

Work has been undertaken to progress towards meeting each of the above recommendations. Recs 3, 5 & 7 have already been met. Efforts are underway towards progressing the remainder. These include:

Rec 1 – work is ongoing to clarify DHC financial arrangements for supporting the Appraisal & Revalidation system for doctors.

Rec 2 – There is a plan for a combined CPD/development afternoon for appraisers from across Dorset to take place in Nov 2025. There are significant challenges inherent in aligning our processes across the federated organisation given the substantial differences in job roles, systems and processes. We are in the process of seeking agreement on SPA time to be allocated for Appraisers in both organisations.

Rec 4 – There is a verbal agreement for the Appraisal & Revalidation Lead to have his appraisal undertaken in Cornwall in the 2025/2026 appraisal year. Cornwall Partnership NHS Foundation Trust is one of over 60 NHS Trusts that use SARD to support appraisal.

Rec 6 – We have made little progress since the time of the HLRO visit but are hopeful that once there is agreement on SPA time and appropriate remuneration for Medical Appraisers it will become easier to both recruit and retain

Baker, Abi
06/10/2025 12:40:16

	Appraisers. We have chosen not to set a minimum number of appraisals to be undertaken per appraiser since even a small contribution to the system can be invaluable and this encourages involvement by senior medical leaders. Rec 8 – Efforts to establish a broader Revalidation team have not progressed as yet. Discussions are ongoing in respect of how best to support the Medical Appraisal, Revalidation & Job Planning Coordinator in their role. It has been decided that annual appraisal self-declaration forms will no longer be sent to doctors with another designated body.
Action for next year:	Continue work towards meeting recommendations as above.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Y
Action from last year:	Policy for the management of medical agency locums (IN-153) due for review 31 March 2025
Comments:	IN-153 due for review and ratification at the JLNC July 2025
Action for next year	Nil

1B – Appraisal

1B(i) Doctors in our organisation have an [annual appraisal](#) that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the

appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Y
Action from last year:	Develop our utilisation of the SARD system.
Comments:	Review of electronic systems to take place and decision to be made regarding renewal of the SARD system in October 2025. Review of Edgecumbe system for MSF and decision taken to switch over to use of SARD for MSF once the existing Edgecumbe licences have been exhausted.
Action for next year:	Further develop our utilisation of electronic systems.

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	N/A
Action from last year:	Ensure that there are sufficient trained appraisers to provide appraisals for all of our doctors.
Comments:	Work is underway to clarify arrangements for SPA time and remuneration for our Trust Medical Appraisers. Once agreed it is hoped that this will assist with both recruitment and retention. This will be through the identification of a separate Appraisal budget.
Action for next year:	For the Trust to provide adequate resource to ensure that there are sufficient trained appraisers to provide appraisals for all our doctors.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Y

Action from last year:	Update Policy for Medical Staff Appraisal to support Revalidation (IN-122) if necessary and review August 2026
Comments:	IN-122 was reviewed and ratified at the JLNC in July 2024
Action for next year:	Update IN-122 if necessary and review July 2027

1B(iv) Our organisation has the necessary number of trained appraisers¹ to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	Y
Action from last year:	Ensure that there are sufficient trained appraisers to provide appraisals for all of our doctors.
Comments:	A proposal paper has been written to suggest a new framework for job planning SPA time for appraisal work. This should assist with both recruitment and retention of medical appraisers. Develop and advertise the role of Trust Appraiser
Action for next year:	Ensure that there are sufficient trained appraisers to provide appraisals for all of our doctors.

1B(v) Medical appraisers participate in ongoing performance review and training/development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements ([Quality Assurance of Medical Appraisers](#) or equivalent).

Y/N	Y

¹While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

Action from last year:	Continue to develop our provision of training and development for our Trust Appraisers.
Comments:	DHC has continued with our programme of 2 half days a year for peer support, training and development. Building on this a joint Trust Appraiser Development Afternoon is planned for UHD, DCH and DHC to be held 19 November 2025.
Action for next year:	Continue to develop our provision of training and development for our Trust Appraisers.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Y
Action from last year:	Continue submission of a regular medical staff revalidation report on an annual basis for the Trust board
Comments:	The Medical Staff Revalidation Update to the Board is shared with the People & Culture Committee and the Trust Board
Action for next year:	Continue submission of a regular medical staff revalidation report on an annual basis for the Trust board

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Y
Action from last year:	The Trust will continue to operate in line with GMC requirements and the Responsible Officer Protocol.

Comments:	Revalidation recommendations are made to the GMC in line with expected requirements. In the appraisal year 2024/2025 the Responsible Officer made 36 revalidation recommendations. 31 doctors were successfully revalidated. 3 doctors were deferred due to an ongoing process and 2 were deferred due to insufficient evidence.
Action for next year:	The Trust will continue to operate in line with GMC requirements and the Responsible Officer Protocol.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Y
Action from last year:	Continue with current system
Comments:	The Deputy Responsible Officer (DRO) or the Trust Lead for Medical Appraisal & Revalidation discusses with the doctor the reasons for a proposed deferral or non-engagement decision before the recommendation is submitted to the GMC. However, in the case of the outcome being to revalidate the RO would not routinely contact the doctor. The administrative revalidation team informs the doctor of the RO's recommendation. Following on from this the doctor will hear directly from GMC Connect.
Action for next year:	Continue with current system

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Y
Action from last year:	Continue to progress live face to face training and CPD, where appropriate, alongside opportunities for virtual training in suitable areas.
Comments:	Dorset HealthCare has established systems for clinical governance. These processes encompass a number of different departments and are supported by required policies. Important components in this include the following: a. A system for medical appraisal. All appraisers in the Trust are familiar with the requirements for Revalidation and the need for doctors to be actively involved in Quality Improvement activities (including audit). b. Operational line management arrangements have recently been re-organised with a new structure created. The CMO is supported by two Medical Directors, one for the Directorate of Mental Health, Learning Disabilities, Children & Families Services and the other for Integrated Community services (ICS). The MD for ICS also acts as the deputy RO. There are a number of Associate Medical Director (AMD) posts each with a specific defined portfolio of responsibilities and designated time to do the work. The Medical Leadership team will also include Lead Consultants for specific areas and the process of appointing these Leads is ongoing. The Medical Leadership team works closely with the department of Human Resources. c. There is a plan to create a new AMD role with a focus on patient safety. This will involve close collaboration with the Nursing, Therapies and Quality Directorate and involve work that includes suicide prevention, PSIRF and our Culture of Care. d. Specific individual members of staff within the Human Resources department have defined responsibilities for medical staffing.

Baker, Abi
06/10/2025 12:40:16

- e. A system for medical education led by the Director of Medical Education (DME) with dedicated administrative support. The DME is assisted by an Associate DME. Medical education covers all grades of doctor employed by the Trust which includes Consultants, NHS Locums, SAS doctors and all trainees on rotation. There is an educational programme which runs weekly, and the Trust also provides a placement for undergraduates from Southampton University. The DME is supported by education leads for consultants, SAS & Locally Employed doctors and for postgraduate and undergraduate medical trainees. Members of the medical education team participate in regional Annual Review of Competence Progression (ARCP) panels run by the Wessex Deanery, which support the revalidation of doctors in training.
- f. All Consultants and SAS doctors within mental health are required to join a peer group to support Continuing Professional Development (CPD) activities.
- g. The Trust supports the system for consultant staff to come together as a body for two days a year for learning, CPD, updates from conferences attended and sharing of good practice. Following the Covid-19 pandemic these meetings resumed on 1 December 2022 with subsequent meetings held roughly every 6 months. These events take place at an external venue and are now funded by resource drawn from the senior doctors' study leave budgets.
- h. Those doctors employed by the Trust who work in the community hospitals also have access to CPD opportunities. For doctors in the community hospitals, there are bimonthly meetings that last for an hour and are concerned with clinical governance and CPD. Each of the hospitals also organise monthly multi-disciplinary mortality review meetings. The Contraception and Sexual Health doctors meet for CPD

Baker, Abi
06/10/2025 12:40:16

Baker, Abi 06/10/2025 12:40:16	activities. All CPD is considered at annual appraisal to ensure that it is relevant and addresses the whole scope of practice for each individual practitioner. i. Doctors employed by the Trust and linked to a Medical Royal College must be in good professional standing for CPD. j. In addition to medical staff requirements to undertake CPD that covers the whole scope of practice, the Trust has internal standards for mandatory training. Compliance with mandatory training requirements is monitored and upheld by the Executive PA to the Chief Medical Officer. k. The Nursing, Therapies and Quality Directorate is headed by the Chief Nursing Officer. The portfolio includes the system for patient safety incident investigations as well as responses to complaints, incident reporting and risk. There are close links with the Learning and Development Service where specific modules have been developed concerned with clinical risk. There are audit facilitators within the Directorate available to help, advise and support doctors and other staff with clinical audits. l. All doctors employed on substantive NHS contracts with the Trust must undertake a 360-degree appraisal within each 5 year Revalidation cycle. This includes feedback from patients as well as colleagues. There is a requirement that the outputs receive focus within appraisal meetings and that any learning feeds into the development of Personal Development Plans (PDPs) for individual doctors. The Trust is in the process of switching from Edgecumbe 360° appraisal to the integrated SARD MSF tool.. This has the advantage of a single system and will also be associated with a small cost saving. m. Annual appraisal must include consideration of any significant events, patient safety incident investigations,

	complaints etc. Such information is collated and provided for Trust doctors together with their allocated appraiser. n. The Trust is working to improve the quality, reliability and usefulness of the data we hold concerned with patient outcomes. Alongside reports from serious incidents, this will enable individuals and teams to reflect on performance and seek opportunities for improvement.
Action for next year:	Continue to progress live face to face training and CPD, where appropriate, alongside opportunities for virtual training in suitable areas.

1D(ii) Effective [systems](#) are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Y
Action from last year:	Implement improvements identified by reviews regarding sharing information about SIs and complaints with doctors for appraisal and revalidation
Comments:	Any serious incidents or complaints in which the individual doctor has been named must be brought to annual appraisal for discussion and reflection on any learning points. Individual doctors sometimes choose to discuss less formal complaints communications or difficulties they may have encountered. The Trust has a policy for the Handling of Concerns and Disciplinary Procedures relating to the Conduct and Performance of Doctors (IN-768). Medical line managers work closely with other management colleagues should problems arise and are supported in this by the Department of People and Culture. (Human Resources). Whenever possible concerns about conduct or performance are managed and resolved locally. However, it is sometimes necessary to seek guidance from the Employment Liaison Advisor (ELA) and rarely this results in a GMC referral.

Baker, Abi
06/10/2025 12:40:16

Action for next year:	Implement improvements identified by reviews regarding sharing information about SIs and complaints with doctors for appraisal and revalidation

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Y
Action from last year:	Review our current process and align with Dorset County Hospital
Comments:	Status of revalidation of doctors is presented and shared with the Revalidation Team in the same format as DCH at bi-monthly meetings. This spreadsheet is available for the Revalidation Team to access on MS Teams.
Action for next year:	Review our current process and align with Dorset County Hospital

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns [policy](#) that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Y
Action from last year:	Nil
Comments:	There is a Policy for Handling Concerns and Disciplinary Procedures relating to the Conduct and Performance of Doctors and Dentists (IN-768), and this is based on "Maintaining High Professional Standards". This policy covers arrangements that apply should concerns about a doctor or dentist be raised. This includes circumstances in which remedial and supportive action is appropriate as well as what to do in the event of more serious concerns.

Baker, Abi
06/10/2025 12:40:16

	All concerns about employed medical practitioners are brought to the attention of the Chief Medical Officer. The policy describes issues around exclusion or restriction on the doctor's practice and when such sanctions are considered appropriate. There are sections which deal with misconduct, capability issues, health of doctors as well as the investigation process. In the past year the Trust has formally created a RO Advisory Group (ROAG) which will support consistent decision-making in this area. Fitness to Practice issues are discussed at the Responsible Officer (RO)-Chief Medical Officer (CMO) & GMC Employer Liaison Adviser (ELA) meetings which are held regularly. The GMC ELA is available for informal and formal discussions by telephone between face-to-face meetings.
Action for next year:	Nil

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	Y
Action from last year:	Continue to monitor ethnic origin and gender balance of medical workforce and of our Trust Appraisers. Continue to encourage colleagues from diverse backgrounds to be involved in this work. Share information with the Trust Directorate of People and Culture to inform the ongoing dialogue and Equality, Diversity and Inclusion (EDI) work of the Trust.
Comments:	The Trust is in the process of agreeing the SPA time allocation for our medical appraisers and will be seeking a consistent approach with Dorset County Hospital. Once this has been agreed and the expectations are clear we will undertake further recruitment, keeping in mind the expectation of an appraiser group which is representative of the medical workforce as a whole.

Baker, Abi
06/10/2025 12:40:16

Action for next year:	Continue to monitor ethnic origin and gender balance of medical workforce and of our Trust Appraisers. Continue to encourage colleagues from diverse backgrounds to be involved in this work. Share information with the Trust Directorate of People and Culture to inform the ongoing dialogue and Equality, Diversity and Inclusion (EDI) work of the Trust.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with [appropriate governance responsibility](#)) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Y
Action from last year:	Ongoing monitoring of compliance with annual declaration form returns from doctors who undertake some work for Dorset HealthCare but have a different Designated Body.
Comments:	The medical practice information transfer form (MPIT) is routinely used for communication between organisations when a doctor connects for the first time to Dorset Healthcare. The MPIT will also be used in the event that another RO at a different Trust requests information about a doctor who undertakes work in Dorset Healthcare. It has been decided that annual declaration forms will no longer be sent.
Action for next year:	Nil

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref [GMC governance handbook](#)).

Y/N	Y
Action from last year:	The Department for People & Culture is involved with Trustwide EDI work. Information concerned with

	investigations and other disciplinary processes involving our Trust doctors will be monitored by HR.
Comments:	HR policies include an Equal Opportunities Impact Assessment
Action for next year:	The Department for People & Culture is involved with Trustwide EDI work. Information concerned with investigations and other disciplinary processes involving our Trust doctors will be monitored by HR.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Y
Action from last year:	Nil
Comments:	Dorset HealthCare's Trust Board approves, annually, a schedule of matters which it reserves to itself. These include the power to set the vision, strategic aims, objectives and budget for the Trust. Other matters are delegated to Board Committees, which operate within defined terms of reference. The Audit Committee is a committee of the Board of Directors responsible for overseeing, monitoring and reviewing corporate reporting, the adequacy and effectiveness of the governance, risk management and internal control framework and systems and areas of legal and regulatory compliance at Dorset HealthCare and the external and internal audit functions. This includes speaking up (including whistleblowing) and counter fraud. There are three Non-Executive Director members of the Committee, all of whom are independent. The Chief Finance Officer, Chief Nursing Officer and Chief Operating Officer regularly attend meetings and the Trust's Freedom to Speak Up Guardian attends meetings at least twice each year. The Mental Health Legislation Assurance Committee has been established by the Board of Directors to provide specialist advice to the Board and Quality Governance Committee in respect of compliance with law and best

Baker, Abi
06/10/2025 12:40:16

Baker, Abi 06/10/2025 12:40:16	practice in relation to the rights of mental health services users. The Committee's membership is made up of a mix of Non-Executive and Executive Directors. There is a clear separation of the Committee's role in acquiring and scrutinising assurances as to quality governance in mental health services and that of conducting the review process for detained patients in accordance with the required provisions of mental health legislation, undertaken by Mental Health Act Panel members. Panel members are independent lay people who have been trained in mental health legislation and provide a pool of individuals from which members of Mental Health Act Panels for individual cases can be drawn. The chair of the Committee also chairs the Trust's Mental Health Act Panel Members' Forum. The Quality Governance Committee acquires and scrutinises assurances that Dorset HealthCare has a combination of structures and processes at and below Board level that equip it to deliver high quality clinical services. The QGC provides further scrutiny of the quality of services. The membership of the QGC is made up of a mix of Non-Executive and Executive Directors. This QGC is supported by the Quality Governance Group (formerly known as the Clinical Governance Group), which meets monthly to examine the internal quality and clinical processes and provide an in-depth review of data to ensure the effectiveness of the systems operated by the organisation. In September 2020, the Board established the Transformation Committee to provide support to, and assurance in respect of, the development and delivery of the Trust's transformation programme. The Committee's membership is made up of a mix of Non-Executive and Executive Directors. From September 2023, the Committee took on responsibility for overseeing, monitoring and reviewing financial planning and performance and the development and delivery of the Trust's capital plan, becoming the Finance and Transformation Committee. The Working Together Committee was established in 2023 by the Board of Directors of Dorset HealthCare and Dorset County Hospital to strengthen collaboration, promote integration and to simplify decision-making relating to the Working Together Programme for the benefit of patient care and experience and population health. The Committee oversees and scrutinises all aspects of programme

governance, patient safety, experience and the delivery of expected benefits and programme aims of: prevention of ill health tackling health inequalities parity of esteem and better integration between physical and mental health joined-up workforce planning and development.

The Working Together Committee operates as a committee in common (two separate committees meeting at the same time and same place with the same agenda). Its membership comprises an equal number of Non-Executive and Executive Directors from each trust, including the Joint Chair and Joint Chief Executive Officer.

The Board has established an Appointments and Remuneration Committee which is responsible for appointing Executive Directors and reviewing and determining their remuneration. All Non-Executive Directors are members of the Committee. The Chief Executive has a right to be in attendance as a member of the Committee when other Executive Director appointments are being determined and may be invited to attend when the remuneration of the other Executive Directors is under discussion.

The Senior Leadership Group is an executive committee formed in 2023 and is responsible for supporting the Chief Executive Officer (the CEO) in the performance of their duties as accounting officer of Dorset HealthCare University NHS Foundation Trust and all Executive Directors in fulfilling the duties and responsibilities delegated to them by the board of directors of the Trust. The SLG is not responsible for approving decisions otherwise delegated to individual directors or senior management pursuant to the Trust's scheme of delegation and reservation of powers to the Board or the Trust's standing financial instructions. The Executive Directors will incorporate any matters of significance considered by the SLG or where actions or improvements are needed to the Board of Directors through existing reporting mechanisms, including the Chief Executive Officer's report, the integrated corporate dashboard and the Board Assurance Framework.

The Executive Workforce Strategy Committee is an executive committee responsible for agreeing and reviewing the workforce and organisational development (OD) strategies and strategic workforce objectives and priorities for Dorset HealthCare and overseeing the delivery of the workforce strategy delivery programme and monitoring the risks to delivery of workforce priorities. Patient safety standards are monitored and reported to the Trust Board on

Baker, Abi
06/10/2025 12:40:16

	a monthly basis. We also report on our performance against key patient safety priorities in the Quality Account. All patient safety incidents are reported to the National Reporting and Learning System (NRLS) and the Care Quality Commission, as well as to the Trust Board. This data is then analysed to identify potential hazards, risks and opportunities, to improve the safety of patient care. The Patient Safety Incident Response Framework (PSIRF) sets out the approach in the NHS to developing and maintaining effective systems and processes for responding to patient safety incidents. It is not just an updated version of previous national frameworks but provides an opportunity to do things differently – so that we can continuously develop as an organisation, allowing time to learn thematically from patient safety insights. Dorset HealthCare is keen to promote an organisational culture where people feel safe and supported to talk – this applies equally to our patients, their families, and our staff. Speaking to those involved if harm has occurred, developing an understanding of the decisions made in caring for patients, identifying learning, validating decisions, and facilitating psychological closure for those involved are all core objectives. Mortality Governance Reviewing and learning from the mortality of patients known to the Trust is integral to our patient safety approach. Mortality Governance is a key feature of our overall governance arrangements, with our Mortality Governance Group, chaired by the Chief Medical Officer overseeing how we review and learn from both expected and unexpected deaths
Action for next year:	Nil

1D(ix) Systems are in place to review professional standards arrangements for [all healthcare professionals](#) with actions to make these as consistent as possible (Ref [Messenger review](#)).

Action from last year:	Formalise a Responsible Officer Advisory Group The Lead for Medical Revalidation and Appraisal, the Clinical Director for Adult Mental Health, Children & Learning

	Disability Services, the interim Chief Medical Officer for Adult Mental Health, Children & Learning Disability Services and the Appraisal and Revalidation Coordinator to attend Effective Responsible Officer training.
Comments:	The restructure of medical leadership means that the above action from last year no longer applies. A ROAG is in place
Action for next year:	Nil

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Y
Action from last year:	Nil
Comments:	There is a system in place to ensure appropriate pre-employment background checks are undertaken for all doctors who come to work for Dorset HealthCare including Locum doctors. This process is led by Human Resources working in collaboration with medical managers. In addition to pre-employment checks there are systems to share information once a doctor has been offered a contract: Sharing of information regarding new doctors entering employment occurs via MPIT forms from RO to RO. GMC processes also allow appropriate information sharing when there are Fitness to Practice concerns. Information sharing processes adhere to Caldicott principles.
Action for next year:	Nil

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Y
Action from last year:	Continue to improve our systems and work in collaboration with Dorset County Hospital to share best practice.
Comments:	We have a robust appraisal and revalidation system which includes evidencing quality improvement activity and a Maintaining High Professional Standards Framework. The updated Good Medical Practice professional standards were shared with the Trust Appraisers at the Appraiser Development Forum in September 2023 and with the Medical Leadership Team in June 2025. Building on previous work within mental health in the Trust, the Appraisers' Support & Development Forum held a meeting in November 2024 involving presentation, reflection and a discussion concerned with Civility Saves Lives. This was raised again at the Senior Doctors Peer Day in June 2025 following which the CMO and the AMD for Appraisal & Revalidation met with one of the National Leads. In the future we aim to undertake a larger piece of work in the Trust to roll out the Civility Saves Lives agenda to all staff groups involved in clinical care.
Action for next year:	Continue to improve our systems and work in collaboration with Dorset County Hospital to share best practice. Undertake a project to publicise and disperse the important messages of Civility Saves Lives for all clinical staff in the organisation.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Y
Action from last year:	Continue to find ways to improve ways to ensure and demonstrate fairness by gender and ethnicity
Comments:	Promoted within Trust values and within policies. Wellbeing Champions in each area. ED and I training is mandatory for all staff. Sexual safety charter released with training mandated for all staff
Action for next year:	Nil

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Y
Action from last year:	All staff to complete new mandatory Freedom to Speak Up training
Comments:	The FTSU Guardian provides quarterly and annual reports to the Board all contacts are treated confidentially but themes are shared in the reports. The FTSU Guardian also has a six monthly senior meeting where they meet with the Exec Chief people officer / the Chief Nurse / and NED where they discuss high level emerging themes so if there was something they were concerned about regarding any staff group they would raise it here but the reality is it wouldn't wait for a meeting they would be attending to it immediately.

Baker, Abi
06/10/2025 12:40:16

Action for next year:	All staff to complete mandatory Freedom to Speak Up training

1F(iv) Mechanisms exist that support feedback about the organisation's professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	Y
Action from last year:	Evaluate whether to continue with the Edgecumbe reporting system or to utilise the MSF function included in SARD.
Comments:	Formal complaints are handled in line with national guidelines by the Nursing, Therapies and Quality Directorate. The Trust is in the process of switching from using Edgecumbe for 360 degree appraisal for doctors to using the MSF tool that is integral to SARD. This change will be made once all the existing licences for Edgecumbe have been exhausted.
Action for next year:	Nil

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the [Equality Act](#).

Y/N	Y
Action from last year:	The Trust is establishing a ROAG and this will enable more structured collation of this information with an agreed threshold for when concerns are brought to the ROAG
Comments:	ROAG in place

Action for next year:	Nil

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Y
Action from last year:	Complete developmental and supportive recommendations from the HLRO review visit report by March 2025 and any actions suggested by the external reviews.
Comments:	Recommendations completed
Action for next year:	Nil

Baker,Abi
06/10/2025 12:40:16

Section 2 – metrics

Year covered by this report and statement: 1 April 2024 – 31 March 2025 .

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	120
Total number of appraisals completed	112
Total number of appraisals approved missed	2
Total number of unapproved missed	0
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	36
Total number of late recommendations	0
Total number of positive recommendations	31
Total number of deferrals made	5
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	14
Total number of trained case managers	3
Total number of concerns received by the Responsible Officer ²	1
Total number of concerns processes completed	1
Longest duration of concerns process of those open on 31 March (working days)	N/A
Median duration of concerns processes closed	15 months
Total number of doctors excluded/suspended during the period	0
Total number of doctors referred to GMC	0

² Designated bodies' own policies should define a concern. It may be helpful to observe <https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/>, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	8
Total number of new employment checks completed before commencement of employment	8
Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld ³	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report

CMO and RO role reviewed and Deputy RO role now undertaken by the Deputy Chief Medical Officer.

Closer working links & collaboration between DHC & DCHFT with Dr Lucy Knight taking the role of Responsible Officer for the Federation.

Responsible Officer Advisory Group established with terms of reference and membership. Review planned in September 2025

Actions still outstanding

None

³ Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

Current issues
Retention and replacement of medical appraisers remains a challenge. Remuneration for appraisal under review.
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
Continue work towards meeting HLRO recommendations. Further develop our utilisation of electronic systems and digitisation of processes. Ensure that there are sufficient trained appraisers to provide appraisals for all of our doctors. Implement improvements identified by reviews regarding sharing information about SIs and complaints with doctors for appraisal and revalidation. Review our current processes and align with Dorset County Hospital.
Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):
We comply with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013). There are new postholders of Responsible Officer (Dr Lucy Knight) and deputy Responsible Officer (Dr Andy Dean) since the last Board Report. A Responsible Officer Advisory Group (ROAG) has been established across the Federation and outcomes will be reviewed in September 2025.

Baker, Abi
06/10/2025 12:40:16

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	Dorset HealthCare University NHS Foundation Trust

Name:	Matthew Bryant
Role:	CEO
Signed:	
Date:	

Baker, Abi
06/10/2025 12:40:16

Report to	Board of Directors, Part 1 (DHC)	
Date of Meeting	7 October 2025	
Report Title	Mental Health Act Scheme of Delegation	
Prepared By	Gavin Macfarlane, MHL Manager, DHC	
Approved by Accountable Executive	Lucy Knight, Chief Medical Officer (DHC)	
Previously Considered By	Mental Health Legislation Assurance Committee – 31/07/2025 Reviewed and approved in August 2025 outside of the formal meeting.	
Action Required	Approval	Y
	Assurance	N
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? <i>Delete as required</i>	
Care	Yes	
Colleagues		No
Communities	Yes	
Sustainability		No
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 Quality and Safety SR2 Culture	
Financial	Low – The CQC can issue penal actions and warning notices against registered providers.	
Statutory & Regulatory	Reporting mechanisms ensure statutory and regulatory expectations are met and compliance with the Mental Health Act (MHA) and Deprivation of Liberty Safeguards (DoLS) is monitored.	
Equality, Diversity & Inclusion	Not applicable	
Co-production & Partnership	Not applicable	

Executive Summary
The Mental Health Act 1983 (as amended) (the MHA) specifies a range of responsibilities, powers and duties for ‘hospital managers’, which is defined in the MHA as the Trust itself, and these are exercised by the Board of Directors on behalf of the Trust. The Mental Health Act 1983: Code of Practice (the MHA Code) provides guidance on the exercise of hospital managers’ functions and on specific powers and duties. The Trust must have regard to the MHA as statutory guidance. On a day-to-day basis, most of the powers of hospital managers are exercised by individuals (or groups of individuals) within the Trust on behalf of the Board of Directors. The MHA Code specifies that the arrangements for who is authorised to take which decisions should be set out in a scheme of delegation approved by the Board of Directors. However, there are special rules that apply to the exercise of hospital managers’ power to discharge patients from detention or community treatment orders, which can only be delegated to managers’ panels made up of people appointed specifically for the purpose who are not officers or employees. This Scheme of Delegation was reviewed in July 2025 in consideration of best practice, and it was confirmed that there have been no changes which require amendment. Mental Health Legislation Committee in Common members reviewed and approved the scheme in August 2025 outside of the July 2025 formal meeting.

Recommendation
The Board of Directors is requested to approve the Mental Health Act Scheme of Delegation

Mental Health Act Scheme of Delegation

Baker, Abi
06/10/2025 12:40:16

Contents

Section	Page
1 Introduction	3
2 Governance Arrangements	3
3 Functions that cannot be delegated to officers of the Trust	5
4 Functions delegated to officers of the Trust	5
5 Review of Scheme of Delegation	8

Baker, Abi
06/10/2025 12:40:16

1. Introduction

- 1.1. Under the Mental Health Act 1983, as amended by the Mental Health Act 2007 (the **MHA**), NHS trusts and foundation trusts themselves are defined as the 'hospital managers' for the purposes of the MHA.
- 1.2. Hospital managers have the authority to detain patients under the MHA. They have the primary responsibility for seeing that the requirements of the MHA are followed. In particular, they must ensure that patients are detained only as the MHA allows, that their treatment and care accord fully with its provisions and that they are fully informed of, and are supported in exercising, their statutory rights.
- 1.3. In practice, most of the decisions of the hospital managers are actually taken by individuals (or groups of individuals) on behalf of the Trust's Board of Directors. In particular, decisions about discharge from detention and community treatment orders are taken by panels of people specifically selected for the role (see paragraph 2.3 below).
- 1.4. A revised Code of Practice for the MHA came into effect on the 1 April 2015. The Code of Practice (paragraph 37.9) requires that the arrangements for who is authorised to take which decisions on behalf of the Trust's Board of Directors should be set out in a scheme of delegation.
- 1.5. This scheme of delegation identifies to whom the Trust's Board of Directors delegates its responsibilities under the MHA.
- 1.6. The term 'patient' is used in this scheme of delegation to reflect the terminology used in both the MHA and the MHA Code of Practice.

2. Governance Arrangements

- 2.1. The Trust's Board of Directors is responsible for the use and application of the MHA.
- 2.2. The Trust's Board of Directors receives assurance regarding the use of mental health legislation from the Mental Health Legislation Assurance Committee. This Committee is a Committee of the Trust's Board of Directors and is chaired by a Non-Executive Director. The terms of reference of the Committee are set out in the Governance Manual.
- 2.3. The Trust's Board of Directors delegates the power to exercise the discharge of patients detained under the MHA to the MHA Panel Members through Managers Panel Hearings. These are referred to as hospital managers' panels in the MHA Code. MHA Panel Members are specifically selected and trained for the role and are provided with administrative support from the Mental Health Legislation Office. MHA Panel Members may include Non-Executive Directors of the Trust, but not Executive Directors who are employees of the Trust.
- 2.4. A Non-Executive Director of the Trust's Board of Directors chairs a quarterly MHA Panel Members' Forum.

Baker, A.
06/10/2025 12:40:16

2.5. The Trust's Board of Directors also delegates responsibilities to Trust staff who are also referred to in the MHA as "officers" of the Trust.

Baker, Abi
06/10/2025 12:40:16

3. Functions that cannot be delegated to officers of the Trust

3.1. As required by the MHA and The Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008, the following powers are reserved to MHA Panel Members:

FUNCTION	STATUTORY REFERENCE*	MHA CODE OF PRACTICE REFERENCE	AUTHORISED PERSON(S)
Review of patient's detention	Section 20(3)	Chapter 38	MHA Panel Members
Review of patient's community treatment order	Section 20A(5)	Chapter 38	MHA Panel Members
Discharge of unrestricted patients and patients subject to community treatment orders	Section 23	Chapter 38	MHA Panel Members

4. Functions delegated to officers of the Trust

4.1. The following functions are delegated to officers of the Trust:

FUNCTION	STATUTORY REFERENCE*	MHA CODE OF PRACTICE REFERENCE	AUTHORISED PERSON(S)
Admission and detention of patients (Completion of form H3)	Sections 5(2), 40(1) and 40(3)	Chapters 35 and 37	Mental Health Legislation Administrator (MHLA), Registered Mental Health Nurse
Receiving and scrutinising documents	Section 11(2) and Regulation 3	Chapter 35	Receiving documents MHLA, Registered Mental Health Nurse Scrutinising documents MHLA, Registered Mental Health Nurse, Lead Mental Health Consultant
Recording admission	Regulation 4	Chapter 35	MHLA, Registered Mental Health Nurse

Baker, Abi
06/10/2025 12:40:16

FUNCTION	STATUTORY REFERENCE*	MHA CODE OF PRACTICE REFERENCE	AUTHORISED PERSON(S)
Rectification of applications and medical recommendations	Section 15 and Regulation 4	Chapter 35	Administration process - MHLA Power to rectify - Registered Medical Practitioners (RMP), Approved Mental Health Professionals (AMHP)
Receipt of renewal documentation	Section 20(3)(b)	Chapter 35	MHLA, Registered Mental Health Nurse
Authorisation of the transfer of patients	Section 19 and Regulation 7	Chapter 37 Paragraphs 37.16 – 37.22	Power to Authorise - Responsible Clinician Administration Process - MHLA, Registered Mental Health Nurse
Notification to local authorities of patients detained after application by nearest relative	Section 14 and Regulation 19	Chapters 5 and 37 Paragraphs 37.14 – 37.15	MHLA
Transfer to guardianship	Section 19 and Regulation 7	Chapter 37 Paragraphs 37.28 – 37.29	Responsible Clinician
Transfer of a patient on a community treatment order who has been recalled	Section 17 and Regulation 6	Chapter 37 Paragraph 37.30	Power to Authorise - Responsible Clinician Administration Process - MHLA, Registered Mental Health Nurse
Reassignment of responsibility of patient on a community treatment order	Section 19 and Regulation 17	Chapter 37 Paragraph 37.31	Power to Authorise - Responsible Clinician Administration Process - MHLA, Registered Mental Health Nurse
Authorisation of section 17(3) leave	Section 17(3) and Regulation 19	Chapter 27	Responsible Clinician
Authorisation to take and return detained patients or those recalled from supervised community treatment (in addition to those listed in	Section 18 and Regulation 19	Chapter 27	Any Trust officer authorised in writing by the Responsible Clinician

Baker, Abi
06/10/2025 12:40:16

FUNCTION	STATUTORY REFERENCE*	MHA CODE OF PRACTICE REFERENCE	AUTHORISED PERSON(S)
section 18(1)(c))			
Submission of statements to Tribunals (Mental Health)	Rule 6 of the Mental Health Review Tribunal Rules 1983 (S.I. 942)	Chapter 12	MHLA
Referral of cases to Tribunals (Mental Health)	Section 68	Chapter 37 Paragraphs 37.39 – 37.43	MHLA
Requesting a reference to a Tribunal by the Secretary of State for Health and Social Care	Section 67	Chapter 37 Paragraphs 37.44 – 37.46	Responsible Clinician Administration process - MHLA
Assisting patients with Tribunals (Mental Health) applications or request a MHA Panel hearing including how to contact a suitably qualified legal representative, and other organisations that may be able to help them		Chapter 37	MHLA, Registered Mental Health Nurse
Giving information to patients and nearest relatives	Sections 132, 132A and 133	Chapters 4, 19 and 37 Paragraph 37.32 – 37.33	MHLA, Registered Mental Health Nurse, Mental Health Support Workers can support this function, but must be overseen by Registered Mental Health Nurse
Providing information regarding Independent Mental Health Advocacy service	Section 130A	Chapters 6 and 37 Paragraphs 37.14 – 37.15 and 37.33	Responsible Clinician, Registered Mental Health Nurse and MHLA. Mental Health Support Workers can support this function, but must be overseen by Registered Mental Health Nurse
Duties in respect of victims of crime	Domestic Violence, Crime and Victims Act 2004	Chapters 37 and 40 Paragraphs 37.34 – 37.36	Responsible Clinician, MHLA

Baker, Abi
06/10/2025 12:40:16

FUNCTION	STATUTORY REFERENCE*	MHA CODE OF PRACTICE REFERENCE	AUTHORISED PERSON(S)
	Schedule 6		
Withholding patients' correspondence	Section 134	Chapter 37 Paragraphs 37.37 – 37.38	Power to withhold – Responsible Clinician Administration Process – MHLA
Exclusion or restriction of visitors		Chapter 11	Doctors, Registered Mental Health Nurse
Implementation of any 'blanket restrictions' to patients		Chapter 8	Responsible Clinician, Senior Nursing staff
To ensure part 2 and 3 patients are allocated a Responsible Clinician	Section 34	Chapter 36	Chief Medical Officer
Appropriate accommodation for children and young people	Section 131A	Chapters 19 and 37 Paragraph 37.47	Responsible Clinician, Registered Medical Practitioner, Child and Adolescent Mental Health Service (CAMHS) Tier 4 Manager, Clinical Site Team
Assisting patients detained under sections 35 and 36 in exercising a right to an independent psychiatric report.		Chapter 22	Registered Mental Health Nurse, MHLA
Maintaining register of approved clinicians		Chapter 36	Medical Staffing MHLA

*Sections and schedules referred to are in the Mental Health Act 1983 as amended by the Mental Health Act 2007 and regulations referred to are in The Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008 (S.I. 1184).

5. Review of scheme of delegation

1. The Scheme of Delegation is subject to change when either legislation and/or case law requires a change in legal responsibilities under the MHA.

5.2. This Scheme of Delegation was reviewed in July 2025 in consideration of best practice and it is confirmed that there have been no changes which require amendment. In the event of any changes which impact on this, a review will be undertaken.

Baker, Abi
06/10/2025 12:40:16