DCH Board of Directors Part 1 - 12/08/2025

Tue 12 August 2025, 09:30 - 13:30

MS Teams

Agenda

09:30 - 09:45
15 min

1. Patient Story

09:45 - 09:50
5 min

2. Formalities

- 1a DRAFT Agenda DCH BoD Part 1 August 2025 DCS.pdf (3 pages)
- BOD COG Declarations of Interest 2025-26 Final.pdf (1 pages)
- 1b Draft Minutes BOD Part 1 10 06 2025.pdf (35 pages)
- 1c Action Log DCH BoD PART 1 August 2025.pdf (1 pages)
- DCH DHC Board Annual Work Plan 2025-26.pdf (2 pages)

09:50 - 09:55
5 min

3. Chair's Comments

09:55 - 10:05
10 min

4. CEO Report

- 3. CEO Report Aug 2025 Final.pdf (5 pages)

10:05 - 10:15
10 min

5. Board Assurance Framework

- 5a DCH Board Assurance Framework Q1 Board Aug 25.pdf (3 pages)
- 5b Appendix A BAF DCH Board Q1 Aug 25.pdf (13 pages)

10:15 - 10:25
10 min

6. Corporate Risk Register

- 6a Front Sheet Corporate Risk Register July 25.pdf (5 pages)
- 6b Corporate Risk Register Appendix.pdf (15 pages)

10:25 - 10:35
10 min

7. Quality Committee Assurance Report

- 7.1 Assurance Report QCIC 29 July 2025.pdf (5 pages)

10:35 - 10:50
15 min

8. Maternity Safety Report

- 7.2a DCH front sheet Maternity Neonatal Report May_June (July) 2025 Board Final.pdf (3 pages)
- 7.2b DCH maternity neonatal quality_safety report July 2025.pdf (31 pages)

10:50 - 11:00
10 min

9. Joint Food and Drink Strategy

- 7.3a Food and Drink Strategy 2025-2028 front sheet.pdf (2 pages)
- 7.3b Food and Drink Strategy 2025-2028.pdf (10 pages)

11:00 - 11:10
10 min

10. Safeguarding Adults and Children Annual Report

- 7.4 Safeguarding Annual report 2024- 2025 Board_Final.pdf (17 pages)
- 7ci.2 DCH Safeguarding 2025 -2027 QI plan.pdf (8 pages)

11:10 - 11:20
10 min

11. Infection Prevention and Management Annual Report

- 7.5a DCH Front Sheet Infection Prevention Managment Annual Report 2024-2025 Board.pdf (3 pages)
- 7.5b DCH Infection Prevention Managment Annual Report 2024-2025.pdf (64 pages)

11:20 - 11:30
10 min

Coffee Break

11:30 - 11:40
10 min

12. Finance & Performance Committee Assurance Report

- 8.1 FPC July 25 Assurance Report.pdf (5 pages)

11:40 - 11:50
10 min

13. Balanced Scorecard

- 8.2 Board Balanced scorecard report Aug 25 meeting (June data).pdf (13 pages)

11:50 - 12:00
10 min

14. Finance Report

- 8.3a Front Sheet DCH FPC M3.pdf (2 pages)
- 8.3b DCH Finance Report Q3 2025-26 FPC.pdf (14 pages)

12:00 - 12:10
10 min

15. Operational Resilience and Capacity (Winter) Plan

- 8.4 Operational resilience and capacity plan (Winter) 202526 Final.pdf (25 pages)
- 8.4b Board Assurance Statement - NHS Trust DCH.pdf (6 pages)

12:10 - 12:20
10 min

16. People & Culture Committee Assurance Report

- 9.1 PCC July 25 Assurance Report.pdf (4 pages)

12:20 - 12:30
10 min

17. Medical Appraisal & Revalidation Annual Report

- 9.2a Medical Appraisal and Revalidation Front Sheet.pdf (2 pages)
- 9.2b DCH Medical Appraisal and Revalidation Annual Report.pdf (20 pages)

12:30 - 12:40
10 min

18. Strategy, Transformation & Partnership Committee Assurance Report

- 10.1 STP Jul 25 Assurance Report.pdf (4 pages)

12:40 - 12:50
10 min

19. Audit Committee Assurance Report

- Assurance Report DCH Audit Committee 04 August 2025.pdf (3 pages)

12:50 - 12:55
5 min

20. Charitable Funds Committee Assurance Report

- 11.3 Assurance Report - DCH Charitable Funds Committee (22.7.25).pdf (2 pages)

12:55 - 13:00
5 min

21. Mental Health Legislation Committee Assurance Report

- 11.2 MHLC July 25 Assurance Report.pdf (3 pages)

13:00 - 13:00
0 min

22. Green Strategy Annual Report

- 12.1a Board Paper Green Plan Annual Report NZC DCH DHC STP (002).pdf (11 pages)

- 12.1b Dorset County Hospital Heat Decarbonisation and Heat Network Feasibility Study final.pdf (48 pages)

13:00 - 13:00
0 min

23. Social Value Action Plan & Progress Report

- 12.4a Front Sheet and report - DCH Social Value Report (Aug 2025 - Board 12.8.25).pdf (1 pages)
- 12.4b DCH Social Value Programme report (Aug 2025).pdf (10 pages)
- 12.4c Enc 1. Tilbury Douglas Q2 2025 Social Value Report ED and CrCU DCH.pdf (9 pages)
- 12.4d Enc 2. DCH Arts in Hospital Social Value (Jun 25).pdf (2 pages)
- 12.4e Enc 3. Social Value Activity Report 2024-25.pdf (6 pages)

13:00 - 13:00
0 min

24. National Cost Collection Exercise

- 12.6 National Cost Collection Exercise.pdf (6 pages)

13:00 - 13:05
5 min

25. Questions from the Public

13:05 - 13:10
5 min

26. AOB

Dorset County Hospital
NHS Foundation Trust

Meeting of the Board of Directors (Part 1) of
Dorset County Hospital NHS Foundation Trust
Tuesday 12th August 2025 at 9.30am to 1.30pm
Board Room, Trust Headquarters, Dorset County Hospital, Dorchester and via MS Teams

AGENDA

Ref	Item	Format	Lead	Purpose	Timing
1.	**Patient Story**	Presentation	Jo Howarth (Sandra Firth, Hannah Williams)	Information	9.30-9.45
2.	**FORMALITIES** to declare the meeting open.	Verbal	David Clayton-Smith Trust Chair	Information	9.45-9.50
	a) Apologies for Absence	Verbal	David Clayton-Smith	Information	
	b) Conflicts of Interests	Verbal	David Clayton-Smith	Information	
	c) Minutes of the Meeting dated 10 June 2025	Enclosure	David Clayton-Smith	Approve	
	d) Matters Arising: Action Log	Enclosure	David Clayton-Smith	Approve	
	e) Board business calendar	Enclosure	David Clayton-Smith	Information	
3.	**Chair's Comments**	Verbal	David Clayton-Smith	Information	9.50-9.55
4.	**CEO Report**	Enclosure	Matthew Bryant	Information	9.55-10.05
5.	**Board Assurance Framework** (August Audit Committee)	Enclosure	Jenny Horrabin	Assurance	10.05-10.15
6.	**Corporate Risk Register** (August Audit Committee)	Enclosure	Jo Howarth	Assurance	10.15-10.25
7.	**Quality**				
7.1.	**Quality Committee Assurance Report**	Enclosure	Claire Lehman	Assurance	10.25-10.35
7.2.	**Maternity Safety Report** (July QC)	Enclosure	Jo Howarth (Jo Hartley)	Assurance	10.35-10.50
7.3.	**Joint Food and Drink Strategy** (July QC)	Enclosure	Jo Howarth	Approval	10.50-11.00
7.4.	**Safeguarding Adults and Children Annual Report** (July QC)	Enclosure	Jo Howarth	Assurance	11.00-11.10
7.5.	**Infection Prevention and Management Annual Report** (July QC)	Enclosure	Jo Howarth	Assurance	11.10-11.20
	Coffee Break 11.20-11.30				
8.	**Finance and Performance**				
8.1.	**Finance and Performance Committee Assurance Report**	Enclosure	Dave Underwood	Assurance	11.30-11.40
8.2.	**Balanced Scorecard**	Enclosure	Anita Thomas Executives	Assurance	11.40-11.50
8.3.	**Finance Report** (July FPC)	Enclosure	Chris Hearn	Assurance	11.50-12.00
8.4.	**Operational Resilience and Capacity (Winter) Plan (incl. Board Assurance Statement)** (July FPC)	Enclosure	Anita Thomas	Approval	12.00-12.10

9.	**People and Culture**				
9.1.	**People and Culture Committee Assurance Report**	Enclosure	Frances West	Assurance	12.10-12.20
9.2.	**Medical Appraisal and Revalidation Annual Report** (July PCC)	Enclosure	Rachel Wharton	Approval	12.20-12.30
10.	**Strategy, Transformation and Partnership**				
10.1.	**Strategy, Transformation and Partnership Committee Assurance Report**	Enclosure	David Clayton-Smith	Assurance	12.30-12.40
11.	**Audit and Governance**				
11.1.	**Audit Committee Assurance Report**	Enclosure	Stuart Parsons	Assurance	12.40-12.50
11.2.	**Charitable Funds Committee Assurance Report**	Enclosure	Dave Underwood	Assurance	12.50-1.00
11.3.	**Mental Health Legislation Committee Assurance Report**	Enclosure	Jenny Horrabin	Assurance	1.00-1.10
12.	**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.				
12.1.	**Green Strategy Annual Report** (July STPC)	Enclosure	Chris Hearn	Approval	
12.2.	**Social Value Action Plan and Progress Report** (July STPC)	Enclosure	Nick Johnson	Assurance	
12.3.	**National Cost Collection Exercise** (July FPC)	Enclosure	Chris Hearn	Approval	
13.	**Questions from the Public**	Verbal	David Clayton-Smith		1.10-1.20
	In addition to being able to ask questions about discussion at the meeting, members of the public are also able to submit any other questions they may have about the trust in advance of the meeting to Abigail.baker@dchft.nhs.uk				
14.	**Any Other Business** Nil notified	Verbal	David Clayton-Smith	Information	1.20-1.25
15.	**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 **Trust HQ Boardroom and via MS Teams.**				
	Resolution Regarding Press, Public and Others: To agree, as permitted by the National Health Service Act 2006 (as amended), the Trust's Constitution and the Standing Orders of the Board of Directors, that representatives of the press, members of the public and others not invited to attend to the next part of the meeting be excluded due to the confidential nature of the business to be transacted.				

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

Part 2 Items
- Chair's Comments

- CEO Update
- Finance Review Outputs
- Future Care
- Estates and Facilities Backlog / Six Facet Survey
- Federated Working – Establishing a Board in Common
- Remuneration and Terms of Service Committee:
    - Assurance Report (including Annual Report and Committee Effectiveness Review)
    - Terms of Reference
    - DCH SubCo Ltd Director appointment
- One Dorset Provider Collaborative Board Minutes

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NHS
Dorset County Hospital
NHS Foundation Trust

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

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

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

The minutes are being reviewed and will be made public in due course

BoD Action Tracker, Part 1 - 2025/26

Topic	Minute Reference & Name	Date of Meeting	Action	Lead	Deadline	Response	Status
Declarations of Interest	BoD25/057 / Matters Arising: Action Log	10.06.2025	EJ and DCS declarations of interest to be updated	AB	12.08.2025	Complete: EJ and DCS declarations of interest have been updated and published on the Trust's website	Complete
Maternity Support Worker Sickness	BoD25/064 / Maternity Safety Report	10.06.2025	Detail to be provided about any possible underlying cause fror the sickness levels amongst maternity support workers	DD	12.08.2025	Since the June Board report one colleague on long term sickness has returned to work. Recommend close action The causes for sickness absence are varied, with stress being the most frequently reported reason for absence.	Complete
Review of the Trust's efficiency programme	BoD25/070 / Finance Report	10.06.2025	Consideration to be given to how to feed back to the Board the conclusions made by David Moon and Mark Mansfield regarding their review of the Trust's efficiency programme	MBr / CH	12.08.2025	Reported to Finance and Performance Committee 30 July 2025 and on part 2 Board agenda – Complete	Complete
ED/CrCU fundraising	BoD25/088 / Any Other Business	10.06.2025	Board members to submit fundraising suggestions to the Corporate Governance team	Board members	12.08.2025	No suggestions received. Recommend close action	Complete

Actions to other Committees

Topic	Minute Reference & Name	Date of Meeting	Action	Lead	Deadline	Response	Status	Committee referred to
Ridgeway Ward Redesign	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	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.	Open - Overdue	FPC

Board of Directors - Workplan 2025/26												
Dorset County Date						08-apr-25	10-jun-25	12-aug-25	07-okt-25	09-des-25	10-feb-26	
Dorset Healthcare Date						09-apr-25	11-jun-25	13-aug-25	08-okt-25	10-des-25	11-feb-26	
Activity (* indicates item can be taken under consent)	Purpose	Comments / questions	DCH	DHC	Frequency	apr-25	jun-25	aug-25	okt-25	des-25	feb-25	Executive Owner (Author)
Minutes of the previous meeting	Approval		X	X	Bi-monthly	X	X	X	X	X	X	Chair
Action Tracker	Review		X	X	Bi-monthly	X	X	X	X	X	X	Chair
Business Calendar	Review		X	X	Bi-monthly	X	X	X	X	X	X	Chair
Review of meeting	Review		X	X	Bi-monthly	X	X	X	X	X	X	Chair
Register of Interests	Information		X	X	Bi-monthly	X	X	X	X	X	X	Chair
Patient story	Information		X	X	Alternate meetings	X		X		X		Chief Nursing Officer
Staff story	Information		X	X	Alternate meetings		X		X		X	Chief People Officer
Chair's Comments	Information		X	X	Bi-monthly	X	X	X	X	X	X	Chair
CEO Report	Information		X	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	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
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		X	X	Bi-annual	2026			X			Chief Nursing Officer (DCH), Chief Medical Officer (DHC)
Patinet Carer Race Equality Framework (PCREF)	Assurance			X	Annual	2026			X			Chief Medical Officer
Complaints Annual Report	Assurance		X	X	Annual				X			Chief Nursing Officer
Nutrition Strategy and Annual Report	Assurance		X	X	Annual			X				Chief Nursing Officer
Infection Prevention and Management 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	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 - not yet ready	X	X	Annual			~~X~~	~~X~~			Chief Finance Officer
Estates Compliance Report	Assurance		X	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	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 People Officer
GMC Survey Results and Action Plan	Approval		X		Annual				X			Chief Medical Officer (Paul Murray)
Medical Appraisal and Revalidation Annual Report	Approval		X	X	Annual			X				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	X	Bi-monthly	X	X	X	X	X	X	Strategy, Transformation and Partnership Committee Chair
Joint Strategy Implementation Update	Assurance	Deferred pending discussion at STPCIC	X	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	Chief Strategy, Transformation & Partnerships Officer
Audit and Governance												

Activity (* indicates item can be taken under consent)	Purpose	Comments / questions	DCH	DHC	Frequency	apr-25	jun-25	aug-25	okt-25	des-25	feb-25	Executive Owner (Author)
Audit Committee Assurance Report	Assurance		X	X	Bi-monthly	X	X	X	X	X	X	Audit Committee Chair
Risk Management Strategy Update	Approval	Deferred to Dec Audit Committee, pending ongoing work	X	X	Annual			~~X~~		X		Joint Chief Nursing Officer
Risk Appetite Statement Annual Review	Assurance	Deferred to Dec Audit Committee, pending ongoing work	X	X	Annual			~~X~~		X		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				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	X	Annual	2026	X					Director of Corporate Affairs
Committee Terms of Reference	Approval		X	X	Annual	2026	X					Director of Corporate Affairs
Committee Annual Reports	Assurance		X	X	Annual	2026	X					Director of Corporate Affairs
Board effectiveness review	Assurance		X	X	Annual	2026	X					Director of Corporate Affairs
Constitution Review	Approval				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		Chief Finance Officer
Mental Health Legislation Assurance												
Mental Health Legislation Assurance Committee Assurance Report	Assurance		X	X	Bi-monthly	X	X	X	X	X	X	Mental Health Legislation Assurance Committee Chair
Mental Health Scheme of Delegation	Approval			X	Annual			X				Chief Medical Officer
Approval of Associate Hospital Managers	Approval			X	Annual						X	Chief Medical Officer

Report to	DCH Board of Directors	
Date of Meeting	12 August 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? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	Implications for all strategic risks with specific implications detailed in individual reports	
Financial	No specific implications arising from the report	
Statutory & Regulatory	Update on ICB Merger	
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:

- NHS Ten year Plan
- Penny Dash Quality Review
- Maternity service review
- Resident doctor industrial action
- ICB update
- Electronic Health Record
- Performance Assessment Framework
- Glendinning Unit – MHA Monitoring Visit
- DCH New Hospitals Programme
- DCH Chemotherapy unit

Recommendation

Members are requested to receive the report for information.

Chief Executive Officer's Report – April 2025

1 National updates

1.1 NHS10 Year Plan – Fit for the Future

On Thursday 03 July the Government published the 10 Year Health Plan for England and it focusses on three shifts in the way health service operates, setting out a vision for moving from analogue to digital, from treatment of ill health to prevention and from hospital to more community-based care. The aim is to prevent ill health, reduce waiting times, deliver more accessible care and to tackle health inequalities.

The main thrust of the plan is to bring the NHS closer to people's homes through neighbourhood health services and to shift care out of hospitals and into the community. This is something that I welcome hugely - the direction of travel is very aligned with our own vision of healthier lives, empowered citizens and thriving communities. In terms of neighbourhood healthcare, we have been doing considerable work to develop Integrated Neighbourhood Teams in Dorset in partnership with primary care colleagues, so we are now well placed to take this work forward with even greater pace.

After all the months of anticipation it is good to be able to see this plan - and it feels like it will give a sense of coherency and direction to change in the NHS, with a long-term vision built around improving population health. As we work through the detail and start implementing it I'm sure there will be many challenges - and of course our financial challenges remain - but I feel optimistic about the opportunities the plan offers for us to make a difference for our population and lead the reshaping of the NHS to make it stronger and better for the future.
You can find the full 10 Year Health Plan and a summary here.

1.2 Penny Dash Quality Review

In July the Department of Health and Social (DHSC) published an interim report from Dr Penny Dash into the operational effectiveness of the Care Quality Commission (CQC). Dr Dash's full report will be published in the autumn. The Secretary of State for Health and Social Care responded to the report announcing steps the department and CQC would take immediately as a result. The review recommends:

- Rapidly improve operational performance
- Fix the provider portal and regulatory platform
- Rebuild expertise within the organisation and relationships with providers in order to resurrect credibility
- Review the SAF to make it fit for purpose
- Clarify how ratings are calculated and make the results more transparent particularly where multiyear inspections and ratings have been used

We will be considering any recommendations and implications arising from this through the Quality Committee in Common.

1.3 Maternity Service review

In June a rapid national investigation into NHS maternity and neonatal services was requested by Health and Social Care Secretary, Wes Streeting.

The investigation will urgently look at worst-performing services in the country but also across the entire maternity system, bringing together the findings of past reviews into one clear national set of actions to ensure every woman and baby receives safe, high-quality and compassionate care.

Crucially, it will be co-produced with clinicians, experts and parents all feeding in. It will begin its work this summer and report back by December 2025.

1.4 Resident doctor industrial action

Strikes took place from 7am on Friday 25 July until 7am on Wednesday 30 July. After a ballot on industrial action, found 90 per cent of eligible members had voted yes on a turnout of 55 per cent.

The teams at both DCH and DHC showed strong collaboration and cross divisional work to ensure that robust plans were in place which minimised the impact on patients during this time.

2 Dorset Updates

2.1 ICB Appointments

Interviews have taken place for the Chair of the new ICB cluster covering Bath and North East Somerset, Swindon and Wiltshire and Somerset and Dorset. The outcome of this has not yet been reported. However, once announced we are anticipating that the clustering arrangements will move at pace.

2.2 Electronic Health Record

We are delighted to have successfully achieved another major milestone in creating a unified electronic health record (EHR) for Dorset and Somerset – our Outline Business Case (OBC) has been officially approved by the Cabinet Office.

This means we can now forge ahead with the procurement of an EHR system to realise our vision to give healthcare colleagues one complete picture of each person's health. This will help us improve care and avoid the need for patients and service users to retell their story as they move around the health system.

The programme has adopted a new name for the next phase of its work – 'healthset'. This name acknowledges the programme's commitment to supporting the health of our population and incorporates the identities of both counties, with 'set' being a traditional term for 'inhabitants'. The design of healthset includes an ammonite and an apple, representing Dorset and Somerset respectively.

Colleagues who helped us shape the OBC and colleagues new to the programme will be involved in the next phase of work and we will keep you posted about the opportunities to share your views and expertise.

2.3 DCH DHC Oversight Framework

The segmentation score for both Dorset County and Dorset Healthcare was due to be published in July however there has been a delay in the publication of data.

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. It has been developed with the engagement and contributions from the NHS leadership and staff, representative bodies and think tanks, including through two public consultations. They said that NHS England's approach to oversight and

performance improvement needs to be consistent and our interactions coherent. Full details are provided at NHS England » NHS Oversight Framework 2025/26.

The segmentation of providers will involve four steps:

- Organisational delivery score: Each provider will receive an organisation delivery score between 1 (high performing) and 4 (low performing).
- Financial override: The organisational delivery score will be considered alongside each organisation's financial position to produce an initial segment. Provider organisations in deficit or receiving deficit support will be limited to a segment of no greater than 3.
- Identification of the most challenged providers: An additional segment (segment 5) has been introduced for the most challenged providers. These providers will be considered for the PIP (Provider Improvement Programme). In exceptional cases, providers in higher segments may enter PIP if NHSE identifies serious concerns about a provider's capability.
- Finalisation of segments: Once NHSE approves the final segmentation, it will be communicated to each organisation and published on NHSE's website. Segmentation data will be reviewed at least quarterly.

We are reviewing our performance reports to ensure we have clear oversight of the key metrics informing the Oversight Framework.

2.4 Glendinning Unit – Mental Health Act 1983 monitoring visit

On 5th June Glendenning unit received an unplanned Mental Health Act visit from CQC. Following the visit the unit received high praise from the report with incredibly positive comments from patients and carers. It was noted in the report that all patients felt safe and cared for on the ward.

This is a fantastic report for the unit and the team and is a great testament to the hard work that the team puts into the high quality of care for the patients at Dorset HealthCare.

The report has been considered at the Mental Health Legislation Committee.

2.5 DCH New Hospitals Programme

Work to build the new £100million Emergency Department (ED) and Critical Care Unit at Dorset County Hospital (DCH) has reached a major milestone.

Contractor Tilbury Douglas has started the main construction phase of works for the new state-of-the-art building which will care for patients in need of urgent and life-saving care. The building is due to open in 2027.

Funded by the New Hospital Programme, the building will provide two floors of clinical space, including a dedicated paediatrics area, 24 critical care beds, mental health facilities and an ambulance arrivals and fast assessment area. A link corridor will connect the new building to the existing hospital and a £2million rooftop helipad is being funded by the HELP Appeal charity.

2.6 DCH Chemotherapy Unit

Dorset County Hospital's chemotherapy unit has been transformed following a £2million refurbishment. Patients undergoing chemotherapy on the Fortuneswell Unit will now receive their treatment in a vastly improved area with new facilities. The layout has been reconfigured to provide more space for patients, and a new outdoor courtyard area has been created to offer a calming escape from the clinical environment.

It also features artwork by local artist Bethan Venn. Commissioned by the Arts in Hospital team, Bethan custom designed prints that feature within the unit. Inspired by nature, plants in the courtyard and the four seasons, the aim is to bring the outside in for patients on the unit.

The work was carried out by LST Projects and was jointly funded by the Trust and money raised through Dorset County Hospital Charity's Chemotherapy Appeal, which included major support from the Fortuneswell Cancer Trust, local charitable trusts and the community.

Report to	Board of Directors - DCH	
Date of Meeting	12 August 2025	
Report Title	Board Assurance Framework – Quarter 1	
Prepared By	Jenny Horrabin, Joint Director of Corporate Affairs	
Approved by Accountable Executive	Jenny Horrabin, Joint Director of Corporate Affairs	
Previously Considered By	Assigned risks considered by Committees w/c 28 July 2025 and full BAF considered by Audit Committee 4 August 2025	
Action Required	**Approval**	No
	Assurance	Yes
	Information	No

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

Executive Summary

1. Overview

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

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

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

2. Review Process

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

- Each risk has an unmitigated, mitigated and target score using the 5x5 scoring matrix previously reported. The unmitigated score is the level of risk before any mitigating actions are taken. The

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

- Controls and assurances are identified in terms of:
  - Priority Strategies and Plans
  - Risk controls and Plans
  - Oversight Governance and Engagement
- Each assurance has been assessed as Positive / Neutral / Negative. Where there is a gap in control or assurance this has been categorised as 'neutral'.
- Each of the three categories above have an overall assessment based on the controls and assurances in place as Red / Amber / Green. Where there is an assessment of Amber or Red there will be a corresponding action to improve the level of control and/or assurance. There is guidance in place to support this assessment and this is combined with a judgement depending on the relative significant of the assurances identified.
- Each action is marked as:
  - On Plan (Green)
  - Behind Schedule' (Amber)
  - Significantly behind schedule (Red)
  - Complete (Grey)
- Each risk has been assigned to an Executive Lead who has signed off the BAF for their assigned risk.
- The BAF was reviewed and agreed by the Joint Executive Management Team.
- Each risk has been reviewed by the responsible Committee during w/c 28 July 2025. The BAF was then reviewed by the Audit Committee on 4 August 2025.
- Following review at the Audit Committee the actions related to SR9 Digital and SR10 Cyber were moved to 'behind schedule' – so in accordance with the originally agreed date rather than the revised dates to reflect the number of risks related to these areas and the need to maintain the required focus.

3. Developments since the last review

The developments below were planned for this reporting cycle. A status update is provided below. The delays do not impact on the BAF requirements, and all developments are further enhancements.

Key metrics will be assigned to each risk – key metrics were planned to be assigned to each risk. Work to identified key metrics is being reviewed in the light of the Performance Assessment Framework and the Ten-Year Plan.

Risk Appetite - A survey has been sent to all Board members. We will the collate the results of this survey and present the results at a facilitated discussion at a Board Development Session, with the aim that we will arrive at a collective view of the risk appetite across DCH and DHC. This is now scheduled for September 2025. The revised timeline for this is as per below:

Process	Original Date	Revised Date
Present process for Risk Appetite Review to DCH and DHC Audit Committees for endorsement	May /June 2025	N/A Complete
Undertake survey of all Board Members	June 2025	July 2025
Collate results of Survey and present to respective Senior Leadership Groups for review and comment	June/ July 2025	Aug 2025
Facilitated Board Development Session	July 2025	Sept 2025
Present finalised risk appetite statement to Board for approval	August 2025	Oct 2025

4. Quarter One Board Assurance Framework

Risk Scores

The highest scoring risk identified within the assurance framework (based on the mitigated risk score) continue to be SR3: Workforce Capacity; SR5 Estates; SR6: Finance and SR9: Digital Infrastructure (each with a score of 15 or more).

There score in respects of SR5 Estates has increased from 16 to 20 in the last quarter (with an increase in the likelihood score to 5). This is as a result of the results of the Six Facets Survey.

Actions

Gaps in controls and assurance are identified across all strategic risks and clear actions to address these have been identified.

Where a revised date was agreed at Quarter 4 and the revised date the action was initially marked as 'on plan' – although the history of the date changes remained. However, following review at the Audit Committee the actions related to SR9 Digital and SR10 Cyber were moved to 'behind schedule' – so in accordance with the originally agreed date rather than the revised dates to reflect the number of risks related to these areas and the need to maintain the required focus.

Six out of ten risks have at least one action that is behind schedule, with revised dates agreed. There are 11 overdue actions, with 6 of these relating to digital and cyber.

Recommendation

Members are requested to:

- Receive assurance on the process in place to review the Board Assurance Framework
- Review and scrutinise the risks and identify any areas where further assurance is required

Dorset County Hospital
NHS Foundation Trust

Dorset County Hospital NHS Foundation Trust
Board Assurance Framework
Quarter 1 July 2025

Dorset County Hospital NHS Foundation Trust

Board Assurance Framework Overview - Quarter 1 July 2025	Strategic Objectives				Responsibility		Score					
Strategic Risks	Care	Communities	Colleagues	Sustainability	Committee	Executive	Unmitigated Score	Mitigated Q2 24-25 Score	Mitigated Q3 24-25 Score	Mitigated Q4 24-25 Score	Mitigated Q1 25-26 Score	Target Score
SR1: Safety and Quality If we are not able to deliver the fundamental standards of care in all of our services we will not be providing consistently safe, effective and compassionate care	X				**Quality**	Chief Nursing Officer	**16**	12	12	12	12	**12**
SR2: Culture If we do not achieve a culture of compassion and empowerment and engagement, we will not have a motivated workforce with the required capacity and skills to improve patient outcomes and deliver safe care.	X		X		**People and Culture**	Chief People Officer	**15**	**12**	**12**	**12**	**9**	**6**
SR3: Workforce Capacity If we are not able to recruit and retain the required number of staff with the right skills we will not be able to deliver high quality and safe sustainable services within our resources	X		X		**People and Culture**	Chief People Officer	**15**	**15**	**15**	**15**	**15**	**9**
SR4: Capacity and Demand If we do not meet current and expected demand and achieve local and national measures and targets within available resources we may face regulatory action and patients outcomes will be adversely affected	X	X		X	**Finance and Performance**	Chief Operating Officer	**16**	**9**	**9**	**9**	**9**	**6**
SR5: Estates If we do not have an estate that is fit for purpose and economically and environmentally viable we will be unable to provide the right places for our staff to deliver high quality services to the communities that we serve	X		X	X	**Finance and Performance**	Chief Finance Officer	**16**	12	16	16	20	**9**
SR6: Finance If we do not deliver on our financial plans, including the required level of savings, then and this will adversely impact our ability to provide safe sustainable services, and will impact upon the overall ICS position				X	**Finance and Performance**	Chief Finance Officer	**20**	16	20	20	20	**12**
SR7: Collaboration If we do not have effective and positive partnerships within the ICS then we will not be able to shape decisions and deliver the transformation required.		X		X	**Strategy, Transformation & Partnerships**	Chief Strategy Transformation and Partnerships Officer	**12**	**9**	**6**	**9**	**9**	**6**
SR8: Transformation and Improvement If we do not seek and respond to the views of our communities to co-produce and continuously improve and transform our services, we will not contribute to the reduction of health inequalities within our communities.	X	X		X	**Strategy, Transformation & Partnerships**	Chief Strategy Transformation and Partnerships Officer	**16**	**12**	**12**	**12**	**12**	**6**
SR9: Digital Infrastructure If we do not advance our digital and technological capabilities, including achieving our EHR ambitions, we will not deliver the innovative and sustainable services and the delivery of safe services could be compromised.		X		X	**Strategy, Transformation & Partnerships**	Chief Strategy Transformation and Partnerships Officer	**20**	**12**	**16**	**16**	**16**	**6**
SR10 Cyber security If we do not take sufficient steps to ensure our cyber security arrangements are maintained and up to date then we are at increased risk of a cyber security incidents	X			X	**Strategy, Transformation & Partnerships**	Chief Strategy Transformation and Partnerships Officer	**15**	12	12	12	12	**9**

Dorset County Hospital NHS Foundation Trust

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

Executive Lead

Chief Nursing Officer

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

Rationale for Score

Score unchanged. CQC Report following Maternity inspection awaiting finalisation. Continued use of temporary staff to maintain safe levels. Will review quality indicators in line with segmentation results and 10 year plan

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	*Assessment (See assessment guidance)*
Priority Programmes and Strategies			
Quality Priorities 24/25 (each have a subject matter expert owner)	Board approved 25/26 Quality priorities; 24/25 Quality Report approved and published and regularly reporting in place to Quality Committee for oversight	**Positive**	**Green**
PSIRF Response Plan	Board approved PSIRF Response Plan, updates to Quality Committee (QC) - approved April 25. Board Development session July 25. PSII areas for 25/26	**Positive**	
Contractual obligations 25-26 and NQRB reviewing quality priorites	KPI monitoring and Quality Dashboard	**Positive**	
Maternity Incentive Scheme (MIS)	Maternity Report, Quality Committee, LMNS oversight and reporting, MIS End Point Review Outcome - Compliance; Internal Audit Report	**Positive**	
Risk Controls and Plans			
Quality Priority Improvement Plan (inc agreed standards and measurement)	Quarterly Quality Priorities Report to QC (progress against KPIs)	**Positive**	**Amber**
Patient Experience Metrics and Improvement Plans	Patient Experience monthly, quarterly and Annual Complaints Report (inc local surveys and metrics), Friends and Family Test National Surveys, Patient Story to Board, 15 Steps Challenge; Complaints Policy in line with PHSO standards	**Neutral**	
PSIRF implemented to improve patient safety and Patient Safety Incident Response Plan	PSIRF Huddles, Patient Safety Committee oversight of Patient Incident response Plan and Quality priorities	**Positive**	
Quality Committee Framework	Quality Reports and Dashboards; EQIA SOP approved - reviewing against national template and guidance issued June 25	**Neutral**	
Oversight Arrangements for Governance & Engagement			
Quality Committee	Assurance Reports to Board, Quality Assurance Group in place. Quality Committee in Common from Q1 25/26. Scope confirmed and transition plan in place	**Positive**	**Amber**
Patient Safety Committee	Patient Safety Incidents Report and Assurance Reporting to Quality Committee	**Positive**	
Patient Experience and Public Engagement Committee and Patient Safety Committee and Clinical Effectiveness Committee	Patient Safety Incidents oversight to Patient Safety Committee - reporting will be rveiewed in light on National quality Board recommendations	**Neutral**	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Completion of CQC self assessments and actions plans - Under review following recent CQC changes. Target date moved to Sept 25 (agreed May 25) - on plan for new agreed date	Jhow	~~Mar 25~~ Sept 25	On Plan
Strengthen trriangulation and oversight of finance and workforce metrics and impact on safety and quality - new dashboards in quality report from July 25	Jhow	Jul-25	Complete
Embed EQIA process and commence panels - process in place - action completed - new action below re new template and guidance	Jhow	May-25	Complete
Review metrics and reporting agaisnt National Quality Board Recommendations - expected Dec 25	Jhow	Dec-25	On Plan
Review EQIA template against new national guidance	Jhow	Sep-25	On Plan

Dorset County Hospital NHS Foundation Trust

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

Executive Lead	Risk Score	Consequence	x	Likelihood	=	Score
Chief People Officer	Unmitigated	5	x	3	=	15
	Mitigated	3	x	3	=	9
	Target	3	x	2	=	6

Rationale for Score

Reduced score (consequence) due to improving position against key metrics (turnover and sickness). Joint Inclusion and Belonging Group to meet from Sept 25. Level of change in NHS creates uncertainty in workforce

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

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

Dorset County Hospital NHS Foundation Trust

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

Executive Lead: Chief People Officer

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

Rationale for Score: Score unchanged. WTE reductions- WTE controls & QIA mitigate impact on delivery of safe services. Improving reporting and timely monitoring of progress. Sub Co will impact on workforce and HR on programme board

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

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
More clarity on system implementation long term workforce plan - will respond in line national and regional direction - NHS long term workforce plan is superceded by new 10-year Health Plan for England.- close action and see new action re 10 year plan	NP	~~Dec 24~~ Aug 25	Complete
Develop Talent Management and Succession Planning Approach - Included in Year One People Plan Deliverables and collaborative approach with DHC - in plan for year one	EH	Jun-25	Complete
Ten year Plan publihsed July 25 - implication for workforce to be considered and detailed plans awaited and will respond as published	EH	Dec-25	On Plan
Financial Recovery Board to be established to main oversight of workforec reductions	NP	Jul-25	On Plan

Dorset County Hospital NHS Foundation Trust

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

Executive Lead	Risk Score	Consequence	x	Likelihood	=	Score
Chief Operating Officer	Unmitigated	4	x	4	=	16
	Mitigated	3	x	3	=	9
	Target	3	x	2	=	6

Rationale for Score

No change in score. We continue to respond to demand and have plans in place to manage this.Will rveiew performance in line wth new Performance Assessment Framework (PAF)

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Patient Flow Program (Internal to DCH with partners)	Regular updates against key plans and outcomes via F&P reporting	Positive	Green
UEC Review (Newton - Future Care) with System partners	Board Development Session Nov 24 and Approved Partnership Agreement Dec 24; Board Development session May 25	Positive	
Operational Plan 24/25 (in accordance with national planning guidance and inc Elective Recovery Fund - ERF)	Reported to F&P and Board (including risks to achievement of plan). Underpinning governance shared with FPCIC and agreed	Positive	
Risk Controls and Plans			
Elective Recovery activities and mornitoring against Performance Assessment Framework	Work underpinning is within Divisional Performance and F&P reports / regional oversight of recovery - as at July 25 DCH has the 2nd best implied productivity growth in the Region	Positive	Amber
UEC Improvement Plan	Work underpinning is within Divisional Performance and F&P reports - and underpinned by both Divsional Improvement Plans and Patient Flow Program achieving key targets for ambulance handovers and 4 hous ED performance	Positive	
Performance Management Framework (and resulting deep dive reviews)	Performance Report to F&P and Board and Deep Dives / Internal Audit Reports	Neutral	
Seasonal surge plan	Surge plan reported to F&P with monitoring via Performance Report, Winter Plan approved	Positive	
Oversight Arrangements for Governance & Engagement			
Finance and Performance Committee	Performance Report to F&P and Assurance Report to Board	Positive	Green
System Planned Care Delivery Group /Elective Performance Management Group (EPMG) /Productivity weekly meetings / weekly regional meetings for oversight of the operational plan performance delivery	Performance Report to F&P and Board	Positive	
UEC System meetings - weekly/monthly/Qtrly and Seasonal Surge Planning	Surge plan reported to F&P with monitoring via Performance Report	Positive	
Divisional Performance Meetings	Performance Report to F&P and Board and Deep Dives	Positive	
UEC (Newton) Governance framework agreed and in place	Performance Report to F&P and Board and Deep Dives	Positive	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Use of Performance Management Framework to increase oversight where performance identified for improvement - year end review of performance - Complete	AT	May-25	Complete
Complete review of Integrated Corporate Dashboard for 25/26 reporting - Dashboard reviewed and considered at FPC informal June 25	AT	Ap 25	Complete
Review performance plans in response to Performance Assessment Framework and segmentation	AT	Aug-25	On Plan

Dorset County Hospital NHS Foundation Trust

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

Executive Lead	Risk Score	Consequence	x	Likelihood	=	Score
Chief Finance Officer	Unmitigated	4	x	4	=	16
	Mitigated	4	x	5	=	20
	Target	3	x	3	=	9

Rationale for Score

Increased likehood as result of results of six facets survey re critical infrastructure and backlog. Compliance and understanding of estate - moving in right direction

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	Outcome of assurance	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
New Hospital Programme	NHP Business Case, programme approved and build progressing	Positive	Amber
Joint Estates Strategy to be developed - not yet in place	Six facets survey complete and will inform strategy - six facets survey to FPC July 25 and Board Aug 25	Neutral	
Establishment of a wholly owned subsidiary to incorporate estates and facilities	OBC approved by Board Apr 25 and FBC May 25 Programme Board in place. Due diligence to be undertaken . Currently in pause and NHSE approval process	Neutral	
Capital Programme	Monitoring to Finance and Performance Committee - Internal capital programme with prioritised schemes ranked across digital, estates and medical devices overseen by CAPSUG - cap prog within envelope 24/25 and strong plan for 25/26 with successful bids achieved inc £6m. Six facets survey identified gap in finance related to critical infrastructure and backlog	Negative	
Risk Controls and Plans			
Estates compliance functions	Compliance reports in estates Function and reported to compliance groups - working to identify gaps and mitigations. Reporting in place on progress and commissioning external PAM assessment - Report to F&P May 25 - 8c0& compliance and reportig in place. PAM will provide independent assurance - commissioned and commenced with due date for completion Sept 25	Neutral	Red
Fire safety compliance	Further assurance required on fire safety - review completed to assess gaps and issues and plans in place and ongoing - to F&P May 25 - Monthly meets with fire safety team from fire brigade and content with tracking on imp plan	Neutral	
Backlog maintenance plan	Rported to Capital Investment Meeting - increased funding due to successful bid. However, six facets survey identiid increased level of unfunded backlog maintenance - need new 5 year plan and funding to be identifed	Negative	
Oversight Arrangements for Governance & Engagement			
Finance and Transformation (Performance) Committee for estates planning and compliance and Strategy Transformation and Partnerships Committee for transformation (from Sept 24)	Assurance Reports to Board	Positive	Amber
Capital Investment Meeting	QIA of capital schemes now in place	Positive	
Estates related compliance groups in place (water, fire, health and safety)	Compliance reports on estates and health and safety from Nov 24 to F&P	Positive	
New Hospital Programme Board	Programme approved, NHP Programme Board report to STP & NHSE	Positive	
Shared Services Programme Board	Reports to Our Dorset Provider Collaborative - reporting to be confirmed	Neutral	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Develop Joint Estates Strategy - Ageed date change to Nov 25 as the enabler for Estates Strategy is a Six Facet Survey to be completed across DCH and DHC - on plan for new date	CH	~~Jul 25~~ Nov 25	On Plan
Completion of all required governance and due diligence in respect of wholly owned subsidiary - revised date to Nov 25 due to pause	DM	Aug 25 Nov 25	Behind Schedule
Re-prioritise critical infrastructure and total backlog maintenance based on funding available	DM	Sep-25	On Plan

Dorset County Hospital NHS Foundation Trust

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

Executive Lead: Chief Finance Officer

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

Rationale for Score: No change in score - on trajectory for £9.8m delivery - Challemge on CIP prog 16% (£4.5m) unidentified (target £29.1m)

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	Outcome of assurance	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Operational plan 2024/25 break even delivery (in year risk adjusted forecast outrun with agreed trajectory at system level) Operational Plan 2025/26 deficit plan of £9.8m within Dorset system overall break even plan requirement	Oversight via Finance Reporting to Finance & Performance Committee and Senior Leadership Group and Trust Board, plus bi-weekly Financial Recovery Board to be re-established to support Trust delivery. Outputs from indendent reiew to FPC July 25 and recommendations to be implemented	Neutral	Amber
2025/26 8.6% CIP target of £29m required in full to meet £9.8m deficit plan, 30% agency reduction, 20% bank reduction, internal 10% Corporate target stretch, 232 WTE reduction of which 85 WTE support services recovery to Apr 22 levels	Medium Term Financial Plan - work over summer 25 linked to 10 year plan and 3 year spending rveiew likely deadline Dec 25 (TBC); Triple Lock governance - £25k limit - all trust exp to go thorugh tripe lock meet- ICB lead with provider representation	Negative	
Medium Term Financial Plan - underlying position recovery and improve future sustainability inc cash focus	Medium Term Financial Plan to Finance and Performance Committee. Cash position improving due to additional income - daily cash monitoring in place	Neutral	
Risk Controls and Plans			
Operational workbook completion supported by Transformation & Finance with EQIA process updates - Trust CIP Tracker master for recording, CFO led support review meetings with all areas	Value Delivery Board Executive SRO oversight and reporting to Finance & Performance Committee, bi-weekly Financial Recovery Board to be re-established	Neutral	Amber
Regular budget meetings, enhanced budget manager training, recovery plans required for all overspending areas, linked to Productivity saving opportunities	Finance Reporting to Divisional Performance Meetings, Finance and Performance Committee & Trust Board	Neutral	
System wide working & development	System groups - triple lock meeting and Medium term Plan Meeting (ICB chair + providers + NHSE - weekly) Segmentation driven by financial deficit	Neutral	
Oversight Arrangements for Governance & Engagement			
Finance and Performance Committee	Escalation Reports to Board, Finance Report to Committee and Board	Positive	Amber
Updated Delivery/Recovery Group to be re-established to prevent deterioration in financial position and workforce controls and support delivery of plans	bi-weekly Financial Recovery Board to be re-established	Neutral	
Value Delivery Board (VDB) - CFO Chair & Executive SROs in place per identified themed area, EQIA process enhanced	Internal audit report HFMA checklist assessment and CIP process audit conducted, EQIA panel being constructed overseen by CNO with reporting to Quality Committee; new grip and control template to be reviewed	Neutral	
System wide working - Medium Term Financial Plan Group CEO Escalation meeting	Financial oversight reports internally and System ICB	Positive	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Re-establish internal Delivery/Recovery group - CIP, WTE and Prodcutivity key focus areas with relevant stakeholder leads - Financial Recovery Board DCH and DHC to be estabished July 25 and governance to be refined in line with independent review recommendations	NJ/CH	Apr 25 Aug 25	Behind Schedule
Enhanced of EQIA Process -process in place - embed EQIA process and commence panels - in place - new national template released (action under quality risk)	DD	~~Nov 24~~ ~~Apr 25~~ May 25	Complete
New Financial Delivery Team arrangements to be establsihed across DCH and DHC to give pace and focus on financial recovery	CH	Sep-25	On Plan
Focus on reducing temporary staffing spend	NP	Sep-25	On Plan

Dorset County Hospital NHS Foundation Trust

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

Executive Lead

Chief Strategy Transformation and Partnerships Officer

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

Rationale for Score

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

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Joint Forward Plan, supports NHS system focus on the same priorities. Ten year plan published	ICB-led Provider Relationship meetings to March 25 replaced with contract meeting and System Executive Group	Neutral	Amber
Our Dorset Provider Collaborative	Our Dorset Provider Collaborative(PC) Board / PC Report to Board / NED PC Oversight Group in place from Nov 24/ B2B2B March 25 / Joint CDIO appointed April 25 / Wholly owned subsidiary being developed across 3 Dorset providers / arrangements strengthened with appointment of programme director	Neutral	
One Transformation Approach	One Transformation Approach - Flagship Programme reporting to Joint Transformation and Improvement Board (JTIB) and STP Committee from Sept 24. 25/26 Transformation work plan to JTIB and STP CiC May 25 - however JTIB not consistentlly meeting and arrangements to be reviewed	Negative	
Risk Controls and Plans			
Compliance with NHS Provider Licence and Code of Governance re duty to collaborate	Provider Licence and Code of Governance Compliance Report to Audit Committee annually reported to Audit Committee May 25	Positive	Amber
Five pillars from Joint forward plan - alignment of all programmes (pending review subject to release of National Long Term Plan)	Joint Strategy aligned to Joint Forward Plan-from November 24 forms part of prioritisation process via JTIB, further work required to understand ICB monitoring of ICB pillars and our role in that - to be reviewed in light of ten year plan	Neutral	
Portfolios of change - INT / MH / Sustainable services / working together / operational redesign	Reporting to JTIB and to STP Committee from September 2024 - however JTIB not consistentlly meeting and arrangements to be reviewed	Negative	
Oversight Arrangements for Governance & Engagement			
ICB and ICP Membership	Chair member of ICP, CEO member of ICB - updates to Board bi-monthly - Changes in progress re ICB clustering arrangememts and ten year plan re ICB membership and ICP	Neutral	Amber
Strategy, Transformation and Partnership Committee - from Sept 2024	Escalation Reports to Board	Positive	
Working Together Portfolio Board and STP CiC from Sept 24	Escalation Reports from Working Together CIC to Board - to Aug 24 and STP from Sept 24. Review of Working Together Programme to STP CiC May 25	Neutral	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Capital planning investment to be aligned to strategic objectives - complete	PL	May-25	Complete
Completion of all required governance and due diligence in respect of wholly owned subsidiary - Remove as covered under Estates and Finance risks	NJ	Aug-25	Complete
Review of Joint Transformation and Imrovment Board	PL	Sep-25	On Plan
Board development session of strategy transformation and improvement approach	PL	Sep-25	On Plan

Dorset County Hospital NHS Foundation Trust

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

Executive Lead

Chief Strategy Transformation and Partnerships Officer

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

Rationale for Score

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

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

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Joint Strategy - Develop the Strategy Dashboard (including metrics to measure reduction in health inequalities) - measures approved but further work to align metrics to strategic objectives and agree form of reporting - executive engagement during Jan 25 to progress. To report to STP May 25 for 'proof of conecpt' and implementation to follow	PL	~~Nov 24~~ ~~Mar 25~~ Sept 25	Behind Schedule
Joint Improvement Framework. Develop the outline plan until Mar 25. 'Discover' stage 1/4 complete. Next stage (2) is 'Define' - Learning is longer timeline required for meaningful engagement. Define to be completed by June 25. Stages 3+4 dependent on outcome of 'Define' stage - on plan for agreed revised timetable - Review of Joint Transformation and Improvement Board required	PL	~~Oct 24~~ ~~June 25~~ Sept 25	Behind Schedule

Dorset County Hospital NHS Foundation Trust

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

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

Rationale for Score

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

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Joint digital strategy DCH/DHC	NHSE Digital Maturity Assessment (DMA), NHSE What Good Looks Like (WGLL)	Neutral	Amber
EHR Programme (OBC)	DCH Board approved OBC - Further approval Dec 24. Dorset and Somerset OBC approvedand procurement commenced. Opportunity to develop an additional OBC for funding for DHC - awaiting OBC approval	Positive	
Risk Controls and Plans			
Digital risks monitored and reported	Monthly Report to Digital Transformation and Assurance Group (DTAG)	Neutral	Amber
Data Security & Protection Toolkit	Submission via Finance and Performance Committee and audited by BDO, reviewed by SIRO	Positive	
Oversight Arrangements for Governance & Engagement			
Strategy Transformation and Partnerships Committee - From Sept 2024	TOR approved - Reporting to Board commenced October 2024	Positive	Green
EHR Programme Board and EHR Advisory Group	EHR Report into Board	Positive	
DCH Digital Transformation & Assurance Group	Monthly reporting includes risks, cyber, projects - redefined to have stronger governnace and clarity on decision making role - new membership and TOR strengthened	Positive	
Joint Digital Services Leadership Group DCH & DHC - in process of being replaced by Dorset wide forum	Governance and reporting reviewed and strengthened	Positive	
Information Governance Group (also covers cyber)	Bi-monthly report to STP	Positive	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Joint digital strategy to be developed and submitted for Board approval - postponed to Sept 25 as new joint CDIO in post from April 25 and Dorset wide strategy to be developed - previously agreed revised date	BB	~~Mar 25~~ ~~Sept 25~~ Dec 25	Behind Schedule
Implementation of Federated Data Platform (NHSE Mandate)	BB	Mar-26	On Plan
Development of Infrastructure roadmap to support joint digital strategy - postponed to Dec 25 as new joint CDIO in post from April 25 and will form part of Dorset wide strategy and integrated approach across Dorset - previously agreed revised date	BB	~~Mar 25~~ Dec 25	Behind Schedule
Establish Dorset wide digital leadership group	BB	Dec-25	On Plan

Dorset County Hospital NHS Foundation Trust

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

Executive Lead

Chief Strategy Transformation and Partnerships Officer

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

Rationale for Score

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

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

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

ASSURANCE ASSESSMENT

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

RISK SCORING MATRIX

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

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

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

Report to	Board of Directors, Part 1	
Date of Meeting	12th August 2025	
Report Title	Corporate Risk Register – Quarter 1 25/26	
Prepared By	Laura Sellick, Risk team	
Approved by Accountable Executive	Chris Hearn, Chief Finance Officer	
Previously Considered By	All board sub-committees reviewed the risks for which they are responsible in the week beginning 28th July 2025 The full report was considered at Audit Committee 4th August 2025	
Action Required	**Approval**	No
	Assurance	Yes
	Information	Yes

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 Safety & Quality SR2 Culture SR3 Workforce capacity SR4 Capacity & demand SR5 Estates SR6 Finance SR7 Collaboration SR8 Transformation & Improvement SR9 Digital Infrastructure SR10 Cyber security	
Financial	Activity and performance will impact on financial sustainability.	
Statutory & Regulatory	This will impact on all CQC Key Lines of Enquiry if risk is not appropriately reported, recorded, mitigated and managed in line with the Risk Appetite.	
Equality, Diversity & Inclusion	Nil specific	
Co-production & Partnership	Nil specific	

Executive Summary

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

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

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

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

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

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

Recommendation

The Board is recommended to:

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

Board of Directors

1 Executive Summary- Overview of Risks

4 new opened risk scoring 20 and above, added last quarter.

1.1 End of Support wireless access points in use within the corporate wireless network
Risk 2152 added on 01/05/25, review date 03/08/25

1.2 Out of support Core Network Infrastructure
Risk 2153 added on 01/05/25, review date is 03/08/25

1.3 Inability to fund the replacement of medical devices from capital
Risk 2157 added on 02/05/25, review date 02/06/25

1.4 Significant delay in receiving results of 24 hour tape, increasing the risk of unidentified Atrial Fibrillation causing further stroke or Transient Ischaemic Attack
Risk 2164, opened on 20/05/25 and review date 20/08/25

7 new opened risks scoring 15-19 added last quarter

1.5 Home Enteral Nutrition (HEN) Service Risk - Growing demand, insufficient staff & supply chain for enteral and SIP feed supplies
Risk 2144 added on 13/05/25, review date 08/08/25

1.6 Mindray Medical Devices need to be upgraded to support new HER
Risk 2158 added on 06/05/25, review date is 31/07/25

1.7 Use of WS-C2960-24TC-L Cisco Switches past their last support date
Risk 2154 added on 01/05/25, review date 03/08/25

1.8 IT support out of hours
Risk 2176 added on 23/6/25, review date 01/10/25

1.9 Careflow Printing & Re-Scanning
Risk 2137 added on 04/04/25, review date 11/08/25

1.10 HICCS Endoscopy system nearing end of life
Risk 2161 added on 13/05/25, review date 18/07/25

1.11 Video platform for Paediatric epilepsy service (V-create platform)
Risk 2169 added on 04/06/25, review date 16/07/25

2 Main narrative

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

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

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

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

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

2.5 Audit committee Risk Register detail 20+ (appendix 2)

2.6 Audit committee Risk Register detail 15-19 (appendix 3)

2.7 Managed and closed risks for last quarter (appendix 4)

3 Conclusion

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

4 Recommendations

4.1 The Board is recommended to:

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

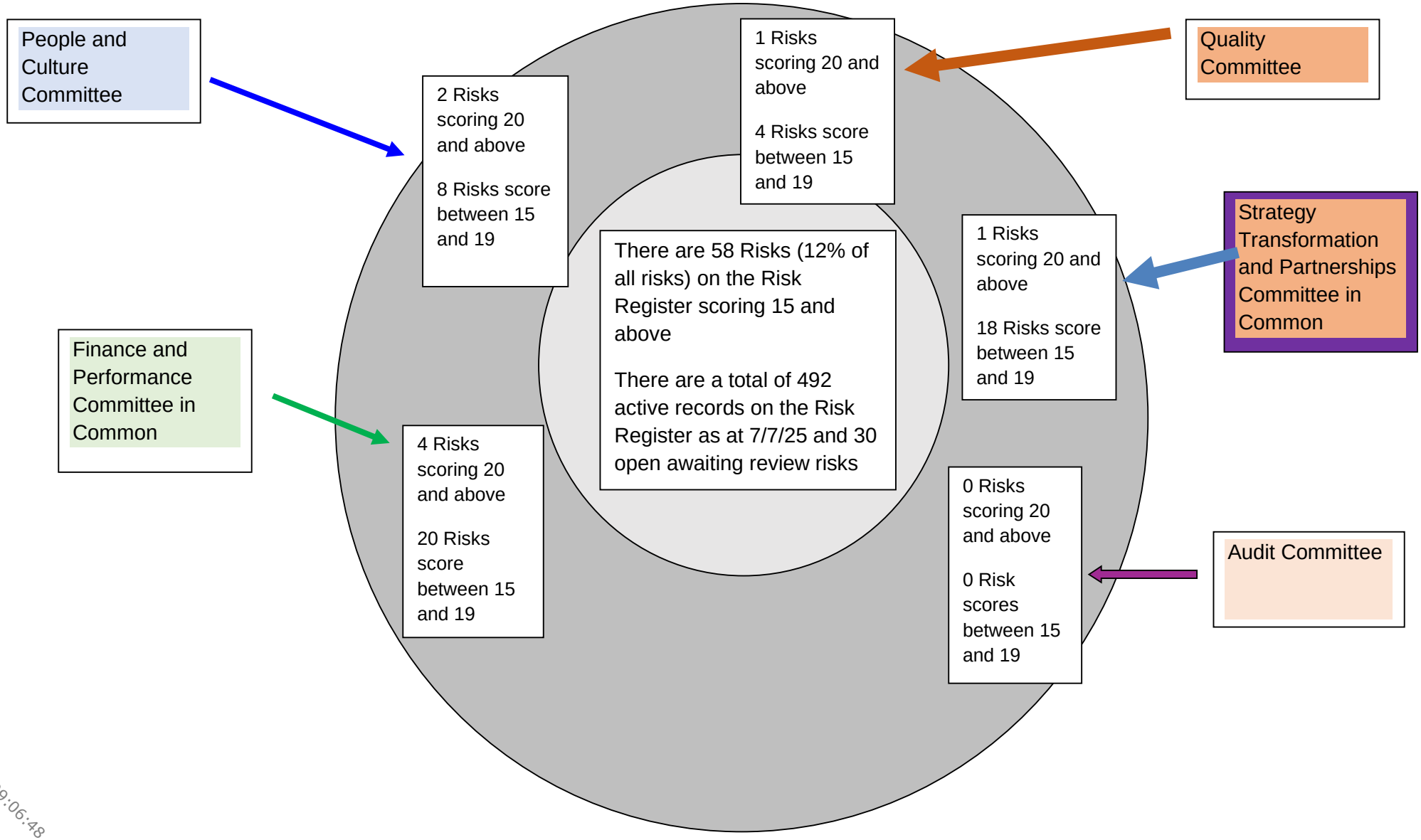
Name and Title of Author: Laura Sellick
Date 16/7/25

5 Appendices

5.1 Appendix 1 • Heat Map
5.2 Appendix 2 • Corporate Risk Register items 20+
5.3 Appendix 3 • Corporate Risk Register items 15-19
5.3 Appendix 4 • Closed Risks

Appendix 1

Corporate Risk Register – Risk scoring for Primary Reporting Committees on 18/7/25



Appendix 2-Active Risk Register items above 20 by Primary Reporting Committee

Approval status	ID	Title	Review date	Opened	Care Groups	Service of responsibility	Risk level (initial)		Risk level (current)	Risk level (Target)	Type of Risk	Mitigations/Controls
Active	2152	End of Support wireless access points in use within the corporate wireless network	03/08/2025	01/05/2025	Chief Information Officer	Digital Technology and Infrastructure (DTI)	20		20	1	Finance and Performance Committee	Replace all access points the plan would be to move the wireless solution on to a newer technology which is cloud hosted and has certain elements built into the system such as RFID tracking and so o that expensive cisco licensing would no longer be required. Newer access points have a newer generation of wireless trechnology in them and would provide a better wireles
Active	2157	Inability to fund the replacement of medical devices from capital	02/06/2025	02/05/2025	Pharmacy, Pathology and Medical Physics (A4)	Across all specialties	16		20	4	Finance and Performance Committee	The Medical Devices Group (MDG) escalates to the Patient Safety Committee, the MDG reviews requirements for replacement and carries out a risk assessment process in or devices. The Triumvirate reviews the information provided by MDG, finance and service needs to make the prioritisation and strategic decision on which devices are purchased. Alternative funding opportunities are kept under review such as speciality networks and charitable organisations.
Active	2153	Out of support Core Network Infrastructure	03/08/2025	01/05/2025	Chief Information Officer	Digital Technology and Infrastructure (DTI)	20		20	1	Finance and Performance Committee	Replace core switches and re-design configuration for flexibility
Active	472	Patient Safety Concerns and Increased Risk of Adverse Outcomes Due to Prolonged Wait Times in Community Paediatrics	30/06/2025	10/09/2018	Family Services (B4)	Paediatrics Service	15		20	10	Finance and Performance Committee	May 2024 – DCH Transformation of Community Services (ASD / ADHD) commenced which is exploring; Waiting list – full validation in progress (commenced June 2024) Process – review of referral routes, and administrative process in referral, triage, and management of the waiting list. To commence PTL meetings once WL validation is comp Workforce – current clinical and administrative models under review. Exploration of job descriptions, roles and remits. Alternative workforce models for consideration. To co into risk 472, specifically around nursing workforce and capacity. Addressing training and development needs. Risk – to ensure that all complaints / FFT are linked to this risk, and community paediatrics team reminded to Datix all incidents that occur in relation to this risk (e.g, delay in referrals, increased waiting times, patients coming to harm on WL, incorrect referral method used, YP turning 18 whilst on WL – this list is not exhaustive) Systems development – Continue t work with the ICB on reviewing and amending the referral, triage and assessment processes for ASD / ADHD across Dorset. Patient Experience – better understanding of how CYP and families are waiting, and learning about their own experiences. Weekly meetings with project team – AE & RD Monthly meetings/ workshops with the wider clinical, management and admin team to progress actions and workstream New Ways of working: Piloting preschool one stop MDT clinics to provide assessment and diagnosis / onward referral in one clinic appointment. Long standing mitigations in place: General Paediatrics already sharing the workload of ADHD / Safeguarding. These functions should sit within the Community Paediatric remit, but there is no capacity. This is a solution. Under 5s ASD diagnostics process is completed as a single clinical diagnosis, rather than MDT diagnosis.
Active	1152	Current Digital Staffing levels present risk to both operational and strategic activities	11/08/2025	14/09/2021	Chief Information Officer	Digital Technology and Infrastructure (DTI)	16		20	9	People and Culture Committee,	As part of the discussions with JEMT and SLG with regard to the reprioritisation of the digital project portfolio and the associated digital recovery plan, a detailed discussions h senior level within the organisation with regard to the most constrained resources within Digital and having an adverse impact on our ability to safely deliver business as usua activities within digital. This process has focused attention on the highest digital clinical safety risks for the Trust but has also enabled the organisation to understand the consequences of what cannc with current digital resources. The longer term resolution for DCH Digital resourcing will come from work to develop the joint digital strategy for Dorset, which is underway
Active	876	Maternity Staffing	05/08/2025	21/09/2021	Family Services (B4)	Maternity Service	12		20	4	People and Culture Committee	Staffing is reviewed very regularly, several times a day. Staff are asked to work different shifts, to stay longer and to work extra. However, they are also supported to know th requests. Community midwives re-allocated to LW as required - this is on a daily basis and of course impacts workload in community. Staff called in oncall - also impacts staffi Specialist midwives & matrons regularly work clinically. Escalation policy utilised as required with escalation to divert occurring regularly during July, Aug and Sept. Good syst the ICS with women diverted to other services.
Active	2164	Significant delay in receiving results of 24 hour tape, increasing the risk of unidentified AF causing further stroke or TIA	20/08/2025	20/05/2025	Integrated and Holistic Care (A2)	Stroke Service	20		20	4	Quality Committee	ZIO patch funding was granted in February 2024 to allow 14 day monitoring for all ischaemic strokes, still awaiting clinical safety sign off.
Active	2133	Inability to undertake necessary clinical systems upgrades	11/08/2025	27/03/2025	Chief Information Officer	Clinical IT Systems	20		20	8	Strategy, Transformation and Partnerships	Risk-based approach to reprioritising digital portfolio, has identified the highest risk/most urgent upgrade (Vitals) to be started c May/June 2025. Portfolio prioritisation process going forwards will account for risks and deadlines in the scheduling process; however, this will not address the fundamental issue related to c Digital recovery plan has been initiated. Work has been started with departmental system leads, as part of a digital landscaping exercise, to look for opportunities to put more effective and robust system manageme Similarly, opportunities to utilise departmental CSOs are being explored.

Appendix 3- Active Risk Register items 15-19 by Primary Reporting Committee

Approval status	ID	Title	Review date	Opened	Care Groups	Service of responsibility	Risk level (initial)		Risk level (current)	Risk level (Target)	Type of Risk	Mitigations/Controls
Active	1903	Age of Washers in EDU	08/08/2025	06/06/2024	Theatres, Anaesthetics, Critical Care & Decontamination (B3a)	Decontamination Service	16		16	2	Finance and Performance Committee	EDU Washer 13H100255 EDU Washer 23H100256 EDU Washer 33H100257 All washers renamed Summer 2024 as all reached maximum counts on TDOC. IHSS Southampton are our contingency site. We had to call upon them for support September 2024 due to water pump failures. ALL breakdowns are recorded as an incident on Datix - details of frequency can be seen in linked records
Active	1530	Digital Systems with Pharmacy Aseptic Suite	04/07/2025	18/10/2022	Pharmacy, Pathology and Medical Physics (A4)	Pharmacy Service	9		16	3	Finance and Performance Committee, Medicine Safety Committee	Clinichemo: alternative providers are being sought, and an options appraisal will be undertaken. This has been delayed due to the workforce challenges in the unit. Mosaiq: this is being addressed trust wide, and the ICS is looking to procure a new chemotherapy prescribing system
Active	1886	financial sustainability 24/25	30/09/2024	09/05/2024	Chief Finance Officer	Finance	16		16	6	Finance and Performance Committee	Budget meetings, monitored at FPC
Active	1896	Fire Team Response to emergencies	17/09/2024	24/05/2024	Chief Finance Officer	Fire Safety	16		16	2	Finance and Performance Committee, Health, Safety, Fire and Security Group	Email sent to Kevin Loader to advise the fire teams of the correct procedures to follow as an interim measure and cc'd to Jason Chambers for information. A formal training package is now being developed for the fire teams for delivery over the next 2 weeks. A further door opening training package will be developed for all staff in departments who carry out the initial alarm investigation prior to the arrival of the fire team. Training provided to key staff, ongoing auditing of responses being carried out
Active	1781	Glaucoma FOWL Long Waiters	14/07/2025	04/01/2024	Head & Neck, Specialist Medicine and Outpatients (B2)	Ophthalmology Service	20		16	6	Finance and Performance Committee, Patient Safety Group, Clinical Effectiveness Group	Additional (in-house) activity is being put on as and when staffing allows. B4 technicians running assessment clinics to release clinicians time needed for F2F appointments Additional virtual reviews being put on as and when staffing allows.
Active	2003	Histopathology Biomedical Scientist Workload Capacity	31/08/2025	08/11/2024	Pharmacy, Pathology and Medical Physics (A4)	Histopathology Service	16		16	8	Finance and Performance Committee	Locum Associate Practitioner (Band 4) in post, working 4 days per week: contract in place until end March 2025. Locum Band 6 BMS in place working full time to support, contract in place until end March 2025. Head of Department / Head BMS required to cover areas of lab that locums and substantive BMS are not trained in: specimen dissection / IHC, taking HoD away from other matters. BMS staff working overtime where possible to help with workload management.

Active	2144	Home Enteral Nutrition (HEN) Service Risk - Growing demand, insufficient staff & supply chain for enteral and SIP feed supplies	08/08/2025	15/04/2025	Integrated and Holistic Care (A2)	Dietetics and Nutrition Service	16	⇔	16	6	Finance and Performance Committee	Internal skill mix review undertaken to increase staffing allocation to HEN service with Band 5 rotational support. Dietetic assistant role in place, with planned progression to registered dietitian through apprenticeship for staff member (LH) commencing Sep-25 Service provision has been reviewed to maximise opportunities for remote reviews. Monthly Datix reporting of missed reviews in place to ensure that risk remains sighted. Future opportunity to explore mitigation of risk through vertical integration / system working with Dorset Healthcare.
Active	2176	IT support out of hours	01/10/2025	23/06/2025	Chief Information Officer	Digital Technology and Infrastructure (DTI)	15	⇔	15	1	Finance and Performance Committee	out of hours provision for IT for front door services. ED reception is a 24/7 service and currently if a user can not access their pas out of hours there is no provision to reset passwords. none viable with out breaching GDPR.
Active	1207	Insufficient HD capacity across all sites - increase in demand does not meet our capacity	18/08/2025	07/02/2022	Vascular and Metabolic (A1)	Renal Service	16	⇔	16		Finance and Performance Committee	Yeovil works currently under way to provide 8 further dialysis stations - 4 to be used initially only. Plans for works at DCH to create further isolation which has been financially approved. To start work Autumn 2025
Active	1635	Lack of Isolation Facilities on Prince of Wales ward	28/11/2025	02/05/2023	Vascular and Metabolic (A1)	Renal Service	16	⇔	16	4	Finance and Performance Committee	Use of rooms is managed on daily basis by juggling the patients who need to be transferred over POW ward. Patients can also be admitted onto other ward side rooms when appropriate and the nephrology team will manage the patient as an outlier. 3 Jan 2024 - Work to make the 2 side rooms useable begins on week commencing 8 January. This will provide 5 side rooms with dialysis capacity. 10 May 2024 - Urgent proposal for future development to cover the shortfall in outpatient isolation & haemodialysis capacity. Once this is resolved the ward will then have 5 side rooms as planned & required. Early 2026 current expectation.
Active	1780	Macular FOWL Long Waiters	09/08/2025	04/01/2024	Head & Neck, Specialist Medicine and Outpatients (B2)	Ophthalmology Service	20	↓	16	6	Finance and Performance Committee, Patient Safety Group, Clinical Effectiveness Group	Additional (in week) activity is being created when staffing allows. Failsafe Officer monitoring waiting list and escalating any clinical concerns to Macular Lead Consultant.
Active	2158	Mindray Medical Devices need to be upgraded to support new EHR	31/07/2025	06/05/2025	Pharmacy, Pathology and Medical Physics (A4)	Clinical Engineering	16	⇔	16	12	Finance and Performance Committee	Requirement to source funding for the Mindary upgrade needs to be identified as part of the DCH capital plan or another source of funding identified.
Active	1629	Move of Hampshire Trust to a Sectra PACS	14/07/2025	21/04/2023	Chief Operating Officer		16	⇔	16	9	Finance and Performance Committee	October 2023 - guidance to be provided to DCH clinicians in the specialities most effected (colorectal and liver cancers) they will have a change of process to request access to imaging if they believe it has been done by Hampshire hospitals.
Active	1862	Neurophysiology EMG equipment	11/07/2025	23/04/2024	Radiology & Neurophysiology (B3b)	Neurophysiology Service	12	↑	15	2	Finance and Performance Committee, Medical Devices Group	Equipment is due for capital replacement - the team has been informed of theses concerns. Failure of equipment will result in loss of service. This will directly effect DM01 Ongoing the situation is being monitored

Active	1466	NHP - Inability to support and finance 'growing our own' skilled staff	10/06/2025	02/08/2022	Chief Finance Officer	Strategic Estates	16	⇔	16	9	Finance and Performance Committee	Increased emphasis on critical pipelines in business and workforce planning. Investment in support to trainees and services e.g. CLIP, Investment in practice education, cohort planning etc. Optimising HEE and ICS support and funding pathways. 02/03/23 - One of the risks is that business planning this and next year may not give us the bridge in resources we require to opening because of the Trust's financial status 07/03/24 - Likelihood reduced given workforce plan has been developed out to 25/26. Trust have established training pathways. Improved employment practices and recruitment and retention initiative. Trust continues to strengthen workforce programmes to achieve recruitment targets. 5/8/24 - Michelle Tamplin has taken over from Louise Hamilton-Welch. 5/3/25 - going through 25/26 business planning round. Ability to recruit & retain staff has improved but there is still uncertainty on funding. 12/05/25 - Business planning on hold due to NHS funding restrictions. Trust review commenced re. bed modelling and workforce requirements.
Active	1168	System revenue affordability pressures	10/06/2025	11/11/2021	Chief Finance Officer	Strategic Estates	16	⇔	16	8	Finance and Performance Committee	Updated risk title 07/03/24 Continued review of revenue requirements for NHP project Dorset Healthcare are leading the system wide discussions with DoFs and we will keep them appraised on the timetable for the DCH OBC to ensure we can minimise any potential delay. Revenue Affordability -proposal of baseline assumptions went to OFRG last Friday 03/12, a team is being put together to look at the strategy and use those baseline assumptions to hit OBC timings Early indications are that timetables will correlate. OBC submitted 10.06.22 OBC on schedule for submission at end of May. 5/8/24 FBC submitted January 2024. Trust submitted a balanced plan for 24/25 fy. 5/3/25 - System has provided a letter of support to the FBC which has now been approved. There is still a high revenue risk across the system.
Active	1221	Tackling the backlog of elective care	31/03/2025	09/03/2022	Chief Operating Officer	Central Appointments	20	⇓	16	8	Finance and Performance Committee, Clinical Effectiveness Group	The trust in on track to deliver against the revised trajectory of zero, 65+ week waits and has made good progress in reducing the number of patients waiting over 52 weeks. Mitigations that remain in place including: 1) Comprehensive insourcing plan, with all activity insourced below the tariff rate 2) 12-week validation programme, which means all patients on the waiting list are contacted every 12 weeks to ensure they still want to be on the waiting list and their condition has not changed 3) PTL management process, which includes clinical oversight to ensure patients clinical priority is regularly reviewed 4) The trust remains in tiering, with weekly review meetings with the ICB and NHSE. The trust values this process as an opportunity to keep stakeholders engaged
Active	1843	There is insufficient capacity for consultant led clinics in Haematology for current demand levels	21/07/2025	06/03/2024	Integrated and Holistic Care (A2)	Haematology Service (blood sciences)	16	⇔	16	2	Finance and Performance Committee, Patient Safety Group	Additional clinics have been put on to try and manage the backlog, but this is putting additional strain on the consultant team. Jason M is increasing capacity - once a month clinic mixed with Audrey Ryan - Gynae pts. Using slots on bone marrow clinics and fast track slots (overbooks) to accommodate for these patients.

Active	2154	[redacted]	03/08/2025	01/05/2025	Chief Information Officer	Digital Technology and Infrastructure (DTI)	16	⟷	16	1	Finance and Performance Committee	[redacted]
Active	1891	[redacted]	03/08/2025	17/05/2024	Chief Information Officer	Digital Technology and Infrastructure (DTI)	6	↑	16	16	Finance and Performance Committee	[redacted]
Active	1860	Adult inpatient dietetic staffing insufficient to meet the demand on the service. Increased wait times to assess patients.	31/07/2025	18/04/2024	Integrated and Holistic Care (A2)	Dietetics and Nutrition Service	9	↑	15	6	People and Culture Committee	Referral criteria being followed Staff to submit DATIX as needed
Active	839	MDT representation in Specialist Paediatric Epilepsy Service	21/07/2025	11/12/2019	Family Services (B4)	Paediatrics Service	2	↑	16	2	People and Culture Committee	New post holder in place for Paediatric Epilepsy service since November 2021 covering 1.0wte in a job share to caseload over 150 epilepsy patients. This is however not sufficient staffing to meet NICE guidance and recommended standards. Additional 12.5 hours given to Epilepsy from core CCN hours to support and maintain a local epilepsy service.
Active	1852	Neurophysiology Workforce levels not meeting Demand	11/07/2025	27/03/2024	Radiology & Neurophysiology (B3b)	Neurophysiology Service	12	↑	15	3	People and Culture Committee	Job planning will be reviewed to address the balance of work to support clinical and quality of service. We are going to review how urgent and IP are covered. There are times when we struggle to meet the IP demand We have created protected time for reporting ambulatories and will review if that is on track For a small team we also need to reflect on impact of this on health and well being for small team This situation is developing the DM01 is currently in a poor position and urgent and IP has doubled for escalation. Review KPI and TATs Stats to be weighted in respect to complexity to help monitor the system
Active	1606	Non Compliance - RCPCH Standards (Facing the Future)	31/07/2025	08/02/2023	Family Services (B4)	Paediatrics Service	10	↑	15	3	People and Culture Committee	Job planning in progress to review capacity risk item 1608. Business Case submitted to address RCPCH standards, YDH CQC inspection and outcome is linked directly to not achieving these standards.
Active	1837	Pharmacy Aseptic Unit staffing not resilient	09/07/2025	27/02/2024	Pharmacy, Pathology and Medical Physics (A4)	Pharmacy Service	12	↑	16		People and Culture Committee, Medicine Safety Committee	- Taken the only other member of staff who is currently trained within another team and relocated them into Aseptics - One further member of staff received broth test back and awaiting final sign off - Another member of staff started their broth tests - Business case in with NHSE for additional staff to provide resilence - Buying more in to offset
Active	1664	Skill Mix within -Paediatric Outpatient Department - No Registered or Lead Nurse	21/07/2025	05/06/2023	Family Services (B4)	Paediatrics Service	12	↑	15	6	People and Culture Committee	Rely on Kingfisher staffing and available Bank staff to support the children's centre with staffing gaps for sickness and training. 4 additional HCAs have been recruited - currently going through recruitment checks.
Active	1556	Theatre Staffing Sustainability	25/07/2025	20/03/2025	Theatres, Anaesthetics, Critical Care & Decontamination (B3a)	Theatre Service	16	↓	15	6	People and Culture Committee, Clinical Effectiveness Group	Workforce review completed, decision on next steps pending. Current mitigation strategy is voluntary overtime and bank shifts being undertaken by Theatre staff in order to reduce the amount of lists stood down due to understaffing. However, this is not a sustainable solution as it is leading to burnout for staff taking on additional hours and is costing the Trust more than substantive staff would.

Active	1607	Tier 2 Paediatric Registrar - BAPM Compliance in SCBU	30/07/2025	08/02/2023	Family Services (B4)	Paediatrics Service	12		15	3	People and Culture Committee, Quality Committee	Rota reviewed to have consultant and tier 2 cover - needs funding and recruitment of additional tier 2 cover. Following ICB investment in response to Yeovil Maternity closure funding to cover 9 month fixed term 0.43 WTE tier 1, and 1.16 WTE tier 2. This will increase the fixed term establishment of tier 2 to 4.16 WTE and achieve BAPM standards for SCU low activity, recognising this is fixed term. This facilitates a dedicated Registrar in SCU. Long term substantive post will need to be part of business planning 2026/27. The ANNP posts will also be transferred into Registrar vacancies due to unsuccessful recruitment into training posts.
Active	1655	Lack of Service Provision for Avoidant/Restrictive Food Intake Disorder	30/07/2025	24/05/2023	Family Services (B4)	Paediatrics Service	12		15	4	Quality Committee	Currently Paediatricians are caring for these CYP within their acute and/or community workloads. There may occasionally be support from SALT with assessment but ongoing management which can be timely and labour intensive sits with the paediatrician. Advise sought as required from regional network but this is a voluntary rather than established network. Paediatric dietitians are accepting referrals for a dietary assessment. They advise on how to make diet nutritionally complete – usually which OTC vitamins and minerals. If not able to manage supplement and at risk of deficiency disease we need to be able to raise this with paediatrics as not safe to hold the risk on our caseload. We will continue to try and support to get vitamins and minerals in BUT we need to be able to escalate them somewhere. Some may need enteral feeding to be explored. There is a prevention of future deaths report re: Alfie Nicholls. In that NHS trust cases reviewed led to 3 PEG's being placed.
Active	659	Medicines Supply Challenges	02/07/2025	20/11/2018	Pharmacy, Pathology and Medical Physics (A4)	Pharmacy Service	20		16	6	Quality Committee	Supply issues are being monitored bi-monthly by the Medicines Committee. This is in relation to COVID 19 and Brexit.
Active	1957	Ophthalmology Lost to Follow Up Patients	04/08/2025	04/09/2024	Head & Neck, Specialist Medicine and Outpatients (B2)	Ophthalmology Service	20		16	4	Quality Committee	Review of all clinics in 2024 needs to be undertaken.
Active	1502	Pharmacy Aseptic Unit - High risk to patient safety	09/07/2025	08/09/2022	Pharmacy, Pathology and Medical Physics (A4)	Pharmacy Service	20		16	8	Quality Committee, Medicine Safety Committee	- Action plan being addressed - 48 hour turnaround time - cap on numbers - improved scheduling on unit - ICS task and finish group being set up to look at medium to long term - Monthly review of action plan progress - business case
Active	1752	[redacted]	03/08/2025	01/11/2023	Chief Information Officer	Digital Technology and Infrastructure (DTI)	16		16	4	Strategy, Transformation and Partnerships	[redacted]

Active	1735	[redacted]	03/08/2025	01/01/2020	Chief Information Officer	Digital Technology and Infrastructure (DTI)	16		16	4	Strategy, Transformation and Partnerships	[redacted]
Active	1745	[redacted]	03/08/2025	16/10/2023	Chief Information Officer	Digital Technology and Infrastructure (DTI)	16		16	3	Strategy, Transformation and Partnerships	[redacted]
Active	1611	Blood results for Renal Patients from Somerset Foundation Trust are not added to eMed (Renal System) as there is no interface	15/08/2025	13/02/2023	Vascular and Metabolic (A1)	Renal Service	9		15	1	Strategy, Transformation and Partnerships	4 June 2024 Somerset have plans to enable access, DCH meeting with Somerset on 12 June 2024 for update.
Active	2137	Careflow Printing & Re-Scanning	11/08/2025	04/04/2025	Chief Information Officer	Clinical IT Systems	16		16	6	Strategy, Transformation and Partnerships	CSST are liaising with Training team to see if there is any enhancement to training that could help mitigate this issue.

Active	641	Clinical Coding Resource	11/08/2025	17/05/2019	Chief Information Officer	Clinical Coding	20	↓	15	3	Strategy, Transformation and Partnerships	In line with the Clinical Coding Workforce Strategy, which was shared with FPC September 2024, a number of actions have been taken to mitigate this ongoing risk including recruiting 2 additional trainee coders further to the previous trainee coders taken on in 2023. We continue to recruit on an ongoing basis to accredited clinical coders but so far this has proved unsuccessful. Also in line with the Strategy we have now introduced a new recruitment retention premium (RRP), which is first being applied to existing clinical coding staff and will be added to new coders recruited. We are however still reliant on agency and bank coders to augment our established resource. We have also now implemented improvements to the coding software that will have a small positive impact on improving productivity for the coders. As part of the digital strategy for Dorset we will be including a shared approach across DCH, DHC and UHD, which may involve pooling resources across the organisations and potentially partners in Somerset. This is part of the longer term Workforce Strategy for Coders.
Active	1877	Clinical digital Safety - DCB0160 assurance debt	01/09/2025	29/04/2024	Director of Strategy and Business Development	Clinical IT Systems	12	↑	16	8	Strategy, Transformation and Partnerships	Trust CNIO collecting baseline data and will author an options paper for discussion at DTAG. CNIO prioritising go lives for new HIT or upgrades to existing systems to mitigate new risks with CSO embedded in digital services. CSO training booked in June and September to train new CSO's.
Active	1650	DCH Patients who have access to their GP records can now see documents for DCH before they have been contacted/seen by theTrust	11/08/2025	18/05/2023	Chief Information Officer	Clinical IT Systems	12	↑	16	12	Strategy, Transformation and Partnerships	Results and clinic letters are uploaded as mandated nationally. Awareness needs to be raised with GPs and clinicians to make them aware of the immediate access for patients.
Active	1919	Electronic Health Record - Insufficient Digital Resource to support EHR readiness and implementation	04/07/2025	12/07/2024	Chief Information Officer	Digital Technology and Infrastructure (DTI)	16	↔	16	12	Strategy, Transformation and Partnerships	Trust Board approval of the OBC is subject to further assurance on readiness and resourcing. Resources may need to be diverted from other strategic or BAU work with consequential risks to other projects or to operational provision
Active	1815	Electronic Health Record, risk of not receiving FD Funding	04/07/2025	02/02/2024	Chief Information Officer	Digital Technology and Infrastructure (DTI)	16	↔	16	12	Strategy, Transformation and Partnerships	Currently working at pace to develop an outline business case with Somerset that includes options that could be affordable and which work jointly for Dorset and Somerset based on pre-market engagement. Earliest indication of whether an affordable option can be considered in mid February 2024
Active	2161	HICCS Endoscopy system nearing end of life	18/07/2025	13/05/2025	Surgery & Gastroenterology (B1b)	Endoscopy Service	16	↔	16	4	Strategy, Transformation and Partnerships	Must be completed by the time rollout of Windows 11 is complete. HICCS is the only system available for booking endoscopy procedures within the Wessex region.
Active	1912	ICE - unsent EDS (Electronic Discharge Summary) issues	11/08/2025	03/07/2024	Chief Nursing Officer	Clinical IT Systems	20	↓	15	12	Strategy, Transformation and Partnerships	Reports currently being generated by ICE. These notify each ward of incomplete EDS's that need to be actioned and are displayed in date order with alerts as the EDS's get older. We understand there are escalation routes to Divisions for outstanding summaries. Some EDS's aren't sent timely as they may have been created in a outpatient spell instead of an inpatient spell on ICE. CSST receive a daily report and move any incorrect spells and to the correct spell.

Active	2007	[redacted]	11/08/2025	19/11/2024	Chief Information Officer	Clinical IT Systems	12		16	8	Strategy, Transformation and Partnerships	[redacted].
Active	2072	Lack of networking segmentation	04/09/2025	19/02/2025	Chief Information Officer	Digital Technology and Infrastructure (DTI)	20		15	6	Strategy, Transformation and Partnerships	A working group will be formed at the beginning of March to address this significant risk. Business planning will be prepared.
Active	2070	Lack of visibility regarding future funding/finance roadmap makes it difficult to procure and maintain continuity of security	04/09/2025	19/02/2025	Chief Information Officer	Digital Technology and Infrastructure (DTI)	16		16	1	Strategy, Transformation and Partnerships	No way to mitigate this - other than to attempt to take advantage on regional and national initiatives (which we do regularly)
Active	1913	TPP SystmOne - EPR core unit	11/08/2025	03/07/2025	Chief Information Officer	Clinical IT Systems	15		15	4	Strategy, Transformation and Partnerships	Regular meetings have been set up with the Interim CIO, Interim Head of Systems, Development, and Digital Transformation, Chief Nursing Information Officer, Data Quality Lead and the NHS Dorset digital team. From these meetings an action plan has been formulated to gain further information on the risk and to explore how best to resolve it, including finding suitable resource to manage open tasks.
Active	1272	Trust Integration Engine	11/08/2025	20/05/2025	Chief Information Officer	Clinical IT Systems	20		16	9	Strategy, Transformation and Partnerships	14/7/25 TS - Mitigation and Options paper drafted and with exec team for consideration via Graham Sheppard. Updated 08/04/2025: As part of the developing digital strategy across Dorset and also the associated work on the integration requirement for the EHR a Dorset wide workstream to look at an integration strategy over the next few years is being mobilised. This will include the critical situation for DCH with regard to systems integrations.
Active	2169	Video platform for Paediatric	16/07/2025	04/06/2025	Family Services (B4)	Paediatrics Service	16		15	1	Strategy, Transformation and Partnerships	None. Funding request sat on Trust capital expenditure list

Appendix 4-Closed and Managed Risks Last Quarter by Primary Reporting Committee

Approval status	ID	Title	Review date	Opened	Care Groups	Service of responsibility	Risk level (initial)	Risk level (current)	Mitigations/Controls
Managed / Tolerated within Risk appetite	657	Blood Sciences failure to reach target turnaround time for hsTNI for ED patients	26/06/2026	19/10/2018	Pharmacy, Pathology and Medical Physics (A4)	Blood Sciences Service - Biochemistry	15	6	To be looked at using process mapping to identify areas for improvement. For completion in the New Year.
	1827	Electronic health record unavailable for SCBU		#########	Family Services (B4)	Special Care Baby Unit (SCBU)	12	6	Planned digitalisation of SCBU delayed by digital transformation as they are reviewing all systems across the Trust. Additionally we have been informed of a pan Dorset/Somerset EPR that is being developed that we have recently been informed we are officially stakeholders.
Managed / Tolerated within Risk appetite	1094	ESTATES: Lack of staff accommodation	18/10/2024	11/05/2021	Chief Finance Officer	Facilities Department	16	12	•Use of B&B's, Hotels and Caravan parks is not an option, as all have advised they are fully booked from June/July 2021, due to a demand in staycations! •Some potential properties have been identified to purchase, however, funding is required to initiate, and the buying and legal elements of the process will not likely complete in time for the shortfall in rooms required. •Discussions with Housing Associations have not been as fruitful as anticipated, although we are still exploring one line of enquiry. •Some success has been achieved in acquiring additional leases, which seems to be the most favorable option, especially as they are mainly cost neutral, with exception to upfront costs of set up and furnishing. We have started to seek new leases directly with potential landlords, by; advertising via the Trusts social media sites and local press. Along the lines of; the Trust is looking to increase its current private lease arrangements to provide additional accommodation for its Clinical/Medical staff and is interested in hearing from landlords who wish to lease their properties the Trust. •Early discussions have taken place with Dorset County Council who has identified a number of their property portfolio for disposal and redevelopment. These are being pursued further that may provide some accommodation opportunities in the longer term, but not in time for our pinch points.
	1924	Intravesical BCG	28/04/2025	24/07/2024	Trauma, Orthopaedics, Urology & Junior Doctors (B1a)	Urology Service	12	12	there is an alternative drug available but it needs to be added to the formulary by our lead consultant.

Managed / Tolerated within Risk appetite	2011	Lack of DEXA Reporting capacity	06/10/2025	22/11/2024	Radiology & Neurophysiology (B3b)	Across all specialties	20	6	Seeking additional reporting capacity Exploring option of outsourcing - despite cost implication although need confirmation that their reports will conform to NOGG 21, and VFA's will be assessed.
	1850	Nursecall Repairs - Mediplan	27/09/2024	22/03/2024	Chief Finance Officer	Estates Department	12	12	When system fails, we do have a temporary nurse call system which can be used. To date, we have not had to utilise these. Current systems are not expected to last more than 5 years. This risk is linked to risk 784 and can therefore be closed.
	1972	Patients and staff cannot rely on the call bells summoning assistance as they are not working effectively	25/11/2024	09/09/2024	Chief Finance Officer	Estates Department	20	6	Three ward areas have had replacement call bells installed (Stroke, Moreton & PoW). Maternity is currently having a system installed, followed by radiology and Kingfisher. There is no assurance that Ilchester and the remaining areas have a plan or any associated timescale. 22.04.25 Linked to Risk 784. Ongoing program of replacement active. This risk is linked to risk 784 and can therefore be closed.
Managed / Tolerated within Risk appetite	1960	SSD - Failure of Equipment	04/10/2024	06/09/2024	Chief Finance Officer	Estates Department	16	12	Weekly engineers visits, increased maintenance costs and equipment failure
Managed / Tolerated within Risk appetite	1964	SSD & Endoscopy RO/Water softener Replacement	13/01/2025	06/09/2024	Chief Finance Officer	Estates Department	16	12	New units would be more cost effective and initial period covered under warranty Maintained by Avidity with maintenance contract in place, but 2-3days response time, thus capability within the Estates Mechanical Team to make do where possible until Avidity arrive in site.

	1800	Temperature Holding Equipment Inadequate	29/01/2024	22/01/2024	Chief Finance Officer	Catering Services	8	8	There are no mitigations we can put in place to increase the food safety standards without the equipment mentioned. I would like to see the missing bowl warmer and thawing cupboard ordered and the RTS unit we need a back up in case of failure to mitigate risk. Potential mitigations include moving away from frozen food and reducing service to areas outside of our remit that we currently serve. We may also have to reduce the availability of high risk items. It should be noted these will incur significant cost pressures to the trust and have an impact on patient experience and nutrition. All mitigating equipment has been purchased and is now inn operation providing the necessary level of compliance with food safety standards required, risk closed down
	1656	Temperature Issues in Theatres	16/06/2025	24/05/2023	Theatres, Anaesthetics, Critical Care & Decontamination (B3a)	Theatre Service	12	12	Theatres raise with Estates via job requests and ring mobile number but not always easy to contact. Theatre lists are occasionally held until an appropriate temperature for patient health and wellbeing has been reached Escalated to Divisional Management.
Managed / Tolerated within Risk appetite	1486	Unable to Provide Ophthalmology Audit Data	12/05/2025	03/08/2022	Head & Neck, Specialist Medicine and Outpatients (B2)	Ophthalmology Service	6	6	No mitigations as require MediSight to be able to complete.
	1742	Additional Obstetric Consultant Capacity Required to meet National KPIs		########	Family Services (B4)	Maternity Service	15	4	Unable to mitigate the handover. Women are being seen on an adhoc basis in the ANDAU and during SPA sessions - this is not a sustainable model.

	769	Inadequate Home Enteral Nutriton staff for demand on service. Increased wait times for patients to be seen by a HEN dietitian.	21/04/2025	17/10/2019	Integrated and Holistic Care (A2)	Dietetics and Nutrition Service	10	4	a) Submit business case for additional staff resource. b) Review service to identify where to withdraw service in order to best manage the risks. c) Meet with the East Dorset HEN Team to evaluate the risks and formulate a plan to achieve equity of service across the county. d) Removing the Dietetic Assistant post from the budget and transfer the money to increase HEN Dietitian wte. e) Reduce the wte of the newly vacant Administrator post and transfer the money to increase HEN Dietitain wte (considered to have a lower impact in the short-term because more risks relate to inadequate clinical capacity than administrative, in the longer term lack of administrative capacity will still have a negative impact and is a risk). Agreement to recruit this post at risk has been granted and recruitment process is underway. as of 8/9/21. Update as of 20/12/21: Have increased nursing by 0.2 and admin by 5 hours per month. Dietetic post and additional admin cover have not yet been recruited. Dietetic post has been out to advert twice and no suitable candidates have been shortlisted. Have reviewed the staffing mix and re-written another role to take on some of the HEN caseload specifically for cancer patients and are reviewing whether the HEN workload could be supported with a dietetic support worker/apprentice. Update 12/5/2022: Locum dietitian hired with a view to holding a caseload of HEN cancer patients. Awaiting business case outcome for funding one additional member of staff to support the delivery of the HEN community service. 08/03/23 - Cancer tube fed patients moved to Acute provision under cancer dietitian. Locum staff in place. Posts recruited to at risk (financial). Service requires Dorset wide review. Similar issues experienced by DHC teams in the East.
	1794	Stone Nurse in Urology	16/07/2024	10/01/2024	Trauma, Orthopaedics, Urology & Junior Doctors (B1a)	Urology Service	20	1	Currently this work is being picked up by consultants. Our urodynamics is being run by our locum consultant who will not be with us after April.
	1684	Agyle Reporting not linking to BI systems	########	########	Unscheduled Care (A3)	Clinical IT Systems	12	1	Increase efficiencies for the ED operational staff.
Managed / Tolerated within Risk appetite	1543	Gender vs Sex rules within the OPD Pathology LIMS	03/03/2025	07/11/2022	Pharmacy, Pathology and Medical Physics (A4)	Pathology Service	12	6	

Managed / Tolerated within Risk appetite	1750	Inability to share all IPC infections and risks within divisional dashboards	01/01/2024	27/10/2023	Chief Nursing Officer	Infection Control Service	6	2	The IPC audit result information is currently emailed to all leads and matrons when the audits are performed and IPC dashboards are updated bimonthly for IPC committee meetings with all the relevant IPC infection information and audits results.
	1080	Patients admitted with an adult eating disorder may not receive the specialist care they need.	30/05/2025	14/04/2021	Integrated and Holistic Care (A2)	Dietetics and Nutrition Service	15	6	New policy has been drafted and has completed final review. It is now to be submitted to clinical guidelines. This new guidance will provide a structure for the management of these complex patients. Once approved by clinical guidelines dietetics will work with gastro docs and wards to consider best way to raise awareness of the guideline to relevant professionals. New policy on the management of patients with eating disorders has been ratified by the Nutrition Steering Group (NSG), we are planning some training sessions in the new year once we have passed through the current COVID Omicron crisis and are back to BAU. In the meantime we will continue to work closely with all professionals involved in these cases using our new policy to guide our decision making and escalations. Discussions with Sonia Gamblen and Andy Miller to discuss management of this patient group with CCG/DHC. Currently there is a gap in service provision for these patients which needs addressing. DCH is only one part of a larger care pathway for appropriate management.
	1122	Failure to comply with Freedom of Information Legislation	########	########	Chief Executive	Corporate Services	15	4	Software solutions are being trialled, although capacity to complete the trial is insufficient. There are currently no other mitigations in place. Now managed by DHC FOI team under contract to DCH
Managed / Tolerated within Risk appetite	1959	IT systems allowing manual input of pathology results by clinical teams	20/08/2025	06/09/2024	Chief Operating Officer	Clinical Site Manager Service	8	1	This is a national IT issue. In the 3 year period following implementation of the BadgerNet maternity system at DCH, we have not identified any known serious incidents that relate directly to this issue. However this has been raised a safety concern. The process of of transcribing has not changed since the use of paper notes, however, the care pathways and treatment is generated by the maternity BadgerNet system by the manual input of results. Staff are promoted on the system to double check when inputting results. The digital team and laboratory management team are working together to identified a suitable and safe solution.

Dorset County Hospital
Dorset HealthCare

Quality Committee in Common Assurance Report for the meeting held on Tuesday 29 July 2025

Chair	Claire Lehman, NED
Executive Lead	Dawn Dawson, Joint Chief Nursing Officer
Quoracy met?	Yes
Purpose of the report	To provide assurance on the main items discussed and, if necessary, escalate any matter(s) of concern or urgent business.
Recommendation	To receive the report for **assurance**

Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework	• Review of the Board Assurance Framework and Corporate Risk Register, as detailed below • Receipt of each trust's winter plan recognising that it is an iterative process and still in development • Recommendation to the board for approval of the joint nutrition strategy
Key issues / matters discussed at the meeting	The Committee received, discussed and noted the following reports: **Chief Nursing and Chief Medical Officer Update (DCH/DHC)** providing updates on hot topics within the trusts, and national and regulatory matters. Of note: • The 10-year plan which had two key implications for the committee. Firstly, the increased focus on patient voice (the need for the trusts to bring this to the fore, the impact patient feedback will have on funding, and the need to listen to local voices when changing or developing services). Secondly, enhanced transparency and openness about quality metrics including league tables. A national implementation plan was due in the autumn. • Penny Dash report which reviewed six regulators of quality in the NHS. There would be changes to those regulators which would impact on trusts and their responsibilities. <u>Dorset HealthCare</u> • LK was now the senior responsible officer for Integrated Neighbourhoods at DHC. Work was moving forward rapidly with plans within two 'places' being submitted for national intensive support. • The trust was intending to become fully recruited to medical posts by April 2026 via international medical recruitment, in order to reduce agency spend and locum usage. Jobs were being offered at present. <u>Dorset County Hospital</u> • No update

Board Assurance Framework (DCH/DHC) noting no change in the score of the strategic risk for which the committee has responsibility, in either trust. New actions had been created reflecting published and awaited national guidance. As the risks were long term strategic risks, it was not expected that the score would change regularly.

Corporate Risk Register (DCH/DHC)

Dorset County Hospital:

- One new risk relating to the reading of 24 hours tapes due to capacity in cardiology.
- Risk scores had been reviewed in light of a recent discussion about the current quality climate; the scores were felt to be correct.

Dorset Healthcare:

- Risk score relating to risk management capacity had reduced since the production of the report due to recruitment.
- High temporary staffing at Kimmeridge Court with a plan to improve the position by the end of September.
- One risk relating to hydrotherapy provision which had been withdrawn for people with learning disabilities.
- Overdue risks had been followed up on; 3 of these had been updated and the remainder were being reviewed.

The impending appointment of a joint head of risk across both trusts will align and improve risk processes.

Quality Report (DCH/DHC)

Dorset County Hospital

- Improvements seen in rates of C. Difficile and pressure ulcers, reading of Section 132 rights, and the management of complaints.
- There was still no digital solution for the friends and family test (FFT). Feedback continued to be sought through hard copy and other routes.
- Mixed sex accommodation figures fluctuated depending no demand. The south west region was an outlier for such breaches. The impact of the Supreme Court ruling on the definition of sex was affecting this position.

Dorset HealthCare

- One case of C. Difficile; introduction of new hybrid mattresses to support pressure ulcer reduction work; one under-18 patient involved in six incidents of restraint; focus on improving duty of candour work; ICUS callbacks were less compliant in May due to the bank holidays.
- Discussion around Serious Mental Health (SMI) population and the risk of widening health inequalities.

Ophthalmology Update (DCH)

- Assurance was provided that the issue had been dealt with, no harm had been identified, and ongoing audits would continue to ensure patient safety.

- While some patients had been lost to follow up this was within the known tolerance set by the CQC, and the trust continued to take these cases seriously.
- There were seven patients who were booked in to clinics; if any harm was identified the committee would be informed.

Dorset Integrated Urgent Care Service – External Peer Review Update (DHC) noting that the review identified that reliance on bank medical staff in the clinical assessment service was typical but sub-optimal and the intention was to move to a substantive staffing model. Clinical governance arrangements in the service were good and would be extended to other areas of the trust. The development of the service would continue although procurement of the service was delayed.

Annual Reports (DCH/DHC)

- **Infection Prevention and Control Annual Report**
- **Medicines Management Optimisation Report**
- **Safeguarding Children and Adults Annual Report**

The reports were taken as read, with questions from committee members relating to learning across the federation and how to improve safeguarding training rates.

Regulatory Compliance Internal Assurance report (DHC) noting strong assurance from the report but that it reflected a gap in DCH, as the report was not produced there.

Quality Impact Assessment Assurance Report (DCH/DHC) detailing the quality impact assessments reviewed in each trust. For DCH this was a new panel and the first report of it's kind. A new national template for quality impact assessments had been released and would be looked at in both organisations.

Seasonal Surge (Winter) Plan (Quality Aspects) (DCH/DHC) noting tighter, short notice timescales than usually expected.

Dorset County Hospital:

- To be presented to Board and would include a Board assurance statement. The vaccination plan was being worked on ahead of the Board meeting.
- A national test of plans will take place in September and DCH is planning to participate in this.
- IPC team had been involved in writing the plan .

Dorset Healthcare:

- Newer process for DHC, not previously a requirement for the trust to the same extent as DCH. The differences in winter planning between acute and community trusts were noted, including that DHC had no surge bed ability.

Discussion around the benefits of and possibility for further federated working in this space.

Hospital at Home (HAH) update on GIRFT system review and progress on actions (DHC) showing how HAH was becoming a more common way of working.

Maternity Reports (DCH)
Maternity and Neonatal Quality and Safety Reports, noting:

- One neonatal death; Apgar scores less than seven at five minutes is significantly higher than the national rate; increase in stillbirths between 2022 and 2024; a significant increase in incidents, escalations due to staffing, workload and acuity.
- Maternity staffing risks remained high and would be put on the Corporate Risk Register
- Staff from the temporarily closed Yeovil maternity unit were joining the trust which was proving positive. The opportunity to improve DCH capacity due to the increased growth from Yeovil was noted.

Receipt of the Perinatal Mortality Review Tool report for Q1

National Patient Survey Results (DCH/DHC) for DCH regarding children and young people experience and for DHC regarding NHS Mental Health Community Survey. Each report detailed the five areas above average performance and five areas with improvement work required.

Joint Nutrition Strategy (Joint) noting no significant changes since the strategy was reviewed at the June informal meeting. It was recognised that the implementation plan would be key to the success of the strategy.

Walkarounds Output Report (DCH/DHC)
Dorset County Hospital:

- 28 Walkarounds undertaken by Directors, Non-Executive Directors, Governors and Senior Management Staff

Dorset Healthcare:

- A total of 24 visits were scheduled between February and June 2025 but only eight took place. Work to take place to understand and prevent short notice cancellations

Quality Governance Groups Assurance Reports (DCH/DHC)
Dorset County Hospital:

- Discussion around post elective admission readmissions, recognising that this had been discussed for some time. A clinical audit was being undertaken to review this. it may also be beneficial for this to be added to the Internal Audit Plan.

Dorset Healthcare:

- Focus on patient flow within mental health inpatient units, a deep dive in to St Brelades, and an update on the Twynham ward action plan. Suggestion of a visit with NED colleagues to Twynham ward.

Organ Donation Report (DCH) taken under consent without discussion.

	Review of the meeting from members and attendees, recognising that it was only the second formal meeting of the committee in common, but that some changes might improve the running of the meeting.
Decisions made at the meeting	• Approval of the Joint Nutrition Strategy
Issues / actions referred to other committees / groups	• Referral to People and Culture Committee in Common regarding DHC international medical graduate recruitment at DHC, particularly in relation to 'people' elements such as induction.

Quoracy and Attendance						
	27 May 2025	29 Jul 2025	23 Sep 2025	25 Nov 2025	27 Jan 2026	24 Mar 2026
Quorate?	Y	Y				
Claire Lehman	Y	Y				
Suresh Ariaratnam	Y	Y				
Dawn Dawson	Y	Y				
Lucy Knight	Y	Y				
Eiri Jones	Y	Y				
Stuart Parsons	Y	Y				
Rachel Small	A	Y				
Anita Thomas	Y	Y				
Rachel Wharton	A	A				

Dorset County Hospital
NHS Foundation Trust

Report to	DCH Board of Directors	
Date of Meeting	12 August 2025	
Report Title	Bi-Monthly Maternity and Neonatal Quality and Safety Report	
Prepared By	Jo Hartley Director of Midwifery and Neonatal Service	
Approved by Accountable Executive	Dawn Dawson Joint Chief Nursing Officer	
Previously Considered By	Joint Quality Committee 29 July 2025 Quality Governance Group 16 July 2025	
Action Required	**Approval**	No
	Assurance	Yes
	Information	No

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 – Safety and quality	
Financial	Achieving the Maternity Incentive Scheme (MIS) provides approx. £220k rebate	
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 May and June (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.

Safe

- The number of incidents submitted has increased to 237 for the two months. There is a significant increase in escalations to OPEL 3 and one to OPEL4. The escalation reflects the impact of increased demand from a neighbouring unit's closure – staffing levels; increased workload and acuity; multiple cases of delayed inductions of labour >24hrs; suspension of the Home Birth service in relation to escalation to divert.

- Eleven incidents of in-utero transfers, including one woman transferred four times before delivery and another transferred three times. Arranging these transfers increases workload with each transfer requiring a midwife to accompany the woman. Of note, UHD were unable to accept two transfers as they were in escalation.

- There have been three incidents of moderate harm and one severe harm. Whilst there were no care concerns identified for the severe harm case, this baby remains in a tertiary NICU with significant, life-changing sequela.

- Two incidents of opening a second theatre.

- Three third degree tears all with follow-up arranged.
- Saving Babies Lives Report – currently at 94% in relation to full compliance.
- There were four neonatal transfers to tertiary NICUs. One baby born at home unexpectedly at 29 weeks gestation and transferred to Southampton NICU

Effective

- KPIs for smoking cessation are positive with a 0.6% smoking at birth. CO recorded at time of booking is slightly below expectation at 86.1%
- The ATAIN percentage remains below 5% at 4.3% for term admissions to SCBU.
- There has been one neonatal death in May. The case will be reviewed and reported via PMRT and the Child Death Overview process.
- In April, the Trust data pertaining to babies >37 weeks gestation, with Apgar scores <7 at five minutes is significantly higher than the national rate. There is an audit underway of all eligible babies born over the past 12 months to identify themes relating to this statistic and actions required to reduce this rate and improve Apgar scores at 5 minutes. Of note, the rate had consistently dropped since November 2024.
- The stillbirth data has increased from one case in 2022, two in 2023 and 4 in 2024. All cases are reviewed through the Perinatal Mortality Review Tool and currently both cases have been graded as A (no issues with care identified from birth up to the point the baby died) in relation to DCH care. The third case (twins) is currently awaiting evaluation.

Well Led

- Training data remains good. Significant improvement in training figures for Safeguarding, Basic Life Support and all other Trust mandated training. There are still challenges with ensuring all anaesthetic doctors attend the multi-professional PROMPT training.
- Minutes from the joint Safety Champions and QUAD included for April and May.
- Workforce data show a continuing increase in sickness. On-call staff are being used regularly to fill vacancies in shifts, to increase staff numbers and for the senior midwives, to fill in for coordinator shifts unfilled due to sickness and unfilled vacancies. This is costly for the Trust and directly contributes to burnout and additional workplace stress. Currently, nearly 10% of all shifts are not fully staffed with midwives and 17% of all shifts not fully staffed with MSWs
- Risk register
  - **2183**, moderate (12) – YDH impact on obstetric workforce - Due to the increased demand on our Obstetric Services following the closure of YDH and the predicted 20% increase in maternity provision we need to review our minimum staffing to increase availability of Tier 1 and Tier 2 cover.
  - **1980**, moderate (9) – EPAC business case has not progressed. In July and August, there are 10 days where the service will be closed due to no staff
  - **1825** moderate (8) – neonatal ventilators will be delivered this month
  - **1689**, moderate (9) – second theatre - options appraisal submitted plus business case provided to Chief Operating Officer and to Divisional Manager. Several elective cases managed in Main Theatre recently – very successful with good patient satisfaction report

- **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. Business case currently being revised in relation to increased workload since YDH closure.

Recommendation

Members are requested to:

- Receive the report for **assurance.**

Dorset County Hospital
NHS Foundation Trust

Maternity & Neonatal Quality and Safety report

Bi-monthly – May/June 2025

Submitted by Jo Hartley, Director of Midwifery & Neonatal Services

Executive sponsor: Dawn Dawson CNO

Executive Summary

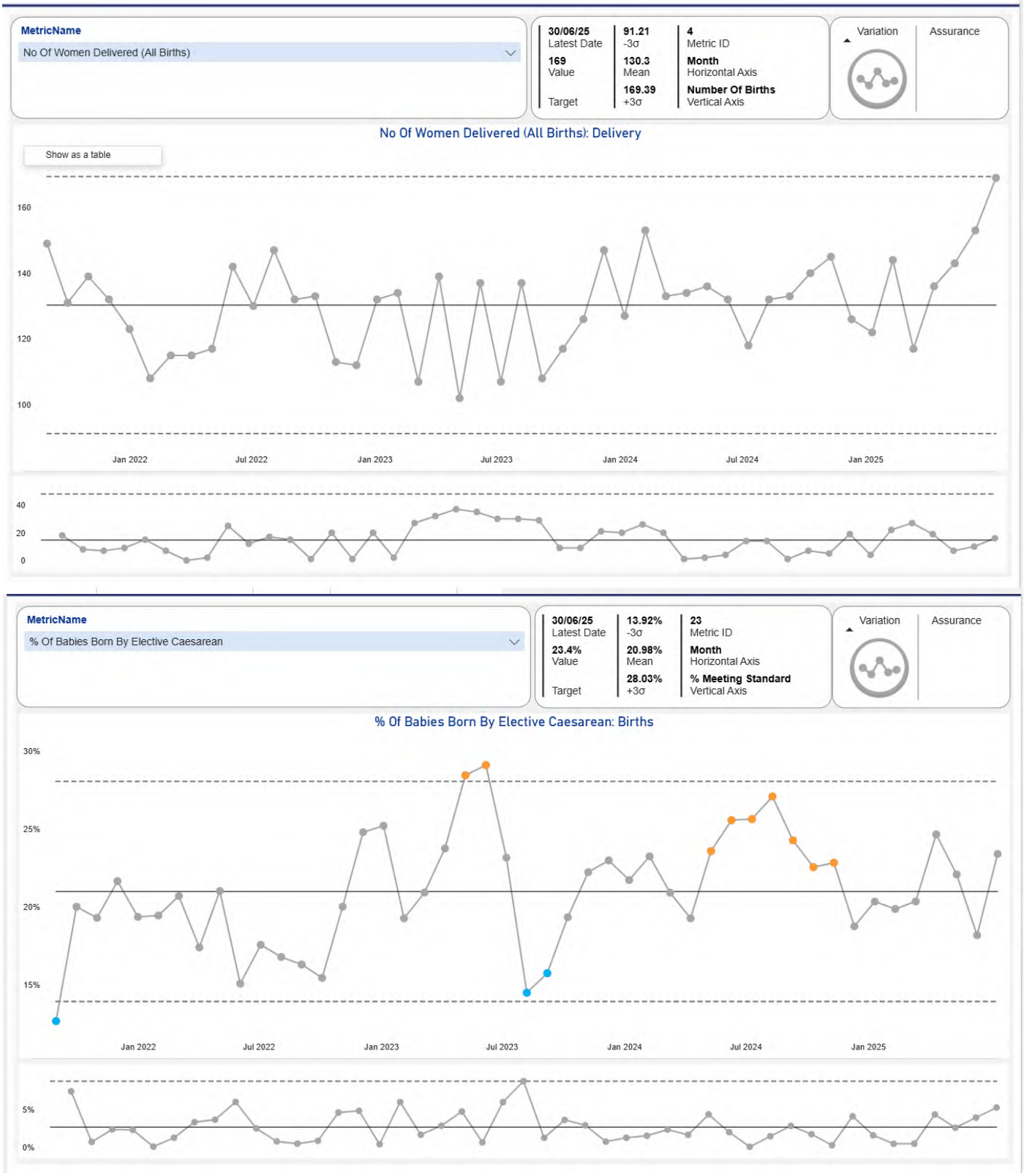
This report sets out the quality and safety activity covering the months of May and June (some dates may vary as specified). This is to provide assurance of maternity and neonatal quality, safety and effectiveness with evidence of quality improvements to the Executive and Non-Executive Team.

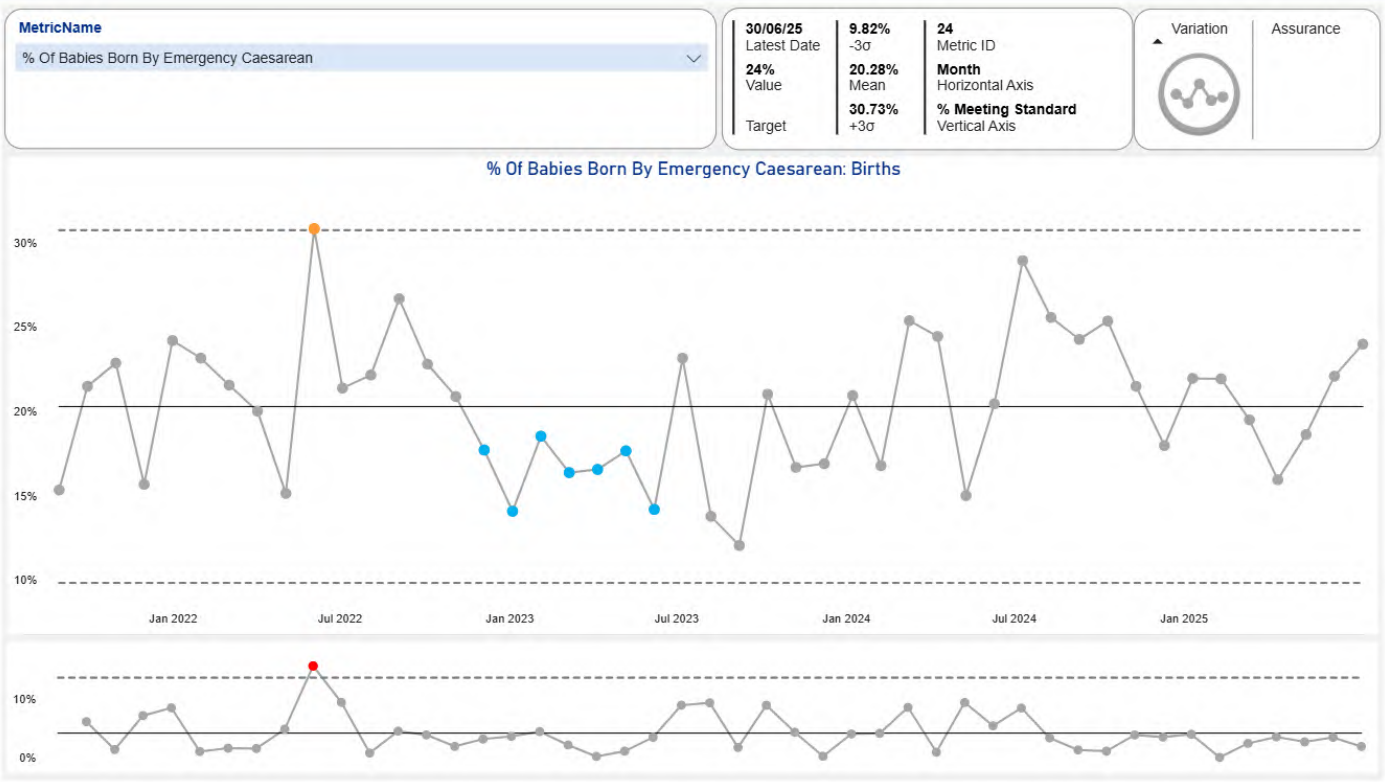
- KPIs for smoking cessation are positive with a 0.6% smoking at birth. CO recorded at time of booking is slightly below expectation at 86.1%
- The ATAIN percentage remains below 5% at 4.3% for term admissions to SCBU
- There has been one neonatal death in May. This was a baby born at DCH, readmitted the next day and transferred out to a tertiary NICU. This will be reviewed and reported on through the normal processes.
- It was identified in April that the Trust data pertaining to babies >37 weeks gestation, with Apgar scores <7 at five minutes is significantly higher than the national rate. There is an audit currently underway of all eligible babies born over the past 12 months to identify themes relating to this statistic and actions required to reduce this rate and improve Apgar scores at 5 minutes. Of note, the rate has consistently dropped since Nov 2024.
- It has been noted that the stillbirth data for DCH has increased from one case in 2022, two in 2023 and 4 in 2024. All cases are reviewed through the PMRT process and currently both cases have been graded as A in relation to DCH care. The third case (twins) is currently awaiting evaluation.
- The number of incidents submitted has increased to 237 for the two months. There is a significant increase in escalations to OPEL 3 and one to OPEL4. The escalation reflected inadequate staffing, increased workload and acuity. Multiple cases of delayed inductions of labour >24hrs. The homebirth service was suspended multiple times in relation to escalation to divert.
- Eleven incidents of in-utero transfers including one woman transferred four times before delivery and another transferred three times. Arranging these transfers takes from one hour to 6-7 hours, phoning multiple maternity and neonatal services trying to identify a bed and cot. Every transfer requires a midwife to accompany the woman – always removing a midwife for at least 2 hours, sometimes 4-5 hours. UHD were unable to accept two transfers as they were in escalation
- There have been three incidents of moderate harm and one of severe harm. Whilst there was no care concerns identified through M&M for the severe harm, this baby remains in a tertiary NICU after three months, with significant, life-changing sequela.
- Two incidents of opening a second theatre in an emergency – one for a massive obstetric haemorrhage and one for a category one caesarean
- Three third degree tears all with follow-arranged
- Risk register
  2183, moderate (12) – YDH impact on obstetric workforce. Due to the increased demand on our Obstetric Services following the closure of YDH and the predicted 20% increase in maternity provision there is a need to review our minimum staffing to increase availability of Tier 1 and Tier 2 cover.
  1980, moderate (9) – EPAC business case has not progressed. In July and August, there are 10 days where the service will be closed due to no staff
  1825 moderate (8) – neonatal ventilators will be delivered this month
  1689, moderate (9) – second theatre - options appraisal submitted plus business case provided to Chief Operating Officer and to Divisional Manager. Several elective cases managed in Main Theatre recently – very successful with good patient satisfaction report
  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. Business case currently being revised in relation to increased workload since YDH closure. Currently, the ward has been extremely busy with multiple escalations to OPEL 3 and one occasion OPEL 4. Reliance on tier two incentives and midwives being reallocated from community and specialist roles.
- SBL Report – very good progress, currently at 94% in relation to full compliance
- There were four neonatal transfers to tertiary NICUs. Plus one baby born at home unexpectedly at 29 weeks gestation and transferred to Southampton NICU
- Training data remains good. Significant improvement in training figures for Safeguarding, Basic Life Support and all other Trust mandated training. There are still challenges with ensuring all anaesthetic doctors attend the multi-professional PROMPT training.
- Minutes from the joint Safety Champions and QUAD included for April and May

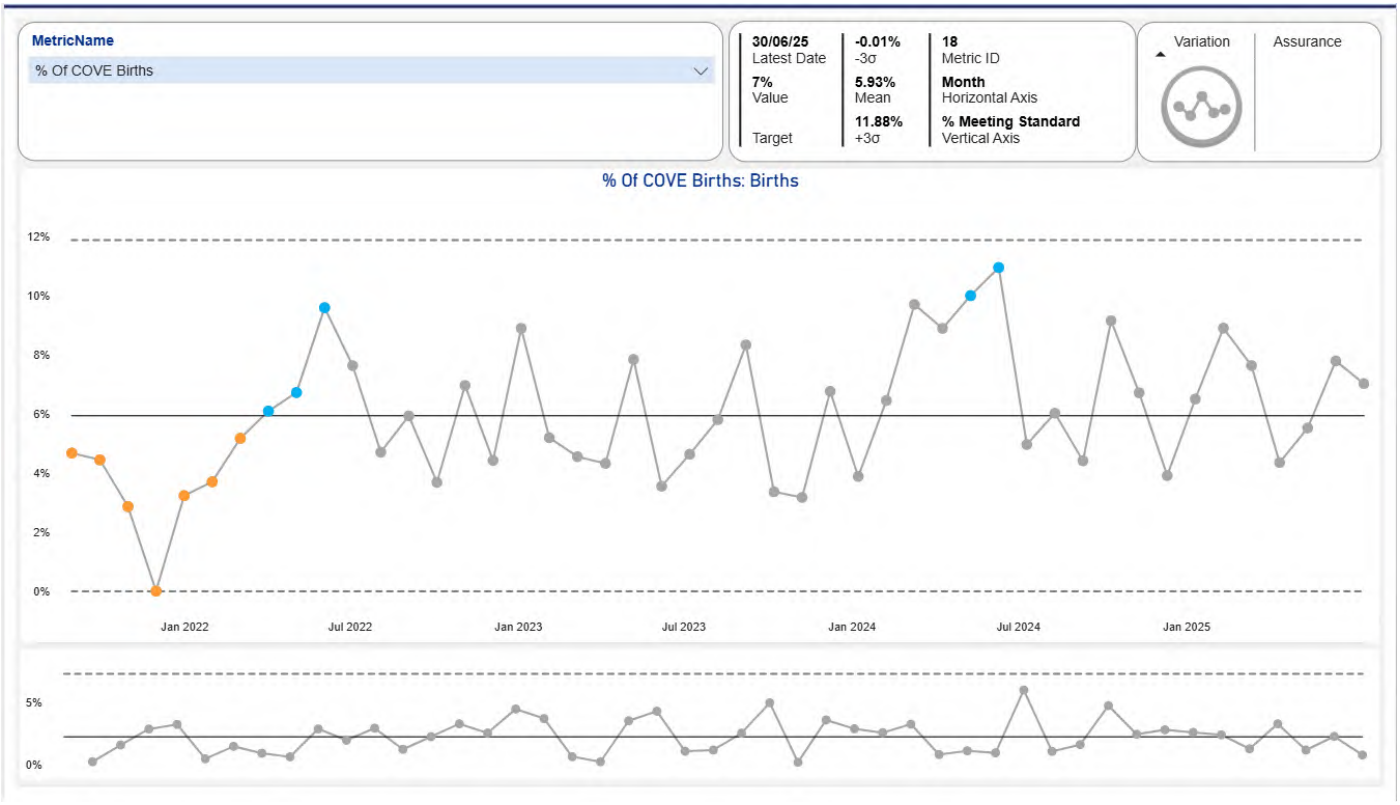
- The workforce data show a continuing increase in percentages of midwives and MSWs off sick. There is a growing reliance on midwives, particularly senior midwives working their oncalls. The oncalls are being used regularly to fill vacancies in shifts, to increase staff numbers and for the senior midwives, to fill in for coordinator shifts unfilled due to sickness and unfilled vacancies. This is costly for the Trust and directly contributes to burnout and additional workplace stress. Currently, nearly 10% of all shifts are not fully staffed with midwives and 17% of all shifts not fully staffed with MSWs.

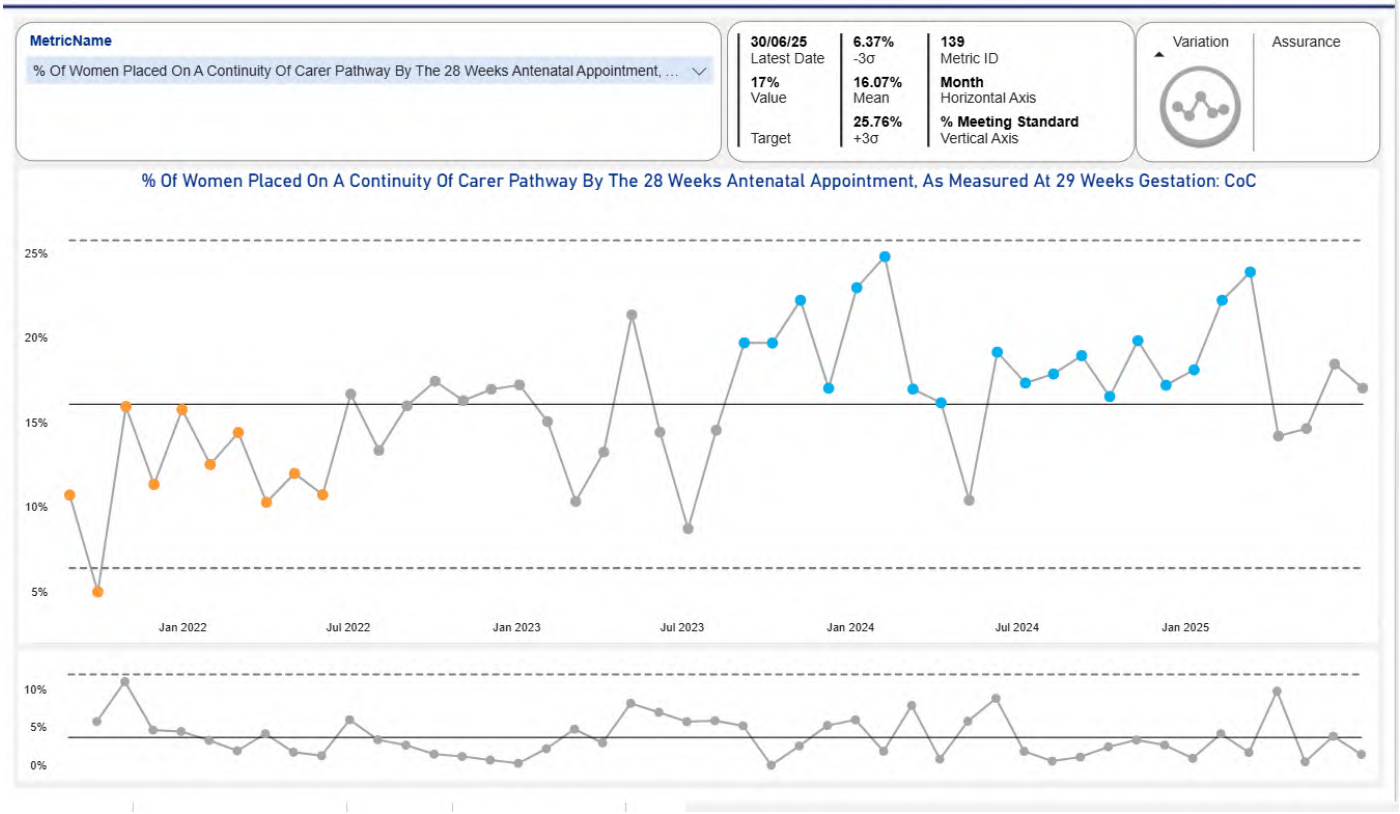
Exception report for SPC charts (NTI – no target identified)

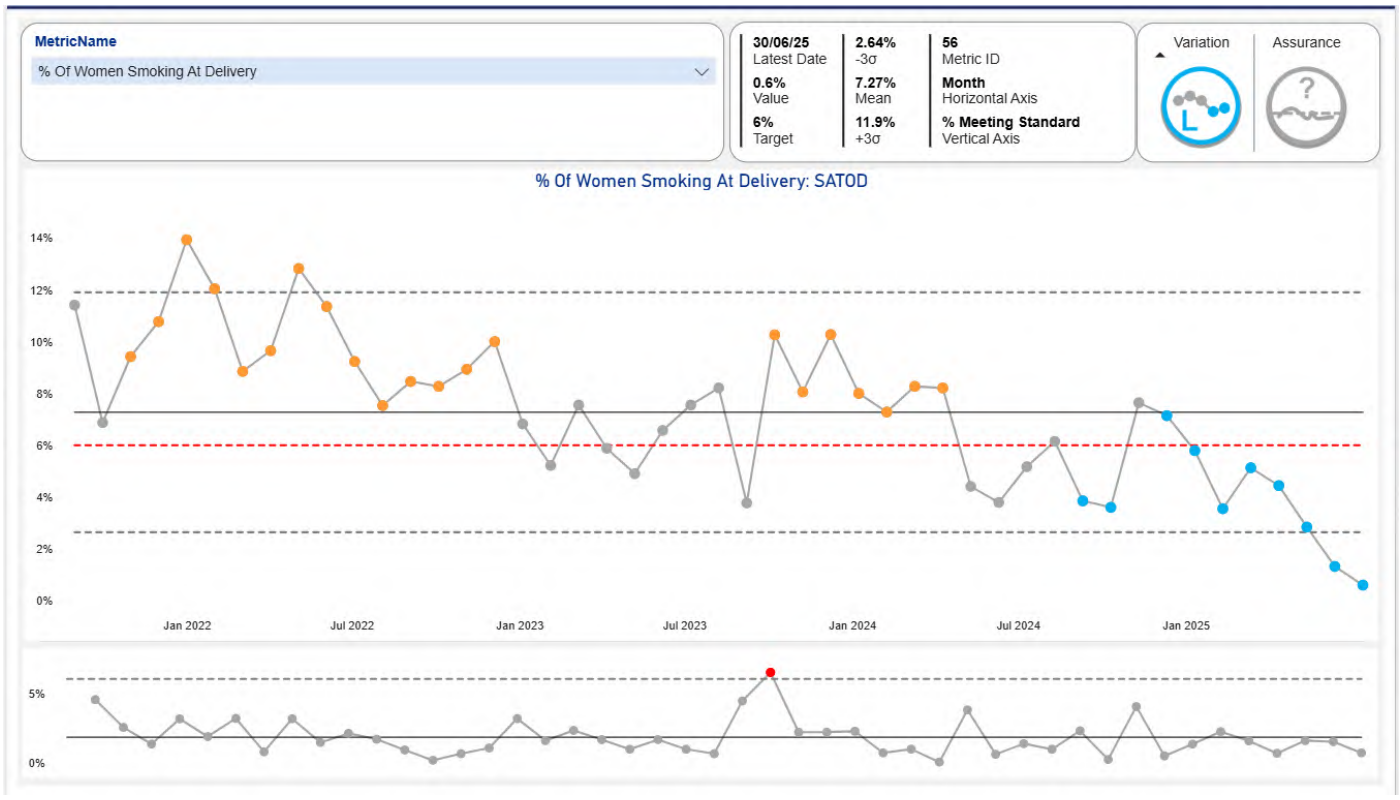
Metric	Target	Current position
Number of women delivered		169
% babies born by elective caesarean	NTI	23.4%
% babies born by emergency caesarean	NTI	24%
% of births in the midwife-led unit (The Cove)	NTI	7%
% of women on a continuity of care pathway by 28 weeks	NTI	17%
% women smoking at time of delivery	6%	0.6%
% CO recorded at booking	95%	86.1%
% CO record at 36 weeks	95%	95.5%
Number of stillbirths		Nil. However, in 2024, there were 4 stillbirths. This represents a rising rate per thousand births (please see below for more information)
Number of neonatal deaths		1 in May
% babies >37 weeks admitted to SCBU	5%	4.3%
Rates per 1000 of PPH >1500mls (current 3 months)	30	23 to 35
Rates per 1000 of 3rd/4th degree tears (current 3 months)	25	20
% live births <37 weeks gestation	6%	4.1%
Hypoxic Ischemic Encephalopathy incidents		Nil
% of babies with 1st feed breast milk	NTI	82.8%
% of babies with fetal growth restriction <3rd 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	19.7

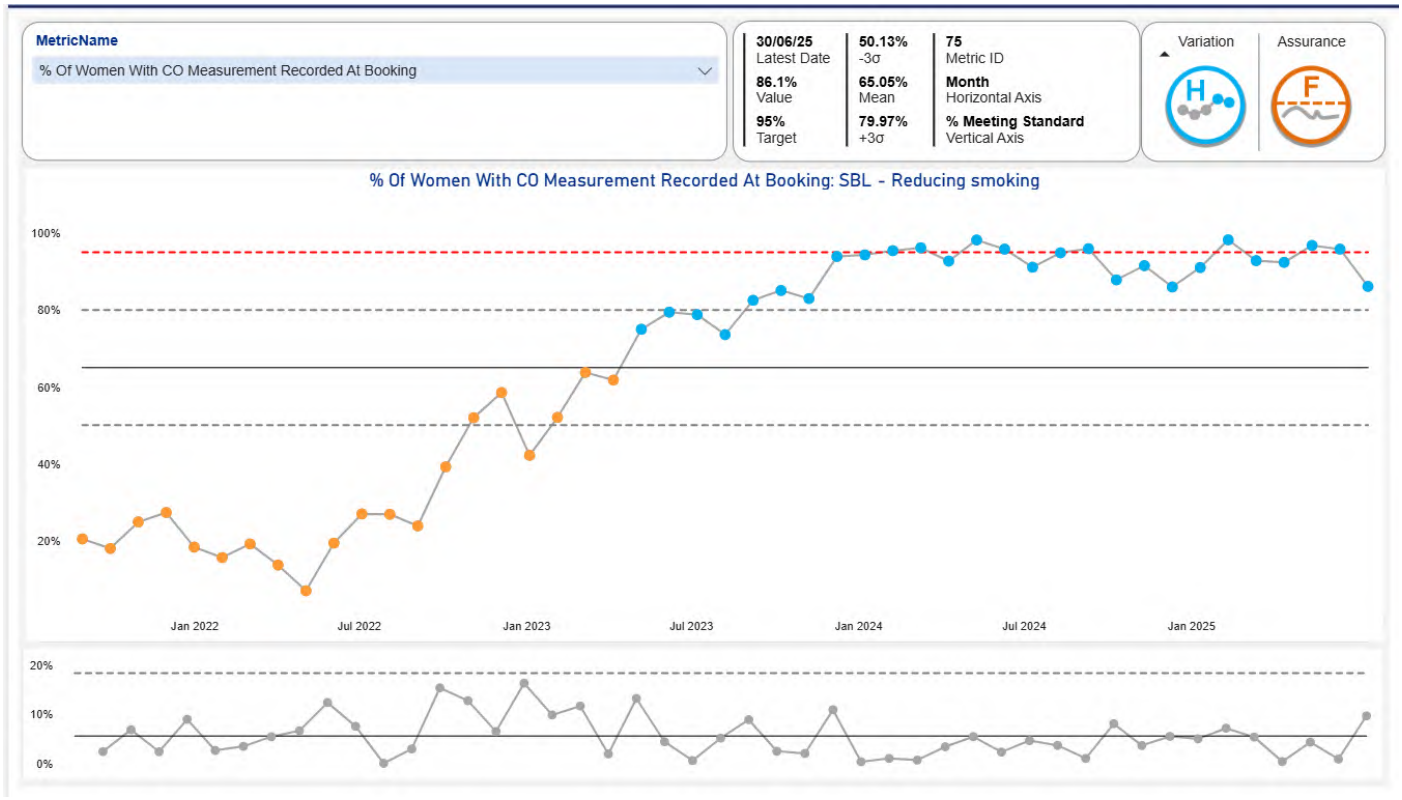


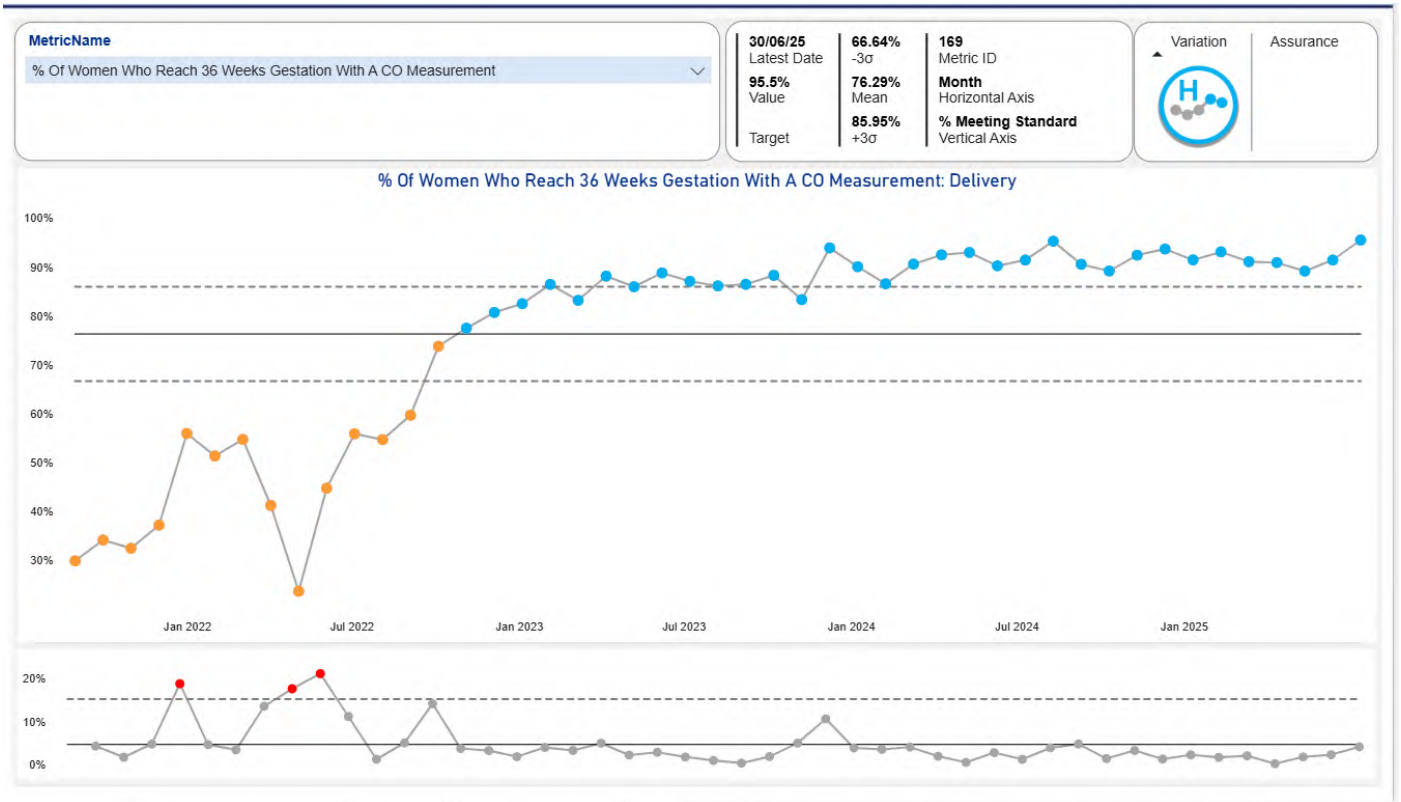


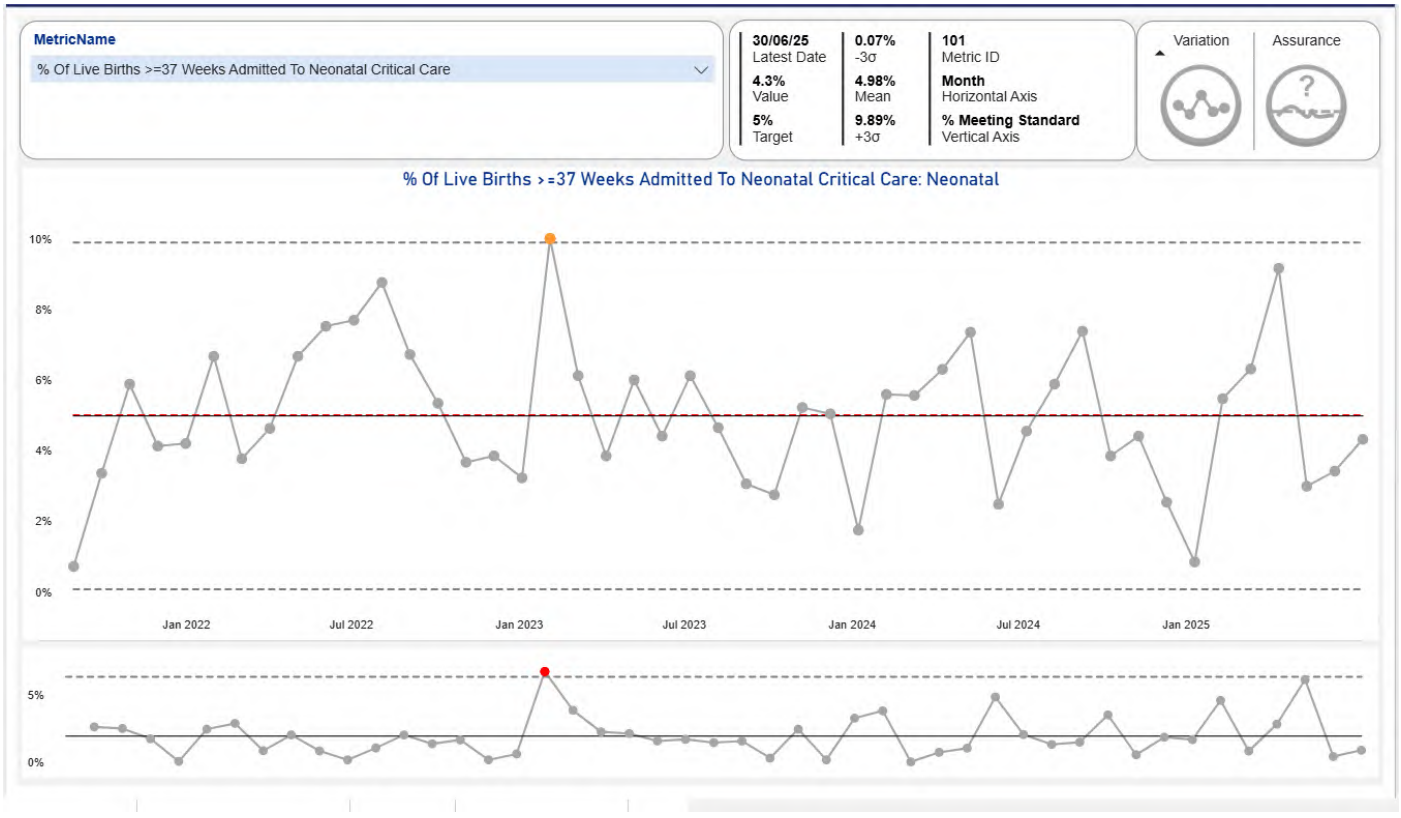


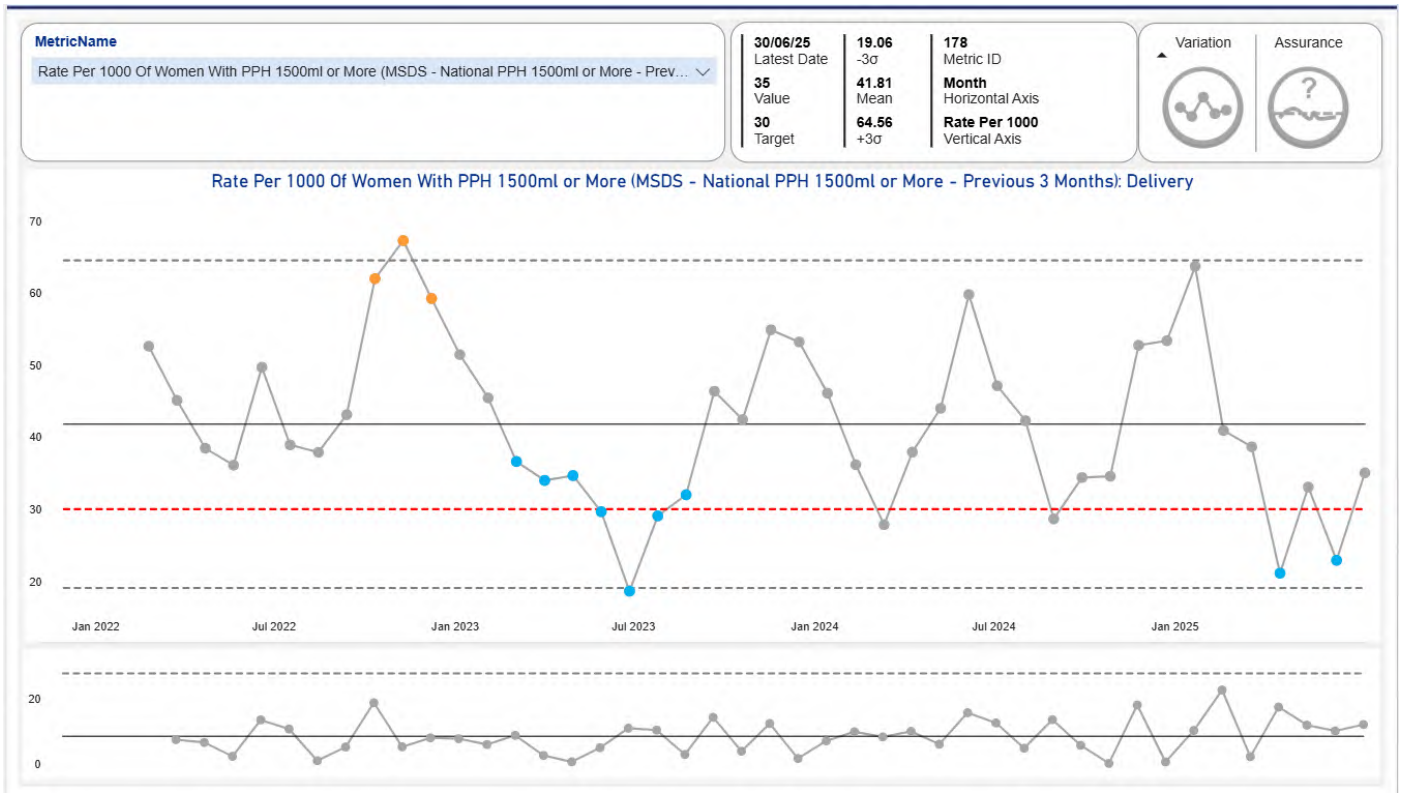


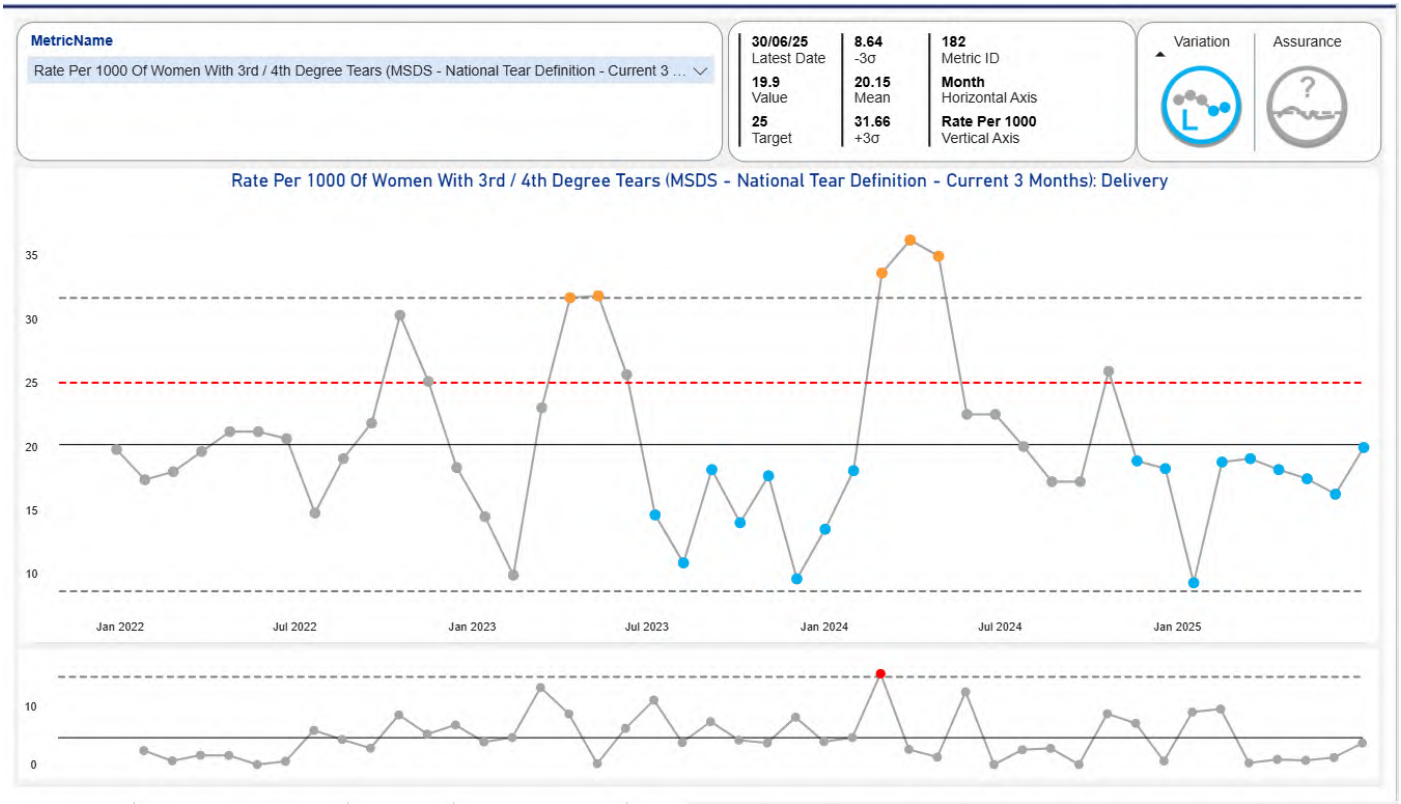


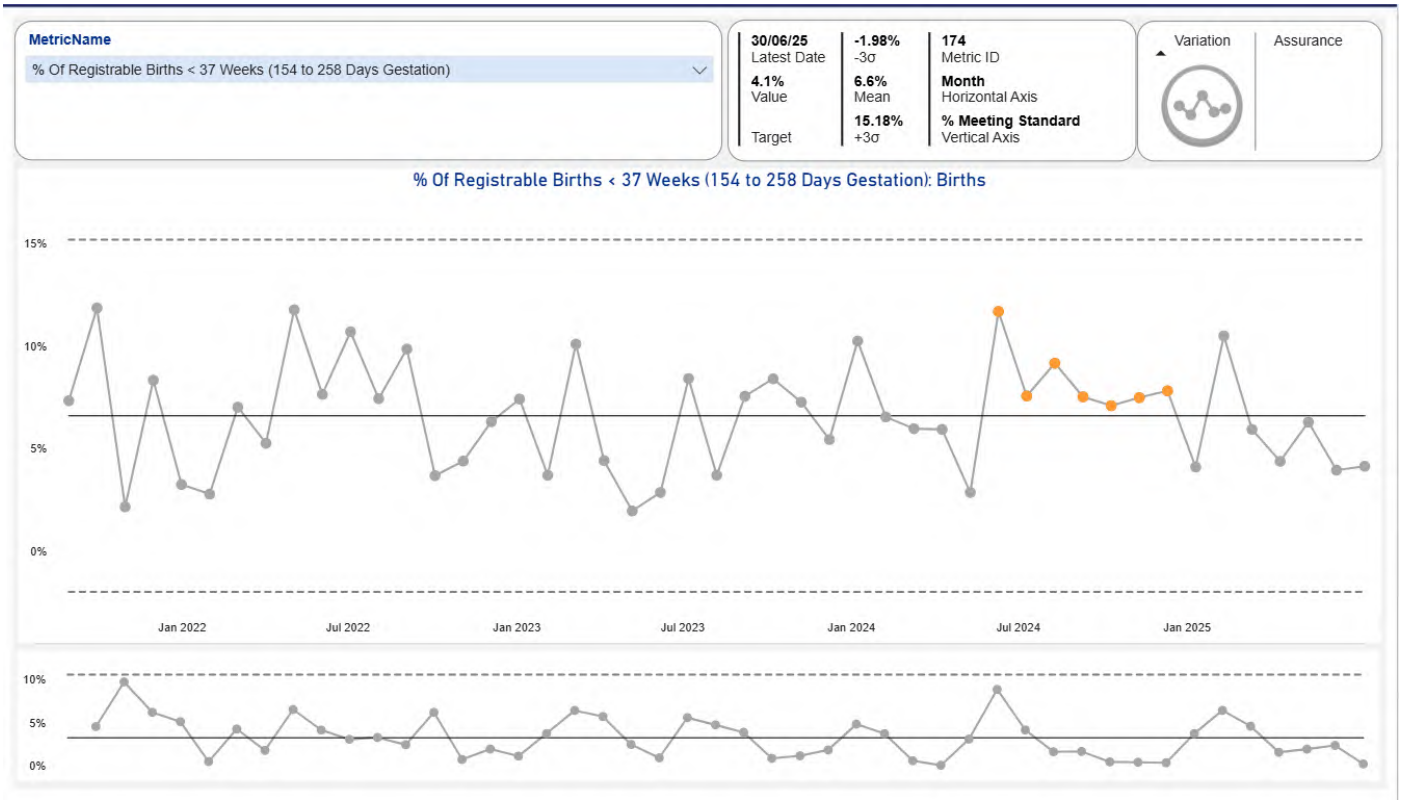


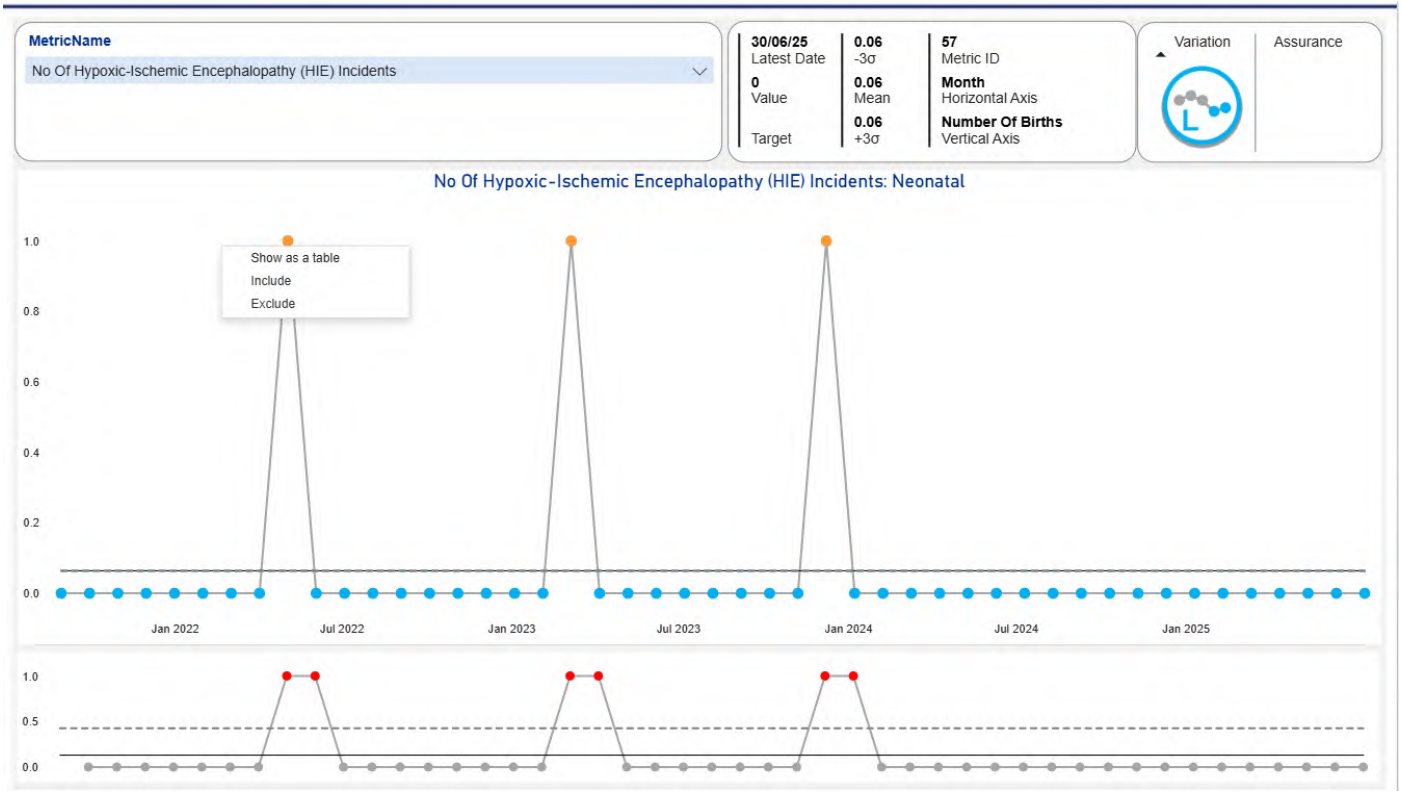


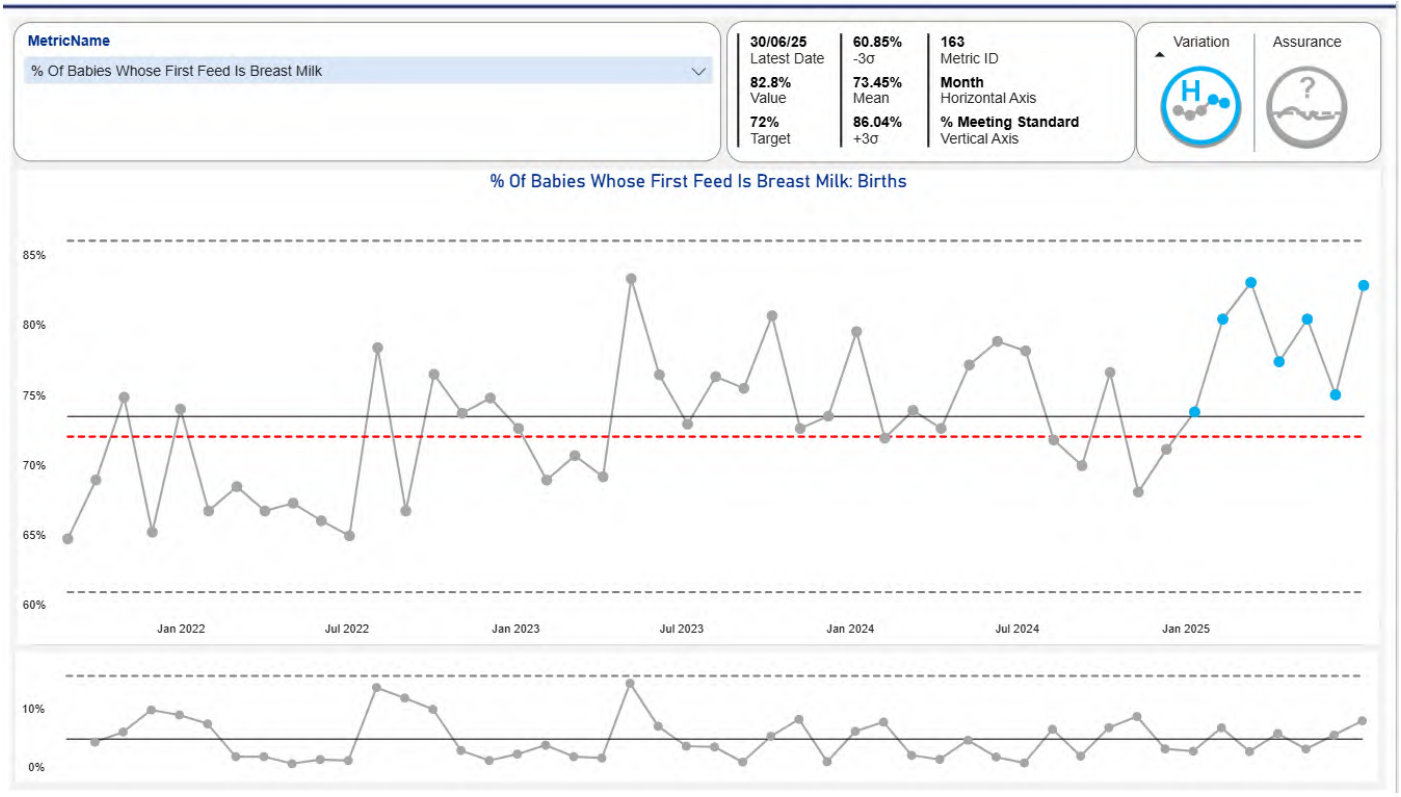


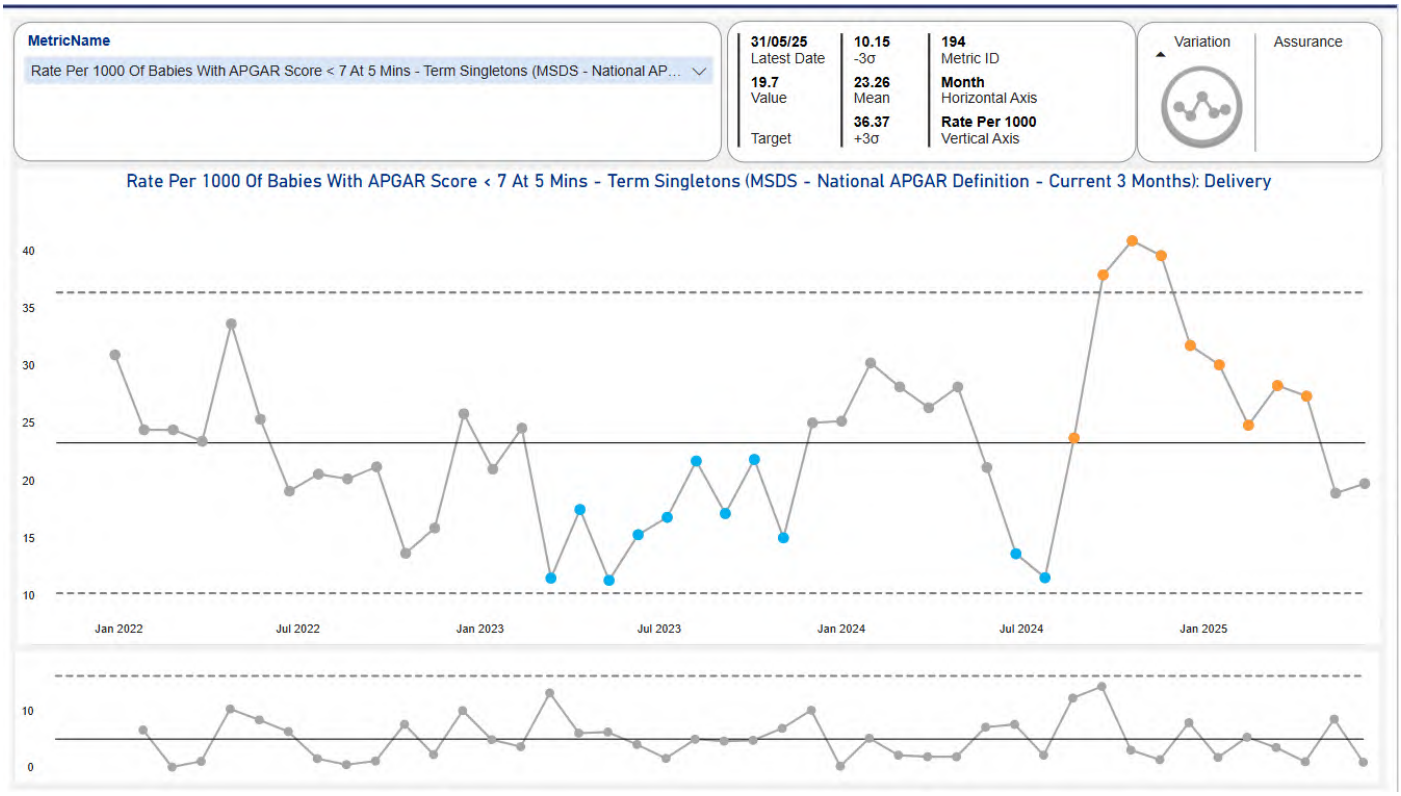




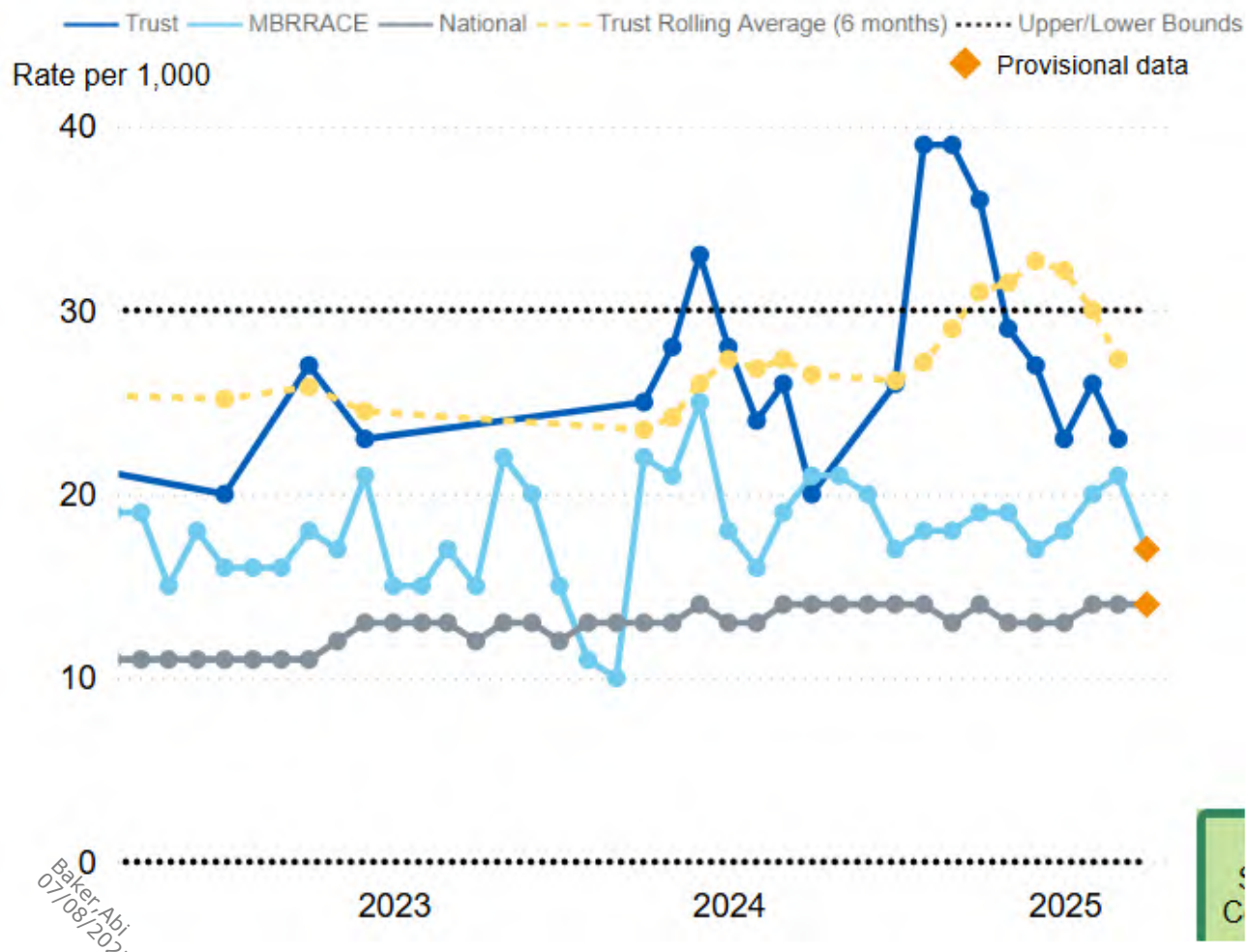








National data for DCH in relation to Apgar <7 at five minutes

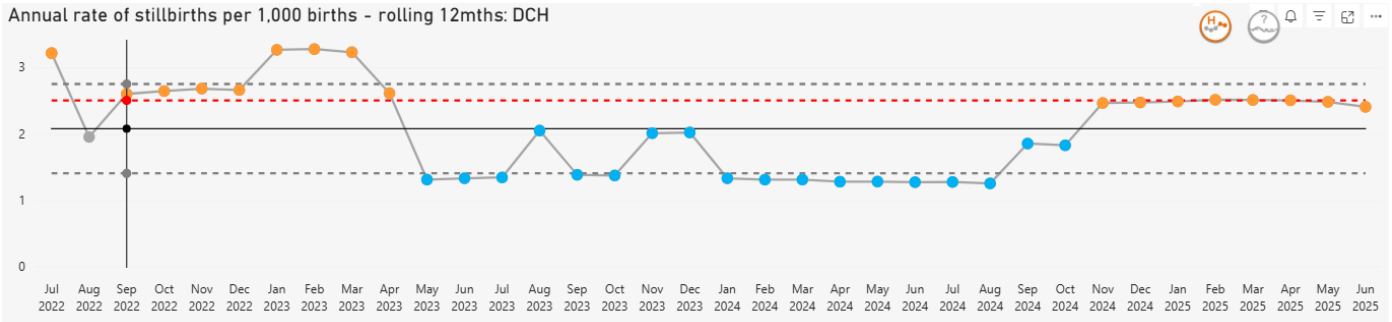


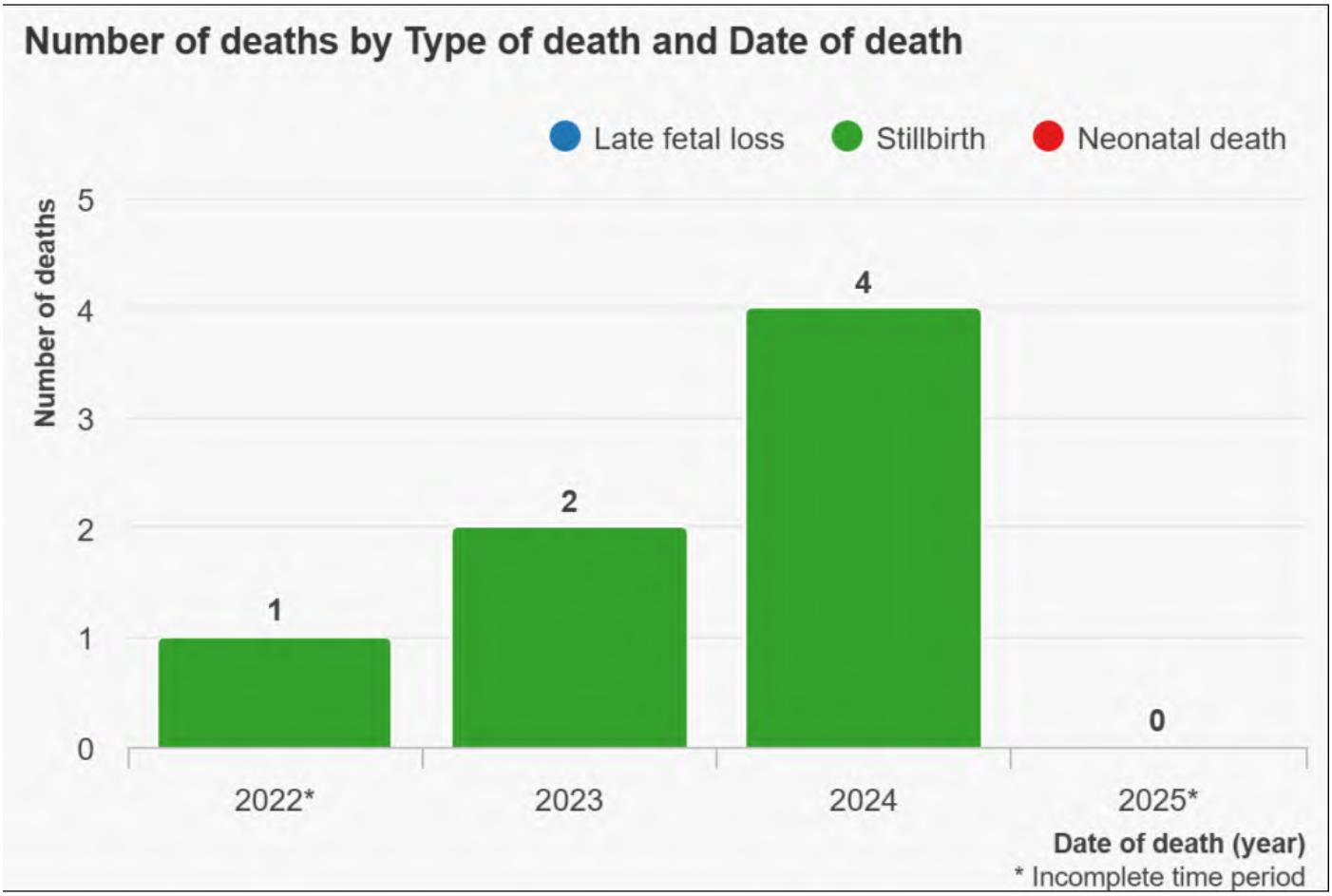
It was identified in April that the Trust data pertaining to babies >37 weeks gestation, with Apgar scores <7 at five minutes is significantly higher than the national rate. There is an audit currently underway of all eligible babies born over the past 12 months to identify themes relating to this statistic and actions required

to reduce this rate and improve Apgar scores at 5 minutes. Of note, the rate has consistently dropped since Nov 2024.

Stillbirth data – noted that the stillbirth data for DCH has increased from one case in 2022, two in 2023 and 4 in 2024. All cases are reviewed through the PMRT process. Currently waiting for the concluding PMRT for the twins.

Dorset Intelligence and Insight Service – annual rate of stillbirths per 1000 births – rolling 12 months





Grading of 2024 cases

		Grading of care of the mother and baby up to the point that the baby was confirmed as having died	Grading of care of the mother following confirmation of the death of her baby
Case 1	41/40 antenatal SB	A	A
Case 2	Concealed pregnancy – thought to term	B	A
Case 3	33 Twin pregnancy	Yet to be graded	
Case 4			

Grading of care of the mother and baby up to the point that the baby was confirmed as having died:	**Grading of care of the mother following confirmation of the death of her baby**
A – The review group concluded that there were no issues with care identified up to the point that the baby was confirmed as having died. B – The review group identified care issues which they considered would have made no difference to the outcome for the baby C- The review group identified care issues which they considered may have made a difference to the outcome for the baby D- The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	A – The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby B – The review group identified care issues which they consider would have made no difference to the outcome for the mother C – The review group identified care issues which they considered may have made a difference to the outcome for the mother D – The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother

Total Number of Incidents submitted for May and June 2025

maternity & neonatal
237

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

Red flag	Descriptor	Incidents for May and June
RF1	Escalation to divert of maternity services & poor staffing numbers, including medical staffing and SCBU	11 OPEL 3 1 OPEL 4
RF2	Missed medication	0
RF3	Delay in providing or reviewing an epidural in labour	1 (plus two further datix about inadequate anaesthetic staffing)
RF5	Full examination not carried out when presenting in labour	0
RF6	Delay of ≥2 hours between admission for induction of labour & starting process	26 for IOL delayed, some >24hrs. Three 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	
31+2	Threatened premature labour. Transferred to Salisbury as UHD in escalation - discharged
31+3	Threatened premature labour. Transferred to Salisbury as UHD in escalation - discharged
28+6	Threatened preterm labour. Transferred to UHD
22+2, 24+3, 26+2 & 27	Premature rupture of membranes, suboptimal CTG Transferred to Southampton x 4 (delivered after fourth transfer)
27+6 and 28+2	Antepartum haemorrhage. Transferred to UHD
29+5 and 30+6 twins	Suboptimal USS. UHD unable to accept as in escalation. Transferred to Southampton (discharged) then to Musgrove (delivered)

harm	incident	Action
Moderate DCH106403	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	This case will be reviewed through the PMRT (Perinatal Mortaility Review Tool) process, CDOP (Child Death Overview Panel) and MNSI will also carry out an independent investigation. STEIS reported
Severe DCH104380	Following the review of three cases of meconium aspiration at the Perinatal M&M in June, the mdt agreed the level of harm for one of the cases was severe. This was a category 2 LSCS for abnormal antenatal CTG at term. The baby was transferred to SCBU at delivery and then to a tertiary NICU. Baby remains an inpatient three months later, with significant, life changing sequela.	Please see below for learning from this M&M. No specific care issues identified for this baby
Initally assessed as no harm but now regraded as moderate DCH107239	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.	For ATAIN review
Moderate DCH107133	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.	For ATAIN review

Opening a second theatre in an emergency	
DCH106876 03/06	Normal birth, massive obstetric haemorrhage 2257mls. CEPOD list utilised for EUA and repair of 2nd degree tear. Maternity theatre in use for an emeregncy caesarean
DCH106951 06/06	Pathological CTG identified whilst maternity theatre in use. Policy followed and patient transferred to theatre 2. Second senior midwife on shift so she oversaw second theatre case

Mortality & Morbidity – Perinatal

Dorset County Hospital NHS Foundation Trust

Dateof Meeting: 25 June 2025

Thematic Review- Meconium Aspiration

Overview of Cases: 3 term babies

- **Case 1**: Baby remains in hospital with severe lung disease and comorbidities, The MDT agreed level of harm: severe
- **Case 2:** Baby discharged home on oxygen, now weaned off
- **Case 3**: Baby home, no oxygen required
- All women had a **BMI >30**, shared care, growth scans, and **meconium-stained liquor**
- CTG traces reviewed by fetal monitoring lead MW, one case identified may have benefitted from a longer CTG.
- Paediatric attendance at delivery inconsistent. **Now standardised**

Learning & Actions:

- **Escalate** to paediatric team clearly, using SBAR and aim for attendance at delivery for meconium
- Use **escalation pathways** if concerned
- **Document in real-time** under correct user ID
- Use **NEWTT2** chart including parental concerns and escalation triggers
- Babies needing continuous sats monitoring = **admit to SCBU**
- **Thermoregulation**
- Staff education- consistent information for new starters

Actions:

- Patient contact and Being Open letter for Case 1
- Case 1 to be shared at DAU staff meeting for learning (longer CTG)
- Inpatient matron to lead wider discussions on cord gases and CTGs, Cord gases to be highlighted at RHCG, added to FM newsletter and Maternity Safety newsletter

Healthier lives Empowered citizens Thriving communities

Quarter 1 scorecard triangulating claims, complaints and incidents

Quarter 1 AprilJune 2025

Trust Claims Scorecard Obstetrics (2014-2024)	
Top 5 injuries by volume	**Top 5 injuries by value**
Psychiatric/psychological Damage (6)	Brain damage (3)
Brain damage (3)	Bowel damage/dysfunction (2)
Bowel damage/dysfunction (2)	Psychiatric/psychological damage (6)
Unnecessary pain (1)	Hypoxia (1)
Fatality (1)	Fatality (1)
Top causes by volume	**Top 5 causes by value**
Fail to warn – informed consent (3)	Fail to warn – informed consent (3)
Fail to monitor 1st stage labour (2)	Birth Defects (1)
Perineal tear 1st, 2nd, 3rd Deg (2)	Perineal tear 1st, 2nd, 3rd Deg (2)
Not specified (2)	Assault etc by hospital staff (2)
Fail to recognise complication (2)	Fail/delay treatment (1)

Complaints 5 complaints in total

2 - Early resolution 3 - Closer Look

- Birth Injury – broken femur at caesarean
- Abnormalities not identified at birth
- Lack of empathy during missed miscarriage

MIS Year 7 requirements

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

Dorset County Hospital NHS Foundation Trust

Monitoring Incident data & areas with significant learning

- Antepartum in-utero transfer out (12)
- 21 ATAIN babies (4.3%)
- Postnatal readmissions for baby for treatment of jaundice (6) ↓
- Postnatal readmissions of mothers (8)
- PPH over 1.5 Litre (16)↑ from 13
- Maternity unit escalation (17)↑ from 9
- SCBU escalation (2)
- Delay of ≥2 hours between admission for induction of labour and beginning of process (34)
- Caesareans delayed for >24 hours (3)

Themes/focus areas

- Acuity and staffing
- Increase in activity due to 19th May YDH closure
- Increase in elective births
- Increase in delays in IOL
- Observations/checks on babies at birth

Action plan Q1

Postnatal care, 2025 local priority PSIRP (patient safety incident response plan)	To review enhanced elective pathway Review model of care and staffing on Postnatal – consider supernumerary /or coordinator Look at flow and discharge as a priority	In progress Target date Q2 2025
Increased activity from YDH temporary closure	Strategic action plan and joint working group and organisational operational working group in place – tracked via organisational action plan	In progress and ongoing
Increase in escalation to divert	Staffing business case to increase midwives on shift from 6 to 8 currently being finalised for submission	Target date beginning of July 2025

3rd & 4th degree tears May and June

Ethnicity	Grade of tear	Mode of birth	Hands on	OASI	Position of woman	Baby's weight	Blood loss	Referral made
White other	3b	forceps	No	yes	lithotomy	3184g 37th centile	684ml	yes
White British	3c	Spontaneous,	yes	yes	Semi prone	3562g, 56th centile	690mls	yes
White British	3a	forceps	yes	yes	lithotomy	3790g 65th centile	430mls	yes

Risk Register

ID	Title	Risk Statement	Open	Risk	responsibility
2183	YDH closure impact on obstetric workforce	Obstetric Workforce currently have a minimum staffing model for our Obstetric Service that ensures we have a Tier 1 and Tier 2 practitioner available and dedicated 24/7 to our Labour Ward. Due to the increased demand on our Obstetric Services following the closure of YDH and the predicted 20% increase in Maternity Provision we need to review our minimum staffing to increase availability of Tier 1 and Tier 2 cover. Following a clinical review of minimum staffing, it was agreed that on a fixed term basis for an initial period of 9 months we need to increase the workforce available primarily for Long Days both Weekdays and Weekends at both Tier 1 and Tier 2 level.		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 this. Awaiting a decision from UHD about withdrawal of the service and from DCH about funding	07/04/2025, Jo Hartley, DoMN Services, quarterly review	moderate 12	Division

1980	EPAC restricted service	**Update** Currently EPAC remains open for most Mondays-Fridays. However, this comes at a cost pressure to maternity as a midwife has been reallocated to EPAC and vacant shifts are being covered by bank staff Business case has been submitted and awaiting amendments **Update** July and August will be impacted with 10 days closed over the two months	20/09/2024, Jo Hartley, DoMN Services, quarterly review	Moderate 9	Division
2031	Maternity Reception Cover	**Update** Successful recruitment, leaving a small vacancy covered by regular bank	19/12/2024, Jo Hartley, DoMN Services, quarterly review	Low 4 closed	Care Group.
1881	Neonatal Nursing	**Update** Risk raised due to daily challenges to fill vacant shifts. Following a discussion at Safety Champions outlining the daily challenges to staff SCBU, there was agreement to recruit 1wte band 6 nurse plus block booking for 2/52 with agency to cover recent vacancies exacerbated by LTS for a fulltime nurse and an HCA. **Update** 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 at present	01/05/2024 Débora Pascoal-Horta, Neonatal Matron, quarterly review	Moderate 9	Division
1825	3 x neonatal ventilator SLE 5000 out of service	Current ventilators available in SCBU (X3) reached end of life and the period of maintained support has now passed. **Update** Estimated date of delivery for ventilators 11 July 2025. Consumables already available	26/02/2024, Debora Pascoal-Horta, neonatal matron, monthly review	Moderate 8	Division

2044	Risk to sustainability of Maternity & Neonatal Digital Service	Currently the maternity digital team is 1 wte midwife only. The admin support has left due to her secondment ending. The band 6 is on secondment (essential role within the Trust Digital Team) Education lead midwife for digital on maternity leave with no replacement identified. **Update** Whilst the maternity digital service is still extremely fragile, the assistance and support from CSST continues and is proving positive and productive. The band 6 midwife who works a couple of days a week is increasing her knowledge. The lead for the service is hopefully returning from work very soon. Therefore, the risk has been reduced to three monthly review and moderate	14/01/2025, Jo Hartley, DOMN, quarterly	moderate 9	division
1689	Opening a second theatre in an emergency &the elective pathway	All incidents where a second theatre is required are reviewed by the Safety Team and where relevant through M&M or other specialist groups. Discussions starting about establishing a pathway for elective theatre work - planned caesareans. **Update** Options appraisal submitted plus business case provided to Chief Operating Officer and to Divisional Manager. Several elective cases managed in Main Theatre recently – very successful with good patient satisfaction report	29/06/2023 managed by Jo Hartley DoM, quarterly review	moderate 9	division
876	Maternity Staffing	**Update** maternity staffing significantly challenged with vacancies of 6.37wte midwives due to maternity leave and LTS (approaching 10% of the band 5&6 workforce). Recruitment unsuccessful for fixed term so currently reallocating midwives from community (potential impact on safety and quality of services in community), specialist services (impacting on national KPIs) and manager oncall required on the ward (impacting on major workstreams as well as appraisals etc). Also staff working significant amounts of overtime and oncall. A further 2.29wte midwives due to start maternity leave soon with no-one returning from maternity leave until the Autumn. The next roster has <10 shifts fully staffed out of a total of approx 90 (early, late and night) **Update** Recruitment agreed for newly qualified midwives, starting October 2025. Midwives starting to transfer from YDH to work at DCH on secondments. Business case currently being revised in relation to increased workload since YDH closure. Currently, the ward has been extremely busy with multiple escalations to OPEL 3 and one occasion OPEL 4. Reliance on tier two incentives and	21/09/2021 Managed by Jo Hartley, Director of Midwifery, monthly reviews	High 20	Division

		midwives being reallocated from community and specialist roles.		

Saving Babies Lives (version 3.1) board report

Saving Babies' Lives (Version 3.1) Board Report

Dorset Local Maternity and Neonatal System

We're proud partners of Our Dorset – Health, care & wellbeing

NHS Dorset

Trust	Dorset County Hospital
Date of report	25/06/2025
Review period	Q4 2024/25
ICB accountable officer	Pam O'Shea (Interim ICB Chief Nursing Officer)
Trust accountable officer	Alastair Hutchison
LMNS peer assessor name(s)	Vicky Garner (LMNS Lead Midwife)

Executive summary:

- 76% of targets with a stretch ambition are either meeting or exceeding the stretch ambition
- 100% compliance has been achieved for Element 2 (fetal growth restriction) for the first time. This is an excellent achievement to be celebrated.
- Saving Babies' Lives version 3.2 (SBLv3.2) released in April 2025 and updated national implementation tool detailing minimum evidence requirements released 04/06/2025. Changes to some interventions, audit and minimum evidence requirements – LMNS Lead Midwife supporting Trust with changes.

% of interventions fully implemented (LMNS Validated)	Q1	Q2	Q3	Q4
Element 1 Smoking in pregnancy:	70%	90%	70%	90%
Element 2 Fetal growth restriction:	95%	90%	95%	100%
Element 3 Reduced fetal movements:	100%	100%	100%	100%
Element 4 Fetal monitoring in labour:	40%	100%	100%	80%
Element 5 Preterm birth:	85%	96%	93%	93%
Element 6 Diabetes:	100%	100%	100%	100%
Total implementation (all elements):	84%	94%	91%	94%

Agreed Improvement Activity and Shared Learning

Element 1	Following targeted quality improvement work, significant improvement in compliance with: • CO measurement at booking (1.1, process indicator 1a.i) • Documented evidence of immediate feedback to the named maternity health care professional when patient does not engage with tobacco dependence treatment service (1.7)
Element 2	• Uterine artery doppler assessment (2.7) compliance sustained. Note small numbers, therefore 12-month rolling data to be used in conjunction with exception reporting to provide assurance of processes.
Element 3	Compliance with next working day ultrasound scans for patients who attend with recurrent reduced fetal movements (3.2) sustained and exceeding new increased minimum target for Q4.
Element 4	• Slippage in overall element compliance due to not meeting minimum target for hourly peer review (4.4). PMRT data provides reassurance of no associated harm. • Exceeding stretch target in four of the five interventions with a stretch ambition. • Audit for onset of labour risk assessment (4.2), hourly holistic review (4.3) and peer review (4.4) removed from minimum evidence requirements in SBLv3.2. Exception reporting introduced for 4.2. Trust to consider how ongoing quality assurance and improvement can be monitored locally.
Element 5	• Improvement required in normothermia (5.24) with compliance falling below SBL minimum target in Q4. • Excellent compliance with early maternal breastmilk (5.25), consistently exceeding SBL target as well as the regional and national averages for this metric. • Minimum evidence requirements updated for SBLv3.2 and now include evidence of learning and improvement from local improvement meetings.
Element 6	New for SBLv3.2: • Hybrid closed loop interventions. • Requirement for outcome indicators to be reported by ethnicity and deprivation.

- Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element.
- Progress against locally agreed improvement aims.
- Evidence of sustained improvement where high levels of reliability have already been achieved.
- Regular review of local themes and trends with regard to potential harms in each of the six elements.
- Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate

Complaints and birth debrief feedback for maternity and SCBU

Total informal and formal

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

Themes
The importance of partners staying

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.

Neonatal transfer out data for May and June

Gestation	Weight	Reason	Transferred to
38+1	2458g	PPHN (persistent pulmonary hypertension of the newborn)- intubated and ventilated at DCH	Southampton NICU and then PICU. Still an inpatient
40+1	3356g	Neonatal seizures, possibly secondary to hypoglycaemia	Southampton. Discharged home 9 days later
41	3680g	Baby readmitted from home the day after discharge. Deteriorated and transferred to SCBU. Ventilated and subdural haematoma identified prior to transfer	Southampton NICU. Baby sadly died
37+2	2826g	Potential plasma exchange for haemolytic disease-triple phototherapy and IVIG given at DCH prior to transfer	Southampton NICU

Neonatal exceptions (babies that should have been born at a maternity unit with a level 2 or 3 neonatal service

29+4	1230g	Unexpected homebirth of preterm baby transferred to Southampton NICU

Babyloss data

Baby loss statistics for April & May			
Intrauterine death	Medical termination	Neonatal death	Late neonatal death
	4		

Training Figures for end of June

Perinatal Training Compliance

Rolling 12-month period ending June 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	94%
SA6 SBLv3 Element 1.9	Very Brief Advice (VBA) for smoking cessation all staff (midwives, obstetricians and MSWs)	93%
SA6 SBLv3 Element 2.11	Practical symphysis fundal height assessment (obstetricians and midwives)	94%
Fetal Monitoring and Surveillance in the AN and Intrapartum period	Obstetric consultants	80%
	Obstetric registers	88%
	Midwives	91%
PROMPT	Obstetric consultants	100%
	Obstetric registrars	100%
	Obstetric SHOs	86%
	Midwives	94%
	MSWs	100%
	Obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors	92%
	All other obstetric anaesthetic doctors contributing to the obstetric rota	81%
Neonatal Basic Life support (NBLS) Yearly	Paediatric consultants	100%
	Paediatric registrars	100%
	Neonatal nurses	100%
	MSWs and SCBU support workers who require this training as per local policy	100%
	ANNP	100%
	Midwives	94%
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	100%
	Obstetric Registrars	100%
	Drs on Obstetric SHO rota	100%

	Midwives	87%
	MSWs	100%
Safeguarding training Level 3	Midwives	76%
	MSWs	38%
Moving and Handling	All maternity clinical staff	84%
Infection Prevention and Control Level 1	All maternity clinical staff	100%
Infection Prevention and Control Level 2	All maternity clinical staff	92%
Deprivation of Liberty Safeguards Level 2 – 3 years	All maternity clinical staff	100%
Mental Capacity Act Level 2 – 3 years	All maternity clinical staff	90%
Information Governance and Data Security	All maternity clinical staff	92%

Perinatal Quad and Safety Champion Meeting April and May

Perinatal Joint Quad & Safety Champion Meeting

Minutes of the Meeting of 30 April 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
Lindsey Burningham – Head of Midwifery & Neonatal Services
Clare Hollingsworth – Paediatric Consultant and Neonatal Safety Champion
Sarah Dominey (SD) – Practice Educator Lead
Eiri Jones (EJ) – NED Safety Champion
James Male – Service Manager
Hannah Eastwood (HE) – MNVP Representative

Chair: Jo Hartley (JoH), Director of Midwifery & Neonatal Services

1.1 Apologies – to note:
Apologies from Jenny Townsend, James Male, Srabani Mukherjee

1.2 Minutes – agreed

1.3 Matters arising from previous meeting

- JH to send CH some slides from the group about Martha's rule. **ACTION:** agreed to remove this action and CH to liaise with Emma Sidey in relation to neonates. JH confirmed this is part of Trust wide work around Martha's Law

- Vacant post remains for MSW Safety Champion – **ACTION:** Claire Williams is now in post **CLOSED**

- To undertake staff engagement with the Safety Champions online to ensure access to those staff who aren't on the ward. Also consider visit to the community. **ACTION:** Teams meetings now set up for all staff to access the DoN, CNO and NED safety Champion **CLOSED**

- JoH shared details of service user feedback relating to postnatal care and women feeling "abandoned" after their birth. Identified the need to improve flow in relation to the elective pathway and discharge. NC leading on the elective pathway in relation to a second theatre for elective caesareans. DD raised the importance of MSW care after caesarean. **ACTION:** EP has shared the priorities for the PSIRP which is a focus on postnatal care and the elective pathway including enhanced recovery **CLOSED**

- EP shared details of challenges over the weekend in relation to a significant obstetric haemorrhage. Safety Team have linked with the family. NC was manager oncall over the weekend. Significant staffing challenges linked to short term sickness – both midwives and doctors. JoH reported there were problems contacting the consultant oncall over the weekend. JH clarified that significant problems contacting the consultant oncall should be escalated to the executive oncall. JH reported they have just completed Seven Day Services Audit – this will include obstetrics and maternity as well. This can be triangulated with the maternity service. **ACTION:** the CD has met with the consultant and discussed the issues and confirmed expectations. Reported into the monthly maternity & neonatal report **CLOSED**. **ACTION:** LB is reviewing the escalation also considering neonatal and system escalation **CLOSED**

- DPH updated that the neonatal ventilators' maintenance contract expires Feb 2025 and an end-of-life notice issued for the ventilators. All three ventilators currently working. **ACTION:** two ventilators on order from Draga **CLOSED**

- DPH updated the meeting about the very significant staffing challenges in SCBU. Currently unmanageable. WTE band 6 still awaiting sign-off for recruitment. **ACTION:** JH confirmed that System sign-off is required for any recruitment over £25k, hence the delay in increasing the neonatal establishment. **CLOSED**

- SD raised the issue of managing mandatory education for maternity including training that is Trust wide (for example Safeguarding and BLS). Currently SD unable to access ESR to track this – requires manager access to ESR. **ACTION:** SD linked with JC. Maternity re now overseeing and managing Safeguarding training with a robust plan to ensure compliance by July. **CLOSED**
-

2. MSW feedback – nothing to add this time

3. MNVP update and feedback

.

Actions carried forward from this meeting:

- 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 econd 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. Also NC, to attend next Safety Champion meeting for update

- LB raised her concerns about the impact of the building and decorating work occurring in Woman's Health Outpatients (Maumbury). Distressed staff had sought her out to discuss the paint fumes and lack of ventilation.

- 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

- CH raised concerns about paediatric attendance for two theatres pout of hours if both neonates required full resuscitation at the same time. **ACTION**: JoH and CH to discuss how this scenario would be managed within the current workforce

- The SCORE survey was discussed. **ACTION**: The action plan currently bring updated and to be discussed at the next Safety Champions Meeting

- The maternity staffing risk was discussed. maternity staffing significantly challenged with vacancies of approx. 10 wte midwives due to maternity leave and LTS. Recruitment unsuccessful for fixed term so currently reallocating midwives from community (potential impact on safety and quality of services in community), specialist services (impacting on national KPIs) and manager oncall required on the ward (impacting on major workstreams as well as appraisals etc). Also staff working significant amounts of overtime and oncall. A further 2.29wte midwives due to start maternity leave soon with no-one returning from maternity leave until the Autumn. The next roster has <10 shifts fully staffed out of a total of approx 90 (early, late and night). **ACTION:** JoH to ensure this is reported through Care Group into the Division and onto Board

Perinatal Joint Quad & Safety Champion Meeting

Minutes of the Meeting of 28 May 2025
Microsoft Teams meeting

Present: Aglaia Salvari (AS) – Anaesthetic Consultant & Safety Champion
Dawn Dawson (DD) – CNO & Executive Safety Champion
Elizabeth Passells (EP) – Maternity Governance Lead & Deputy Safety Champion
Jo Howarth (JH) – Director of Nursing
Débora Pascoal-Horta (DPH) – Neonatal Matron & Deputy Neonatal Safety Champion
Hannah Eastwood (HE) – MNVP Representative
James Male (JM) – Family Services Service Manager & QUAD
Claire Hollingsworth – (CH) Paediatric Consultant, Neonatal Lead, Neonatal safety Champion & QUAD
Beena Dandewate – Obstetric Consultant & QUAD
Claire Williams (CW) – MSW lead, PD team member & Safety Champion

Chair: Lindsey Burningham Head of Midwifery and Neonatal Services & QUAD

1.1 Apologies – to note:
Apologies from Jenny Townsend Anaesthetic Consultant & Safety Champion. Srabani Mukherje Obstetric Consultant & Safey Champion, Nichola Coliandris (NC) – Intrapartum 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 electiv caesarean – due to being cancelled twice already. The requirement for a second theatre for elective wor 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. Also, NC, to attend next Safety Champion meeting for update – UPDATE NC sent apologies as conducting LWC away day – AS & NC have met – elective pathway has been tested once and is ongoing. **ACTION CLOSED**

2. JoH raised concerns about second theatre standard operating procedure and the provision of a surgical assistant out of hours if both cases occurred simultaneously. Reviewed with the divisional director and agr the Surgical SHO will be asked to attend to assist in theatre. Clarity around this aspect to be strengthene the SOP. **ACTION**: LB to update the guidance about this specific issue in the form of a Critical Incic Response Card to be circulated to the CSM team and the Surgical speciality team – Action card compile draft and circulated – **action remains open**

3. CH raised concerns about paediatric attendance for two theatres out of hours if both neonates required f resuscitation at the same time. ACTION: JoH and CH to discuss how this scenario would be managed within the current workforce and considering the second theatre business case and the business case fo the Paediatric medical staffing to be BAPM compliant. UPDATE Actions deferred following discussion about the second theatre business case and relevant theatre staffing. Immediate action already taken to ensure surgical SHO is aware and called. UPDATE June: paediatric business case being considered currently around a 3rd tier – **action remains open**

4. The SCORE survey, Perinatal culture improvement plan was discussed. ACTION: The action plan curre being updated and to be discussed at the next Safety Champions Meeting. UPDATE deferred due significant discussion to be undertaken on today's meeting.

5. The maternity staffing risk was discussed. maternity staffing significantly challenged with vacancies approx. 10 wte midwives due to maternity leave and LTS. Recruitment unsuccessful for fixed term currently reallocating midwives from community (potential impact on safety and quality of services community), specialist services (impacting on national KPIs) and manager on call required on the w (impacting on major workstreams as well as appraisals etc). Also, staff working significant amounts overtime and on call. A further 2.29wte midwives due to start maternity leave soon with no-one returr from maternity leave until the Autumn. The next roster has <10 shifts fully staffed out of a total of approx (early, late and night). ACTION: JoH to ensure this is reported through Care Group into the Division and c Board. UPDATE action **COMPLETED & CLOSED**

2. Meeting summary

Meeting Introduction: LB welcomed everyone to the combined Quad and safety champion meeting, explaining that the meeting would be a discussion about the current situation in maternity and recent events, rather than following a formal agenda.

- **CQC Inspection and High Activity Period:** LB and DD discussed the recent unannounced CQC inspection and the high activity period over the bank holiday weekend, including the need to close the ur to admissions and redirect ambulances (OPEL4).
    - **CQC Inspection:** LB provided context about the unannounced CQC inspection that took place over three days, involving clinical inspections, data collection, and staff interviews. The inspectio is ongoing, with further data requests from CQC.
    - **High Activity:** LB described the high activity period over the bank holiday weekend, which led t the unit being closed to admissions and ambulances being redirected between 21:00 on Sunday and 04:10 Monday morning. The unit was able to de-escalate to OPEL2 by Monday afternoon.
    - **Operational Response:** EP praised the support received from other areas in the trust, including staff from SCBU, Kingfisher, and ICU, who helped manage the high demand and provided essential services such as blood transfusions.

3. Yeovil Closure

- **Risk Register and Yeovil Service Changes:** EP raised a question about the risk register for the Yeovil service changes, and JH explained the ongoing work to track incidents and risks related to the increased acuity of care.
    - **Risk Register:** EP inquired about the risk register for the Yeovil service changes, expressing concerns about the increased acuity of care and the need to track related incidents. JH respond by detailing the programme workbook supported by the transformation team, which includes a ri log and EQIA. She mentioned regular meetings with Somerset Foundation Trust and the creatio of an operational meeting to address these issues.
    - **Incident Tracking:** JH explained that the transformation team is working on tracking incidents through the risk log and EQIA. They are collecting data from Datix incidents since the announcement of the Yeovil closure to monitor the impact and ensure proper documentation an mitigation of risks.
    - **Staffing Impact:** JH discussed the impact of the Yeovil closure on staffing, noting that the risks the risk register have increased, particularly regarding staffing. She mentioned the involvement HR and the creation of a common agreement template to manage the transition of midwives fro Yeovil to the trust.
- **Operational Meetings and Workstreams:** JH and DD discussed the need for operational meetings an

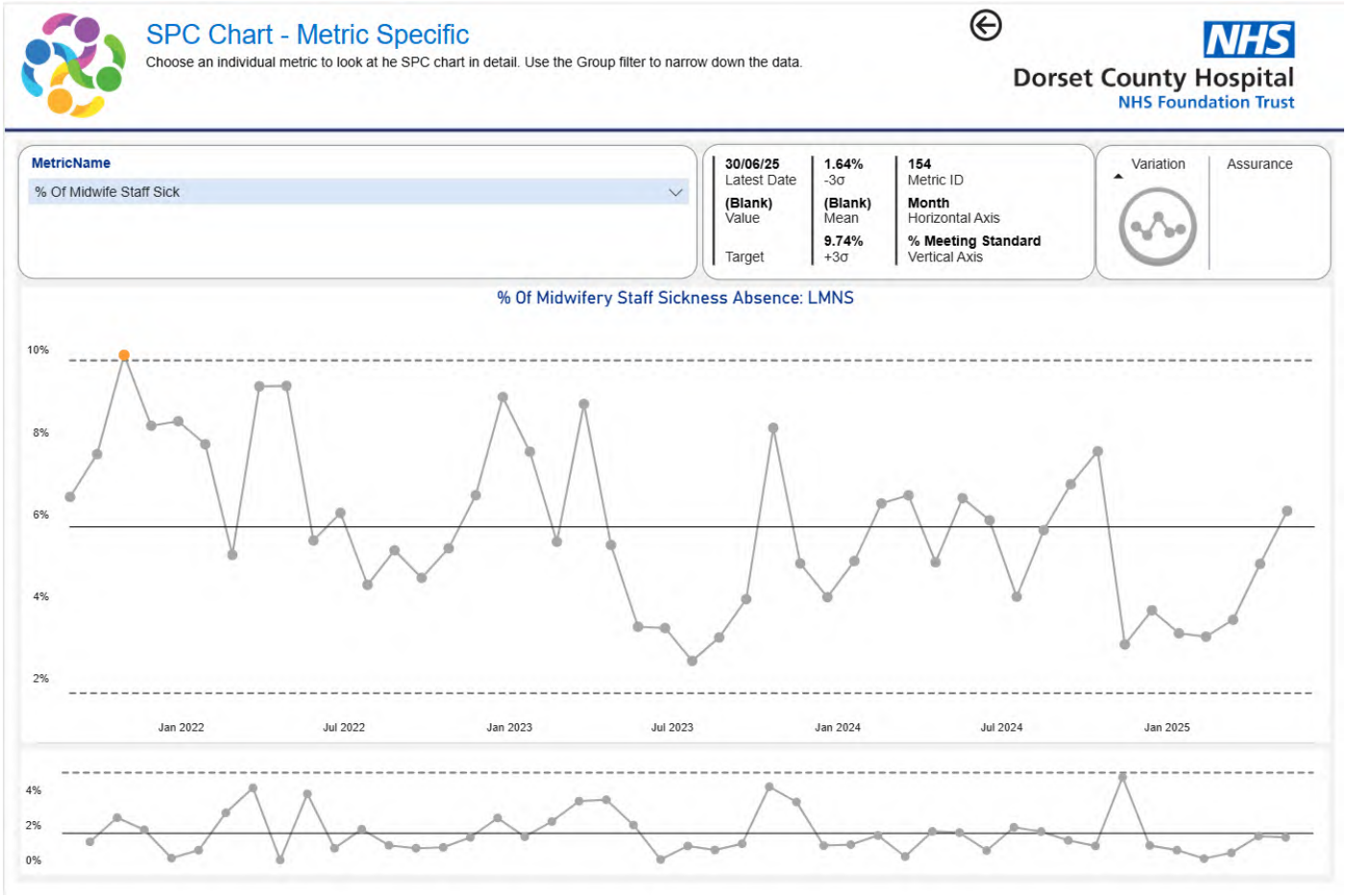
workstreams to manage the increased demand and staffing issues, including the involvement of the transformation team and HR.
    - **Operational Meetings:** JH and DD emphasised the importance of setting up operational meetir to address the increased demand and staffing issues resulting from the Yeovil closure. These meetings will involve various workstreams and the transformation team to ensure a coordinated response.
    - **Workstreams:** JH outlined the different workstreams being established to manage the transitior including HR, modelling, and risk management. She mentioned the involvement of workstream leads and the need for regular operational meetings to keep everyone informed and engaged.
    - **HR Involvement:** JH highlighted the role of HR in managing the transition of staff from Yeovil, including the creation of a common agreement template and the organisation of tours for incomi midwives. She stressed the importance of involving HR in the operational meetings to address staffing concerns.
- **Escalation Policy and External Support:** LB and JH highlighted the need to review and update the escalation policy in the new maternity provision landscape within the region and to include external supp and ensure proper documentation and governance for staff from other areas.
    - **Escalation Policy:** LB and JH discussed the need to review and update the escalation policy to better manage external support during high demand periods. LB mentioned the importance of including external hospitals and SWAST in the review of the policy to ensure a coordinated response.
    - **Documentation:** JH emphasised the need for proper documentation and governance for staff fr other areas who assist during high demand periods. She suggested formalising the escalation process to ensure that staff have the necessary skills and can document their work appropriatel BadgerNet.
    - **Governance Arrangements:** JH proposed creating a standard operating procedure for staff requests during escalation, ensuring that staff from specific departments are called upon based their skills and availability. She stressed the importance of working through governance arrangements to enable proper documentation and access to systems like BadgerNet.
- **Anaesthetic and ITU Support:** AS and JH discussed the need for additional anaesthetic and ITU suppo including the challenges of managing demand and the importance of having a permanent plan.
- **Staffing and Financial Modelling:** JH explained the ongoing work to model staffing needs and secure financial support from Somerset ICB, including the challenges of getting staff on loan and the need for a stabilised MDT workforce.
    - **Staffing Needs:** JH detailed the ongoing work to model staffing needs, including the immediate and long-term requirements for midwives, anaesthetists, and other MDT members. She mention the challenges of securing staff on loan and the need for a stabilised workforce.
    - **Financial Support:** JH explained the efforts to secure financial support from Somerset ICB to cover the costs of additional staffing and resources. She highlighted the importance of agreeing a financial package to ensure the trust can manage the increased demand without incurring excessive costs.
    - **Modelling Impact:** JH discussed the impact of the Yeovil closure on staffing and the need for accurate modelling to forecast future demand. She mentioned the involvement of BI teams in thi process and the importance of capturing data on consumables, medicine costs, and equipment needs.
- **Communication and Feedback:** EP and LB discussed the importance of regular staff updates and feedback sessions to keep everyone informed about the ongoing changes and address any concerns.
    - **Staff Updates:** EP and LB emphasised the need for regular staff updates to keep everyone informed about the ongoing changes and address any concerns. JH mentioned a planned Team staff engagement meeting on Friday 30th for NED and ED Safety Champions to provide updates and engage with staff.
    - **Feedback Sessions:** EP suggested organising feedback sessions to allow staff to voice their concerns and receive updates on the current situation. DD and JH agreed to arrange additional dates for these sessions to ensure all staff from the MDT can participate.
    - **Safety Walkaround:** DD described her safety walkaround on the 22nd of May. Staff appeared ca and positive during the inspection and described their interactions with the CQC interviews and focus groups. DD listened to concerns about the increased workload and was able to assure sta that there would be regular feedback around the operational plans. The unit had been in OPEL3 during her walkaround, but staff described feeling safe and well supported. They described the Manager on Call facilitating breaks. No safety issues raised.
- **Patient Feedback from MNVP:** HE shared positive feedback from patients about the care they received highlighting the friendly and attentive staff and the homely environment. Report shared on teams and HE aims to send to LB today for her to share with staff and formulate any actions for improvement
- **Sharing Feedback:** LB and CW discussed the importance of sharing positive feedback with the team to celebrate their efforts and ensure everyone is aware of the impact of their work particularly in the current

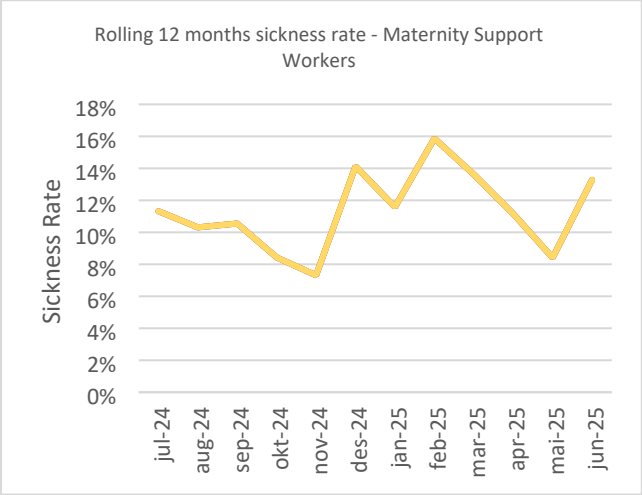
climate.

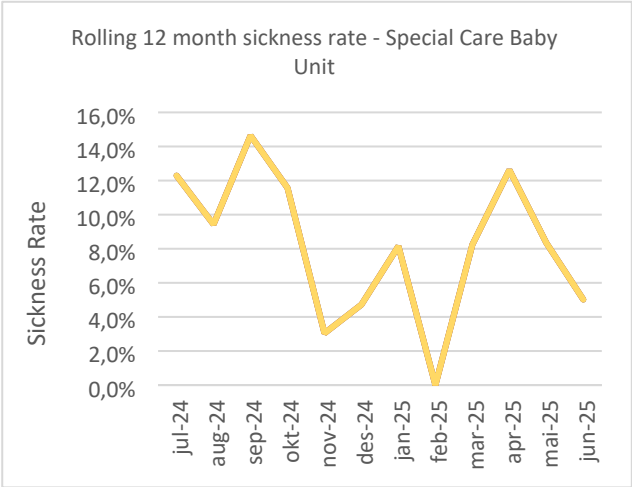
Actions carried forward from this meeting:

- **Risk Register Update:** Update the risk register to include the new risks associated with the Ye service changes. (JH)
- **Operational Meeting Setup:** Set up an operational meeting involving the team to discuss the next st and workstreams related to the Yeovil service changes. (JH)
- **Escalation Policy Review:** Review and update the escalation policy to include external landsc considerations and coordination with other hospitals. (LB)
- **Medication Shortage Escalation:** Email the chief pharmacist to address the ongoing shortage Clexane and ensure adequate stock for the ward. (EP)
- **Staff Engagement Session:** Organise a staff engagement session to provide updates on the Ye service changes and address staff concerns. (JH, DD)

Workforce data

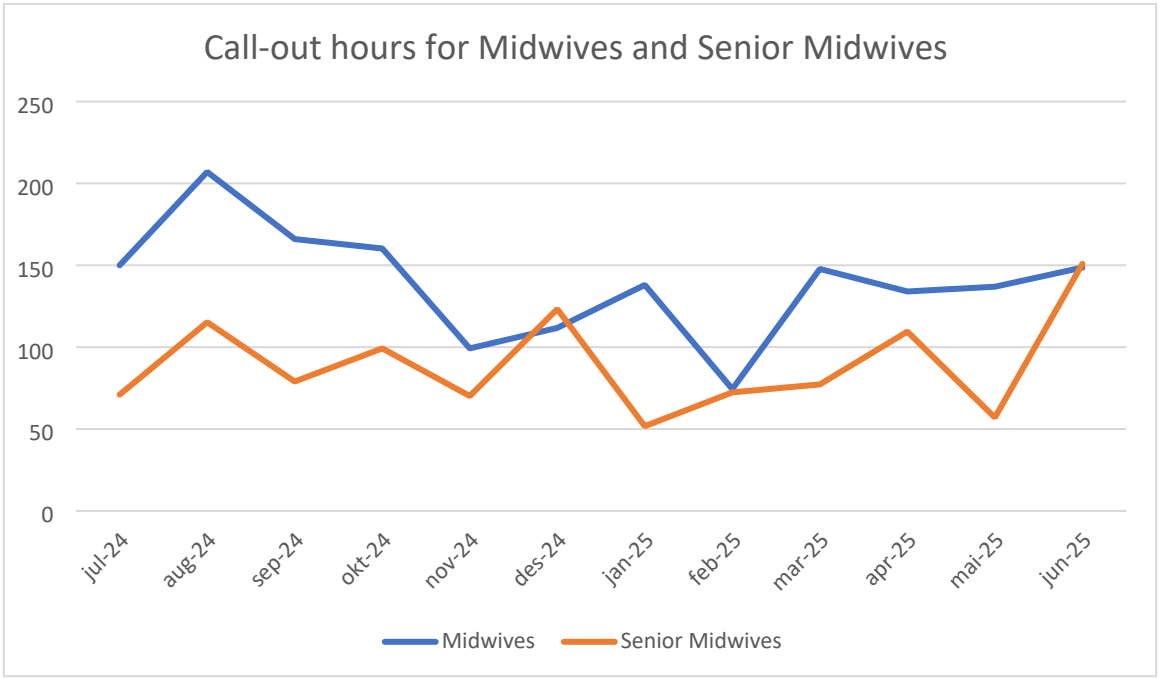






June Call-Out Hours

Midwife call-out for the unit – **148.6 hours.**
Senior Midwives call-out – **150.9 hours**



Bank and Excess hours

	Maternity Unit/ DAU	MSW's / DAU	SCBU Registered	SCBU Band 3
Bank	412 hrs / 109 hrs	212.25hrs/145hrs	112 hrs	44 hrs
Excess/Overtime	719.25 hours	82 hours	86.5 hours (Band 5/6)	

Shifts not covered by substantive or bank staff

Maternity Unit – based on 6 midwives per shift		**Special Care Baby Unit**	
Day Shift	8.3%	Band 5/6	2 shifts not covered
Night Shift	10.5%	Band 3	1 shift not covered
Total	**9.07%**		
Maternity Support Workers			
Day Shift	19.1%		
Night Shift	13.3%		
Total	**17.2%**		

Report to	Board of Directors	
Date of Meeting	13th August 2025	
Report Title	Food and Drink Strategy	
Prepared By	Cara Southgate, Director of Nursing, Therapies & Quality	
Approved by Accountable Executive	Dawn Dawson, Chief Nursing Officer	
Previously Considered By	DHC Quality Governance Group 1st July 2025, DCH Quality Governance Group 16th July 2025 Quality Committee in Common 29th July 2025 (Approved)	
Action Required	**Approval**	Y
	Assurance	N
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues		No
Communities		No
Sustainability		No
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	DHC/DCH SR1 Safety and Quality SR6 Estates SR7 Collaboration	
Financial	N/A	
Statutory & Regulatory	Requirement by NHS England to have a Food and Drink Strategy	
Equality, Diversity & Inclusion	This strategy will support improvements in the provision of a more inclusive offer of food and drink.	
Co-production & Partnership	Produced by DCH and DHC.	

Executive Summary

In 2022 the National Standards for Healthcare Food and Drink were published by NHS England. Every healthcare organisation has a responsibility to provide the highest level of care possible for their patients, staff and visitors. This includes the quality, nutritional value and the sustainable aspects of the food and drink that is served, as well as the overall experience and environment in which it is eaten.

A requirement of the standards is that organisations must have a food and drink strategy.

The attached draft strategy has been compiled as a joint strategy and has had engagement from

- Dieticians
- Speech and Language Therapists
- Inpatient ward managers (COHO and Mental Health)
- Community Hospital Matrons
- Facilities Leads
- Communications

In addition, information and documents were reviewed including

- PLACE reports and action plans
- Survey of patients DHC
- Ward based menus
- Staff survey results

The strategy has three strategic aims that link to the overall Joint Strategy.

The next steps are to work to develop enabling plans.

Recommendation

Board are requested to:

Approve the strategy.

Dorset County Hospital
Dorset HealthCare

NHS

Food and Drink Strategy

Three-year plan 2025-2028

First published: July 2025

Healthier lives Empowered citizens Thriving communities

Contents

1 Foreword

Welcome to our first joint Food and Drink Strategy which outlines our ambitions to continuously strive for excellence in the delivery of safe, high-quality nutrition and hydration care, recognising the importance of offering healthy, balanced food and drink choices for our patients, visitors, carers, volunteers and staff.

Nutritious food and drink is fundamental to healthy living, providing the energy we require to live healthy lives and thrive. Malnutrition and dehydration can be a significant risk for our patients, contributing to extended periods of illness and recovery. Our strategy aims to equip staff to support patients to have the best possible outcomes.

Supporting the health and wellbeing of our staff, visitors and communities is also a core part of our joint strategy, ensuring they have access to a range of healthy food and drink choices.

Our strategy outlines how we intend to build upon our current provision of food and drink for our staff, including a wider range of wholesome, nourishing choices.

We recognise that delivering high quality food and nutritional care requires the support and commitment of a wide range of staff and services across our Trusts working together to realise our aims.

2 Introduction

Dorset County Hospital and Dorset HealthCare deliver a wide range of inpatient and community services across Dorset. We recognise the value of nutrition and hydration in supporting those who are recovering from an illness or procedure and as part of living a healthy life.

Our strategy will deliver on the agreed aims and objectives and build on work already ongoing in each Trust through our collaboration. The strategy will be monitored through an enabling plan.

This Food and Drink Strategy aims to ensure the recommendations contained within the ‘Report of the Independent Review of NHS Hospital Food’ are implemented, together with the updated recommendations of ‘National Standards for Healthcare Food and Drink’ (November 2022).

The Hospital Food Standards Panel published a report which identified five food standards which all hospitals should comply with, in order to provide the highest quality and nutritional value of food for NHS patients, staff and visitors (DH, 2014). These standards are included in the NHS contract.

The Nutrition and Hydration Digest (BDA, 2023) supports the National Standards, and the principles have been a reference guide in the writing of this strategy.

Dawn Dawson

Joint Chief Nursing Officer

3 Our Strategic Framework

The strategy has been developed by a group with representatives from Dorset HealthCare and Dorset County Hospital.

Strategic Aim 1

Our patients' food and drink needs are met through a personalised approach.

Aim	Objective
Menus to be consistent and choice to be available to all patients, including those with additional nutritional or safety needs. 	Identify patients' nutritional needs at time of admission and inform Facilities. Menus to include pictures, digital format as appropriate and colour coded and on a set template. Menus to include provision of modified textures to meet all International Dysphagia Diet Standardisation Initiative (IDDSI) levels. Ensure a range of menus are available to provide meals to meet clinical, allergen, religious and cultural requirements. Consideration to introduction of a named food service Dietitian through business case and benefit evaluation.

Aim	Objective
Embed nutrition screening and assessment of individual needs in everyday practice. 	Ensure the appropriate nutrition assessment tool (Malnutrition Universal Screening Tool (MUST)/Screening Tool for the Assessment of Malnutrition in Paediatrics (STAMP)/St Andrews) is completed within 24 hours of admission for all inpatients and repeated as required. Standardised food intake charts across the trusts. For patients who have increased nutritional risk, ensure their care plan reflects this and is communicated to Facilities supported by a Standard Operating Procedure. Refer patients to dietetic services if patients meet referral criteria. If potential swallowing difficulties are identified by an appropriately trained staff member, refer to Speech and Language Therapy (SALT) as the patient may require texture modified food and fluids.
Support patients to drink more frequently and have access to foods with fluid content. 	Introduce a drinks menu. Access to water and other drinks the Nutrition and Hydration Digest recommends 7 drinks/day. Access to food options with high fluid content. Establish mechanism to record fluid intake where required. Standardise and personalise drinking vessels to support fluid intake. Awareness of current vessel volume to assist recording fluid intake. Drink choices to be reflective of personal choice.

Aim	Objective
Ensure mealtimes are supported to meet individual patient needs. 	Provide an environment conducive to eating and drinking, advocating good patient nutrition and hydration. Provide specialist equipment, if required, following assessment, for example an assessment by occupational therapy. Provide support and assistance to those that need it to support maximum nutritional intake. Meals should be served away from the bedside whenever possible. Hand hygiene is supported before mealtimes. Support volunteers or carers to assist at mealtimes except where patients are having modified textures. Ensure the correct texture-modified meals and drinks are provided to patients with Speech and Language Therapy (SALT) recommendations. Ensure correct special diets (e.g. considering allergens, medical needs) are provided to those who require them.
To ensure mouthcare is regularly provided and/or supported throughout the day, and after mealtimes.	Promote Mouthcare Champions. For the Trusts to implement appropriate support to staff regarding mouthcare provision as per Quality Priority (2024/26 DHC) and in line with guidance.

Strategic Aim 2

Access to healthy food and drink options at all times for our staff and visitors.

Aim	Objective
Healthier options are easy to access for staff and visitors. 	Provide opportunities for staff and visitors to access nutritionally balanced meals and snacks by ensuring healthier options are always available and promoted in all venues. Healthier eating for staff and visitors 24 hours a day. Greater variety, including plant-based options, through dining rooms. Coded descriptions of food to identify “Healthy Options”.
Healthy options and hot food to be available for staff working shift patterns.	Ensure staff working shifts have access to healthy options via food outlets, vending machines or facilities to heat food and drink.
Support staff health and wellbeing. 	Ensure staff have adequate breaks and are provided with opportunities to remain well hydrated during their working period. Encourage use of DHC sites to take a break for community staff. Ensure break areas identified for staff at DCH. Make healthy food fun and interesting. Utilise Health and Wellbeing Champions to elicit staff wishes. Access to information for staff, patients and visitors re food banks and larders to be available.

Strategic Aim 3

Sustainable Procurement for Food and Catering Services.

Aim	Objective
Develop sustainable procurement practices.	Consider economic, environmental and social benefits in all supply routes. All contracts to comply with National Standards for Healthcare Food and Drink.
Monitor, review and actively reduce food waste from production, plate and unserved meals.	Record and benchmark weight of food waste and its monetary value across sites monthly; analyse data and adjust menus/working practices.
Maximise and actively manage waste in line with The Green Plan.	Limit and measure food waste. Minimise single use plastic.
Utilise the full potential of the social value weighting score in food and drink.	

References

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NHS England (2022) National Standards for Healthcare Food and Drink. London.

NHS England (2025) The Green Plan Guidance. London

NHS England (2025) The Green Plan Guidance. London

The Association of UK Dietitians (2023) The Nutrition and Hydration Digest.

The Procurement Regulations 2024

Report to	DCH Board of Directors	
Date of Meeting	12 August 2025	
Report Title	Safeguarding Annual Report	
Prepared By	Sarah Cake Head of Safeguarding	
Approved by Accountable Executive	Dawn Dawson Joint Chief Nursing Officer	
Previously Considered By	Quality Committee in Common 29 July 2025 Quality Governance Group 16 July 2025 Safeguarding Committee quarterly meetings 2024-2025	
Action Required	**Approval**	No
	Assurance	Yes
	Information	No

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability		No
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 Quality and Safety	
Financial	No implication.	
Statutory & Regulatory	• Female Genital Mutilation Act 2003 • Mental Capacity Act 2005 • UN Convention on the Rights of Persons with Disabilities 2006 • Mental Health Act 2007 • Children and Families Act 2014 • Modern Slavery Act 2015 • Serious Crime Act 2015 • NHS Constitution and Values (updated Jan 2021) • Domestic Abuse Act 2021 • Serious Violence Duty 2023 • Prevent Duty 2023 • United Nations Convention on the Rights of the Child 1989 • Children Act 1989 and Children Act 2004 • Working Together to Safeguarding Children 2023 • European Convention on Human Rights • The Care Act 2014 Regulation 13 https://www.cqc.org.uk/guidance-providers/regulations/regulation-13-safeguarding-service-users-abuse-improper NHS Safeguarding Accountability and Assurance Framework July 2024	
Equality, Diversity & Inclusion	As above	
Co-production & Partnership	Dorset Safeguarding Children Partnership, BCP&D Safeguarding Adults Board	

Executive Summary

The Safeguarding Annual Report:

- Offers assurance of the process & activity for Safeguarding at Dorset County Hospital
- Provides a review of activity for safeguarding (adults, children / young people and maternity services)
- Provides a review of activity in relation to Learning disability and or Autism within Dorset County Hospital
- Provides a review of activity in relation to Mental Capacity / Deprivation of Liberty at Dorset County Hospital
- Sets out Mandatory Training activity and
- Identifies risks and mitigation.

The report also sets out the Quality Improvement Plan for 2025 -2027.

Recommendation

Members are requested to:

- Receive the report for **assurance**

Safeguarding Annual Report 2024 – 2025

1.0 Executive Summary

Dorset County Hospital Foundation Trust (DCHFT), its Executive Team, Safeguarding Leads, Practitioners, and Managers are committed to ensuring that safeguarding and mental capacity considerations for our patients, their families, our staff, and our communities are embedded in our Trust values and daily practice.

DCHFT recognises that one of the most important principles of safeguarding is that it is *everyone's responsibility*. Safeguarding children, young people, and adults is only effective when we work collaboratively with partner agencies and respectfully with those who need protection from harm, abuse, or neglect. The Trust is committed to protecting individual human rights, treating individuals with dignity and respect, and safeguarding them from abuse, neglect, discrimination, or poor treatment.

Safeguarding is increasingly multifaceted and challenging, requiring practitioners to balance the rights and choices of individuals with the Trust's duty to act in their best interests and protect patients, the public, and the organisation from harm.

This annual safeguarding report aims to:

- Provide assurance of compliance with local multi-agency guidelines for safeguarding adults (Dorset Adult Safeguarding Board / Dorset Clinical Commissioning Group, Pan-Dorset Children's Safeguarding Partnership).
- Provide assurance of compliance with Care Quality Commission Registration Standards: Regulation 13 (safeguarding service users from abuse and improper treatment), Fundamental Standard 5 (safeguarding from abuse), and the Safe Domain (safeguarding arrangements).
- Inform the Board of safeguarding activity, including progress against the annual work plan.
- Provide assurance of compliance with local multi-agency guidelines for safeguarding children (Dorset Children's Safeguarding Board / Dorset Clinical Commissioning Group and County Council).
- Provide assurance of compliance with Section 11 of the Children Act (1989, 2004).

2.0 Definitions

Safeguarding:

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

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

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

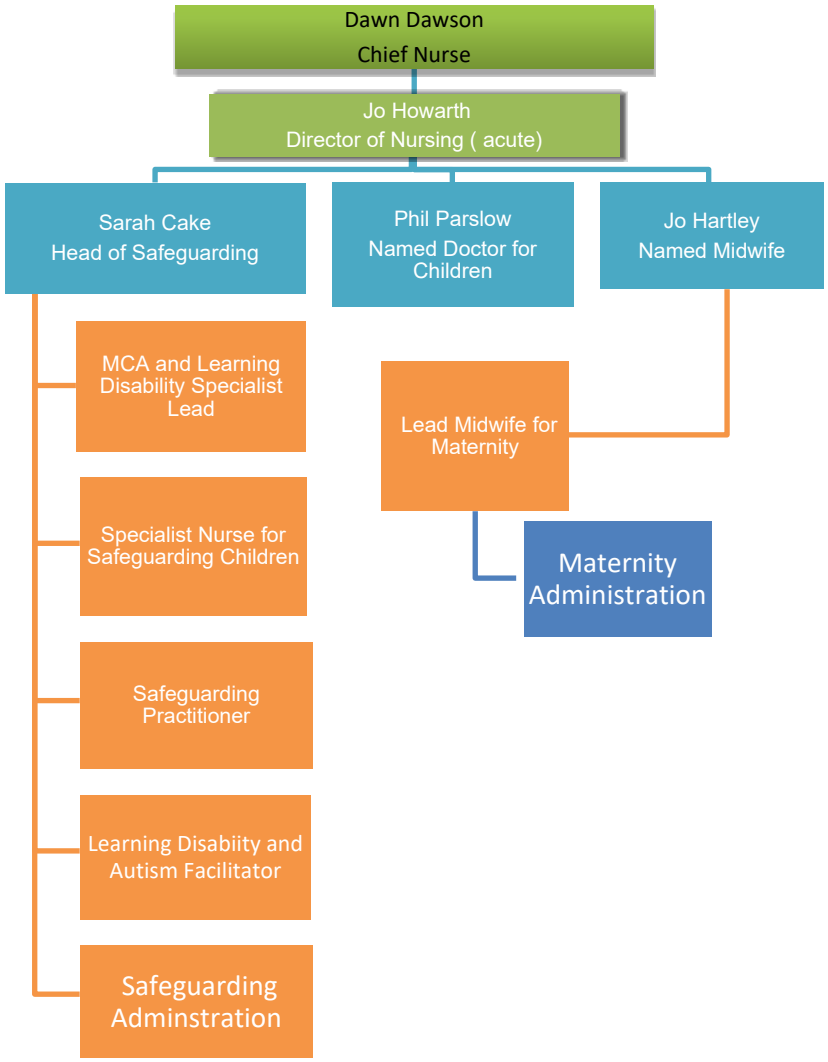
- an adult who has care and support needs (whether the needs are being met or not).
- is experiencing, or at risk of, abuse or neglect.

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

Assurance to support Trust Board confidence.

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

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

There is a clear line of accountability within the organisation for the work on safeguarding	
Service development considers the need to safeguard and promote welfare of all those using our services.	• All service developments incorporate the appropriate risk assessment for safeguarding. • Work through collaborative flagship programmes to ensure a safeguarding lens is applied. • Developments in Midwifery has extended their perinatal mental health offer to those requiring this service.
Training on safeguarding is in place for all staff	• There is a training plan in place to ensure that all staff meet the minimum standards required by the intercollegiate guidelines. • In line with the “Safeguarding Children and Young People: Roles and Competencies for Health Care Staff”, Intercollegiate Document (2019) the Team now work

	towards a "Think Family Approach" which covers Children at Level 3 and Adults at Level 2. • Training is integral to the induction process for all new staff, Safeguarding Annual Report: Aug 2023. • All training is recorded electronically and process a robust audit trail. • Level 1 and 2 training is available via e-learning for staff, however, face to face and target training is also delivered. • Access to Level 3 Teams and e-learning for health training is available to staff and has continued to be accessed during mandatory training sessions. • In addition, the Named professionals provide bespoke Safeguarding Level 3 training face to face. • Trained professionals require a higher level of training / level 4 - 5. • Level 1 and level 2 MCA training is available via e – learning for health, however ward based coaching and other bespoke sessions are delivered to a variety of professions. • The Trust has embraced the delivery of the Oliver McGowan Mandatory Training for learning disabilities and autism.
Safer recruitment procedures including vetting procedures and those managing allegations are in place	• Safer recruitment is in line with statutory guidance. • Disclosure and Barring/DBS checks and references are taken up prior to job offer. • A recruitment training programme is in place for all managers. • Named professionals share responsibility for reporting staff allegations to the Local Authority Designated Officer (LADO) or Adult Local Authority.

3.0 Introduction

3.1 This annual report highlights the work undertaken by Dorset County Hospital Foundation Trust (DCHFT) in fulfilling its commitment and responsibilities to protect those at risk of abuse and neglect. It covers both adult children's and maternity safeguarding.

3.2 DCHFT is required under statute and regulation to have effective arrangements in place to safeguard and promote the welfare of children and adults at risk in every service it delivers. Safeguarding is firmly embedded within the core duties and statutory responsibilities of all organisations across the health system.

3.3 All staff are expected to recognise their individual responsibilities to safeguard and promote the welfare of all individuals and to be equipped to fulfil this task.

3.4 This report covers the period from April 2024 to March 2025 and provides assurance that systems are in place to ensure patients using Trust services are effectively protected and that staff are appropriately supported.

3.5 Safeguarding Accountability and Assurance Framework (SAAF): The *Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework* clearly sets out the safeguarding roles and responsibilities of all individuals working in NHS-funded care settings and commissioning organisations. The Trust is fully compliant with all elements of the SAAF, and assurance audits are completed by the Head of Safeguarding biannually through NHS England.

4.0 Adult Safeguarding

4.1 Over the past 12 months, staff formally submitted safeguarding concerns for 120 individuals using our services. The majority of these were not escalated to full safeguarding investigations but were instead signposted to other appropriate services. There have been numerous enquires that were received via email and or telephone referral.

4.2 There were 5 official concerns raised in relation to Dorset County Hospital Foundation Trust by external agencies. All of these were investigated through a nominated enquire process and did not proceed through to a full safeguarding investigation. As in previous years the main issues highlighted were communication with partner agencies, safe discharge planning and safe transfer into community services. All findings and learning actions are communicated to the department where the incident occurred for learning. Ongoing work to align with Patient Safety Incident Response processes in relation to safeguarding. PSIRF, while focusing on incident response, also plays a crucial role in safeguarding by:

- **Identifying and addressing safety risks:**
- **Supporting compassionate engagement:**
- **Promoting a culture of learning:**

4.4 In addition, the Safeguarding Team recorded from Q2-Q4 over 400 telephone advice calls. Advice through emails was not collated through 2024-2025.

Common themes included discharge planning, safety netting, and mental capacity advice.

4.5 There were no referrals to the Prevent Programme for radicalisation during 2024 – 2025. Data was submitted quarterly through the National NHS Data Collections Portal.

4.6 There were no external investigations by Dorset County Council under Adult Safeguarding Procedures during 2023–2024.

4.7 There were no cases of Modern Slavery requiring referral through the National Referral Mechanism.

5.0 Children's Safeguarding Activity

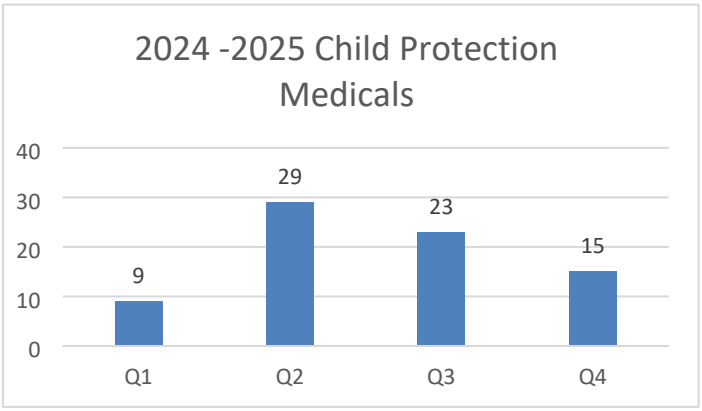
5.1 The Safeguarding Team at Dorset County Hospital align with the Dorset Council approach to safeguarding with a strength-based approach to managing concerns. This methodology formulates part of the training and supervision offered to staff who are more used to a more protection or paternalistic approach.

5.2 The Safeguarding Team continue to review the Emergency Department records for all 0 – 17-year-olds - 8088 records were reviewed. The Team still cannot review CPIS (National flagging information sharing service through AGYLE or DPR). This means that all CYP hospital number details are manually put in through PAS by the safeguarding practitioners reviewing the ED records.

5.3 Integrated liaison Meeting The purpose of this weekly multidisciplinary meeting is to review children and young people who have used our services. The Safeguarding Team in conjunction with Kingfisher Ward/Liaison Psychiatry/ED and Paediatricians review on a weekly basis through the Integrated Liaison meeting any children that have a mental health diagnosis, presented with self-harm and/or a safeguarding concern or a frequent attender to ensure all documentation and processes have been completed. Themes are reviewed and escalated as applicable, learning shared in the departments. Areas of consideration through the past year have included, increasing recognition of children and young people use of ketamine, correct process for reporting dog animal bites , assaults peer on peer, places & spaces where children may be subject to risks of exploitation and adherence to the non-mobile child pathway should they present with an injury. An increased focus has been on adults who attend themselves in crisis either through worsening mental health and or addiction issues and the effects these behaviours may have on those that they care for or have parental responsibility for.

ILM ToR revised 2024_.doc

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



The above graphical illustration shows the contacts that the Safeguarding Team have been advised of, due to the nature of the front door service DCH staff may contact for advice, referral or signposting. On review of the statistics there has been a significant increase in referrals made for adults attending our services that staff have raised concerns regarding their children.

5.5 Extra Familial Harm (EFHR) responses to children experiencing exploitation continues to develop at pace and DCH are working with partner agencies to align processes share information and ensure children in Dorset are offered a level of multiagency protection. The Trust EFHR policy has been updated, attendance at the Dorset wide EFHR strategic group by head of safeguarding, whilst the safeguarding practitioner attends the weekly EFHR panel meetings. A hospital alert is added to the records of those children who have been considered, most at risk of exploitation, at the EFHR multiagency panel.

6.0 Multi Agency Working / Serious Case Review

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

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

6.3 DCH have successfully delivered on their duties during 2024 - 2025 and there have not been any concerns raised regarding the overarching governance, processes, or practice at the Trust.

6.4 Both Adult and Children's Safeguarding Boards/Partnerships are required to undertake when a child or adult dies or is seriously harmed because of abuse or neglect a review A review may be conducted to identify ways that professionals and organisations can improve the way they work together to safeguard children and prevent similar incidents from occurring. DCH requested consideration of a case for review that was accepted for a learning circle review. This was successful in highlighting the issues of disguised compliance, appropriateness of kinship relationships and or the ability of the kinship to meet the needs of the child. This case also highlighted the need for improvements in recognition of systematic neglect.

6.5 DCH have participated actively over the past 12 months, in domestic homicide reviews, Safeguarding Adults reviews, Child Safeguarding practice reviews, multi-agency partnership audits, child death reviews and learning disability mortality reviews.

Learning actions are disseminated through the Safeguarding Committee, training programmes and formulate part of the safeguarding quality improvement programme.

6.6 During 2024 - 2025 the Heads of Safeguarding across the health system have met to review quality improvements collectively, areas reviewed have included managing allegations, review of impact on drugs and alcohol referral services, planned review of all learning actions from serious case reviews that required health implementation of actions.

7.0 Training

7.1 DCH services are expected to have a 90% compliance rate with most safeguarding programmes (Prevent is lower at 85%). Discussions have been had throughout the past 12 months at the Safeguarding Committee due to the drop in compliance & action plans have been formulated within the Divisions.

7.2 Whole Trust Safeguarding Compliance:

Competence Name	Compliance %
NHS|CSTF| Preventing Radicalisation - Basic Prevent Awareness - 3 Years|	90%
NHS|CSTF |Preventing Radicalisation - Prevent Awareness - 3 Years|	84%
NHS|CSTF| Preventing Radicalisation - Prevent Awareness - No Specified Renewal|	95%
NHS|CSTF| Safeguarding Adults - Level 1 - 3 Years|	88%
NHS|CSTF| Safeguarding Adults - Level 2 - 3 Years|	86%
NHS|CSTF| Safeguarding Children - Level 1 - 3 Years|	87%
NHS|CSTF |Safeguarding Children - Level 2 - 3 Years|	87%
NHS|CSTF |Safeguarding Children - Level 3 - 3 Years|	77%
NHS|MAND| Deprivation of Liberty Safeguards - 3 Years|	87%
NHS|MAND |Deprivation of Liberty Safeguards - Level 2 - 3 Years|	78%
NHS|MAND |Mental Capacity Act - 3 Years|	87%
NHS|MAND |Mental Capacity Act Level 2 - 3 Years|	78%
NHS|MAND |The Oliver McGowan Mandatory Training on Learning Disability and Autism Part 1 E-learning|	89%

7.3 *Collaboration with Dorset Healthcare* (2024-2025) Throughout 2024 and into 2025, meetings with Dorset healthcare have been held to align compliance, share resources and make the most of joint training opportunities. These collaborative efforts will continue in 2025 with the goal of developing a shared training strategy.

7.4 Level *3 Adult Safeguarding Training* Progress in delivering level 3 adult safeguarding training has been hindered by technical issues particularly with integrating the digital interface and linking with the national platform. it is anticipated that the education team will resolve these challenges during 2025.

7.5 *Level 3 Children's Safeguarding Training*. A new interactive face to face full day training programme has been initiated that aligns with the Dorset Children's Partnership key priorities and addresses local concerns for our communities. The feedback thus far has been extremely positive.

8.0 SUPERVISION

8.1 The provision of Safeguarding children supervision is important, in order to contain the emotional impact of safeguarding work, for our staff and to ensure achievement of the best possible outcomes for children and families. Supervision also ensures that the process of resolution / escalation is undertaken when progress for children is not being met.

8.2 Twenty-five formal group reflective sessions have been facilitated during this year with teams who manage Paediatric caseloads: Diabetes, Epilepsy, Community Nursing, Allied Therapists, Dietetics and Chronic Fatigue. Sessions have also been held with Emergency department safeguarding nurse, SCBU safeguarding lead and on Kingfisher update days. Themes of supervision: Consent, neglect of health needs and home conditions, parental engagement, disguised compliance and how to manage cases when progress or drift is evident. Supervision and guidance are also sought from paediatricians when dealing with medical neglect.

8.3 We also provide guidance and management daily by attending the children ward handovers and responding to requests for support from telephone and emails from across all services in DCH. Our staff are increasingly managing cases with high level of complex social needs, in additional to clinical care needs, this is increasing with the new pathfinder pilot at Dorset Council Children Services. Support is given to staff when chairing or attending Team Around the Family meetings (TAF) Child In Need meeting (CiN) Child Protection Conferences (CP). Guidance and support is given to ward nursing teams when children have been admitted for Non accidental injury investigations.

9.0 Maternity

Maternity have had two referrals for FGM over the previous year, one Type 1 and one Type 2 and appropriate pathways and discussions were undertaken.

9.1 In the previous year, Maternity received ten Concealed, Denied or Late Presentation of pregnancy. Of these ten 3 were supported by Children's Social Care at Child Protection Level and one baby had sadly demised. Maternity's Safety Team conducted an investigation and external safeguarding partners were invited to share learning from the incident.

9.2 In line with the work being undertaken to develop a Compassionate Pathway for Baby Loss by Removal, Maternity have been funded and provided with several HOPE (Hold On Pain Eases) boxes, which have been designed and the contents chosen by a group of women with lived experience of separation at birth. HOPE boxes are an intervention designed to minimise the trauma experienced by the mother and baby, by supporting them through making memories, allowing connection whilst awaiting decisions re the long-term plan for the baby and to support loss and grief. Funding has also been secured to provide the training of three Maternity staff members to utilise the HOPE boxes to their full potential.

9.3 Maternity recognises that continuity of allocated Midwife for antenatal and postnatal care should be of great support to families, ensuring that they have additional time, increased visits if required and ensure that reports are completed in a timely manner and attendance at meetings.

10.0 Mental Capacity Act and Deprivation of Liberty Safeguards

10.1 The LD and MCA Lead and wider Safeguarding Team have continued to provide advice and support to staff around the application of the MCA in practice. This includes ward-based coaching and support. The MCA training offer for level 1 and 2 has been reviewed and work is ongoing to co-produce the revised modules with Dorset healthcare, ensuring MCA training between the 2 Trusts is aligned.

10.2 An MCA subgroup of the Pan Dorset Safeguarding Adults Board was created with a view to furthering assurance of the appropriate application of the Mental Capacity Act across the system partners. Work includes sharing learning where the application of MCA is highlighted within Safeguarding Adult Reviews; working with system partners to create and share learning resources.

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

10.4 There have been a total of 1010 Deprivation of Liberty Safeguards (DoLs) applications in the reporting period; this is a significant increase from 859 in 2023 – 2024.

11.0 Domestic Abuse

11.1 Throughout 2024 - 2025 Dorset County Hospital NHS Foundation Trust should have been supported through the Commissioned Paragon Health Domestic Abuse Advocate, unfortunately due to protracted absence the support has not been sufficient to meet the full service. No bespoke training has been available, and support has been only through telephone support from the Advocates at University Hospital Dorset.

11.2 There has been a significant rise in contacts and referrals through to domestic violence pathways during 2024 – 2025 with more referrals placed for older adults, children who may have been victims and woman who are pregnant.

11.3 The Domestic violence policy for employees has been refreshed to align with changes to the Domestic Abuse bill.

11.4 Sexual violence and sexual safety have been key priorities for DCH this year after the launch Sexual Safety Toolkit & sexual safety policy. The Safeguarding team have

aided and supported the production of the documents.

12.0 Learning Disability

12.1 DCH submitted data to the NHS I E Learning Disability Benchmarking exercise 2024 - 2025

The standards focus on 5 areas:

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

12.2 The Trust continues to notify the LeDeR (learning from lives and deaths of people with a learning disability & or autistic) programme of any deaths of people with a learning disability or Autism. Any learning from the reviews relevant to areas in the Trust is shared with the Divisions and via the Mental Health and Learning Disability Steering Group. Recently the LeDeR process has been aligned to the PSIRF programme.

12.3 The LD and MCA Lead has worked with the Clinical lead in Community LD team and DCH Business Intelligence team to explore whey people with a learning disability do not attend appointments. This work is ongoing.

12.4 Oliver McGowan Mandatory Training for learning disabilities and autism. DCH is now rolling out face to face training for the Tier 2, level 2 training in collaboration with Dorset healthcare.

12.5 With funding from the Mazars Charitable Trust, 4 Virtual Tours were Co created with Pageant productions alongside with people with a learning disability who are part of the Pageant productions Film club. These are to help people understand what to expect when coming into hospital. How to get here, car parking; coming into the emergency department; coming for an outpatient's appointment and coming in for surgery. These can be viewed using the QR code below.

13.0 Safeguarding Incidents Involving Staff

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

13.2 Changes have been implemented to the employment review process where scrutiny by Head of Safeguarding and Head of People Services will consider the suitability, or any foreseen transferable risks should any historical concerns or convictions appear within the pre-employment disclosure.

14.0 Audit / Quality Assurance

14.1 Peer review meetings held monthly to review all child protection medicals, this is a multi- disciplinary meeting, that children social care also participate in.

14.2 Dorset Safeguarding Children's Partnership (Dorset) & BCPDSAB audit programme contributions made throughout 2024 - 2025.This has included domestic abuse.

14.3 NHS Dorset managing allegations rolling audit.

14.4 Six monthly Safeguarding assurance audit

14.5 NHS England Safeguarding Collaborative Assurance Template (SCAT) audit which currently six monthly aligns with Safeguarding accountability and assurance framework

14.6 Prevent data submissions through NHS England applications, quarterly reports.

14.7 Internal deep dive in Q2 to review application of paediatric Safeguarding checks within the Emergency department.

14.8 Integrated Liaison meeting reports quarterly through Safeguarding Committee.

14.9 Audit 6120 report

Audit 6120 report.docx

14.10 Internal / External Cultural Maturity Review for Safeguarding

14.11 Agreed Clinical Audit for `was not brought` to be completed Q2 2025.

15.0 Risk

Managed / Tolerated Risks

ID	Care Group	Local Manager	Opened	Title	Risk level (current)	Previous Risk level	Risk level Target	Risk level
1927	Radiology	Julia Morris	01/08/2024	Paediatric Reporting of diagnostic images – lack of capacity	Moderate risk	High	Very low risk	Corporate
2163	Family Services	Sarah Cake	06/05/2025	Failure to achieve safeguarding training compliance	Moderate Risk		Low risk	Services specific
2163	Family Services	Sarah Cake	03/04/2025	Named Doctor for Paediatric Safeguarding PA	Low Risk		Low risk	Service Specific

Active Risks

ID	Care Group	Local Manager	Opened	Title	Risk level (current)	Previous Risk level	Risk level Target	Risk level
1099	Chief Information Officer	Chloe Coward	13/05/2021	Recording of carers or parental responsibility on electronic systems	Moderate risk	High Risk	Low	Division
1632	Chief Nursing Officer	Sarah Cake	25/04/2023	Level 3 training children compliance	Moderate risk	Low Risk	Low	Division
1097	Chief Nursing Officer	Sarah Cake	13/05/2021	CPIS child protection information sharing	Moderate risk	High Risk	Low	Division

16.0 Other Activities

Safeguarding Team fully established, dynamic recruitment considering the needs of the service.

Review and creation of an interactive bespoke face to face training package for Level 3 Safeguarding Children.

Both intranet sites for Safeguarding have been updated and refreshed.

Six monthly Safeguarding Newsletters shared with all employees at DCH.

Improvements to recording Safeguarding within the DPR system.

Four virtual tour films.

Refreshed Integrated liaison meeting criteria and purpose.

Learning Circle agreed and held after DCH request to Pan Dorset Safeguarding Partnership key area of concerns, neglect, poor multi agency oversight and disguised compliance.

Published new Extra Familial Harm Policy.

Published new all age` Was Not Brought Policy`.

Reviewed and updated to a policy support for employees who may be victim of domestic violence.

Assisted with Sexual Safety Policy, guidance and establishing reporting mechanisms.

Participation with partners in initiating Families First for Children (Pathfinder) this is the name the governmental reform to redesign and implement some of the most significant improvements to children's services.

Patient specific facilitation to access to DCH services for those with complex learning disabilities and or autism.

Learning disability advocates network established across the Trust.

Aided within the Wayfinders programme to improve hospital navigational and accessibility.

1. Recommendations

1.1. The Board / Committee is recommended to:

a. Receive the report for **assurance.**

Name and Title of Author: Sarah Cake
Date: 19/06/2025

Appendices

1. **SAFEGUARDING DORSET COUNTY HOSPITAL Quality Improvement Plan 2025-2027**

Safeguarding Quality Improvement Programme 2025 – 2027

Introduction

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

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

The Trust in its Strategic objectives reflects the principle that all people coming into our care require safe, effective personalised high-quality care and will fulfil its duties in regard to Safeguarding requirements. These are outlined in Working Together to Safeguard Children (2023), The Children's Act (2004), The Care Act (2014) and are set out in the Care Quality Commission fundamental standards. This enables us to provide assurance that the safeguarding provision at DCH is robust, fit for purpose and it can be demonstrated that Safeguarding is `Everybody's Business`.

What is Safeguarding?

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

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

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

Legislation for all

- The Crime and Disorder Act 1998
- Female Genital Mutilation Act 2003
- Sexual Offences Act 2003
- Mental Capacity Act 2005
- UN Convention on the Rights of Persons with Disabilities 2006
- Mental Health Act 2007
- Children and Families Act 2014
- Modern Slavery Act 2015

- Serious Crime Act 2015
- Mental Capacity (Amendment) Act 2019
- NHS Constitution and Values (updated Jan 2021)
- Domestic Abuse Act 2021
- Serious Violence Duty 2023
- Prevent Duty 2023

Safeguarding children and young people

- United Nations Convention on the Rights of the Child 1989
- Children Act 1989 and Children Act 2004
- Promoting the Health of Looked After Children Statutory Guidance 2015
- Children and Social Work Act 2017
- Working Together to Safeguarding Children 2023
- Children Social Care Reforms
- Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff 2019 (under review)
- Looked After Children: Roles and Competencies of healthcare staff 2020 (under review)
-

Safeguarding adults

- European Convention on Human Rights
- The Care Act 2014
- Care and Support Statutory Guidance- Section 14 Safeguarding
- Adult Safeguarding; Roles and Competencies for Health care staff 2024

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

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

Key Objectives

Objective 1 – Safeguarding patients that we care for:

We will do this by:

- Provide services that protect individual human right and effectively safeguard against abuse, neglect, discrimination, or poor treatment.
- Demonstrate that appropriate systems and processes are in place to discharge statutory duties in terms of safeguarding children and adults.
- Ensuring that we meet the organisation, legal and strategic responsibility under the Children Act and CQC fundamental standards.
- Ensuring we meet the organisation legal and strategic responsibility under the Care Act, Human Rights Act, Mental Capacity Act and CQC fundamental standards.

- We will support all our team members recognising the emotional impact of our work.
- Ensure that staff at all levels are provided with evidence based safeguarding training commensurate with their role.
- We will provide guidelines and policies for staff to fulfil their safeguarding responsibilities.
- We will share learning from reviews and incidents, to improve future outcomes, through changes to practice.
- Ensure that the voice of the child, young person or adult is captured wherever appropriate to improve and better measure outcome and benefits as perceived by individuals.

Objective 2 –

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

We will do this by:

- Maintaining compliance with CQC regulations for the essential standards for quality and safety.
- Review and monitor the application of the Mental Capacity Act/ Review and monitor the applications for Deprivation of Liberty safeguards.
- Review and monitor the documentation of safeguarding through the variety of patient systems to ensure clear concise patient focused documentation.
- Publishing an annual report and biannual improvement plan for Safeguarding.
- Participation in Section 11 audit.

- Assurance https://www.england.nhs.uk/wp-content/uploads/2015/07/B0818_Safeguarding-children-young-people-and-adults-at-risk-in-the-NHS-Safeguarding-accountability-and-assuran.pdf

- Safeguarding supervision for staff groups.

- Improve engagement with people using our services and hear their voices.

Quality Improvement Plan

Identified improvement area	Desired Outcome	Actions	Evidence/ Assurance	Lead/ responsibility	Target Date for completion	Update	Rag
Sharing of information and learning with frontline staff to inform day to day practice	Learning identified from Safeguarding Adult Reviews, Children's safeguarding practice reviews, maternity reviews, 'learning from lives and deaths' is shared with frontline staff	6 monthly updates via newsletter- shared via Trust comms and through Governance Structures. Implement specific learning for individual areas where actions are required .	Update/ newsletter document Minutes of governance meetings- such as Safeguarding Committee/ Mental Health and LD Steering group/ HMG/ Quality Managers	Whole safeguarding team	August 2025 February 2026		
Limited direct feedback from people with a learning disability	To gain patient feedback from people with a	Joint working with community LD team and DCH	Collated feedback to be shared at Patient	LD and MCA Lead	December 2025		

who have accessed DCH services	learning disability	engagement team to create engagement activity/s to elicit feedback	Experience Group/ LD and MH Steering Group	Acute Health Facilitator PWLD/ Autism			
Children with disability placed within residential schools in Dorset who access DCH are not flagged and so not immediately obvious to staff that reasonable adjustments may need to be made.	CYP are flagged (with consent) and reasonable adjustments are made	Contact Specialist residential Schools, asking them to ask parents/ those with parental responsibility if CYP can be flagged on our system (letter with poster)	Increase in numbers of CYP flagged on PAS	LD and MCA Lead- in collaboration with Community Paediatricians	September 2025		
Reducing DNA/ WNB rate for people with a learning disability	Reduced DNA/ WNB for people with a learning disability	Continued joint working with DHC as well as access team Participate in WNB/ DNA audit for pwld/ children	Feedback from DNA project Outcome of DNA/ WNB audit	LD and MCA lead	March 2026		
Improve the recognition and referral through to support services for victims & or children who are	Quantitative & qualitative data indicating correct process undertaken to ensure safety	Review current provision Consider supplementary support for specific teams,		Whole TEAM	March 2026		

subject to domestic violence. Victims in their own right ;Babies, children and young people's April 2025	planning for victims of domestic abuse	to enhance knowledge base Review of training Increase awareness of National VAWG . This is also a DSCP partnership objective Update DV policy for employees					
Review of sexual safety for those using our services	Update and strengthen policy . Data collection of incidents through Risk monitoring and audit against policy			Head of Safeguarding	March 2026		
Pathfinder progression of National Rollout to align with changes to working together 2023 & new **Children`s Wellbeing and School Bill**	Align our processes and timeframes for ICPC/ RCPC reports and monitor Consideration of new wasys of sharing information			Safeguarding team	March 2026		

Report to	DCH Board of Directors	
Date of Meeting	12 August 2025	
Report Title	**Infection Prevention Management Annual Report 2024-2025**	
Prepared By	Emma Karamadoukis, Infection Prevention Management Lead Specialist Nurse.	
Approved by Accountable Executive	Dawn Dawson, Chief Nursing Officer.	
Previously Considered By	Quality Committee 29 July 2025 Quality Governance Group 16 July 2025 Infection Prevention Management Committee 30 May 2025	
Action Required	**Approval**	No
	Assurance	Yes
	Information	Yes

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	*SR1 Quality and Safety*	
Financial	No implication	
Statutory & Regulatory	Health and Social Care Act (2008) – Code of Practice on the Prevention and Control of infections and related guidance, which was a last updated in December 2022.	
Equality, Diversity & Inclusion	No implication	
Co-production & Partnership	No implication	

Executive Summary

As part of the assurance required for Trust Board an annual Infection Prevention Management report is required. This meets the national requirements set via Health and Social Care Act (2008) – Code of Practice on the Prevention and Control of infections NICE, NHSE.

The purpose of the report is to provide assurance that the trust remains compliant with the Health and Social Care Act (2008) – Code of Practice on the Prevention and Control of infections and related guidance Department of Health, 2015. The code sets out 10 criterion which are listed in the contents and the report uses these criterions as a guide to provide evidence and assurance.

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

For noting:

2024 - 2025 was another successful year, meeting key standards and regulatory requirements for IPM. Below documents a highlight for the IPM year: -

- The Trust cases for MRSA Blood Stream Infection (BSI) rates remain low, MSSA BSI rates have significantly dropped this year and are at their lowest rate for the past five years.

- Gram-negative Blood Stream Infection (GNBSI) rates for E Coli and Klebsiella are at the lowest rate for the last 3 years and within the agreed trajectory level set by NHS England.

- Gram-negative Blood Stream Infection (GNBSI) rates for Pseudomonas aeruginosa cases are slightly above the trajectory level set by NHS England. Although, it should be noted the trajectory case rate is set at a very low level of three cases.

- Clostridioides difficile infection rates are slightly over trajectory for 2024-2025. UK Health Security Agency has stood up a National Incident response due to the increase in Clostridioides Difficile infections in England. The response is likely to lead to additional epidemiological and microbiological investigations, these will provide better understanding of the recent increases and help target control measures and mitigations.

- The yearly IPM optimisation plan is developed closely with the completion of the new National Infection Prevention and Control Board Assurance Framework, which was launched by NHS England in March 2023.

- The IPM Patient safety Incident Response Framework (PSIRF) has now been implemented for over a year. The framework allows all cases to reviewed by experts, thematic learning identified, and actions formulated.

- The Trust continued to follow, review and develop the trust winter plan. The winter plan is supported by ED and Paediatric point of care testing helping to reduce the incidence of nosocomial infection and outbreaks.

- Trust Hand hygiene compliance has remained high and sustained at 99%.

- The trust continued to meet mandatory requirements for Surgical Site Surveillance (SSI) for elective hip replacement and breast surgery.

- The Sterile Services department continues to maintain a full Quality Management System and maintain certification to BS EN ISO 13485:2016. The department is also registered with the Medicines and Healthcare products Regulatory Agency (MHRA).

- The IPM team have launched the IPM Education Framework tier 3 training which sets out a vision for the design and delivery of IPM education for our people that supports effective and safe care. We have now performed several training sessions to achieve the IPM education framework - tier 3. The training has a strong Antimicrobial Stewardship (AMS) focus and feedback 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.

- Antimicrobial Stewardship (AMS) has been another key focus for the trust, despite not having had an antimicrobial pharmacist for most of the year. The development of an AMS group with a clear focus towards the newly released governments 2024-2029 UK antimicrobial resistance (AMR) national action plan 'Confronting antimicrobial resistance 2024-2029'. We have now successful appointment a Consultant Pharmacist in a joint post working with University Hospitals Dorset.

- Face to face IPM education and training has continued, combined with an updated IPC e-learning programme. We have increased our face-to-face training within specific departments, especially

when a requirement has been deemed necessary. We have maintained very good compliance with IPM mandatory training.

- Enhanced water monitoring continued to mitigate risk of pseudomonas and legionella in tap water in high-risk areas.
- Trust remains key national benchmark for use of data management system in infection prevention & control (ICNET).

Recommendation

Board are requested to:

- Receive the report for **information**
- Receive the report for **assurance**

Dorset County Hospital
NHS Foundation Trust

2024/2025
Infection Prevention Management Annual Report

Healthier lives Empowered citizens Thriving communities

Contents

Abbreviations

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

EXECTIVE SUMMARY

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

The Director of Nursing – Acute services is the accountable board member responsible for Infection Prevention Management and undertakes the role of the Director of Infection Prevention Management. This year DCHFT Jo Howarth, Director of Nursing – Acute services/Director of Infection Prevention Management, has continued this role. Jo Howarth has a wealth of experience and knowledge within the field of IPM.

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

The yearly IPM Optimisation plan, led by the Infection Prevention Management lead specialist nurse and Infection Prevention Management Team (IPMT), sets clear IPM objectives for the organisation to achieve our new joint strategy. Our vision is for healthier lives, empowered citizens, thriving communities. Our mission is to work in partnership to provide high quality, compassionate services and to nurture an environment where people can be their best. IPM plays a key role in the four strategic objectives: care, communities, colleagues and sustainability. The IPM optimisation plan is developed closely with the completion of the new National Infection Prevention and Control Board Assurance Framework, which was launched in March 2023.

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- Enhanced water monitoring continued to mitigate risk of pseudomonas and legionella in tap water in high-risk areas.

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

INTRODUCTION

The Director for Infection Prevention and Control (DIPC) annual report summarises the work undertaken in the Trust for the period 1st April 2024– 31st March 2025. The Annual Report provides information on the Trust's progress on the strategic arrangements in place to reduce the incidence of Healthcare Associated Infections (HCAI's). The purpose of the report is to provide assurance that the trust remains compliant with the Health and Social Care Act (2008) – Code of Practice on the Prevention and Control of infections and related guidance Department of Health, 2015). The code sets out 10 criterion which are listed in the contents, and the report uses these criterions as a guide to provide evidence and assurance.

The NHS Standard Contract 2024/25 includes quality requirements for NHS trusts and NHS foundation trusts to minimise Clostridioides difficile (C. difficile) and Gram-negative Bloodstream Infections (GNBSIs) rates to threshold levels set by NHS England. These requirements support the delivery of the Antimicrobial Resistance (AMR) National Action Plan (NAP) 2024-2029 which includes a target to prevent any increase in all GNBSIs from the 2019/20 baseline by 2029 and is not limited only to Healthcare-Associated infections. The aging profile of the population between now and 2029 means that this in reality represents a 17% reduction in underlying trends. This is a crude estimate based on modelling of estimated population data, against 2019/20 GNBSI rates. The NAP also includes a target to prevent any increase in a specified set of drug-resistant infections in humans from the 2019/20 baseline by 2029.

The 2024/25 NHS Priorities and Operational Planning Guidance states that: 'Systems are being asked to sustain efforts to combat antimicrobial resistance (AMR) in line with the UK 20-year vision for effective containment, control, and mitigation of AMR, particularly concerning reducing the proportion of antibiotics used from the World Health Organization watch and reserve categories. Effective approaches to healthcare-associated infections (HCAIs) will support both addressing AMR overall and the use of Watch and Reserve antibiotics.

While not part of the Standard Contract requirements, as in previous years, NHS England sets out the thresholds, reflecting that the prevention of infections requires preventative, pathway-based approaches. Having targets within the new NAP focussed upon all GNBSIs, not just healthcare-associated, supports this approach.

The Trust cases for MRSA Blood Stream Infection (BSI) rates remain low with two Hospital Onset Healthcare Associated (HOHA) cases and no Community Onset Healthcare Associated (COHA) cases. MSSA BSI rates have significantly dropped this year and are at their lowest rate for the past five years. Gram-negative Blood Stream Infection (GNBSI) rates for E Coli and Klebsiella are at their lowest rate for the last three years and within the agreed trajectory level set by NHS England. Gram-negative Blood Stream Infection (GNBSI) rates for Pseudomonas aeruginosa cases are slightly above the trajectory level set by NHS England. Although, it should be noted the trajectory case rate is set at a very low level of three cases. Clostridioides difficile infection rates are slightly over trajectory for 2024-2025. UK Health Security Agency has stood up a National Incident response due to the increase in Clostridioides Difficile infections in England. The response is likely to lead to additional epidemiological and microbiological investigations; these will provide better understanding of the recent increases and help target control measures and mitigations.

The Infection Prevention Management team have seen system and partnership working key to supporting the health and safety of the population. We have ensured

continued collaborative working, sharing good practice, offering support where able and championing the benefits of digital support in the management of IPM.

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

Quality improvement requires constant effort to seek, innovate and lead practice. The Infection Prevention Management team epitomizes this quality improvement ethos, and they significantly contribute to achieving our strategic mission, which is to work in partnership to provide high quality, compassionate services and to nurture an environment where people can be their best. Their support for training and engaging with the clinical teams has been of the highest standard, reflective of the care provided and experience by our visiting public.

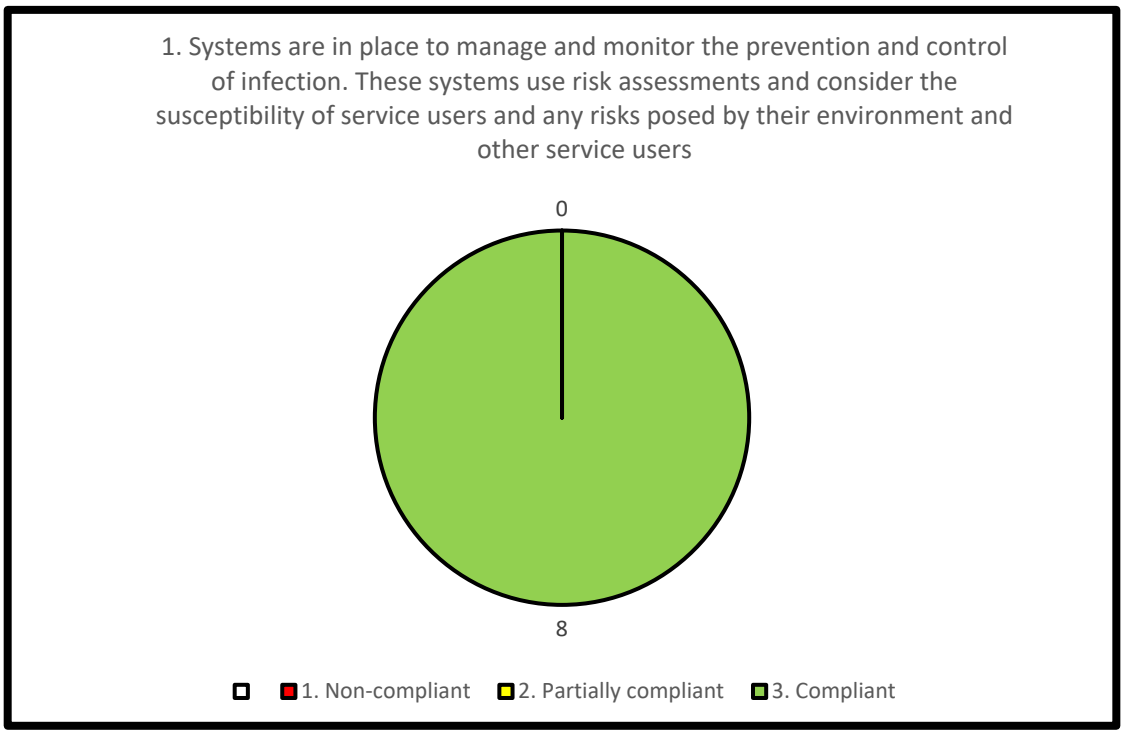
The Health and Social Care Act 2008: code of practice on the practice on the prevention and control of infections and related guidance sets out ten compliance criteria. This IPM Annual Report is divided into these ten-compliance criterion which follow below individually, demonstrating the trust compliance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

Confronting antimicrobial resistance 2024 to 2029

NHS Standard Contract 2024/25: Minimising Clostridioides difficile and Gram-negative bloodstream infections

Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance - GOV.UK

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



INFECTION PREVENTION MANAGEMENT COMMITTEE (IPMC)

The IPM Committee met 6 times during 2024- 2025. It is a requirement of The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections, that all registered providers: "*have in place an agreement within the organisation that outlines its collective responsibility for keeping to a minimum the risks of infection and the general means by which it will prevent and control such risks".*

The IPM Committee (IPMC) meetings have been chaired by Jo Howarth Director of Nursing – Acute services/Director of Infection Prevention and Control (DIPC), with the responsibility for reporting to the sub-board Quality Committee for assurance. (Meeting Chaired occasionally by Louisa Way, Deputy Director of Nursing - Acute services/Deputy Director of Infection Prevention and Control (DDIPC)

DIPC REPORTS TO QUALITY COMMITTEE

DIPC reports to Quality Committee via the Quality Assurance Group.

The DIPC has presented the following items during 2024-2025:

- Monthly Gram-negative Bacteraemia surveillance.
- Monthly *Clostridium difficile* surveillance.
- New emerging themes and IPM actions
- Outbreak and incident reports.
- IPM Escalation reports following bi-monthly IPM committee meetings.

INFECTION PREVENTION MANAGEMENT TEAM

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

- Jo Howarth, Chief Nursing Officer / Director of Infection Prevention and Control
- Emma Hoyle, Associate Director Infection Prevention and Control/Deputy Chief Nursing Officer. Post currently held by Louisa Way as interim.
- Dr Amy Bond, Infection Control Doctor Consultant Microbiologist
- Dr Cathy Jeppesen, Antimicrobial Stewardship (AMS) Doctor and Consultant Microbiologist
- Dr Lucy Cottle, Consultant Microbiologists lead
- Emma Karamadoukis, IPM Lead Specialist Nurse
- Christopher Gover, IPM Specialist Nurse
- Abigail Warne, IPM Specialist Nurse
- Angela Brown, IPM Specialist Nurse
- Helen Hindley, IPM Nurse
- Sophie Lloyd, IPM Nurse
- Sharon Thomas, IPM and Tissue Viability Audit nurse
- Cheryl Heard, Senior Administrator & Fit Mask Co-ordinator
- Darren Wilson, Lead Antimicrobial Pharmacist

The IPM teamwork within the structure of the newly developed IPM optimisation plan, which has been developed alongside the ten criterions. (Appendix A)

IPM Implementation of Patient Safety Incident Response Framework (PSIRF)

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

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

PSRIF

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

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

The IPM team launched the implementation of PSIRF on the 1st of January 2024, and we commenced reviewing our Healthcare Associated Infections (HCAI) differently, working within the framework to identify learning, recurrent themes and improve patient safety. The Root Cause Analysis (RCA) process ceased, and the below organisms are included in our internal PSIRF Programme; Clostridioides Difficile - (HOHA Hospital Onset Healthcare Associated, COHA Community Onset Healthcare Associated), Gram-negative bloodstream infection – (klebsiella spp., pseudomonas aeruginosa, E. coli – HOHA cases), MSSA and MRSA bloodstream infections (HOHA cases). We hold monthly 'learning together' MDT (Multi-Disciplinary Team) meetings to discuss each case that has identified learning following the IPMT/Consultant microbiology after action review. As an IPC ICS (integrated Care system), we also commenced reviewing cases using the PSRIF ideology during our system wide post infection review meetings and cases that trigger an in-depth system wide case review, having triggered a PSII (Patient Safety Incident Investigation) will have an in-depth case review by all

healthcare services involved. Quality improvement projects are then driven following the identified learning and thematic reviews. Escalating concerns via IPMC, PLACE based partnership meetings and Southwest regional meetings.

HEALTHCARE ASSOCIATED INFECTIONS

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

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

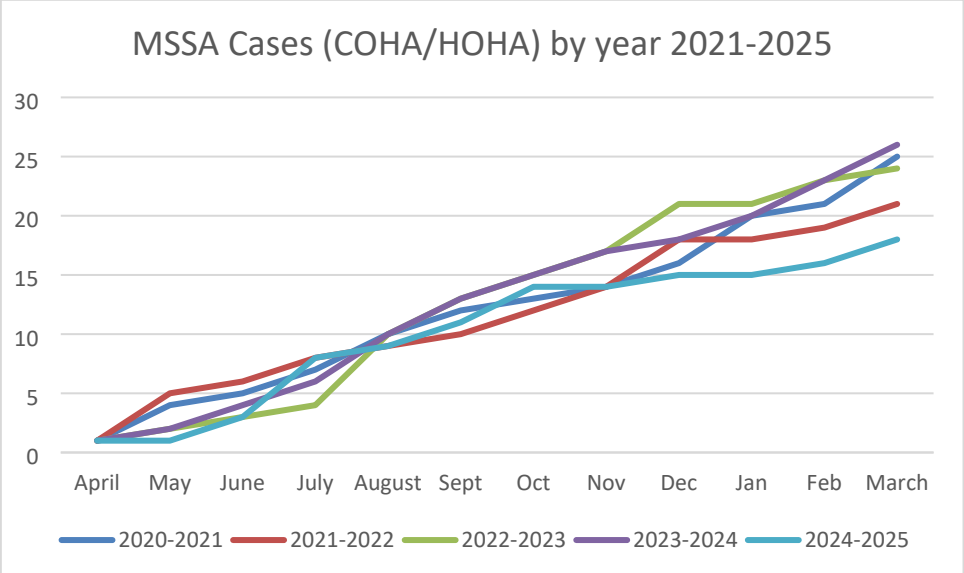
For the purposes of agreed trajectories HOHA and COHA are now combined in reporting.

METICILLIN RESISTANT *STAPHYLOCOCCUS AUREUS* (MRSA)BACTERAEMIA

Following an in-depth case review using the IPM PSIRF process, there were two preventable cases of MRSA bacteraemia in 2024-2025 assigned to the Trust. This provides confidence that the IPM practices in place have been sustained. In 2024-2025 the trust had 2 MRSA Bacteraemia cases in total.

STAPHYLOCOCCUS AUREUS BACTERAEMIA (MSSA)

In 2024-2025 there were a total of 18 cases of MSSA bacteraemia (HOHA and COHA), a reduction year on year for the last 4 years. The previous year we identified 19 HOHA cases, and 10 HOHA cases identified this year (cases detected >48 hours after admission). No national trajectories have been set for these organisms. At DCHFT this demonstrates stability in cases over the last three year and a reduction in HOHA cases.



To manage MSSA blood stream infections we have implemented control measures that include, screening for certain high-risk patient groups, decolonisation of high-risk patients prior to procedures and close monitoring of indwelling devices via audit. All Hospital Onset Healthcare Associated MSSA infections have an in-depth case review using the IPM PSIRF process, with the results and learning feedback to IPM Committee and senior leaders within the trust, quality improvement projects are then driven following these conclusions.

GRAM NEGATIVE BLOOD STREAM INFECTIONS (GNBSI)

In England, the incidence of GNBSIs is projected to increase. As part of the Governments 2024-2029 UK antimicrobial resistance (AMR) national action plan 'Confronting antimicrobial resistance 2024-2029'. One of the targets in this document is by 2029, we aim to prevent any increase in Gram-negative bloodstream infections in humans from 2019-2020 financial year baseline.

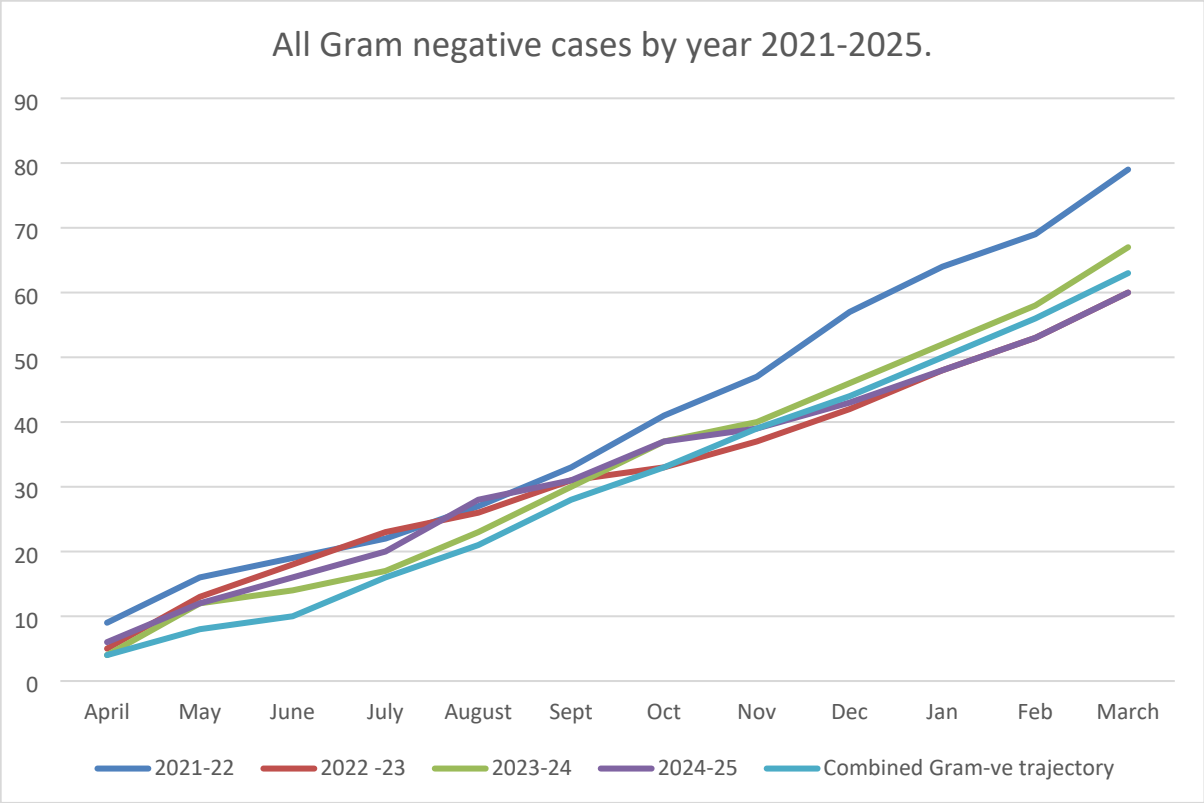
The Gram-negative reportable organisms are *Escherichia coli (E. coli), Pseudomonas aeruginosa (P. aeruginosa)* and *Klebsiella* species (*Klebsiella spp.).*

Mandatory data collection has been in place for many years for E. coli. In addition, from April 2017 additional mandatory data collection and surveillance has been in place for Klebsiella app. and Pseudomonas aeruginosa. The 2024-2025 formal trajectories for gram-negative blood stream infections were set by NHS England at 63 cases (45 Escherichia coli, 3 Pseudomonas aeruginosa and 15 Klebsiella sps). Noting this trajectory is for HOHA and COHA combined. All cases of Gram-negative BSI HOHA cases are reviewed by the IPM team using the IPM PSIRF process. In 2024-2025 a total of 60 HOHA and COHA cases for all Gram-negative reportable organisms - *Escherichia coli (E. coli), Pseudomonas aeruginosa (P. aeruginosa)* and *Klebsiella* species (*Klebsiella spp.).* This is the lowest level for four years.

In 2024-2025 there were a total of 42 positive BSI samples for E. coli which were attributed to the Trust – HOHA & COHA. Noting this is the lowest rate for the last three year. A full data collection process is carried out in accordance with UKHSA guidance; this includes all mandatory and optional data.

In 2024-2025 there were a total of 11 positive BSI samples for Klebsiella, which were attributed to the Trust – HOHA & COHA. Noting again this is the lowest level for the last three years and a significant drop from last year. A full data collection process is carried out in accordance with UKHSA guidance; this includes all mandatory and optional data.

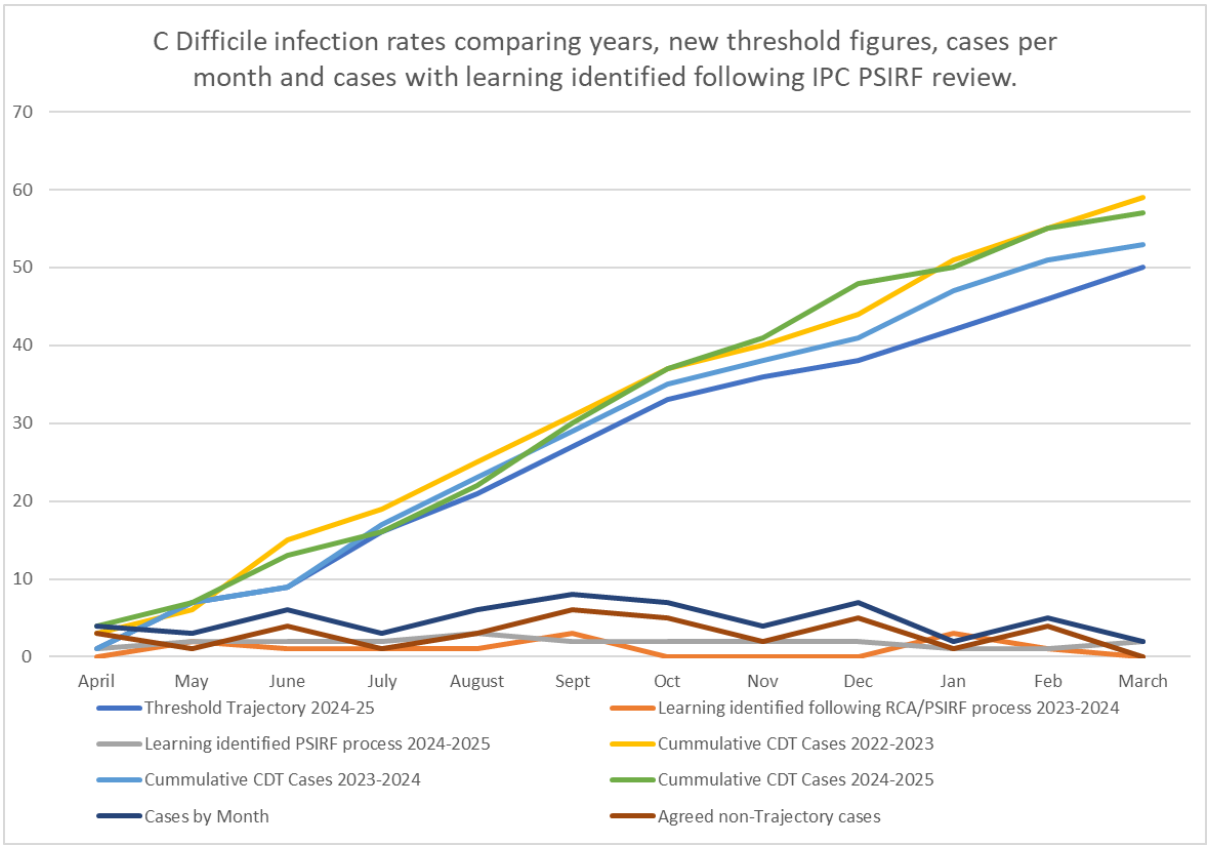
In 2024-2025 there were a total of 7 positive BSI samples for Pseudomonas aeruginosa, which were attributed to the Trust – HOHA & COHA. Noting a slight increase in cases from last year and that our trajectory level is set very low at only 3 cases total per year (HOHA/COHA). A full data collection process is carried out in accordance with UKHSA guidance; this includes all mandatory and optional data.



CLOSTRIDIOIDES DIFFICILE INFECTION (CDI)

In 2024-2025 Clostridioides Difficile infection formal trajectories for were set by NHS England at 50. In total, the trust reported 57 detected HOHA/COHA cases. Of these cases 22 were identified as preventable with lapses in care; and learning implemented trust wide. This data represents a slight increase in total number of cases from 53. UK Health Security Agency has stood up a National Incident response due to the increase in Clostridioides Difficile infections in England. The response is likely to lead to additional epidemiological and microbiological investigations; these will provide better understanding of the recent increases and help target control measures and mitigations.

Consideration is being given to metrics being planned for 2025-26 to include variation in diarrhoeal sampling and CDI testing rates. These will be monitored to understand their effect on surveillance data. To support preparations for this, it is recommended that organisations validate the accuracy of the CDI sample and testing data that they submit on a quarterly basis in 2024–2025.



All cases CDI HOHA and COHA cases have an IPM PSIRF investigation. The results following these investigations are escalated to IPM committee and all the IPM PSIRF learning and actions are presented quarterly to the IPM committee meeting. The thematic process of IPM PSIRF allows the development of wider quality improvement projects. The IPM team and consultant microbiologists have continued a CDI review of all the CDI cases, looking for trends, areas of improvement and emerging themes. In 2023, the IPM team have also completed an extensive collaborative data collection on all Potential CDI and CDI cases. NHS England have used this data to help identify causes for a national increase in CDI cases. The IPM team have continued to ensure the correct use of Peracetic Wipes across the trust, which are to be only used for commode and equipment cleaning within side rooms for patients with known CDI, with the aim to support environmental cleaning for CDI.

The trust declared one Period of Increased Incidence (PII) of CDI in September 2024. All PII CDIs follow national guidance, weekly meetings to review the situation and appropriate actions are taken as necessary. A formal report is produced at the end of the PII CDI, which is escalated to the IPM committee meeting.

OUTBREAKS OF INFECTION

NOROVIRUS

There have been three outbreaks of Norovirus in the reporting year 2024-2025. This is against the backdrop of a large incidence of norovirus within the community across the country. All declared outbreaks follow our trust procedural policy and the IPM lead always carries out a de-brief meeting afterwards, with the senior ward leadership team and escalates learning via IPM Committee meeting. A formal report is produced at the end of any outbreak, which is escalated to the IPM committee meeting. Prompt isolation of symptomatic patients at the front door is greatly assisted by close monitoring and continued risk assessments of the trust isolation cubicles throughout

the day by the IPM team and the use of ICNET (Clinical Surveillance System). This is used by Clinical Site Managers (CSM) team and housekeeping team.

INFLUENZA/RESPIRATORY VIRUSES

During winter of 2024-2025 cases of Influenza A, B & RSV increased over the Christmas and new year period, linking to the national epidemiological data. The identification of these viruses at point of admission into DCHFT has been greatly assisted by point of care testing available in our emergency department and paediatric unit, which has enabled prompt isolation of patients attending for emergency care and subsequent admission and therefore reducing transmission in hospital and the occurrence of outbreaks. This winter we implemented measures to help reduce the spread of infection, such as increasing the use of fluid resistant surgical masks in some areas and extending the staff vaccine campaign. Cohort nursing the same respiratory viruses together improved our isolation capacity and prompt daily reviews and medical de-escalation of cases supported flow within the hospital. We experienced a potential shortage of point of care COVID/Flu/RSV inactivation media due to overwhelming demand and delayed supplier restock due to the Christmas break. Therefore, we moved to a different, more responsive supplier that manufacture locally. In the interim we stood up an enhanced lab-based testing solution to maintain stocks of media in ED and the paediatric ward for overnight testing when the lab was not available. The inactivation media supports effective rapid 24/7 POCT testing in ED and the paediatric ward as part of the DCH Winter Plan. In preparation for 'seasonal flu' all Trust staff were offered the annual flu vaccine.

The 2025 Winter Plan will be updated to include: when the IPM team should cover at weekends taking into account the epidemiological data, continue to recommend suitable cohort areas for respiratory cases across the trust, PPE stocks will continue to be closely monitored linking to the national availability, a detailed plan when to recommend escalation into fluid resistant surgical masks in some areas, and a plan to use a targeted approach for staff vaccinations, including the use of peer vaccinators particularly in areas expected to have high prevalence of Flu and/or covid-19.

Critical Care Carbapenemase Producing Enterobacteriaceae (CPE) Outbreak

We declared a CPE outbreak in our critical care unit in 2024 (lasting four weeks). The outbreak was fully investigated using national guidance, support from other trusts who have experienced a similar outbreak, NHS England and UKHSA. A formal report was produced at the end of the outbreak, which was escalated to the IPM committee meeting and escalated as necessary. Any learning identified has been actioned.

CLINICAL AUDIT

SURGICAL SITE SURVEILLANCE

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

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

SSI for all surgery involves 3 stages of surveillance:
Stage 1- collection of data relating to the surgical procedure and inpatient stay.

Stage 2 (not mandatory) collection of post discharge surveillance at 30 days post procedure.
Stage 3- review of patients readmitted within 365 with SSI.

During 2024-2025 the IPM team have supported 2 modules for surveillance between April 2024 – March 2025. The IPM team facilitate a less time-consuming model of data collection utilising the IPM data tool ICNet. The system facilitates readmission alerts, and data upload from PAS, theatre and microbiology systems and the ability to directly upload the data to PHE SSI site.

January 2024 – March 2025 surveillance.

- Repair of neck of femur data collected between January – March 2024. No SSI's identified during this period. Data not collected since 2020 Q1 and 2020 Q3.

- Knee Replacement data collected between January – March 2024. No SSI's identified during this period. Last 4 periods 2 x all SSI identified = 1.1% SSI rate.

- Elective Hip replacement data collected between October – December 2024. One SSI identified during this period. Last 4 periods 3 x all SSI identified = 1.9% SSI rate.

- All breast surgery data collected between April – June 2024.
  1 x SSI identified during this period = 0.8% SSI rate. Over the last 4 periods 4 x all SSI identified = 1.2% SSI rate, demonstrating an improved percentage. This would coincide with improvements made regarding MRSA/MSSA screening and decolonisation PGD implementation.

PERIPHERAL VENOUS CANNULA (PVC) and CENTRAL VENOUS CATHETER (CV) AUDITS

PVC/CVCs are devices commonly used in acute hospitals for the administration of intravenous fluids and medication. Failure to monitor these devices correctly can result in early signs of infection being missed with the potential for serious infections to develop. The evidence presented in the national guidance suggests a move away from routine PVC replacement to regular review and early removal if signs of infection are evident or when the PVC is no longer required. The IPM team have redesigned the audits this year. The audits are performed monthly, with the aim to provide assurances that the care of these devices correlates to policy. These audits now feed into the ward dashboards and the IPM dashboard, allowing wards to take ownership of their own results. Any learning identified and any escalations feed into divisional meetings and then to IPM committee meeting.

COMPLIANCE WITH URINARY CATHETER POLICY

Insertion of a urinary catheter is known to be a significant risk factor in the development of urinary tract infections and the risk increases with the duration of catheter insertion. It is therefore important to ensure there is a comprehensive process in place to ensure that the risk of urinary tract infection is considered prior to insertion of the urinary catheter and there is a continuous process for review.

The IPM team have redesigned the audits this year. The audits are carried out monthly, with the aim to provide assurances that the care of these devices correlates to policy. These audits now feed into the ward dashboards and the IPM dashboard, allowing wards to take ownership of their own results. Any learning identified and any escalations feed into divisional meetings and then to IPM committee meeting.

CARBAPENEMASE PRODUCING ENTEROBACTERIACEAE AUDIT (CPE)

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

In the UK we have seen a rapid increase in the incidence of infection and colonisation by multi-drug resistant Carbapenemase-producing organisms. A number of clusters and outbreaks have been reported in England during 2024 - 2025, some of which have been contained, providing evidence that, when the appropriate control measures are implemented, these clusters and outbreaks can be managed effectively.

UK Health Security Agency (UKHSA) recommends that as part of the routine admission procedure, all patients should be assessed on admission for Carbapenemase-producing Enterobacteriaceae status. UKHSA advice was updated in September 2022, and we have a dedicated policy for CPE, and it remains that all patients admitted to the trust must have a screening risk assessment carried out on admission.

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

Results show that the overall compliance with undertaking the admission screening risk assessment was 89%. This was the same as last year and the previous year's 81% result, which demonstrates sustained compliance. To demonstrate continued adherence to CPE guidance and Trust policy this audit will be repeated quarterly for 2025-2026.

CANDIDA AURIS SCREENING

Following an outbreak of candida Auris within the region, and new guidance published from the UK Health Security Agency the IPM team reviewed our own internal screening and policy guidance against national recommendations mid-2023, and we have updated the local trust policy. To support the updated guidance, we have improved our own testing availability via our microbiology laboratory and developed a robust screening risk assessment, which now sits alongside our CPE screening triggers. Therefore, the CPE audit noted above also demonstrates our compliance with the trust Candida Auris screening policy for this year.

COVID-19

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

We have declared no Covid-19 outbreaks between April 2024 and March 2025. This is excellent comparing outbreak figures for other inpatient setting in the Southwest region, especially considering the extremely transmissible nature of Covid-19 and increased prevalence in the community. The identification of the symptomatic cases at point of admission into DCHFT has been greatly assisted by point of care testing available in our emergency department and paediatric unit, which has enabled prompt isolation of patients attending for emergency care and subsequent admission and therefore reducing transmission in hospital and the occurrence of outbreaks.

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

STANDARD INFECTION CONTROL PRECAUTIONS MONITORING TOOL

We have rolled out the use of the above-mentioned Standard Infection Control Precautions monitoring tool. Department matrons are requested to complete this tool quarterly.

This Standard Infection Control Precautions (SICPs) monitoring tool has been developed to support implementation of the National Infection Prevention and Control Manual (NIPCM) for England. The monitoring tool is for use by all those involved in care provision in England to provide assurance in NHS settings or settings where NHS services are delivered. This monitoring tool is not compulsory, but as a trust we felt it would be a useful tool to demonstrate and provide assurances of IPM practices. It can be used in place of, or in addition to local tools used by organisations to ensure application of guidelines as set out in the NIPCM for England.

The purpose of this monitoring tool is to support self-assessment of SICPs* and to identify areas:

- of good practice
- for improvement (including providing education and training)
- which require immediate action to improve IPC practice and mitigate risk.

The terms used in this tool has been aligned with the NHSE Board Assurance Framework (BAF) and therefore can also be used to provide evidence to support completion of the BAF.

INFECTION PREVENTION & CONTROL WEEK - OCTOBER 2024

To celebrate 'International Infection Prevention and Control week' on the 14th – 18th October 2024. The IPM team organised a 'Bug Hunt'! Our not-so friendly cartoon bacteria were hiding in plain sight around the hospital. We hope to bring a bit of light-hearted fun whilst also raising awareness of the typical infections we are trying to prevent and treat. The aim of the game is to find as many of these bugs as possible, with the winner (having shown evidence of their 'catches') finding the highest number by the end of the week.

The overall aim is to improve staff knowledge and increase awareness on any IPM practice, we also provided a busy week's agenda, which included daily IPM clinics, rep visits, staff training, and IPM quiz.

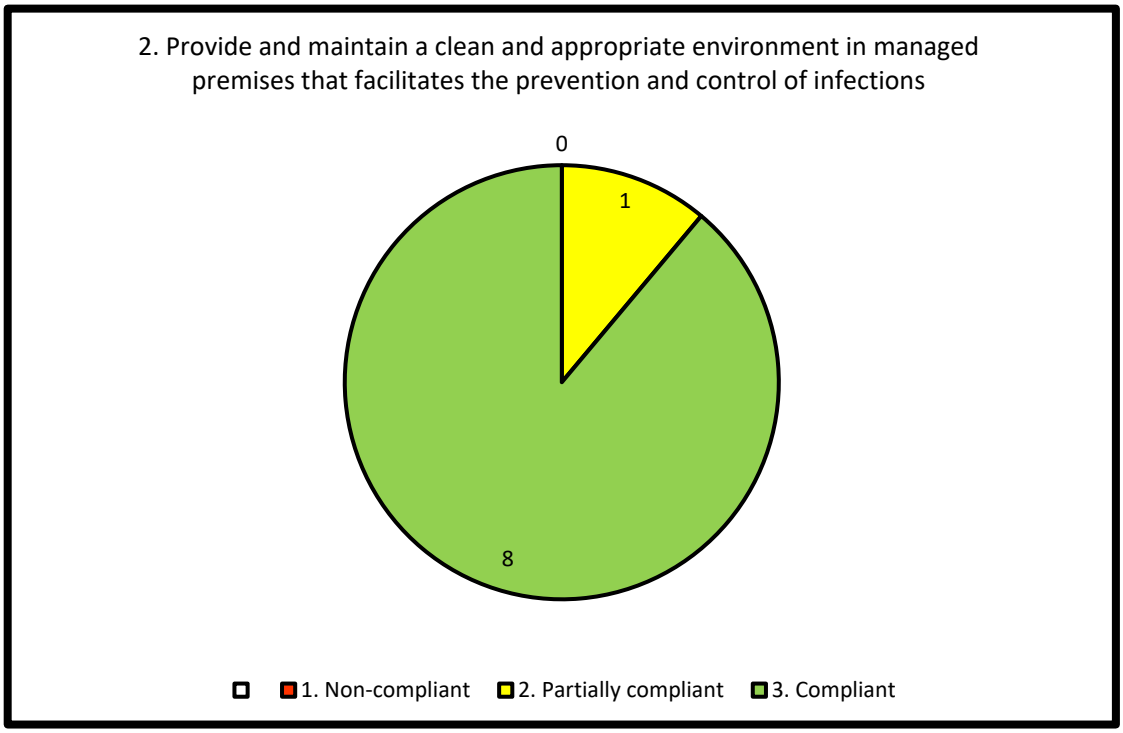
WORLD HAND HYGIENE DAY - May 2024

To celebrate world hand hygiene day the IPM team asked staff trust wide to design a new poster for the Hospital, to promote good hand hygiene. There was an overwhelming response to the competition with so many to judge, it was tough to

decide on a winner as they were all worthy. During the day the IPM team decorated a “test your hand washing skills” trolley, with bacteria bunting and rewards for the “best washed hands”. Travelling through to the wards, we were greeted with an air of trepidation; all professions love the idea of getting a free pen and a sticker to say “well done” but not wanting to show their skills of hand washing! We explained that this is not a finger pointing exercise but a bit of fun just to promote good hand washing. For each contender we explained that the fluorescent powder used will need to be rubbed all over their hands, then they put their skills to the test by washing the powder off, “With soap and water?” one staff member asked! Yes please, washing their hands by giving them a good scrub and drying, hoping for a good result by seeing their efforts pay off. All the wards that took part were fantastic and full of enthusiasm!

The importance of hand hygiene day is to promote reducing the risk of spreading bacteria and viruses that are a cause of some infections that can be serious to health.

CRITERION TWO:
Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.



Partially compliant: 2.9 Food hygiene training is commensurate with the duties of staff as per food hygiene regulations. If food is brought into the care setting by a patient/service user, family/carer, or staff this must be stored in line with food hygiene regulations. Mitigation: Hotel Service Manager will look to increase the monitoring of this, and the possible introduction of a ward hostess service will support this. Update 2024 , several wards now have hostess roles within the wards. Updated 2025 this role is being reviewed.

ESTATES REPORT

VENTILATION – T Markin Electrical & Mechanical Manager

The Estates team continue to carry out routine inspections and maintenance on all ventilation systems and formal validations on all Theatre and Critical Areas in compliance with HTM 03-01 Part B and carrying out remedial work where required.

In the past year 3 new AHU's have been installed, Theatre 8, Ridgeway Ward and the yet to be commissioned Chemotherapy Ward.

Estates have instigated a new AHU service sheet that incorporates a permit to work specifically for critical areas that require an audit trail, this has been approved by the VSG and will be in place until such time as we upgrade our reporting system and start using tablet type devices to enable electronic records

With the exception of the isolation rooms all AHU's that require verification are up to date, the isolation rooms we are hopeful will be verified between 16th & 19th June 2025.

The AP(V) works under the auspices of an AE(V) maintaining the Permit to work system and ensure all statutory and regulatory records are validated. Following changes to the HTM 03-01 all ventilation issues are discussed at the Ventilation Safety Group.

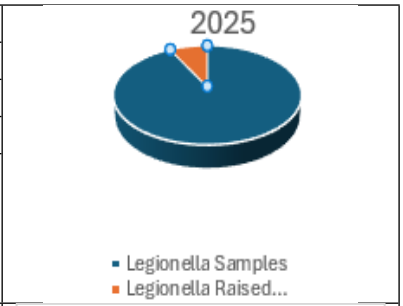
WATER QUALITY- T Markin Electrical & Mechanical Manager

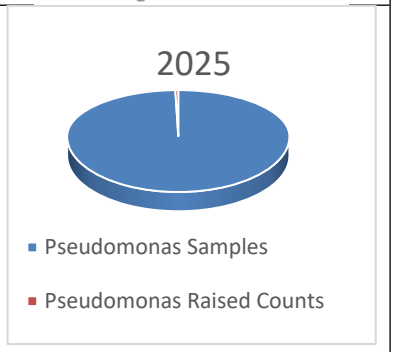
The Estates Team are responsible for maintaining the Trust's water systems, across the main hospital site and satellite properties, and reporting status to the Water Quality Management Group (WQMG) and Infection Prevention Management Committee. Provisions for water safety are independently audited by experts from the Water Hygiene Centre, who provide the Trusts third party Authorised Expert for water safety. Toby Markin is now water RP; Unfortunately, due to a series of events the AP roll remains open however we are hopeful to fill this post within the next 2 months. There are multiple CP's and further training is expected for new starters.

Work is well under way to install a new water main through North Wing and up to the water storage tanks including local connections to various supplies, this was (still is) the most troublesome source of significant leaks with the potential to cause substantial damage, the new pipe line is of stainless steel construction which is considerably more durable that the previous/existing copper pipe, we also took the opportunity to install better quality, thicker insulation making the water system more resilient to temperature fluctuations due to heat gains.
2.Regular sample testing has been maintained in high-risk areas as well as an expanded portfolio of general outlets throughout the Trust along with out by Estates dedicated Operatives delivering an improved scope of sampling.

There have been 175 reactive calls to leaks in the period 01/05/24 – 20/05/2025 of various descriptions, with (approx.) (7.5% or 13 Emergencies/Urgent): (9.5% being out of hours, the remainder were of various descriptions with a lesser significance. This is a significant improvement on the previous year with over 75% reduction in reactive calls for water leaks.

Legionella Samples	2025	611
Legionella Raised Counts	50	8.18%
Legionella Samples	2024	538
Legionella Raised Counts	13	2.40%
At first glance this looks like a significant increase in legionella raised counts, which it is, however 39 of these raised counts are from 8 outlets all of which have been resolved. The 3 raised Pseudomonas raised counts are from the same single outlet and is the only raised count in over 2 years		
Pseudomonas Samples	2025	582
Pseudomonas Raised Counts	3	0.5%
Pseudomonas Samples	2024	511
Pseudomonas Raised Counts	0	0%
3 x POW shower (now Isolated) until infection cleared		





REPLACEMENT FLOOR COVERINGS (Floor Works) DECORATION AND ENVIRONMENT (painting) – A Kersley - compliance and Assets Officer.

The re-flooring and redecoration work that has been done in the last 12 months is below.

Estates Completed 41 calls to flooring works; 29 jobs were completed by contractors.

We have worked closely with two local contractors, Future Flooring & Carpets 2000. Both contractors liaise with clients well & always give a very high standard of work. We seem now to have eliminated most of the carpeted areas in & around the wards & are implementing cap & cove where required to clinical areas, this allows for much better cleaning & less areas to repair moving forward.

Estates have completed 152 painting jobs; however, we have a long way to go & only one painter makes this very difficult.
In the last 12 months the following areas were given full redecorations:

- Children's Centre
- Endoscopy
- ENT
- Dermatology
- Maternity
- Trust H/Q
- Old SECURITY Office
- NW Level 3
- Cardiac Care Ward

CAPITAL WORKS – R Swatton - Estates Capital projects Manager.

Projects 2024/25	Description of works
Fortuneswell Chemotherapy Outpatients	Full strip out and refurbishment. Service decanted for the duration of the works
Surgical Admissions Lounge (SAL)	Conversion of decanted Outpatient Consultation spaces into open plan SAL
Mary Anning - MH Funding	Redecoration and replacement flooring throughout
Sensory Garden	Creation of quiet garden space with seating. Non-clinical but adjacent to Special Care Dentistry and access/egress through Hospital Streets
Colposcopy	Creation of additional Colposcopy Suite, storage room and adaptation of reception
Portesham Unit	Ongoing defect rectification

HIVE Volunteer Hub	Refurbishment of space including; redecoration, partition installation and replacement flooring. Non-clinical but adjacent to main hospital street
Frailty SDEC	Adaptations including additional storage, track adaptation, addition of access control and push button access/egress
Renal	Adaptation of the old Discharge Lounge to allow utilisation as a Renal training room following Renal Pod closure
POW	Adaptations following closure of Renal Pod
Theatre 8	Full strip out and refurbishment to create Theatre, Recovery Room and all further support spaces
Ridgeway	Alteration to ward layout to support ringfencing of bed spaces for Orthopaedic recovery
Roofs	Priority Roof works - full strip and replacement
Chemotherapy Decant Space	Minor refurbishment of 3x rooms to allow for use as Chemotherapy decant space
MDT	Conversion and refurbishment of DTI footprint to form new dedicated MDT space
DTI Offices	Refurbishment and creation of DTI Offices to support decant from MDT space - non-clinical but access/egress via streets
Hospedia Arm Removal	Full removal of TV screens and arms throughout Trust
Junior Doctor's Office	Full refurbishment including redecoration, cooling and flooring replacement
Nurse Call Replacement	Radiology Ilchester Maternity SCBU POW Moreton
6 Facet Survey	Survey throughout Trust - non-intrusive but attending clinical areas

<u>DECONTAMINATION SERVICES REPORT</u> – **Gaurika Kapoor – Service Manager: Theatres, Anaesthetics, CRCU and Decontamination, Fiona Sallows – Assistant Service Manager.**

STERILE SERVICES DEPARTMENT

Quality Management System - Accreditation

The department continues to maintain a full Quality Management System and maintain certification to BS EN ISO 13485:2016. The department is also registered with the Medicines and Healthcare products Regulatory Agency (MHRA).

As a result of Brexit there are some ongoing changes in regulatory requirements. The Medical Device Directive has transferred to the Medical Device Regulation UK MDR 2002 (as amended). Our Notified Body that was based in Sweden as an EU Representative has been transferred successfully after a transitional audit to a UK based competent authority. The Accreditation held by the service continues to give quality assurance on the products and allows the department to provide services for external customers.

External Customers

The department provides a service to various external customers, including Dorset Community Dental Service, DHC Podiatry across Dorset, a local GP practice and the Dorset & Somerset Air Ambulance. Undertaking work for external customers is only possible due to the accreditation achieved by the service. We are looking to potentially increase our external customers for the service to other local GP Practices & Dentists.

Environmental Monitoring

The Clean Room Validation is completed by an accredited external laboratory on a quarterly basis. This consists of:

- Settle Plates
- Contact Plates
- Active Air Samples
- Particle Count
- Water – Total Viable counts (TVC)
- Detergent testing

The laboratory also tests:

- Product bio burden on three washed but unsterile items per machine – Quarterly
- Water Endotoxin - Annually

The latest testing of all areas occurred in February 2025 and the pack room was given a Class 8 clean room status, which is appropriate for the service.

All results are analysed for trends, and corrective actions are undertaken for any areas or items found to be outside of acceptable limits. There are no areas of particular concern currently.

For compliance with HTM 01-01, ProReveal testing is undertaken on a quarterly basis; this involves 50 instruments per washer (200 in total) being tested to detect any residual protein on the instrument surface, after being released from the washer-

disinfector but prior to sterilisation. Results have been in excess of 99% for each test; this gives assurance that the detergent used in each validated washer-disinfector is effective.

Tracking and Traceability

Patient registration by clinical users against sterile items at the point of operation is undertaken in one Theatre and two Outpatient Departments.

Best practice would see this system being used in all patient treatment areas and this has been recommended through the Decontamination Group Meeting; currently there is insufficient funding for the purchase of the necessary scanners and software licences. Patient tracking at the time of use significantly reduces the risk of expired items or used instruments being inadvertently used on a patient.

Shelf-Life Testing

Products that had been packed and sterilised for greater than 365 days (our maximum shelf life) are sent for sterility testing or when a new wrap is introduced. Historical testing has showed 100% sterility which gives assurance that the decontamination process is effective.

Staff Training

All Managers and 80% of our supervisors have achieved qualifications relevant to their role. We had one new Supervisor start in post December 2024 and they are due to complete their qualifications before our full accreditation audit which is due in early 2026. This gives assurance that they have a full understanding of the Decontamination process and can effectively manage SSD on a day-to-day basis.

All members of staff receive training appropriate to the area of production they are working in and are observation-assessed following initial training. Refresher training is repeated for all staff after 3 years of service followed by further observation assessment by a supervisor. No member of staff will work independently without having been assessed as being competent to undertake the role.

Joe Lythe, Deputy Divisional Director of Operations is the Trust's Decontamination Lead.

ENDOSCOPY DECONTAMINATION UNIT

Quality Management System

The department is not accredited for external customers but continues to maintain a full Quality Management System. This service is not registered with the MHRA, as the unit does not have a controlled environment product release area, therefore full registration cannot be achieved; this means that an endoscope reprocessing service cannot be offered to external customers.

Environmental Monitoring

Validation is completed by an accredited external laboratory on a quarterly basis. This consists of:

- Settle Plates
- Contact Plates

- Active Air Samples
- Particle Count
- Water – Total Viable counts (TVC)
- Detergent testing

The laboratory also tests:

- Product bio burden on cleaned endoscopes at point of release from the washer and at 3 hours following release which is the maximum usage period following release – Annually
- Product bio burden on surrogate scopes stored in a drying cabinet for 7 days and at 3 hours following release - Annually.

The latest testing of all areas occurred in February 2025 and the Endoscopy Decontamination clean room was given a Class 8 clean room status, which is appropriate for the service

Tracking and Traceability

Patient registration by clinical users at point of use is undertaken in all 3 treatment rooms in Endoscopy and the Outpatient Urology Suite. This provides accurate traceability of all endoscopes used and significantly reduces the risk of endoscopes that have expired the 3-hour window for being used on a patient.

HOTEL SERVICES REPORT- CLEANING SERVICES - Sarah Jenkins - Hotel services manager.

During the past year the Housekeeping Team have continued to work hard to maintain the cleanliness on both the main Trust site and across the wider estate, coping with the changes and additional clinical areas, both temporary and permanent. Staff shortages at times have led to challenges which the team have overcome, and the recruitment of some new staff will help with the ever-increasing workload.

This would not have been possible without the support we have received from our colleagues across the Trust. The new National Standards of Healthcare Cleanliness 2025, which have been published in the past weeks, reemphasise the importance of cleanliness and this being everyone's responsibility and not just that of the housekeeping team. This supports the multi-disciplinary approach which has been taken for many years, and it is this that helps us maintain our standards across all departments.

Cleanliness

Cleaning services throughout the buildings occupied by the Trust, both on and off the main hospital site, in both clinical and non-clinical areas, are provided by an in-house team of staff supervised through a 24/7 rota by a team of supervisors. This team is augmented by external contractors, managed by the Hotel management team, who undertake the window cleaning and pest control aspects of cleanliness. Both these contracts have been retendered in the last year, and the frequency of external window cleaning has increased to give better assurance.

As far as is practicable staff are allocated to a particular area, giving them a sense of ownership, and belonging to the area as well as continuity in the cleaning regime. The

amount of time allocated daily is determined by the frequency of cleans as outlined in the Standards of Healthcare Cleanliness 2025 and by input from the clinical and housekeeping teams. We continue to review these considering changes to IPM guidance, presence of infection outbreaks and the differing pressures caused by reduced numbers of staff at times of increased sickness. The housekeeping schedules are being reviewed with a view to potential change in light of the new 2025 National Standards.

Standards of cleaning are monitored through the audit process, the frequency of which is determined by the functional risk category assigned in accordance with the national standards, in consultation with our IPM colleagues. The frequency can be changed, for example in a period of increased incidence of infection or when there are other concerns as to the standard in any area. These standards also set a timetable for the rectification of failures based on the risk category. Standards are further monitored through reports received from PALS, the environmental audit process and through PLACE. Feedback is given to staff on the areas from these audits.

Deep Cleaning

The continued pressures on the hospital have meant that the annual deep clean programme has once again been delayed. Whilst we would like to be able to carry out a full deep clean programme, the pressures on the hospital and the lack of space in which to decant patients from wards/ bays means that this is challenging. Along with our IPM colleagues we have identified a priority list which will indicate to us both when a deep clean of a ward / department may be needed and then a plan will be enacted with collaboration with the area concerned and other interested parties. The triggers are:

1. Concerns highlighted at an efficacy audit conducted by a team consisting of a minimum of a representative from estates, one from housekeeping and one from the IPM team.

2. Repeat low environmental audit scores.

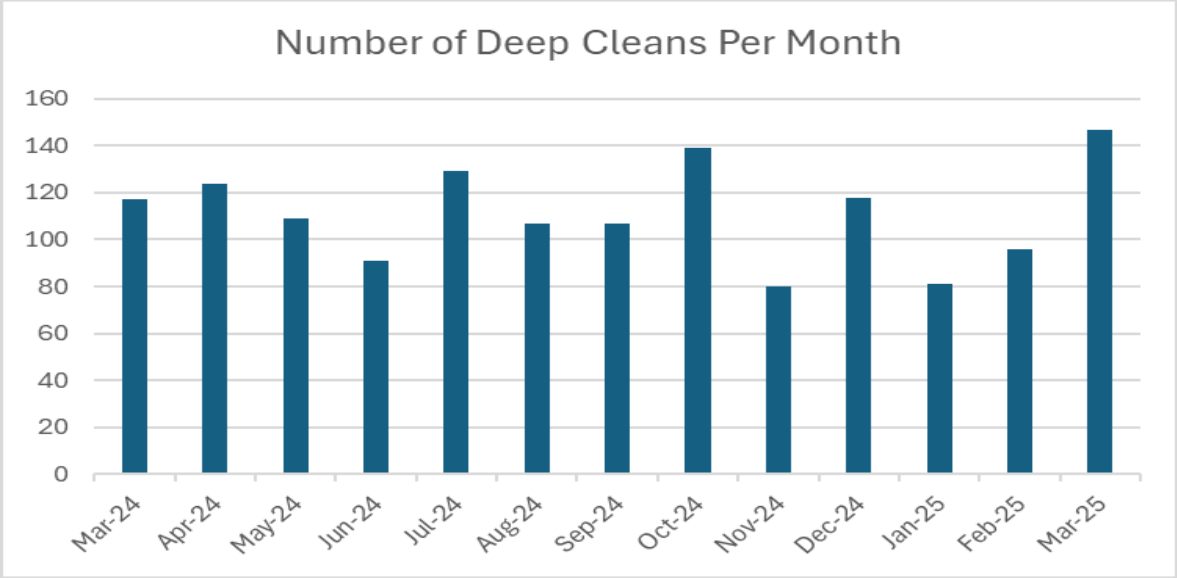
3. Post infection outbreak.

4. Post Period of increase incidence.

5. Following refurbishment or extensive estates works, for example on duct cleans

6. Concerns escalated by matron.

The deep clean process is supported by fogging with a hydrogen peroxide vapour. We have 3 machines which enable us to carry out cleans in a timely manner which will help flow. Training continues to be rolled out to staff across all shifts so that we can carry out deep cleans throughout each 24-hour period, and further training is planned so there should always be someone on site to carry out these cleans. The new machines provide far greater assurance in terms of reporting of itself and in ease of checking that an area has been cleaned and are safer for the operatives, in that the machines are turned on remotely once the operator has sealed the room, the vents and fire alarm sensors are covered without the operator having to use a ladder and reports are generated to confirm successful operation.



Internal Monitoring

The housekeeping team monitor the cleaning standards through audits. The frequency of these audits is dependent on the functional risk categories to which the area is assigned, and these vary from weekly to annually. The timescale for rectification, by the cleaning, estates, and nursing teams, of failures is also dictated by this categorisation and further by the severity of the risk.

Star ratings are being assigned for display instead of the percentage of cleanliness achieved, rated from 5 to 1 star. The percentage needed to achieve the five-star status is also linked to the functional risk category. Should an area receive 3 stars or less than a list of remedial actions is followed to ensure that the area is brought back up to and remains at standard. Our audit software can be used to document action plans and so we will be able to report on the improvement plans as well as the progress of special projects.

The housekeeping supervisors complete the audits on our audit software and on the completion of the audit, the results are emailed to the department leads, the estates team and the Hotel Services management team, leading to greater awareness and more transparency than previously. It is hoped that the rectifications needed by the cleaning team will be immediately sent to either the member of the cleaning team working on the ward or a rapid response team who will help remedy the failings in the department, but staffing shortages have meant there has been a delay in the roll out of new software.

Average Audit Results April 2024- March 2025

FR Rating	Examples of Area	Audit Frequency	Average Score	Target Score
FR1	Theatres, Fortuneswell Ward	Weekly	98%	98%
FR2	General Ward Areas	Monthly	97%	95%
FR3	Radiology	Bimonthly	97%	90%
FR4	General OPDs and Streets	Quarterly	94%	85%

FR5	Medical Physics	Twice Yearly	96%	80%
FR6	ICT	Annually	96%	75%

Efficacy Audits

Efficacy audits are a management tool to provide assurance that the correct cleaning procedures are consistently delivered to satisfy IPM and safety standards. These audits inform the healthcare organisation that correct training, IPM, health and safety, and safe systems of work are being used. We also identify any estates jobs that are required during the audit and monitor standards such as the general appearance of staff and hand hygiene. These audits also focus on the process of cleaning rather than its outcome to ensure that standards are maintained in the process and not just the outcome.

Once a week a team including a member of the IPM team, a representative from estates and one from housekeeping undertake the efficacy audit of all wards and departments across the Trust. All clinical areas have been risk stratified to provide assurance of our process for the schedule of our efficacy audits, but each clinical area is reviewed at least yearly or more frequently if concerns are raised through the processes mentioned within the deep clean plan above.

The results are fed back to the ward lead and matron to acknowledge good practice and address poor service and actions required to drive continuous improvement.

PLACE

We once again carried out a Patient Led Assessment of the Care Environment, (PLACE) in the autumn of 2024.

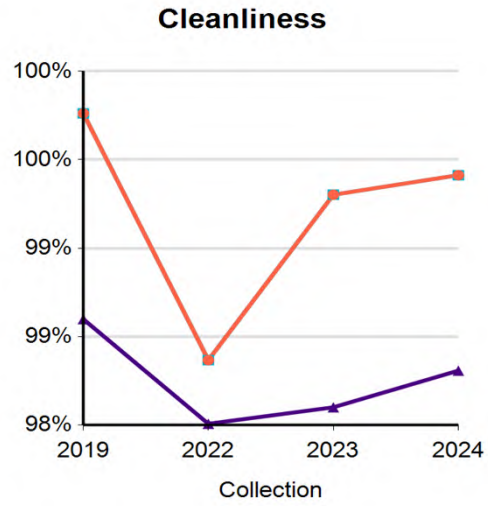
PLACE assessments are an annual appraisal of the non-clinical aspects of healthcare settings, undertaken by teams made up of staff and members of the public, known as patient assessors. The questions are focussed around 6 domains, the relevant ones for this report being the cleanliness and condition of the buildings.

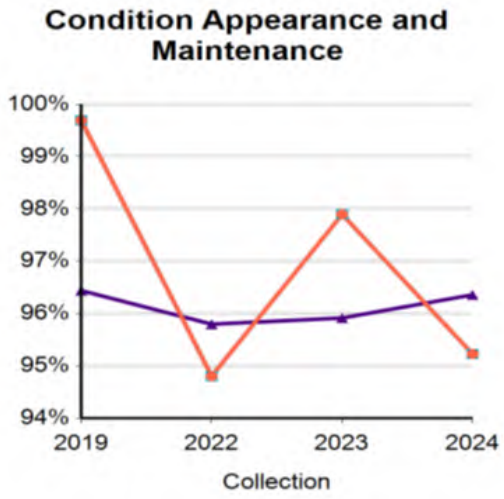
It should be noted that the PLACE findings represent a snapshot of the areas as they were found on the day, and the good scores in these domain areas are a testament to the hard work of the housekeeping and wider estates teams as they strive to maintain the environment with stretched resources. We saw an increase in the cleaning score from the already good result from the previous year but saw a fall in the scores for the condition of the estate, which reflects the increasing maintenance backlog despite the best efforts of the estates team.

The failings identified in the exceptions report form part of a action plan, which is used to inform the estates and facilities departments of areas which require attention and improvement, and some projects are already underway and completed, such as the provision of a new changing places toilet.

We unfortunately have not had the resource this year to carry out any PLACElite audits but hope to hold some in the coming months. These act as a mini-PLACE audit and allow us to see areas in which we have improved and those areas where there is still room for action. We are joined on these by our patient assessors, to give the patient's perspective on the environment, and whilst we do not report on these nationally, they give us an indication of areas for improvement

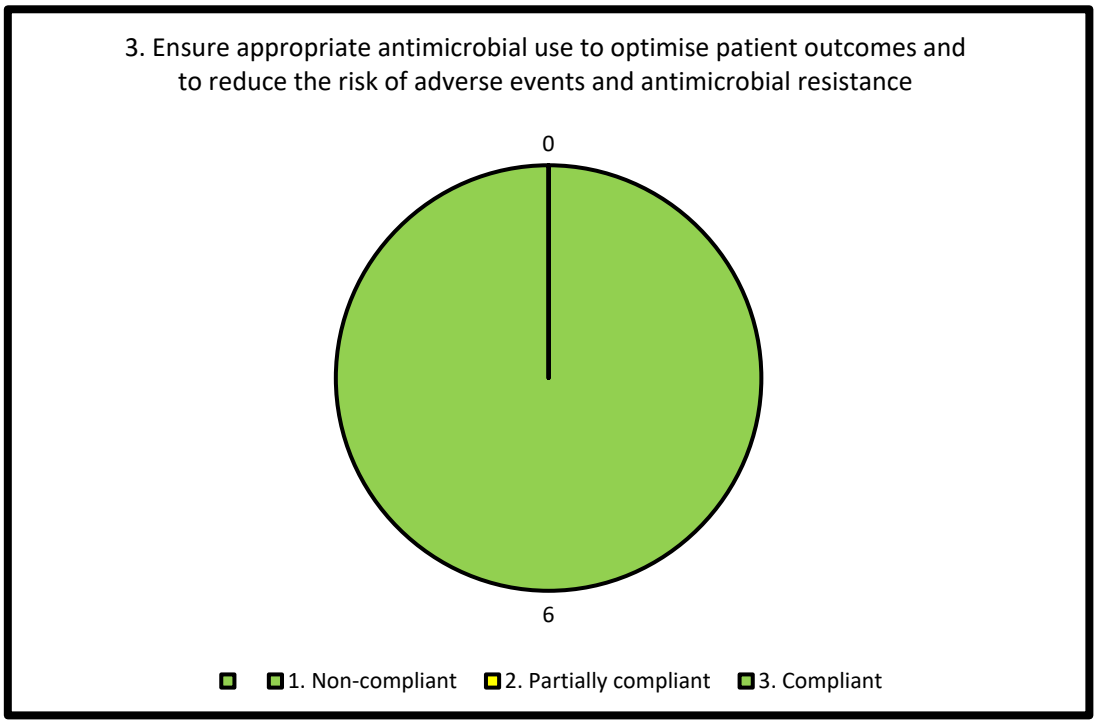
Graphs showing the scores in recent years as compared to the national average





Organisation Average **National Average**

CRITERION THREE: Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.



Antimicrobials: Summary report for financial year 2024/25.

Catherine Jeppesen, Ben Squibb and Darren Wilson

Introduction

Antimicrobial resistance (AMR) is a pervasive threat which is already causing people to suffer longer from infections which are more difficult to treat. If AMR continues to spread, some infectious diseases which, in the UK, would normally be simple to treat with an antibiotic, may become significant new causes of illness and death. In 2024 the UK published the latest five-year AMR National Action plan (NAP) 2024 – 2029 "Confronting Antimicrobial Resistance", which aims to take the UK closer to reaching its vision of containing and controlling AMR by 2040. The next 5 years are described as a pivotal period in addressing the global threat of AMR.

The 4 key themes of the plan are:

Theme 1 – reducing the need for, and unintentional exposure to, antimicrobials

Theme 2 – Optimising the use of antimicrobials.

Theme 3 – Investing in innovation, supply and access

Theme 4 – being a good global partner

The plan also emphasises the importance of taking a One Health approach, with collaborative working across agriculture, animal and human health sectors necessary to achieve success. Theme 2 is the most relevant theme for secondary care AMS teams, and will be discussed in more detail below, but we also work collaboratively

Box 1: National Action Plan Theme 2 – Optimising the use of antimicrobials.

Outcome 1 - Antibiotic stewardship (and disposal). Includes the aims of:

- Supporting frontline clinicians to target antimicrobials to those most likely to benefit
- Supporting front line clinicians to optimise the agent, dose, route and duration of treatment for individual patient
- Reducing total antibiotic prescribing by 5% by 2029, compared to 2019 baseline
- Aiming for ≥ 70% of prescriptions to be from the Access* group (UK version of the WHO classification). This may refer to the whole health system, not necessarily for individual secondary care providers. Trust level targets in this area have not yet been set.

Outcome 2 – AMR workforce. Includes the aims of:

- Embedding completion of IPM and AMS training for all health and social care workers and students, and to provide career pathways and promote skills retention for specialist posts.

*Based on the AWARE antibiotic classification system, antibiotics are classified into three groups; Access, Watch and Reserve. Access antibiotics tend to be narrower spectrum and should be used first line, whereas watch and reserve antibiotics are generally broader spectrum with activity against more resistant organisms, and their use should be limited

with the Infection Prevention Management (IPM) team around theme 1. The Dorset AMR board is being re-vitalised to provide strategic support and guidance across IPM and AMS.

For much of 2024/25, the AMS team at DCH has been without an antimicrobial pharmacist, but fortunately this situation ended in January 2025 with the appointment of Darren Wilson to a joint senior/consultant AMS pharmacist position split 50:50 across DCH and UHD. Prior to his appointment, Dr Cecilia Priestly did a fantastic job of chairing monthly meetings of the AMS group to maintain momentum and motivation. She has now handed over the chair to DW. It is intended that this post will lead to more joint working across the Dorset acute trusts, harmonisation of guidelines over time, and facilitate benchmarking and the sharing of best practice and learning.

The AMS team now consists of Darren Wilson, lead AMS pharmacist (0.5 WTE), Ben Squibb AMS pharmacy technician (0.5 WTE) and Dr Cathy Jeppesen, microbiology lead for AMS.

Optimising the use of antimicrobials

A summary of desired outcomes relating to theme 2 of the NAP is shown in box 1. Notable achievements by the AMS team during the year 2024/25 which contribute to these outcomes include:

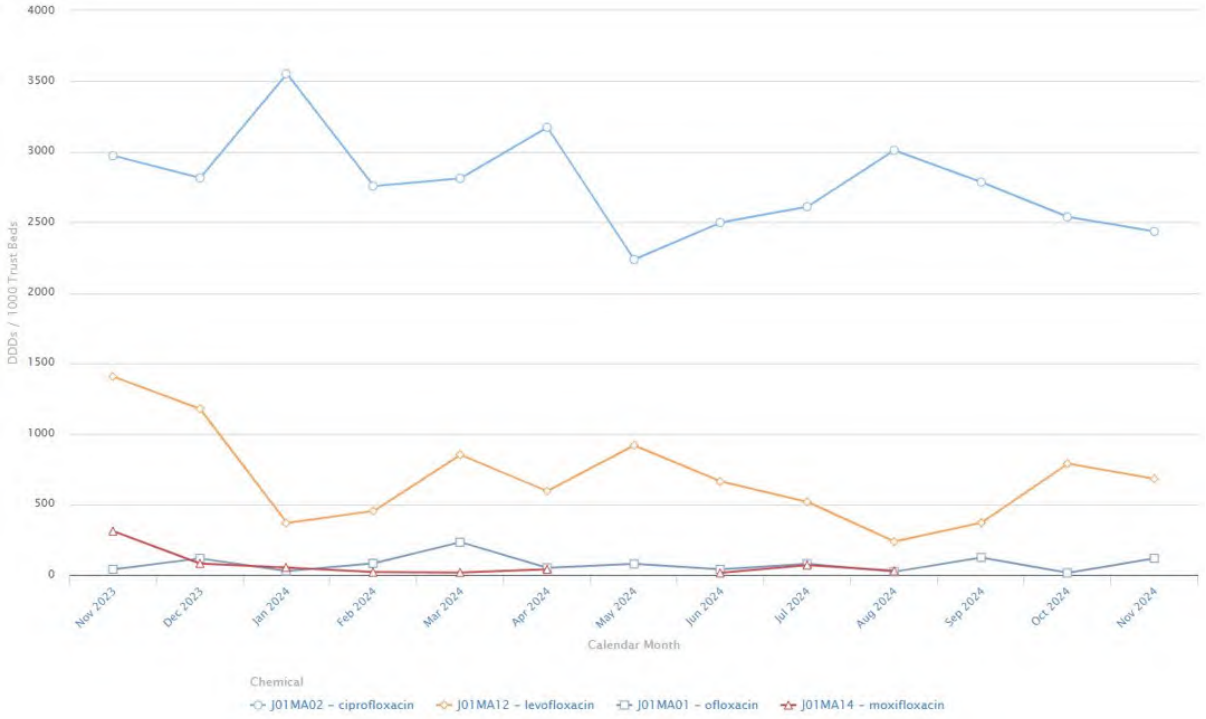
- **Migration of DCH antibiotic guidelines from SharePoint to the Eolas platform**. This is an online platform and App which took over the Microguide App during 2024, and as such is used by the majority of trusts in UK to house their antibiotic guidelines. It will support clinicians in using the most appropriate agent, dose and duration of antimicrobial in an easy-to-access, easy-to-update format. This was a substantial piece of work involving clinical review and formatting of over 100 guidelines. Many were updated and/or aligned with UHD, with some new guidelines adopted from UHD or written de novo to address gaps. The DCH Eolas

antibiotic guidelines were launched on Nov 16th, 2024, during antibiotic awareness week, with communications and a poster campaign.

- **Quinolone prescribing**.
  The AMS team has undertaken a number of measures to reduce inappropriate quinolone prescribing in response to updated MHRA warnings about their risks. A quinolone alert was produced, circulated by email and added to Eolas. Indications for quinolones have been removed from a number of guidelines including non-severe HAP, and the MHRA message has been included in educational sessions for F1s, medical directorate, pharmacists, senior nurses and the surgical governance meeting.

  This appears to have been effective based on a repeat snapshot audit of quinolone use, which demonstrated that half as many inpatients were taking quinolones during audit days in April 2025 compared to March 2024, and 100% were deemed appropriate (according to guidelines or as directed by microbiology) compared to 88% last year. There is still some overuse in patients documented as penicillin 'allergic', however, where their reaction is either non-severe allergy or minor intolerance, so this is an area for further work.
  Figure 1 below also suggests the activity has been successful with a downward trend in total monthly quinolone usage (includes both in and outpatient).

Fig 1 – DCH Fluoroquinolone usage (DDDs per 1000 beds by month) Nov 23 – Nov 24



- **Penicillin allergy de-labelling**.
  Penicillin allergy is reported in up to 10% of the general population, however, over 90% of patients reporting such an allergy tolerate penicillin without incident. True penicillin induced anaphylaxis is exceedingly rare (0.015%-0.04% of patients).
  Inappropriate penicillin allergy labelling has negative impacts on health care. Patients labelled as penicillin allergic have longer hospital stays and increased exposure to suboptimal antibiotics (for example, quinolones).

BS performed an audit of 188 inpatients labelled on JAC as penicillin allergic during May – July 2024 (trust audit 6076). 79 (42%) patients were able to give at least partial answers to the questionnaire; the remainder were unable due to mental or physical barriers to participation. The questionnaire covered questions used in the PEN-FAST tool (Trubiano et al 2020), namely details of the allergy symptoms and how long ago it occurred.

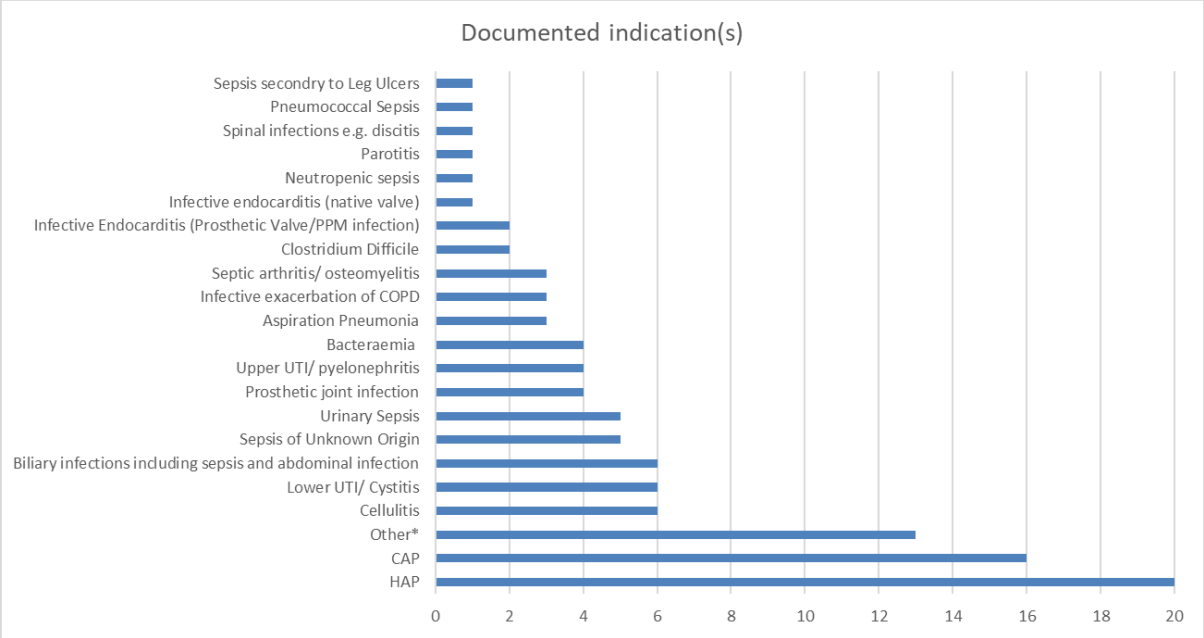
7 (9%) of the 79 patients stated that they were not allergic to penicillin-group antibiotics, and they were unsure why this label had been added to their primary care records. The audit identified 40 patients that were categorized as very low or low risk by the PEN-FAST tool (17 and 23 respectively) who could be suitable for oral challenge, potentially allowing them to be given penicillin's in the future. Penicillin de-labelling will be explored further in the coming year, although there are challenges around who would perform de-labelling, and whether successfully de-labelled patients would inadvertently regain their allergy label from other care records.

- **Staff education**.
  The microbiology consultants have delivered medical teaching sessions on AMS to new starter F1s in September 2024, a second session for F1s in March 2025, and a joint AMS session with a gerontologist for the medical directorate teaching programme in March 2025. CJ has also presented a section on AMS as part of the new IPM training for TEIR 3 senior nurses, which is a new staff group for AMS training and feedback was very positive.
  This is a start towards embedding AMS awareness and education for all staff groups, in line with the NAP recommendations, however AMS is currently not part of the national mandatory training agenda, and as such there are hard to reach groups such as existing medical staff, and all training material has to be developed locally. There are opportunities to share training strategies and materials with UHD and the SW region which will be explored in the coming year.

- **PSIRF learning**
  Microbiologist LC has produced 2 succinct and well-received educational emails for all clinical staff, to feedback the findings and themes from C difficile PSIRF reviews.
- **Local Point prevalence surveys and Data Dashboard**.
  Since starting in post, DW has begun a programme of quarterly point prevalence surveys. The first PPS, in February 2025, found that 110 of 337 inpatients (32.6%) were prescribed antibiotics on the day of survey. The indications are shown in figure 2.

  This is the start of a data dashboard which is being developed by the AMS team and will include several key AMS metrics. The aim is to provide information for action: to inform strategy and priorities, for reports and assurance, and will to trend analysis over time and assessment of the effectiveness of interventions.

Fig 2 – Documented indication for antibiotics in the Feb 2025 point prevalence survey



Antibiotic Consumption Data 2024-25

There were no mandatory CQUINS or AMS targets in the standard contract for 2024/25. The locally produced consumption graphs below demonstrate a mixed picture. In recent years our total antimicrobial consumption is trending down, which is good, however it is higher than it was in 2019, the comparator year used by in the national action plan. The proportion of antimicrobials from the Access category is stable at around 52%, and there is likely to be room for improvement if we compare ourselves with UHD. But for context, the southwest is the region with the lowest use of Watch and reserve antibiotics in the UK, and UHD is one of the lowest users in the SW. So, while there is certainly scope to learn from practice at UHD, we should also allow for the differences in our patient populations – DCH has an older patient demographic, and for example the commonest indication for inpatient antibiotics from our first quarterly point prevalence data was hospital acquired pneumonia, which necessitates broad spectrum coverage.

Figure 3. Annual Total Antimicrobial consumption data (DDDs per 1000 admissions including day case) from 2016/17 to 2024/25. This demonstrates a downward trend over the past 3 years which is encouraging, although when compared to the 2019, the year used as a comparator year in the NAP, our total consumption has gone up. (DCH data extracted from RxInfo)

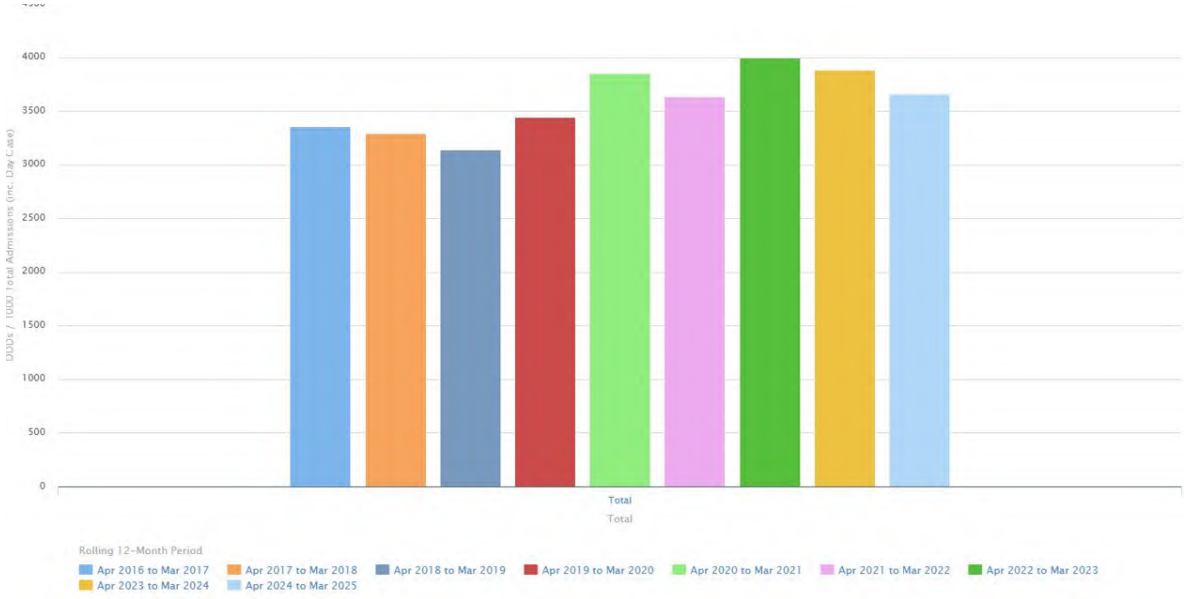


Figure 4. Proportion of DCH Antimicrobial Consumption data from the Access, Watch and Reserve categories (DDDs per 1000 admissions including day case), annual data from 2016/17 to 2024/25. This shows a fairly static picture around with around 53% of consumption from the desired Access category. (RxInfo)

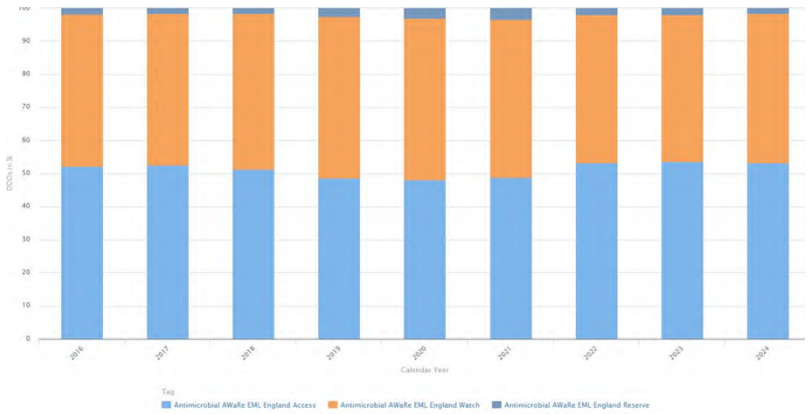


Figure 5. Proportion of Antimicrobial Consumption data from the Access, Watch and Reserve categories (DDDs per 1000 admissions including day case), 2024/25 data across SW trusts. This suggests our proportions are close to average for similar sized trusts in the SW region, but higher than our neighbouring Dorset trust, UHD, where over 60% are from the Access group. (data from RxInfo)

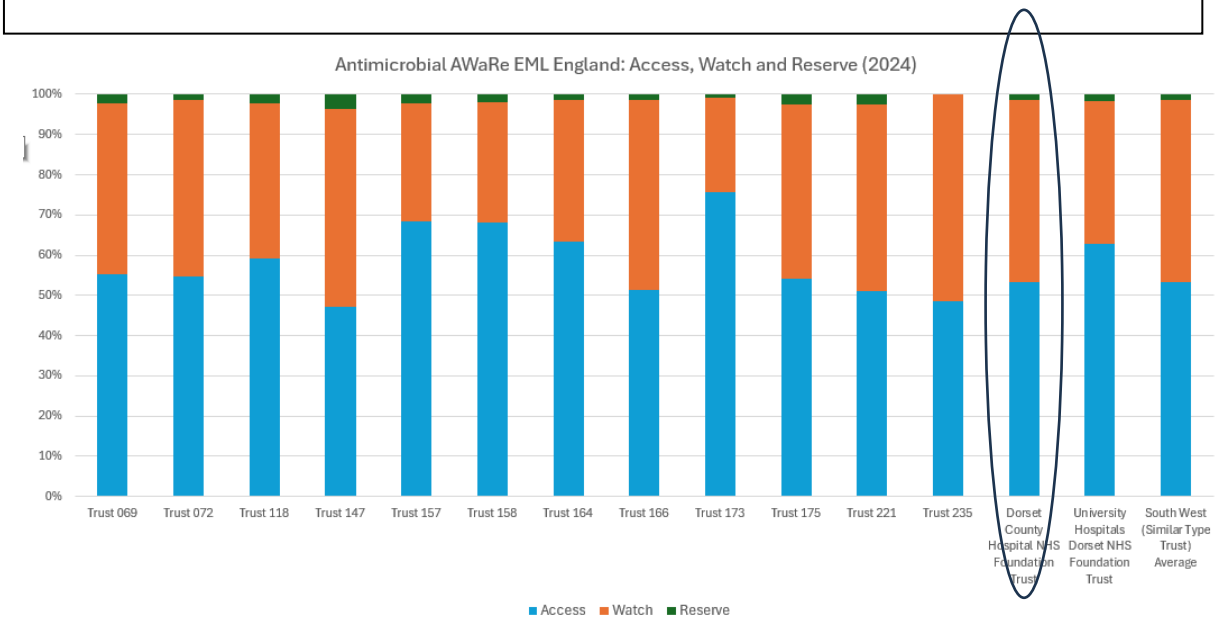
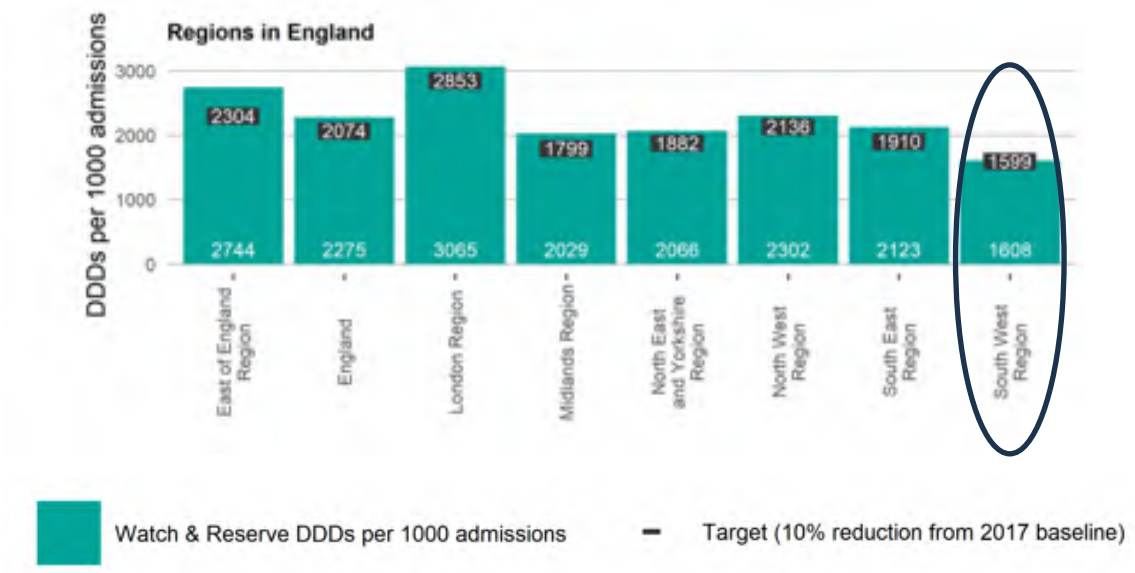


Figure 6. Watch and reserve antibiotics (DDDs per 1000 bed days) for the 4 quarters to Q2 2024/25, data by regions across England. For context this data from the NHS England demonstrates that the SW is the region with the lowest usage of Watch and Reserve antimicrobials in England.

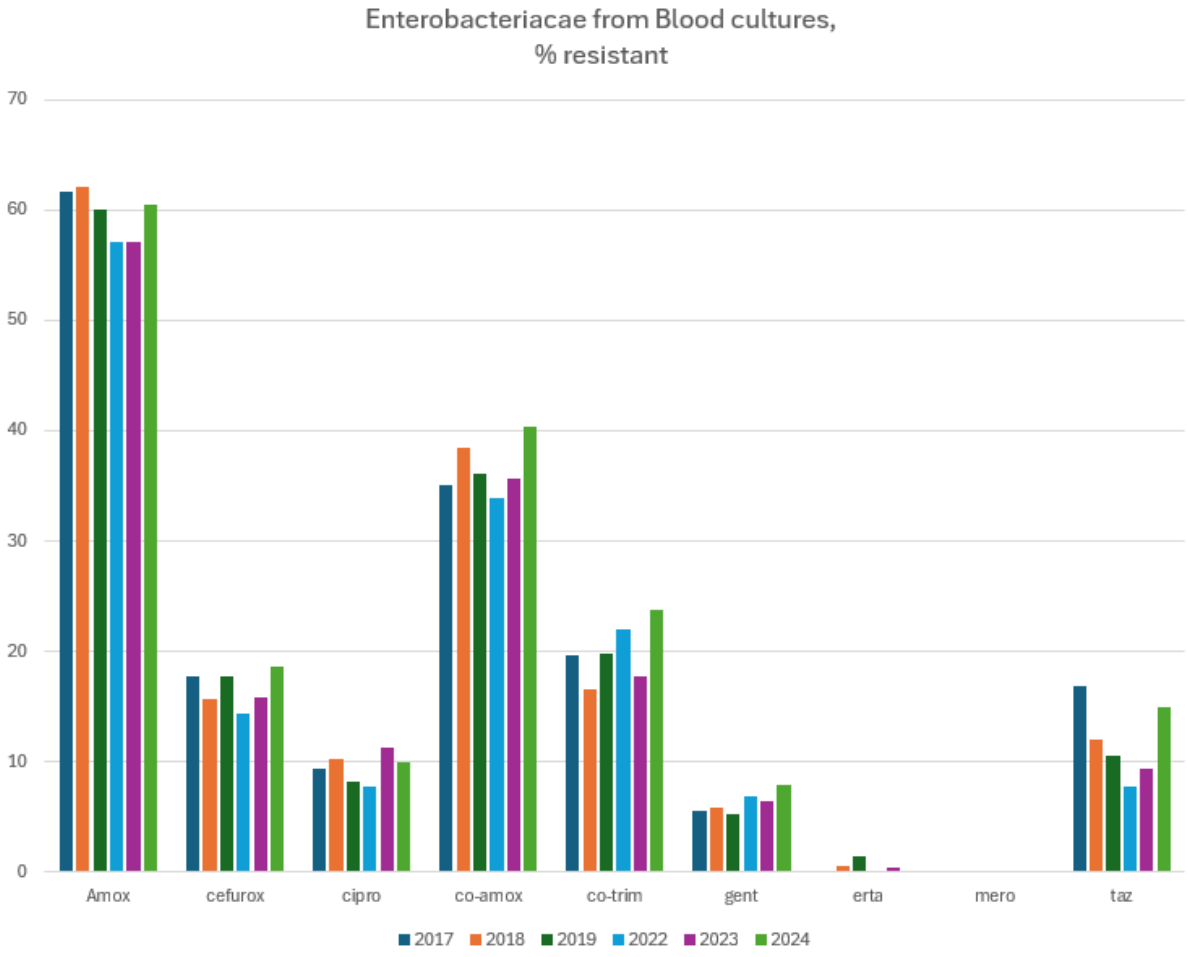


Antibiotic resistance surveillance data

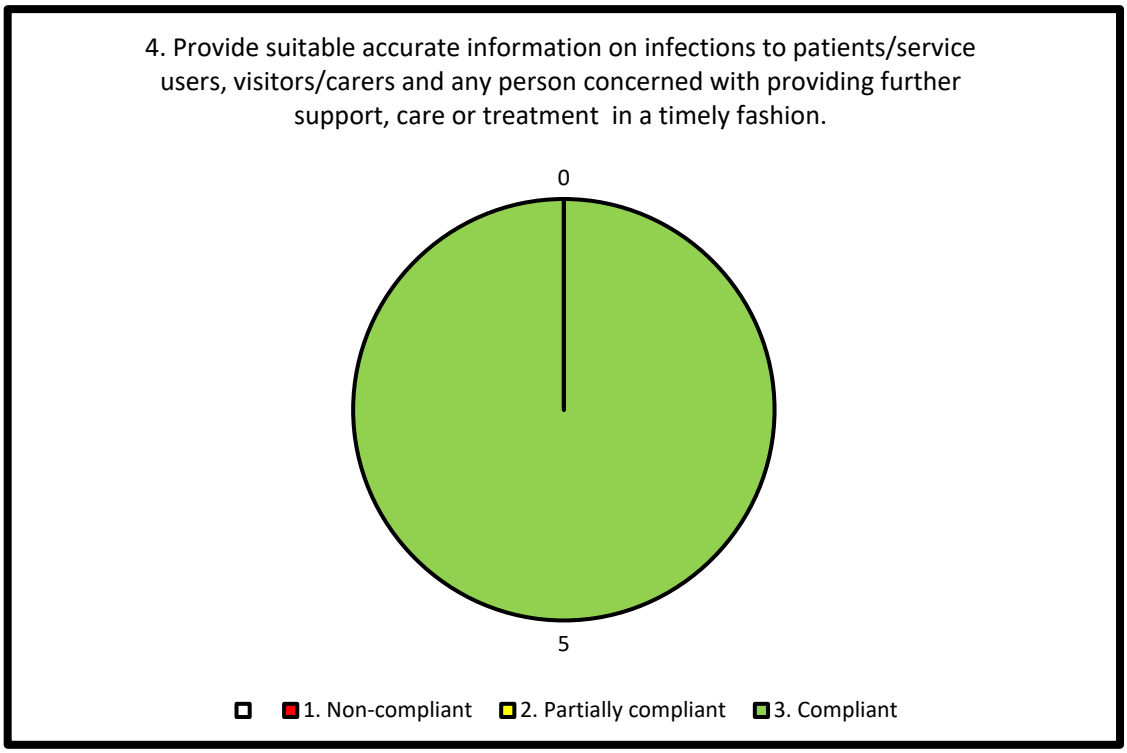
Local antibiotic resistance data is important for informing empiric treatment guidelines and detecting changes in resistance patterns. Gram negative organisms such as E coli and Klebsiella spp have the greatest variability in susceptibility patterns, with many possible chromosomal and plasmid mediated resistance mechanisms, including the extremely difficult-to-treat Carbapenemase-producing organisms (CPEs). The chart below shows resistance rates in gram negative (Enterobacteriaceae) blood culture isolates from DCH patients over the last 6 calendar years.

Fortunately, Carbapenemase resistance is still extremely uncommon in blood stream infections at DCH, although we are seeing increasing numbers of isolates from other sites. There appear to be upward trends of resistance to gentamicin, tazocin and co-trimoxazole which need to be monitored – especially as we are increasingly using co-trimoxazole as an 'Access group' oral alternative to co-amoxiclav and quinolones. However, it is possible that some of this can be explained by changes to laboratory reporting of the 'ATU' (area of technical uncertainty) category of susceptibility testing in recent iterations of the EUCAST testing rules.

Source: DCH laboratory reporting of blood culture isolates, extracted using ICNet.



CRITERION FOUR: Provide suitable accurate information to patients/service users, visitors/carers and any person concerned with providing further support or nursing/medical care in a timely fashion.



The IPM Team works closely with the clinical site managers, ward leads, ward staff and facilities service and attends all bed meetings throughout the day to support patient placement and cleaning requirements. Infection control Patient Activity summary (PAS) flags are added as applicable to all newly identified infections.

The IPM team visit in person all newly diagnosed patients with MRSA and CDI infections, providing the patient with an information leaflet, discuss the diagnosis and answer any questions.

The IPM Team work closely with the communications team and together we update staff via email and staff bulletins all when new guidance that is implemented. We also have a dedicated IPM section on the trust intranet site, which is updated regularly, especially when any guidance changes are implemented. We also review the IPM information leaflets regularly and update the hospital IPM internet pages.

The IPM team monitor all CDI and Potential CDI infections daily and include an in-depth weekly review of patients. Escalating concerns to medical teams, wards, and consultant microbiologists. Our consultant microbiologists contact GP's directly when patients are diagnosed with CDI. We also send out GP letters, in a timely manner alerting them of any new CDI, Potential CDI, MSSA, MRSA and Gram-negative Blood stream infections. We also use isolation posters. Which are used for placement outside cubicles containing updated clear information about the recommended cleaning, Personal Protective Equipment and visiting guidance. We audit the correct

use of the posters across the trust twice yearly and our last audit results for 2024-2025 demonstrated 94% compliance with the use of correct cubicle signage. This demonstrated a compliance improvement over the previous 4 years.

The IPM team work closely with the IPM ICS to identify the needs of the local population and develop strategies, collaboratively to ensure joined up working. We also have monthly post infection review meeting to share learning, raise concerns and discuss our systemwide priorities.

INFECTION PREVENTION MANAGEMENT SURVEILLANCE SYSTEM (ICNET)

Over the last few years, we have worked jointly as an ICS IPM team on the procurement and implementation of a county wide utilisation of ICNet, an infection prevention management surveillance system supplied by Baxter Healthcare Ltd.

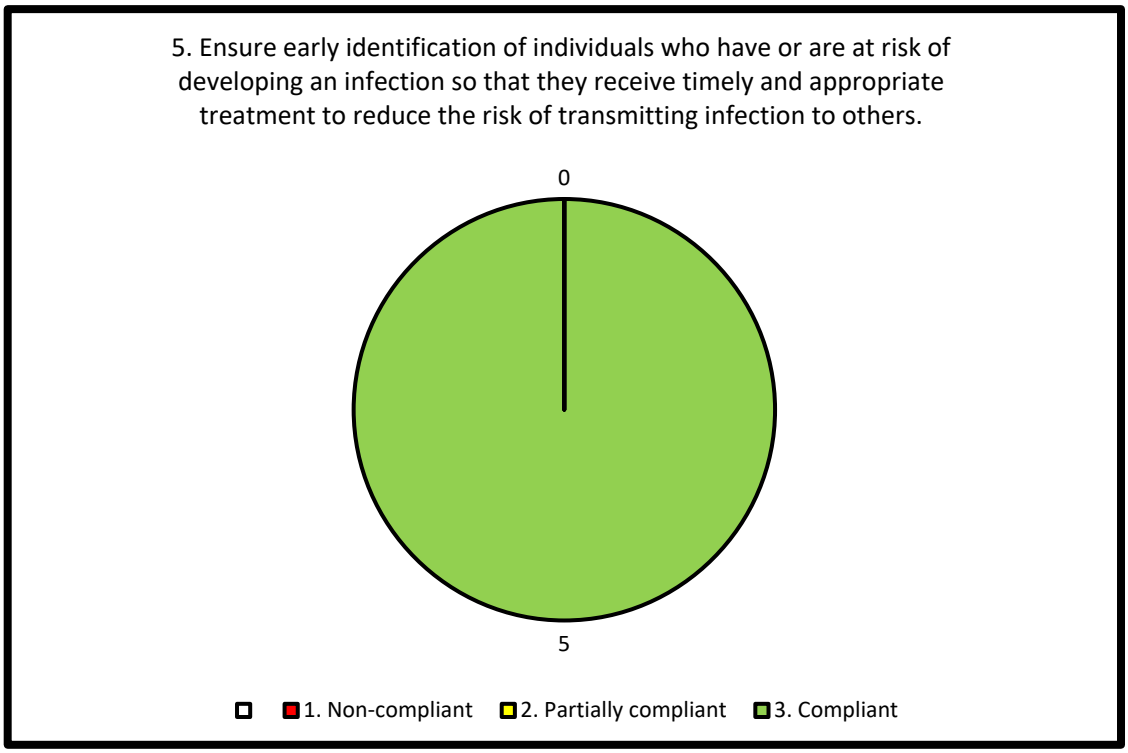
The IPM implementation Programme is divided into three phases:

- Phase 1 – DCHFT migration to hosting by DHC – completed July 2020.
- Phase 2 – UHD (both sites) implementation – completed 2021.
- Phase 3 – DHC implementation – Completed September 2022.

During 2024-2025 the system has been running smoothly across all the Dorset system trusts, and we continue to work collaboratively together to ensure as a Dorset system we are using the ICNET effectively and advantageously. We are working collaboratively to ensure that our Clinical safety case report, Hazard log and clinical risk management plan are all up to date.

Within Dorset County hospital the Clinical Site Managers and the housekeeping team have access to ICNET, and they use it to support isolation of patients promptly and effectively and also ensure the correct cleaning is achieved. The IPM team continuously update the isolation list within the system to support prompt isolation and continuously risk assess as necessary, ensuring patient safety is paramount and effectively achieved with regards to cleaning and isolation.

CRITERION FIVE: Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infections to others.



The use of ICNET allows the IPM team and clinical site managers out of hours to be alerted to any new alert organisms or existing alert organisms. The IPM team are constantly reviewing these patients. The microbiology consultants also use the ICNET system for note documentation to enable seamless sharing of information between teams. This information is also shared across NHS Dorset following the rollout of ICNET across Dorset Trusts.

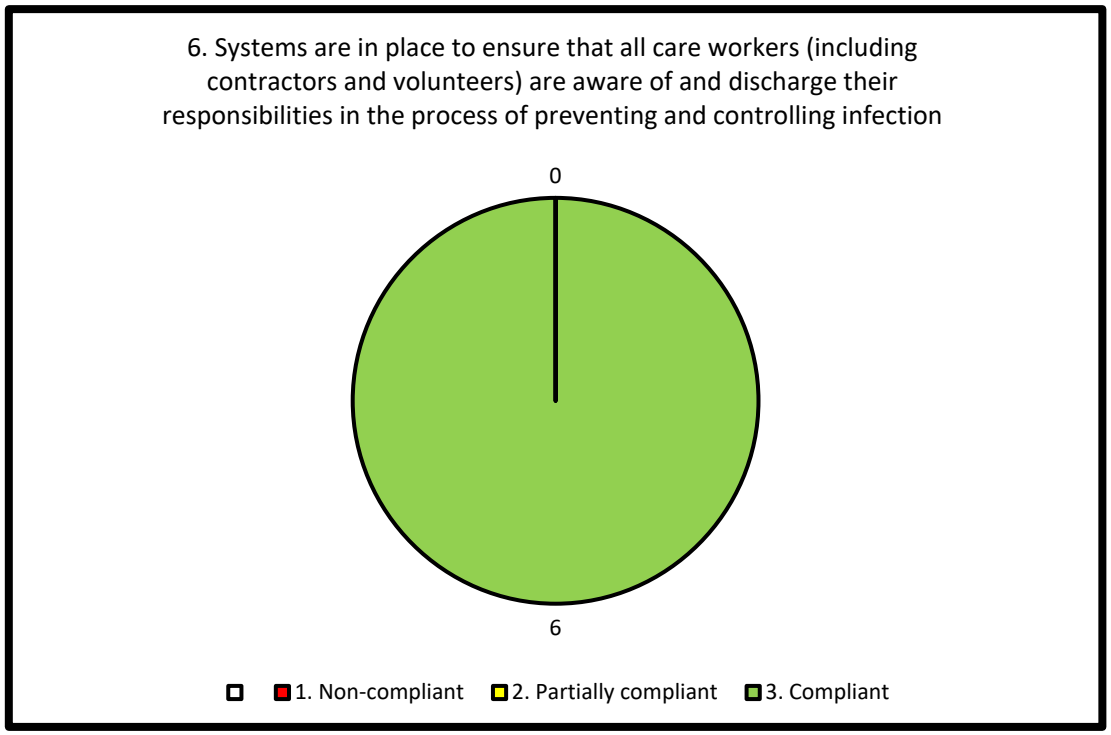
As a team we link closely with GP's, ensuring they are promptly informed via letter or verbal contact via the consultant microbiologists of any new organisms, such as C Diff, Potential C Diff infection, MSSA and MRSA BSI's and Gram-Negative organisms.

The Trust is able to demonstrate that responsibility for infection prevention management is effectively devolved to all professional groups by means of inclusion in all job descriptions and mandatory inclusion in appraisal documentation including for medical staff.

The IPM Team are involved in the management of outbreaks and periods of increased incidence. The IPM team monitors all alert organisms to identify trends and potential links between cases based on their location. If links are identified, a Period of Increased Incidence (PII) investigation is commenced and a weekly meeting to discuss potential cases is held as soon as possible. This task is greatly aided using ICNET.

In 2024/2025 1 Periods of increase incidents of C Diff, 3 Norovirus outbreaks and 1 CPE outbreaks which were declared during this time frame. These figures are much improved from last year. All outbreaks are discussed for the purpose of shared learning and service development through divisional governance meetings and IPM committee meetings. The IPM team always produce a report, which is noted and discussed at IPM Committee meeting and the IPM lead specialist nurse always conducts a de-brief following a PII or outbreak. Recurring themes from these investigations are disseminated through the IPM Committee meetings. Action plans that are put in place by the ward manager and/or matron are supported and monitored by the IPM team for compliance.

CRITERION SIX: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.



EDUCATION

The Infection Prevention Management Team continued to provide formal and informal face to face education training sessions for both clinical and non-clinical staff. IPM team have also been incorporated into the following teaching programmes and all the nursing team were involved in delivering the sessions:

- Care Certificate for Health Care Support Workers
- Medical Tutorial Teaching programme
- Overseas Recruitment Training
- Clinical Practice Educators

Mandatory IPM Training for clinical and non-clinical staff has been offered via an online e-learning workbook. Overall compliance with mandatory IPM training over the year has remained very high for clinical staff. Compliance is part of the yearly appraisal review process for all members of staff. The Divisions are responsible to release staff to access their training. The E-learning IPM Mandatory training programme uses a national programme.

The IPM team continue to provide extra training to specific groups of staff as and when necessary, this has included Allied Health Professionals, Porters, housekeeping staff etc. The team have also supported yearly training in areas that maybe required to care for patients with a suspected or confirmed High Consequence Infectious Disease (HCID). Including the correct PPE donning and doffing procedures to further protect themselves in their working environment. The trust has rolled out employing Clinical Practice Educators in most clinical areas, this group of staff support and provide

education within the ward area and have a close link with IPM and support ongoing IPM best practice.

This year the IPM team rolled out the IPM educational recommendations within the National IPC Educational Framework. Which sets out a vision for the design and delivery of IPM education for staff that will support effective and safe care. The framework supports and enhances the skills and expertise in our existing workforce and deliver a positive impact for all learners, our people, educators, patients in our care and our populations. The learning outcomes are a minimum expectation and do not preclude additional outcomes being developed. There are three tiers, which are incremental, building from tier 1 to tier 3. We are currently fully achieving mandatory training for tier 1, tier 2, and tier 3. Tier 3 training is suitable for staff who are responsible for an area of care and involves a yearly face to face training session and includes a large (Antimicrobial stewardship) AMS element.

The IPM team continue to carryout daily ward rounds, during these ward rounds we support staff, monitor practice, provide advice, and provide continued IPM education.

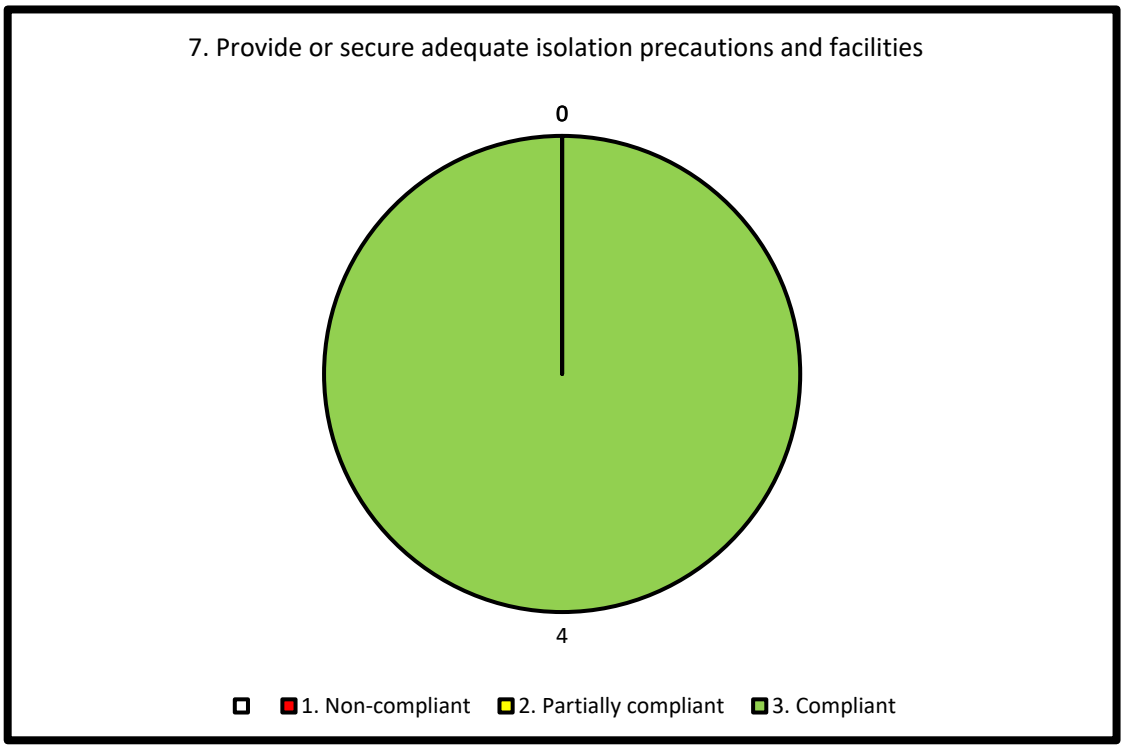
FACE MASK FIT TESTING

As per plans from last year, several more staff have been trained to be face mask fit testers on both the hood and machine, making it more accessible to ward staff. However, some areas have managed to test staff, but other areas still lack the time and capacity to fulfil the testing requirements.

Update training has been offered to those previously trained, but little has been completed. This has been raised many times at IPM and remains a concern.

As we move into 2025-2026, The Fit test co-ordinator plans to gain a permanent place where staff can drop in on various allocated days to make it even more accessible to staff on wards. Compliance with fit mask testing will not improve unless staff are given time and space to carry out this legal requirement.

CRITERION SEVEN: Provide or secure isolation facilities.



ISOLATION

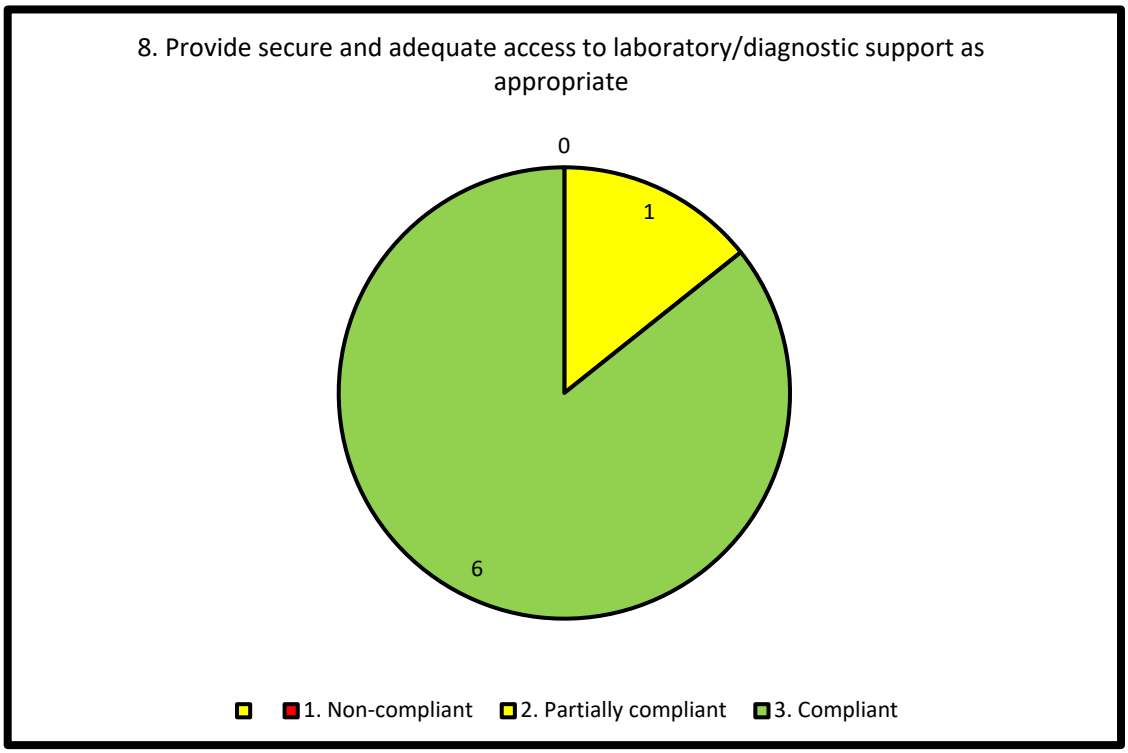
DCHFT has 65 isolation cubicles against the standard bed base (figure taken at the time of audit). There is no recent statistics to compare this figure to the national average within acute trusts. This percentage can impact the ability to isolate patients according to the national guidance, the National Infection Prevention and Control Manual for England 2024. Using the concept of cohort nursing patients during high prevalence of certain infections such as Flu A, Flu B, Covid-19, or RSV, which the IPM team continue to suggest, support, and provide guidance on, when necessary. Isolation capacity is consistently well managed and the requirement to isolate patients as required is largely achieved and if not, in-depth risk assessments are carried out to support best practice depending on the organism.

The IPM team carryout daily ward rounds to review the use of side rooms, providing an ongoing updated isolation list on ICNET, which housekeeping and clinical site managers can access. The IPM Team risk assess as necessary, supporting ward staff and clinical site managers to ensure the most effective use of side rooms according to risk, and this is carried out throughout the day.

ISOLATION AUDIT

This year the side room isolation audit took place twice in August 2024 and January 2025 and looked at all inpatient areas with results as follows; Out of 65 rooms in use an average of 89% of side rooms had the correct signage, 11% incorrect signage and a total of 100% overall side rooms where in use across the trust. This data demonstrates a much-improved percentage compared to last year's audit. At the time of the audit being carried out, staff were educated on the importance of using correct signage to protect not only the patients but also themselves, visitors and thus reducing the transmission of infection. Last year we have developed and implemented new trust isolation posters.

CRITERION EIGHT: Secure adequate access to laboratory support as appropriate.



Partially compliant: 8.1 Patient/service user testing for infectious agents is undertaken by competent and trained individuals and meet the standards required within a nationally recognised accreditation system. Mitigation: The microbiology lab voluntarily withdrew accreditation to the ISO15189:2012 standard and will continue until resource is available for accreditation to the current ISO15189:2022 standard.

MICROBIOLOGY LABORATORY UPDATE – G Rees – Head BMS Microbiology

The laboratory services are located on the DCH site, there is seven-day laboratory working and 24 hour access to microbiology advice, this includes a 24 hour Point-Of-Care Testing in ED and Kingfisher paediatric ward supporting respiratory testing PCR (COVID, Flu, RSV). The IPM team are physically located next to the Laboratory department and have a close working relationship with the Microbiology Consultants, we also have a weekly meeting between the IPMT, microbiology consultants and head biomedical scientist.

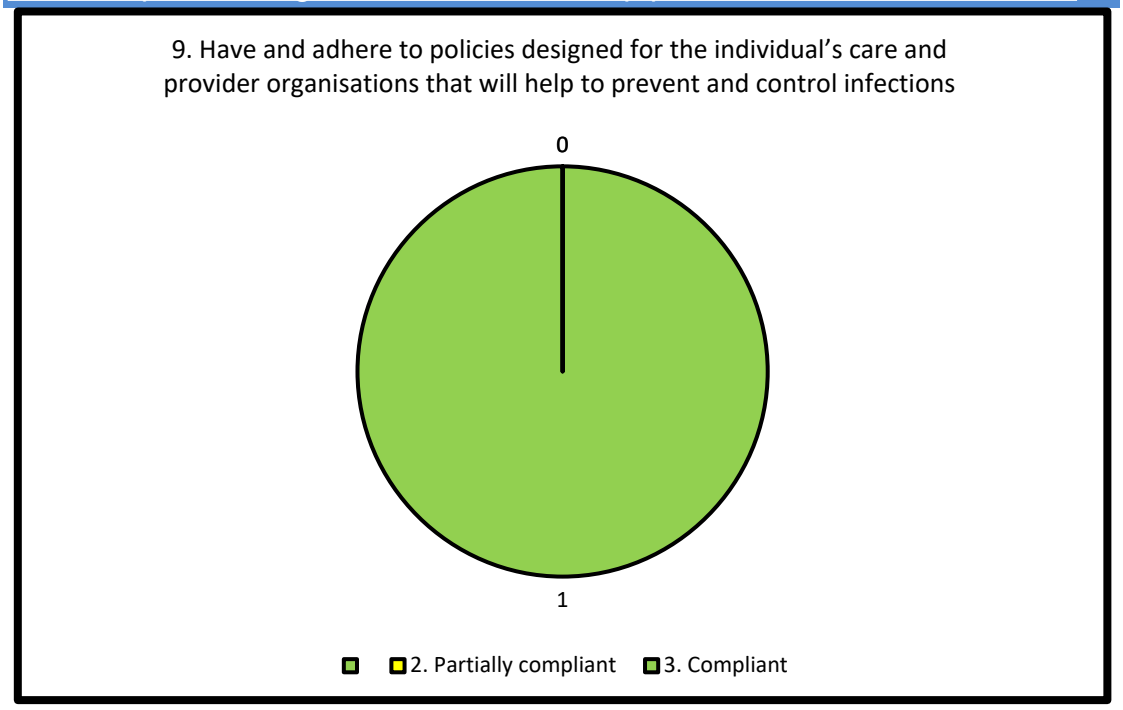
Screening activity and outbreak working remains all year round although a large peak in winter saw the respiratory testing double, this year peaking at around 1100 tests (~£50k on kits) per month. A cross DCH team effort succeeded in maintaining patient flow when a supplier was late delivering inactivation buffer needed for efficient workflow. A new supplier had already been identified, and we were planning to change later in the year, this process was accelerated.

Laboratory tests continue to increase in number, some have doubled since pre COVID, with the same staffing and equipment resource. This has impacted our UKAS accreditation recovery, and we are planning to become accredited once sufficient

resources are available. Increasing demand for testing without increasing capacity continues to be a service risk.

One Dorset Pathology Network (DCH and UHD) continues to develop. The Tier 1 (band 8b) management structure has been completed, the Tier 2 (band 8a) individual laboratory managers is in progress and Tier 3 (band 7 to 2) is due to start, staff at DCH will still be employed by DCHFT. Processes are becoming aligned between pathology at Dorchester, Poole and Bournemouth sites, specialisms are developing i.e., high volume Chlamydia and Gonorrhoea molecular testing for Dorset is now located at Dorchester. South Six Pathology Network are concluding the Lot 5 Molecular Tender after 6 years, this will bring an equipment refresh for the molecular platforms (refresh in bacteriology is long overdue as equipment is 17 years old) to DCH and bring a new syndromic molecular capacity including rapid meningitis/encephalitis agent detection.

CRITERION NINE: Have and adhere to policies designed for the individuals care and provider organisations that will help prevent and control infections.



POLICY DEVELOPMENT/REVIEW

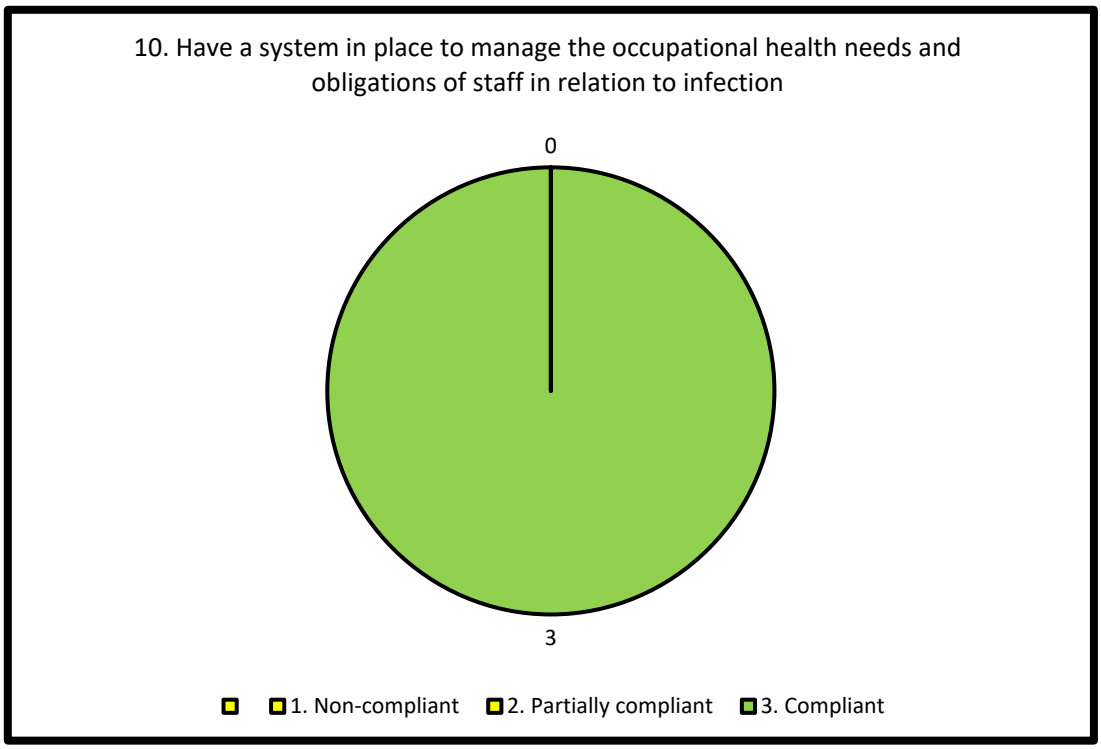
There is a comprehensive list of Infection Prevention Management policies, procedures, and guidance on the trust intranet. These polices are reviewed by the IPM team and relevant specialities on a three or five yearly review date or when guidance changes, these documents are evidenced based and reflect national guidance. Compliance is audited with key polices as detailed in Criterion one.

The following policies have been developed / reviewed / removed during the year 2024-2025:

0793-infection-control-standard	0853-Major-OB.
0856-VHF	0684-aseptic-tech.
0779-Ward-Outbreak-pack-2009	2248-Measles
0802-pandemic-flu	0296-scabies
2058-IPC-ultrasound-gel	0289-MRSA/MSSA
0386-hand-hygiene-policy	2266-SOP-Pertussis.
1446-Discharge-with-Urinary-Catheter	1865-PGD-Naspetin-for-MRSA-MSSA-decolonisation.
1440-PGD-Octenisan-for-MRSA-MSSA-decolonisation.	2063-PGD-Suspected-neutropenic-sepsis-meropenem.
1174-Policy for Infection Prevention and Control Operational Haematology/ Cancer Ward	

The IPM team have worked collaboratively to develop one High Consequence Infectious disease (HCID) policy, archiving four other policies, this policy has now been ratified and is available on SharePoint.

CRITERION TEN: Have a system in place to manage the Occupational health needs and obligations of staff in relation to infection.



OCCUPATIONAL HEALTH REPORT – H Hunt Head of Occupational health.

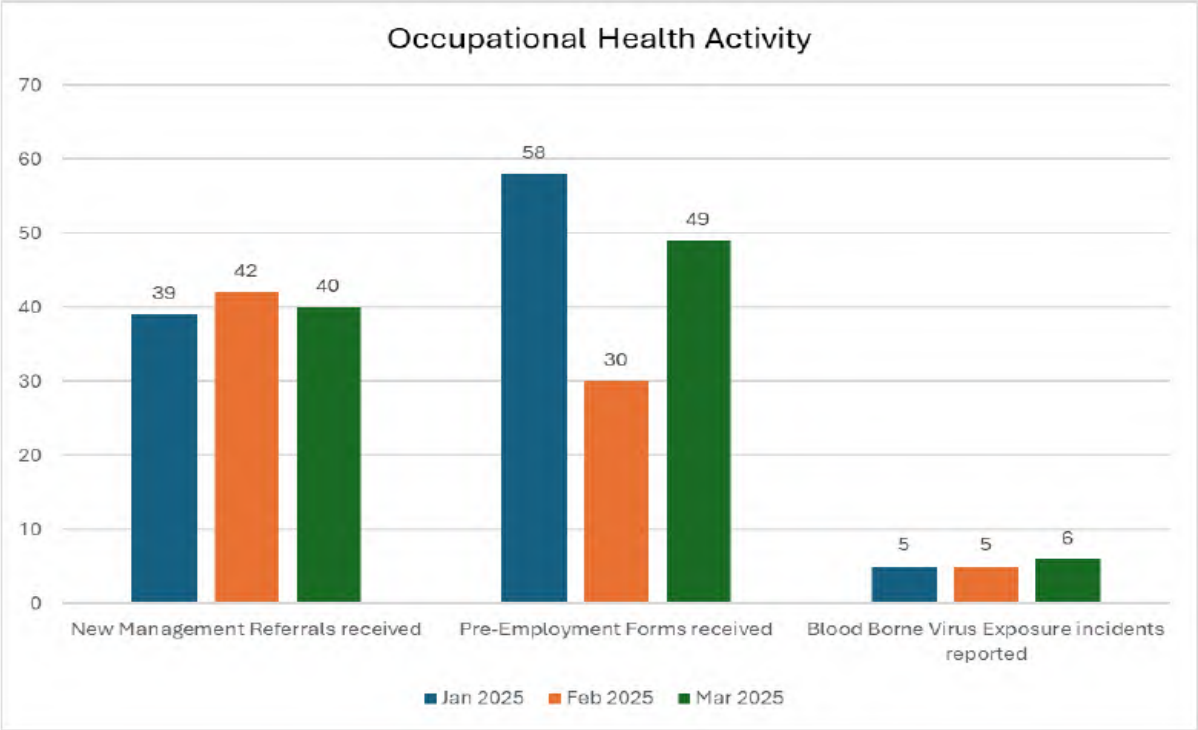
Occupational Health Report
Dorset County Hospital
Infection Prevention Management Committee
Q4 2024/25 Report

From: Helen Hunt Head of Occupational Health Services
Department: Occupational Health Services, Dorset HealthCare NHS Trust

General Summary of Work relevant to the Infection Prevention Management Committee
Introduction The contract for Dorset Healthcare University NHS Foundation Trust to provide Occupational Health services to Dorset County Hospital commenced on 01 January 2024. This report reflects the work carried out in Q4 2024/25. **Activity** The graph below also provides annual figures for 2024/25:

Activity
Monthly activity summary:

	Apr 2024	May 2024	June 2024	July 2024	Aug 2024	Sept 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	**Mar 2025**	% change on previous month	Q1 24/25	Q2 24/25	Q3 24/25	**Q4 24/25**
New Management Referrals received	31	47	37	44	36	40	46	42	32	39	42	**40**	-5%	115	120	120	**121**
Pre-Employment Forms received	66	124	103	83	47	64	41	36	38	58	30	**49**	63%	293	194	115	**137**
Blood Borne Virus Exposure incidents reported	6	6	3	6	9	6	4	5	6	5	5	**6**	20%	15	21	15	**16**



Reasons for Management Referral

There were 37 attended Management Referral appointments in March 2025.

The highest reasons for these Management Referrals were:

- Musculoskeletal
- Advice on Workplace Adaptations
- High Sickness Absence

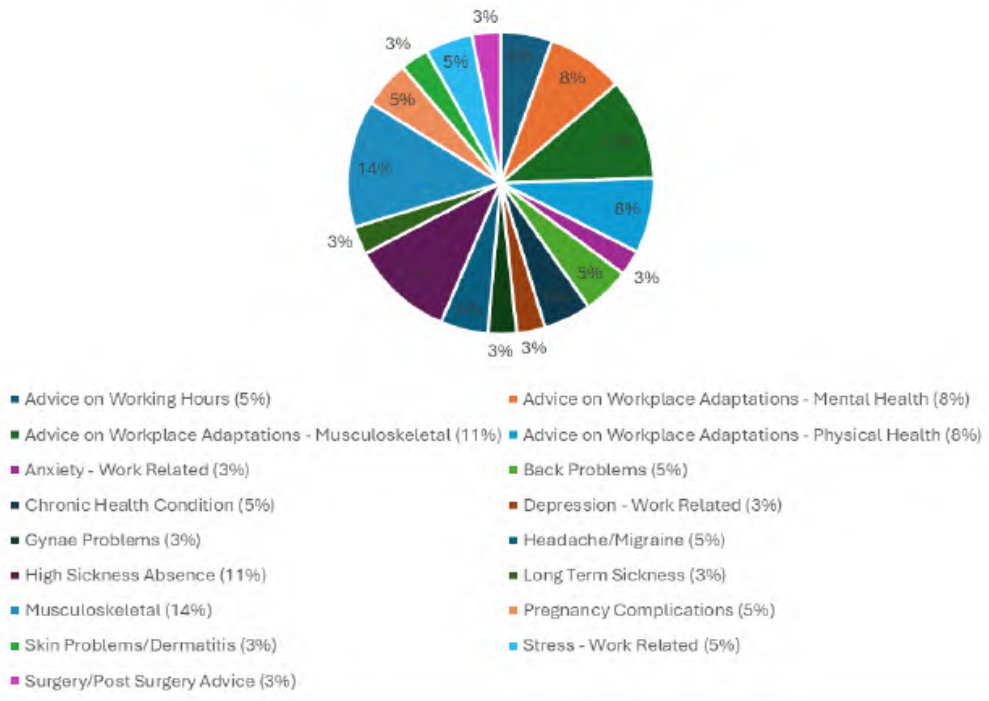
Further information was added for the below reasons:
Advice on Workplace Adaptations:

- Musculoskeletal
- Back Pain
- Hip Pain following a fall

Advice on Workplace Adaptations

- Physical Health
- Review of workplace adjustments
- Advice sought on working environment together with high sickness absence

Reason for Referrals March 2025



Blood Tests

Activity	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sept-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Total
Hepatitis B Accelerated Serology	11	5	10	3	13	13	8	1	6	11	4	6	91
Hepatitis B Core Antibodies	0	0	0	0	1	0	1	0	1	0	0	0	3
Hepatitis B Surface Antibodies	11	17	21	15	26	11	19	13	19	29	21	32	234
Hepatitis B Surface Antigen	7	5	4	1	2	3	2	1	8	5	6	2	46
Hepatitis C Antibodies	7	7	6	1	4	4	5	4	7	9	7	5	66
Hepatitis C RNA	1	4	2	0	3	6	2	1	4	0	2	1	26
Hepatitis B Core Antibodies (EPP)	0	0	0	0	0	0	0	0	1	0	0	0	1
Hepatitis B Surface Antibodies (EPP)	6	5	3	17	17	3	8	6	4	4	1	2	76
Hepatitis B Surface Antigen (EPP)	6	13	4	24	28	4	9	4	3	6	2	8	111
Hepatitis C Antibodies (EPP)	6	12	4	25	28	5	9	4	3	6	2	8	112
Hepatitis C RNA (EPP)	1	0	0	0	0	0	0	0	0	0	0	0	1
HIV Test (EPP)	7	12	4	26	29	5	8	3	3	5	2	9	113
HIV Test	9	9	8	1	5	12	5	4	7	11	8	5	84
IGRA Test	14	23	23	26	27	12	17	4	9	6	5	9	175
Measles Antibodies (IgG)	57	27	30	24	49	14	35	9	18	28	17	19	327
Rubella Antibodies (IgG)	43	26	29	24	49	13	35	9	17	28	18	19	310
Varicella Antibodies (IgG)	18	21	19	21	27	8	24	10	14	13	10	12	197
Total	**204**	**186**	**167**	**208**	**308**	**113**	**187**	**73**	**124**	**161**	**105**	**137**	**1973**

Vaccinations

Activity	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sept-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Total
Hepatitis A & B Twinrix 1st Vaccination	1	0	0	0	0	0	0	3	0	0	0	0	4
Hepatitis A & B Twinrix 2nd Vaccination	0	1	1	0	0	0	0	0	2	0	1	0	5
Hepatitis A & B Twinrix 3rd Vaccination	0	0	0	0	0	0	0	0	0	1	0	0	1
Hepatitis B 1st Accelerated Vaccination	8	11	15	9	18	2	1	0	0	0	1	0	65
Hepatitis B 2nd Accelerated Vaccination	9	11	9	10	15	16	6	2	0	0	0	0	78
Hepatitis B 3rd Accelerated Vaccination	6	7	8	7	8	20	3	0	0	0	1	0	60
Hepatitis B 1st Accelerated Secondary Vaccination	6	4	3	4	7	4	0	0	0	0	0	0	28
Hepatitis B 2nd Accelerated Secondary Vaccination	0	4	0	3	3	7	1	0	0	0	1	0	19
Hepatitis B 3rd Accelerated Secondary Vaccination	0	0	0	2	6	3	1	0	0	0	0	0	12
Hepatitis B 4th Accelerated (12 Month)	1	1	0	0	1	1	3	1	1	3	3	5	20
Hepatitis B 1st Standard Vaccination	0	0	0	0	0	5	17	11	8	9	14	7	71
Hepatitis B 2nd Standard Vaccination	0	0	0	0	0	1	7	7	13	13	9	15	65
Hepatitis B 3rd Standard Vaccination	0	0	0	0	1	0	5	0	6	7	9	10	38
Hepatitis B 1st Standard Secondary Vaccination	0	0	0	0	0	0	6	2	7	2	7	2	26
Hepatitis B 2nd Standard Secondary Vaccination	0	0	0	0	0	2	5	4	5	3	6	6	31
Hepatitis B 3rd Standard Secondary Vaccination	0	0	0	0	0	0	1	2	2	1	6	3	15
Hepatitis B Challenge Vaccination	0	0	0	0	0	0	1	0	1	3	8	1	14
Hepatitis B Immediate Booster	5	7	4	2	12	6	7	3	4	7	7	4	68
BCG Vaccination	7	2	4	1	0	3	3	6	3	4	3	8	44
Mantoux Test	7	2	4	1	0	3	3	6	3	4	4	9	46
MMR 1st Vaccination	11	3	5	6	13	10	7	6	6	9	5	7	88
MMR 2nd Vaccination	10	7	3	7	6	8	12	6	5	11	9	7	91
Pertussis Vaccine	5	4	1	5	9	1	1	0	4	3	3	1	37
Varicella 1st Vaccination	8	0	3	2	5	3	5	0	5	3	0	3	37
Varicella 2nd Vaccination	0	1	3	1	2	4	2	5	1	3	3	1	26
Total	**84**	**65**	**63**	**60**	**106**	**99**	**97**	**64**	**76**	**86**	**100**	**89**	**989**

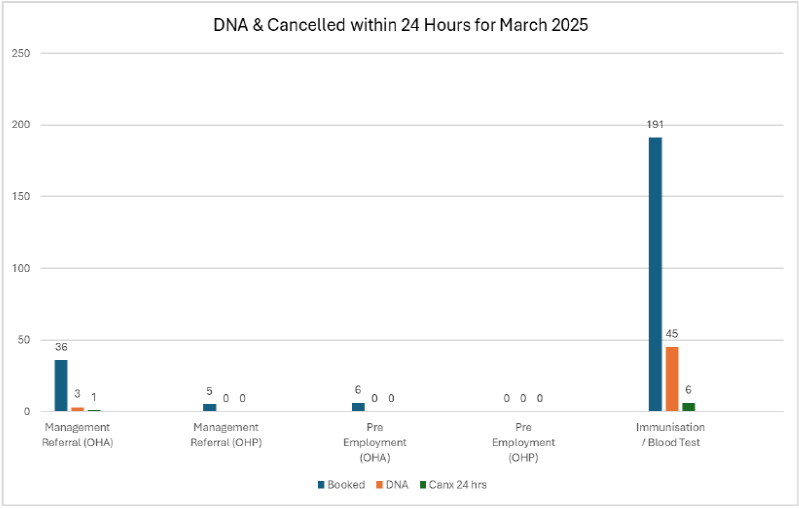
DNA (appointment that did not attend)
Data for DNAs and cancelled within 24 hours for March 2025

March 2025	Booked	DNA	Canx 24 hrs	% Not Attended
Management Referral (OHA)	36	**3**	**1**	**11%**
Management Referral (OHP)	5	**0**	**0**	**0%**
Pre Employment (OHA)	6	**0**	**0**	**0%**
Pre Employment (OHP)	0	**0**	**0**	**N/A**
Immunisation / Blood Test	191	**45**	**6**	**27%**

DNAs (appointment that did not attend) accounted for **20%** of appointment slots.

Appointments that were cancelled within 24 hours by the staff member accounted for **3%** of appointment slots.

In March a total of **21** hours of clinical time was lost due to non-attended appointments.



Cost of DNAs in March: £1,596. (Immunisations = £1,1260).
This is a reduction of £1,175 as Feb which was £2,771 in total.

Blood Borne Virus (BBV) Data

January 2025:
5 BBV incidents were reported to OH - 2 x Theatres, 2 x Endoscopy & 1 x Home Treatment service.

February 2025:
5 BBV incidents were reported to OH – 2 x Theatres, 1 x Portesham Ward, 1 x Cardiac care, & 1 x Ilchester Ward.

March 2025:
7 BBV incidents were reported to OH – 3 x no specific area identified, 1 x Endoscopy, 1 x Ridgeway, 1 x medical & surgical ward and 1 x Prince of Wales.

Occupational Health will continue to send monthly BBV figures and details to DCH H&S Manager to review compliance with Datix reporting.

Other

Following a review of OH referrals, from Jan 2025 to date 6 x Management Referrals have been received where concerns have been raised from employees since the introduction of the new soap commenced. This has been raised with DCH H&S Manager and requires further discussion.

CONCLUSION

2024-2025 has been a successful year. The Trust cases for MRSA Blood Stream Infection (BSI) rates remain low, MSSA BSI rates have significantly dropped this year and are at their lowest rate for the past five years. Gram-negative Blood Stream Infection (GNBSI) rates for E Coli and Klebsiella are at the lowest rate for the last 3 years and within the agreed trajectory level set by NHS England. Gram-negative Blood Stream Infection (GNBSI) rates for Pseudomonas aeruginosa cases are slightly above the trajectory level set by NHS England. Clostridioides difficile infection rates are slightly over trajectory for 2024-2025.

This year we successfully implemented the IPM Patient Safety Incident Response framework, completed the IPM Board Assurance Framework, and linked our compliance with the yearly IPM optimisation plan. We have reviewed and developed many IPM related polices and continued our improved Candida Auris screening processes. Our ongoing IPM audits are showing improved percentages, with some of the audits having been fully reviewed and improved to provide extra assurances of practice and care.

This report demonstrates the continued commitment of the trust and demonstrates the success and service improvement through the leadership of a dedicated and committed IPM team. Infection Prevention Management is the responsibility of all the Trust employees and the IPM team do not work in isolation. The successes over the last year have also only been possible due to the commitment for infection prevention management of all DCHFT staff ensuring IPM is high on everyone's agenda.

The annual IPM optimisation plan for 2024-2025 reflects a continuation of support and promotion of IPM. Looking forward to 2025-2026 we will strive to maintain high standards within IPM and continue to develop strong Antimicrobial Stewardship, ensuring our staff maintain a high level of compliance with IPM. A robust governance

structured approach across the whole organisation will remain crucial in the prevention of all healthcare associated infections.

Throughout 2025-2026 the IPM team will continue to strengthen and support close working relationships with the IPM Integrated Care System. Dorset-wide use of ICNET will continue support this work.

The trust remains committed to preventing and reducing the incidence and risks associated with HCAI's and recognises that we can do even more by continually working collaboratively together with colleagues, patients, service users and careers to develops and implement a wide range of IPM strategies, quality improvement projects and initiatives to deliver clean, safe care in our ambition to have no avoidable infections.

Emma Karamadoukis
IPM lead Specialist Nurse

REFERENCE

Department of Health (2015) Health and Social care Act 2008, Code of practice on the prevention and control of infections and related guidance, Available at: Health and Social Care Act 2008: code of practice on the prevention and control of infections , Accessed 15.04.2023

National Infection Prevention and Control manual for England (2022), NHS England » National infection prevention and control

Dorset County Hospital
NHS Foundation Trust

Infection Prevention Management Optimisation Programme

April 2024 to March 2025

Emma Karamadoukis, IPM Lead Specialist Nurse

Written: April 2024 and continually updated

Introduction

The programme will be monitored through the Infection Prevention Management Committee with a quarterly progress report presented to the meeting and any escalations included in the escalation reports presented at the Quality Committee meeting. Information is also incorporated within the annual report. Each work stream / action is RAG rated as follows:

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

The Key Objectives have been identified from the completion of the IPM Board assurance framework, which aims to demonstrate compliance with the Health and Social Act 2008 and the Ten Criteria outlined in the Act. The objectives have been identified as partially complaint and therefore an area for development or improvement.

Key Objectives

Objective 1: Education - This objective links to the National IPC education framework and compliance with Tier three of the IPM education framework, Tier 1 & 2 have been reviewed, and the trust meets the expected level which is already covered by the IPM mandatory training. The IPM team plan to implement separate face to face training to cover tier three and this work will continue from 2023-2024.

Linked to Criterion 1 IPM **BAF – 1 Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them, specifically - 1.7 All staff receive the required training commensurate with their duties to minimise the risks of infection transmission and Criterion 6** IPM **BAF Appendix 1- Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection, Specifically , - 6.2 The workforce is competent in** IPM **commensurate with roles and responsibilities.**

We will do this by:

- The IPMT to continue to review the recommendations of the IPM education framework - specifically Tier 3 of the framework and plan an implementation training programme to encompass all the learning outcomes. This will be largely but not inclusively, be relevant for all staff who are responsible for an area of care.

- The IPMT will liaise with all ward leads and Matrons to ensure compliance with the IPM education framework.

Objective 2: **Patient Safety - This objective links to IPM monthly audits. Ensuring our audits provides assurance to the trust, that best IPM practice is evidenced with particular reference to Peripheral venous catheter and urinary catheter care.**

Linked to Criterion 1 IPM **BAF – 1 Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them, specifically – 1.4 - They implement, monitor, and report adherence to the NIPCM.**

We will do this by:

- Review each policy related to the audits and identify areas of practice to audit.
- By reviewing our IPM audits and linking with the clinical audit team to ensure our audits link with other trust systems. These audits will support the implementation of the IPM Patient Safety Incident Response Framework (PSIRF).

Objective 3: **Compliance - The IPMT will liaise with specific departments to ensure robust governance structures are in place to ensure close links, demonstrating IPM assurance and departmental collaboration. Which will feed into IPM Committee meetings, highlighting areas of concern and demonstrate clear escalation processes.**

Linked to Criterion 2 IPM **BAF - Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections, specifically** IPM **BAF sections 2.3 - There are clear guidelines to identify roles and responsibilities for maintaining a clean environment (including patient care equipment) in line with the national cleanliness standards, 2.4, There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan. 2.4.1 Ventilation systems are appropriate and evidence of regular ventilation assessments in compliance with the regulations set out in HTM:03-01.**

2.4.2 Water safety plans are in place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM:04-01, 2.8 There is evidence of compliance and monitoring of decontamination processes for reusable devices/surgical instruments as set out in HTM:01-01, HTM:01-05, and HTM:01-06, and Criterion 3 IPM **BAF Appendix 1- Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance, specifically** IPM **BAF sections 3.5 - Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMR are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including:**

- **total antimicrobial prescribing.**
- **broad-spectrum prescribing.**
- **intravenous route prescribing.**
- **treatment course length, 3.6 - Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must**

include all care areas and staff (permanent, flexible, agency, and external contractors).

We will do this by:

- By the IPMT attending all relevant committee meetings and provide IPM support and guidance when relevant.

- The IPMT will request and remind departments for their reports for discussion and review, with recommendations and presentation at the bi-monthly IPM committee meetings.

- The IPMT will liaise with AMS microbiologist and attend the AMS Group meetings to support the role and support the planned QI improvement programme within this speciality.

Objective 4 – Patient Safety - The Implementation of PSRIF (Patient safety Incident Response Framework) within IPM and within the wider Integrated Care system (ICS) for Dorset. Using this framework to review reportable infections whether they be COCA (Community Onset Community Associated), COIA (Community Onset Indeterminate Associated), COHA (Community Onset Healthcare Associated) or HOHA (Hospital Onset Healthcare Associated) cases.

Linked to Criterion 1 IPM **BAF - 1 Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them, specifically** IPM **BAF sections 1.3 - That there is a culture that promotes incident reporting, including near misses, while focusing on improving systemic failures and encouraging safe working practices, that is, that any workplace risk(s) are mitigated maximally for everyone.**

We will do this by:

- The IPM lead, after attending the trust PSIRF workshops and PSIRF training to continue to develop and improve the IPM PSIRF plan.

- The IPM ICS team to work closely together with the aim of developing and improving the PSIRF Post Infection reviews of all COHA & HOHA CDI, MSSA and MRSA cases, exploring and improving out systemwide end-to-end reviews of the patient's journey that led to an infection.

Objective 1 – Education							
Issue	**Desired Outcome**	**Action(s)**	**Evidence/Assurance**	**Lead(s)**	**Target Date**	**Update**	**RAG**
1.1 Ensure DCH achieves Tier 3 of the IPM **education framework**	All Staff responsible for an area of care are complaint with the IPM education framework Tier 3	• IPMT to review the learning outcomes and devise a training plan appropriately.	• System in place.	Emma Karamadoukis/Chris Gover	End 2024	Programme in place by Winter 2024. First session 18th November.	**G**
		• IPMT to review a behaviour change approach, as suggested the COM-B model, and identify how it can be implemented.	• Understand the model and implement with the training programme	Emma Karamadoukis	End 2024	Programme in place by Winter 2024. First session 18th November.	**G**
		• IPMT to link with other specialist teams to support the training programme. IPM to attend and present to the mandatory training request meeting to gain agreement for Tier 3 to be placed on the mandatory training list for specific clinical staff.	• System in place and all clinical leaders attend the training yearly.	Emma Karamadoukis/Chris Gover	End 20204	Programme in place by Winter 2024. First session 18th November.	**G**

Objective 2 – Patient Safety							
Issue	**Desired Outcome**	**Action(s)**	**Evidence/Assurance**	**Lead(s)**	**Target Date**	**Update**	**RAG**
2.1 This objective links to IPM monthly audits. Ensuring our audits provide assurance to the trust, that best IPC practice is evidenced with particular reference to Peripheral venous catheter and urinary catheter care.	IPM audits are robust, ensuring and providing supporting evidence that trust clinical practice, for peripheral venous catheters and urinary catheter care follows policy and supports improvements in compliance across the trust using the audit cycle and audit reports.	• IPMT to review peripheral venous catheters and urinary catheter care polices and ensure they are evidenced and up to date.	• Polices reviewed and up to date.	Emma Karamadoukis/Abigail Warne	May 2024	Roll out completed and continues to be reviewed under PDSA cycle.	**G**
		• IPMT to link with the clinical audit team to develop ways to improve the specific IPC audits, linking with trust systems and ensuring the audit questions provide the assurance required.	• IPMT to improve the specific audit processes, linking with polices and aim to roll out a new audit plan for peripheral venous catheters and urinary catheter care.	Emma Karamadoukis/Abigail Warne	May 2024	Roll out completed and continues to be reviewed under PDSA cycle.	**G**
		• Update the specific IPM audits and update the audit registrations and audit reports as necessary.	• New audits in process that provides the trust with assurance regarding the clinical practice for peripheral venous catheters and urinary catheter care.	Emma Karamadoukis/Abigail Warne	May 20204	Roll out completed and continues to be reviewed under PDSA cycle.	**G**

Objective 3 - Compliance							
Issue	**Desired Outcome**	**Action(s)**	**Evidence/Assurance**	**Lead(s)**	**Target Date**	**Update**	**RAG**
3.1 The IPT will liaise with specific departments to ensure robust governance structures are in place to ensure close links with other key departments related to IPC, supporting IPC assurance and agreement.	IPMT support housekeeping with their compliance, with regards to national cleaning standards.	• IPMT to liaise closely with Sarah Jenkins and support Audits and overall hospital presentation.	• Efficacy audits • PLACE and PLACE LIGHT reviews	Emma Karamadoukis/Chris Gover/Sarah Jenkins/Helen Hindley/Sophie Lloyd	Ongoing but end of 2024.	PLACE and PLACE LIGHT dates to be set for the year 2024. Update date set winter 2024	**G**
	IPMT support the water safety Group with IPM compliance.	• IPMT to liaise closely with Toby Markin the Trusts Authorising Officer and Terry May. • IPMT to attend the Water Quality Management Group (WQMG) meetings and link closely when concerns are raised. Ensuring assurance is provided and any escalations actioned appropriately and escalated to IPM committee meeting.	• Clear escalation plans • Close monitoring of water safety reports and these should feed into the Water Safety Group and IPMC	Emma Karamadoukis/Chris Gover/ Toby Markin/Andrew Kersley	Ongoing but end of 2024.	Summer 2024, water assurances much improved and they are fed into IPCC bimonthly.	**G**
	IPMT support the Ventilation safety Group with IPM compliance	• IPMT to liaise closely with Colin Carver, the Trusts Ventilation Authorising Officer. • Emma Karamadoukis and Cheryl Heard to request a ventilation update for all IPMC meetings. • IPMT to attend the Ventilation Safety Group meetings and link closely when concerns are raised.	• Clear escalation plans • Close monitoring of Ventilation reports and these should feed into the water safety groups and IPMC	Emma Karamadoukis/Chris Gover/Colin Carver/Terry May	Ongoing but end of 2024.	Emma Karamadoukis has requested a Ventilation update for IPCC, using a suggested chart to provide cleaning assurance 2023 - 2024. Ongoing assurance requests. Assurance improving with new joint federation lead within estates.	**G**

Objective 3 - Compliance							
Issue	**Desired Outcome**	**Action(s)**	**Evidence/Assurance**	**Lead(s)**	**Target Date**	**Update**	**RAG**
	IPMT support an effective antimicrobial stewardship in accordance with local and national guidelines.	• Antimicrobial Stewardship action plan to be supported by the IPMT. • AMS working group started 11/12/2023, Dr Cecilia Priestley leading the group. • If IPM funding/staff budget allows, to recruit into a newly developed AMS nurse specialist post.	• Action plan and reports submitted to ICS Antimicrobial Stewardship Committee (ASC) and reviewed at Medicines Committee and Infection Prevention Management Committee.	Cecila Priestley	Ongoing but end of 2024.	Trust appointing consultant AMS pharmacist by end 2024. AMS group has a 24-25 optimisation plan and escalation process, feeding into medicines committee.	**G**
	IPMT support the Decontamination Group with IPM compliance.	• IPMT to liaise closely with Joe Lythe, the Trusts Decontamination Lead. • Emma Karamadoukis and Cheryl Heard to request a decontamination update for all IPMC meetings. • IPMT to support the decontamination lead and deputy in their role.	• Escalation reports and decontamination assurance trust wide, with a robust decontamination trust plan.	Chris Gover/Joe Lythe	Ongoing but end of 2024.		**G**

Objective 4 – Patient Safety							
Issue	Desired Outcome	Action(s)	Evidence/Assurance	Lead(s)	Target Date	Update	**RAG**
4.1 Continued Implementation of IPM PSIRF (Patient safety Incident Response Framework) plan within IPC and the wider Integrated Care system (ICS) for Dorset, aiming to review process and make improvements as deemed necessary.	• DCH IPMT to review and continually develop the implementation of PSIRF for Gram negative/MRSA/MSSA and CDI organisms.	• Emma Karamadoukis to continue to review, develop and escalate the IPC PSRIF plan.	• The IPM PSIRF is robust and follows the PSIRF ideology.	Emma Karamadoukis	Ongoing but end of 2024.	Roll out complete and working well.	**G**
		• IPM lead to link with ward leads, matrons, and divisional heads to ensure an excellent IPC PSIRF plan that identifies learning and quality improvement plans.	• Learning is identified, patient safety improved and ultimately a reduction in healthcare associated infections.	Emma Karamadoukis	Ongoing but end of 2024.	Roll out complete and working well, feeds into IPCC bimonthly.	**G**
	• Following IPM PSIRF thematic review. The IPM lead has suggested a Quality Improvement (QI) plan: To gain assurance that Central venous catheter (CVC) line care practice is consistent across the trust and within policy, aiming to reduce the risk of healthcare associated infections related to CVC care.	• IPM lead and Nutritional nurse lead to develop a QI project in relation to CVC line care practice and driver diagram to focus our plan.	• Completion of the QI project over the following year and CVC line audits to demonstrate improvements and infections rates to show a reduction in HCAI related to CVC line care.	Emma Karamadoukis and Jen Ashmore	March 2025	Update September 2024 - QI project on going and under regular review. Update February 2025 – this project is not via the patient safety governance route and the training will continue via the pathway.	**G**

	• Following urology Audit and escalation of concerns. To ensure better trust documentation for urinary catheter insertions and therefore aim to improve urinary catheter care. Poor documentation noted following a urology audit.	• The trust to agree an improved method for documenting the insertion of urinary catheters and roll out this agreed plan trust wide.	• Urology documentation re audit to demonstrate improved compliance and IPC Urinary catheter Audits to demonstrate improved compliance against agreed standards.	Abigail Warne, Helen Hindley and urology team	March 2025	Nov update, new insertion documentation developed and currently with the documentation group for approval. Still awaiting support from documentation group. However, all IPC action shave been completed and awaiting agreement from documentation group lead.	**G**
	• The System wide process for PSIRF is reviewed regularly and a continual process of development and improvement for the Post Infection review Process is evidenced.	• IPC Integrated Care System (ICS) PSIRF PIR plan to be reviewed regularly and developed with system wide collaboration. Meetings planned 6 monthly to review processes.	• Close working with the wider Dorset system and develop an implementation programme.	IPC ICS Dorset system	Ongoing but end of 2024.	Roll out under constant review but currently fully actioned and working well, with collaboration from the IPC ICS team. SW IPM strategy under review and actioned appropriately.	**G**

Appendix 1 – IPC Board assurance Framework

Linked separately due to large file content.

Appendix 2 – IPC Education Framework

NHS England » Infection prevention and control education framework

Dorset County Hospital
Dorset HealthCare

Finance and Performance Committee in Common Assurance Report for the meeting held on Wednesday 30 July 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

- The DCH board assurance framework risk score has increased for Estates (SR5) resulting from the recent six facet survey which identified a gap in finance related to critical infrastructure and backlog. The DHC six facet survey is not yet complete.
- The Financial Recovery Review Paper and recommendations were considered and discussed in detail by the committee and assurance was provided on the short, medium and long-term organisational approach to meeting the financial challenges. The report was well received and commended by the committee.
- The committee recognise there is significant risk in the delivery of financial plans for both trusts. Acknowledgement that the plans are robust, but incredibly demanding.
- Improvements in Early Intervention in Psychosis and inappropriate out of area placements at DHC were commended by the committee.
- The compressed timelines and interdependencies on system partner plans to produce final winter plans to be noted.

Key issues / matters discussed at the meeting

The committee received, discussed and noted the following reports:

- **Board Assurance Framework (DCH/DHC) – Assigned Risks**
  Three risks are assigned to this Committee:
  - SR4 Capacity and Demand
  - SR5 Estates
  - SR6 Finance

  For DCH, the risk score has increased for Estates (SR5) resulting from the recent six facet survey which identified a gap in finance related to critical infrastructure and backlog. The DHC six facet survey is not yet complete. For DHC the risk scores remain unchanged. There is one overdue action relating to the subsidiary company (which is currently on pause).

- **Corporate Risk Register – Assigned Risks**

The Committee received the DCH and DHC reports covering quarter 1 (Q1) for assurance. For DCH there are 4 risks rated 20+ and 12 risks have been closed since last quarter. For DHC, no new risks have been identified in Q1, no risks have been closed and there has been a reduction in scores for 4 risks. The committee agreed more work can be done on how information is presented and pulled through from the risk management 'system' such as clear indication of mitigations in place, and dates of an expected change.

- **Performance Assessment Framework Update**
  A draft NHS performance framework has been received, and DHC and DCH will be undertaking a baseline assessment against the framework to determine any areas for development in current performance reporting. The final outputs of the assessment will be re-presented to the Finance and Performance Committee in September 2025 for both Trusts.

- **DCH Performance Report**
  - Demand has increased for ED and admissions in June along with rising average length of stay and high numbers of patients with no reason to reside, which in part is being addressed by the Futurecare initiative.
  - There have been strong elective activity levels. The total waiting list size has decreased and the number of patients waiting over 52 weeks is on plan.
  - Diagnostic performance has declined, with a growing backlog in Endoscopy, Cardiology, Ultrasound and Neurophysiology. A whole trust recovery plan is in development for this key metric.
  - A new operational productivity section was summarised and well received by the committee noting that DCH benchmarked well which is a credit to the teams

- **DHC Performance Report**
  - The previously reported off track Early Intervention in Psychosis (EIS) metric returned to within threshold as anticipated in June 25 mainly due to resolution of staffing issues.
  - Out of area placements remain within planned trajectory. An ambitious target is in place to reach 0 by the end of August 2025 and some fluctuations are to be expected.
  - Concerns raised about on the deteriorating dementia diagnosis rates. The ICB leads on this metric and are reviewing diagnostic pathways to inform improvements.
  - Deteriorating position on CYP mental health gateway access indicator is anticipated to recover in the next quarter.
  - Challenges continue in meeting the national 20-minute call back standard in the Integrated urgent care service. Currently reliant on temporary workforce and hope to move to more substantive workforce.

- Improvement in inpatient flow and overall length of stay.

- **Winter Plan**
  Following publication of the NHSE Urgent and Emergency Care Guidance, the rhythm of winter planning has been brought forward for 25/26, requiring all provider trusts to take winter plans to August Board meeting. This therefore required the plan to be developed and tabled to committee in July. The draft plans for respective Trusts were summarised to committee recognising that the level of detail in the plans will increase in the coming weeks as more information comes to light from system partners. All plans need to be delivered within existing financial envelopes, no additional will funding will be received for winter pressures. Subject to additional further changes and layers of detail, the committee recommended the plans to respective Trust Boards.

- **Finance Review Outputs**
  The committee received a verbal summary of the Financial Recovery Review paper which resulted in good quality discussion and recognition amongst committee members of the significant financial challenges ahead acknowledging the risks to delivery of plans, balanced with strong solutions and governance structures to support the meeting of the large scale challenge. The review was undertaken in June 2025 by South Warwickshire Clinical services and was designed to assist the Trusts in the delivery of their financial recovery objectives for 2025/6 and beyond. The series of recommendations in the report have been accepted by both Trusts and used to inform an action plan. The review identified that both trusts have made commendable progress on this agenda given the scale of the requirement and were very engaged in the review process. Areas for action include, but are not limited to, the appointment of a financial recovery director and the creation of a financial recovery board across both Trusts to meet on a bi-weekly basis chaired by the CEO and underpinned by an internal PMO largely comprising knowledgeable and experienced internal staff.

- **DCH Finance Report**
  At month 3, DCH delivered a deficit of £2.3million which is very closely in line with plan leading to a YTD planned deficit of £7.7m. Agency expenditure has continued at lower than budgeted levels. There has been increased usage of Bank workforce. Enhanced workforce controls are in the process of being determined to support pressures in bank overspends The DCH efficiency target for the year is £29.1m which is 9% of expenditure budgets. At month 3, £2.7m has been delivered against £3m plan. Total schemes identified stand at £24.5m with £4.5m of unidentified schemes. The cash position as at 30 June was £24.6m, £8.9m ahead of plan. Capital plan spend is ahead of plan by £0.4m.

- **DHC Finance Report**
  At month 3, DHC delivered a deficit of £1.4m which is favourable to plan by £94k. The Trust has delivered savings of £1.7m against a month 3 ytd target of £1.6m. The Trust's full year efficiency target is £38.5m. The forecast indicates an actual year-end deficit of £9.47m against a planned surplus of £9.77m. This assumes no further savings are found and spend continues at current rates. Positive work recognised to reduce the spend on out of area placements and agency usage, however, spend on bank usage has increased compared to last year.

- **Risk Management System Procurement**
  Paper was deferred to be updated and brought back to next committee.

- **Somerset HASU Update**
  The business case for the Extension of the Stroke HASU was presented to FPC (29th May) and Board (10th June) and approval was given to proceed subject to capital affordability, at this time a gap in capital funding of £422k was highlighted. The tender exercise resulted in a reduction to expected capital costs of £456k against the pre-tender quote. While work is still ongoing to finalise total capital project works including enabling works, equipment and VAT assumptions, current estimates indicate capital affordability due to this improvement. An update was received for awareness.

- **Health and Safety (including fire and water) Compliance Report (DHC)**
  No areas of concern were raised from the annual report. The Design in Mental Health conference in June saw Seastone CAMHS development winning 'Project of the Year' for Future Design (UK) which was commended by the committee.

The following escalation reports from sub groups were received for assurance by the committee members:

- DHC
  - Capital Investment Meeting
  - Better Quality, Better Value
- DCH
  - Capital Planning and Space Utilisation Group
  - Value Delivery Board

Decisions made at the meeting

Approvals by DCH and DHC committees:

- Radiology Service Transfer
- National Cost Collection Report

	• 2 Nuffield Road Project – Committee agreed the increase in the updated cost plan of an additional £480k to enable the project to progress.
Issues / actions referred to other committees / groups	• None

Quoracy and Attendance				
	29/05/2025	**30/07/25**		
Quorate?	**Y**	**Y**		
Dave Underwood	Y	Y		
Frances West	N	Y		
Stephen Tilton	Y	Y		
Andreas Haimbock-Tichy	Y	Y		
Chris Hearn	Y	Y		
Nick Johnson	N	N		
Rachel Wharton	N	N		
Anita Thomas	Y	Y		
Lucy Knight	Y	N		
Rachel Small	N	Y		

Report to	Board of Directors	
Date of Meeting	12th August 2025	
Report Title	Balanced Scorecard- An integrated report for the reporting month of June 2025	
Prepared By	Adam Savin, Director of Operational Planning and Performance	
Approved by Accountable Executive	Anita Thomas, Chief Operating Officer	
Previously Considered By	Anita Thomas, Chief Operating Officer Claire Abraham, Deputy Chief Finance Officer Emma Hallett, Deputy Chief People Officer Louisa Way, Deputy Director of Nursing	
Action Required	**Approval**	-
	Assurance	X
	Information	-

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues		No
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	Safety and Quality, capacity and demand and strategic risks	
Financial	ERF	
Statutory & Regulatory	Reporting against, constitutional and contractual standards	
Equality, Diversity & Inclusion	N/A	
Co-production & Partnership	N/A	

Executive Summary

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

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

Key areas to highlight:
Quality

- Emergency readmissions within 30 days of discharge have remained relatively static at 11.11% compared. This is below the 13% target but is special cause variation of a concerning nature, with a mean of 8.58%.
- Electronic Discharge Summary sent within 24h of discharge remains below target at 75.13% but it has improved by 12% since December, which was at 63.73%. The metric is special cause variation of a concerning nature, with a mean of 76.92%.
- SHMI has remained within the expected range and continues to show as special cause variation of an improving nature, with a value of 1.05 and a mean of 1.13.

Performance

- UEC performance against the 4 hour standard, did meet the national planning guidance of 78% and is showing as common cause variation with a mean of 81.74%.
- Cancer performance did achieve the 28 day to diagnosis standard and the 31d but the 62 day treatment standards was met.
- The total waiting list size is larger than plan but is reducing. The waiting time measures did achieve the standards. The continues to be no patients waiting over 65 weeks.
- Bed occupancy was higher than plan, but the number of occupied beds was lower. Attendances and admissions were above plan for quarter 1, driving the need for few occupied bed days.

People

- Essential skills rate dropped slightly to 88% and is 2% below target
- Appraisal rate dropped slightly to 78.4% from 79.12% in April
- Vacancy rate increased from 4.19% to 5.9% and is above the 5% target. This is driven by holding vacancies as part of the workforce reductions.
- Turnover reduced to 9.2% from 9.49% and remains better than target
- Sickness rate reduced to 4.04% from 4.19%, this is higher than target for this time of year

Finance

- Adjusted financial plan is £7k ahead of plan
- Agency underspend vs plan of £390k YTD.
- Capital expenditure is slightly ahead of plan, due to timing of expenditure digital and medical equipment replacement, along with Digital EHR and stroke works design fees.

Recommendation
The Board are asked to note this report.

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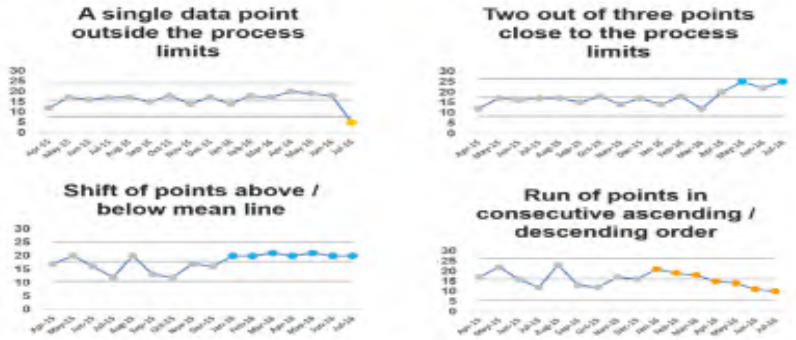
1) Understanding Statical Control Charts (SPC)

Is Performance Changing?

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

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

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



What are Summary Icons showing?

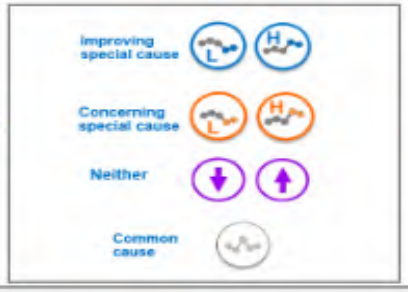
Blue icons indicate significant improvement or low pressure.

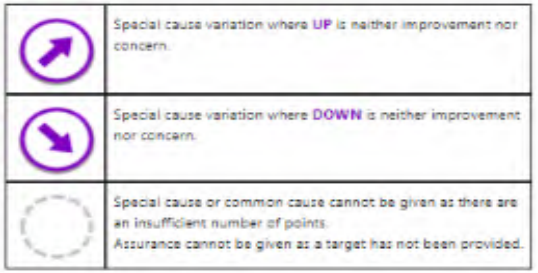
Orange icons indicate significant concern or high pressure.

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

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

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





What is a Moving Range Chart showing?

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

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

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

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

The moving range chart will display below all SPC visualisations.

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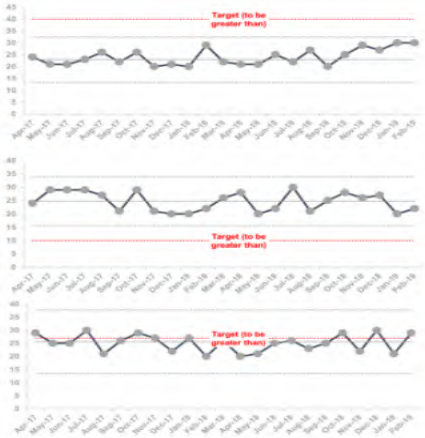
Assurance icon

Up is good (need to be greater than the target



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

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

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

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

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2) Executive Summary- metrics that are classed as "concern for variation and/or "fail" for assurance

QUALITY & SAFETY

Metric Name	Assurance	Variation	Value	Target
Incidents - Pressure Ulcers Category 4 Hospital Acquired by Incident Date	F	H	1	0
Inpatient - EDS % Available < 24 Hours of Discharge	F		75.13%	90%
Inpatient - EDS % Available < 7 Days of Discharge	F		85.05%	100%
Inpatient - Emergency Re-Admissions % (1 month in arrears)	P	H	11.11%	13%
Inpatient - SHMI Value	F	L	1.05	1

PERFORMANCE

Metric Name	Assurance	Variation	Value	Target
Cancer - 31 Day Decision to Treatment Standard Performance	?	L	94.77%	90.95%
ED - Ambulance Handovers Average (Minutes)	P	H	16.91	21.11
ED - ED Attendances % Waiting 12+ Hours	P	H	6.16%	11.52%
ED - Unplanned ED Attendances	?	H	5054	4739
Inpatient - Average Adult General and Acute (G&A) Bed Occupancy	?	H	312	312
RTT - 52+ Week Waits % of Waiting List	F	L	1.68%	1.8%
RTT - Patients % Waiting < 18 Weeks	F	H	58.98%	58.7%
RTT - Waiting List Size	P	H	22415	21649

PEOPLE

Metric Name	Assurance	Variation	Value	Target
Appraisal rate	F		74.81%	90%
Essential Skill Rate	F	L	88%	90%

FINANCE

Metric Name	Assurance	Variation	Value	Target
Agency Spend	F	L	367.21	456
Efficiency Delivery	P	H	944	1163
Local Supplier % of Catering Spend	?	L	16.44%	25%
Local Supplier % of Total Spend	F		7.1%	30%
Off Framework Agency Spend	F	L	1	0

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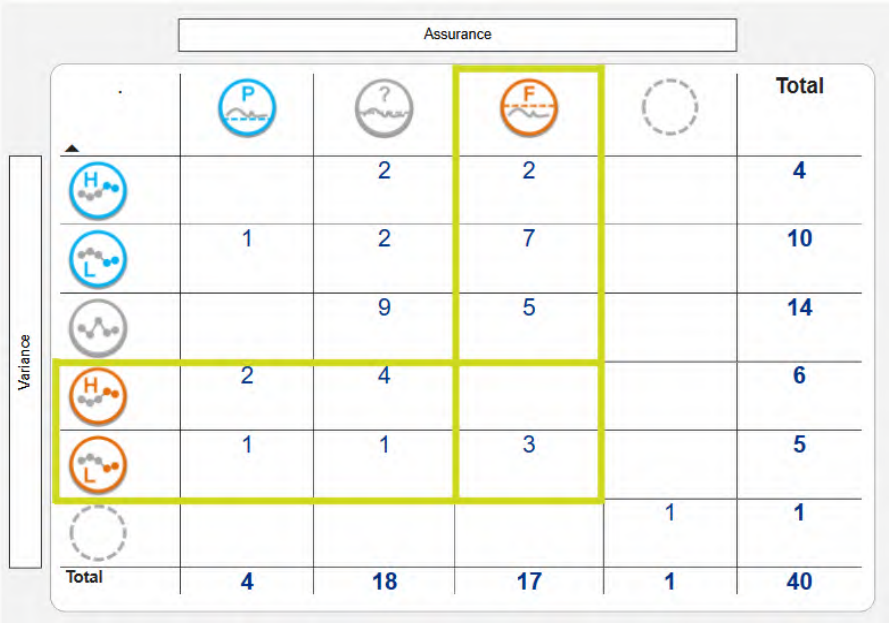
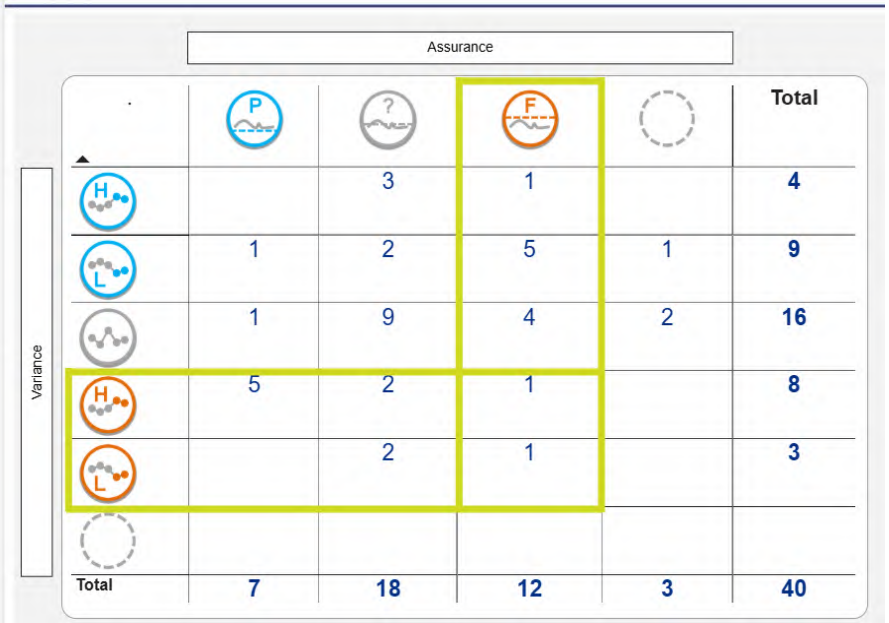
April 2025 data



June 2025 data



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

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3) Quality and Safety dashboard

Metric Group	Metric	Group	Latest Month	Value	Target	Variance to Target	Mean	PY - Month Value	YTD Value	Variation	Assurance
Effectiveness	Inpatient - EDS % Available < 24 Hours of Discharge	0 - Total	Jun-25	75.13%	90%	-14.87%	76.92%	75.3%	75.13%		
Effectiveness	Inpatient - EDS % Available < 7 Days of Discharge	0 - Total	Jun-25	85.05%	100%	-14.95%	87.31%	83.57%	85.05%		
Effectiveness	Inpatient - Emergency Re-Admissions % (1 month in arrears)	0 - Total	May-25	11.11%	13%	-1.89%	8.58%	9.91%	11.11%		
Experience	Complaints - All Complaints Received	0 - Total	Jun-25	96			67	128	249		
Experience	Friends and Family - Overall % Recommendation Rate	0 - Total	Jun-25	98.08%	94%	4.08%	92.46%	90.8%	98.08%		
Safety	Incidents - Confirmed Never Events	0 - Total	Jun-25	0	0	0.00	0.07	0	0		
Safety	Incidents - Falls Resulting in Severe Harm or Death by Incident Date	0 - Total	Jun-25	0			0.11	0	0		
Safety	Incidents - Medication Incidents by Incident Date	0 - Total	Jun-25	82			86.13	98	224		
Safety	Incidents - Pressure Ulcers Category 4 Hospital Acquired by Incident Date	0 - Total	Jun-25	1	0	1.00	0.11	1	1		
Safety	Incidents - Serious Incidents Investigated and Confirmed Avoidable by Pan...	0 - Total	Jun-25	0	0	0.00	0.37	0	0		
Safety	Infection Control - C-Diff Healthcare Associated Cases	0 - Total	Jun-25	2	4.17	-2.17	3.85	6	10		
Safety	Infection Control - Gram Negative Blood Stream (Klebsiella spp / Pseudom...	0 - Total	Jun-25	1	1.08	-0.08	1.52	0	6		
Safety	Inpatient - SHMI Value	0 - Total	Jan-25	1.05	1	0.05	1.13	1.11	1.05		

- Electronic Discharge Summary – Qi project with revised membership now confirmed. E have been in discussion with SFT colleagues who have recently undertaken this work. Meetings arranged to learn from their project and see where we can implement improvements both within clinical and digital workflows.

- Emergency readmissions – (data is 1 month in arrears) we remain below the upper threshold of 13%, however we note the last 3 months have demonstrated a downward trajectory

- Standardised Hospital Mortality Index – (data is 5 months in arrears) maintaining a stable downward trajectory towards the target of 1. Mapping has occurred against new parameters and we remain within range.

- Falls – There were no falls in June that resulted in severe harm or death. However, we noted the spike in all harm fall events during May and are performing a deep dive to identify any themes, reporting through the Patient Safety Committee. Joint working with DHC on falls prevention and management is beginning.

- Medication incidents – The SPC parameters for incident reporting are now reset to reflect the positive reporting of no and low harm events and are now within expected range. No severe events reported in month.

Narrative provided by Louisa Way, Deputy Director of Nursing (Acute Care).

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4) Performance dashboard

Metric Group	Metric	Group	Latest Month	Value	Target	Variance to Target	Mean	PY - Month Value	YTD Value	Variation	Assurance
Cancer	Cancer - 28 Day Faster Diagnosis Standard Performance	0 - Total	Jun-25	75.46%	75....	0.40%	70.81%	73.01%	75.46%		
Cancer	Cancer - 31 Day Decision to Treatment Standard Performance	0 - Total	Jun-25	94.77%	90....	3.82%	95.74%	90.57%	94.77%		
Cancer	Cancer - 62 Day Referral to Treatment Standard Performance	0 - Total	Jun-25	64.23%	70%	-5.77%	71.09%	74.92%	64.23%		
Outpatient	RTT - 52+ Week Waits % of Waiting List	0 - Total	Jun-25	1.68%	1.8%	-0.12%	6.69%	7.95%	1.68%		
Outpatient	RTT - Patients % Waiting < 18 Weeks	0 - Total	Jun-25	58.98%	58.7%	0.28%	56.08%	51.36%	58.98%		
Outpatient	RTT - Patients % Waiting < 18 Weeks for First Activity	0 - Total	Jun-25	64.7%	65%	-0.30%	62.29%	56.13%	64.7%		
Outpatient	RTT - Waiting List Size	0 - Total	Jun-25	22415	21649	766.00	20027.56	22619	22415		
UEC	ED - Ambulance Handovers Average (Minutes)	0 - Total	Jun-25	16.91	21.11	-4.20	14.8	21.23	16.91		
UEC	ED - DCH 4 Hour Performance %	0 - Total	Jun-25	68.26%	58....	9.62%	68.67%	58.65%	68.26%		
UEC	ED - ED Attendances % Waiting 12+ Hours	0 - Total	Jun-25	6.16%	11....	-5.36%	4.74%	11.5%	6.16%		
UEC	ED - Overall 4 Hour Performance %	0 - Total	Jun-25	83.42%	78....	5.24%	81.74%	78.19%	83.42%		
UEC	ED - Unplanned ED Attendances	0 - Total	Jun-25	5054	4739	315.00	4443.48	4640	14745		
UEC	Inpatient - Adult General and Acute (G&A) % Bed Occupancy	0 - Total	Jun-25	98.82%	96....	1.93%	97.81%	98.71%	98.82%		
UEC	Inpatient - Average Adult General and Acute (G&A) Bed Occupancy	0 - Total	Jun-25	312	312	0.00	300.13	304	312		

For the reporting month of June 2025, 2 metrics had failed assurance, 8 were hit or miss and 4 were pass. All metrics have a target, which is included in the 2025/26 operating plan.

Cancer- Performance of the 28 days to diagnosis standard overachieved against the target. The FDS metrics has a variation of common cause and an assurance of hit or miss. The 31-day cancer indicator did achieve the target, with an assurance rating hit or miss. The trust did not achieve the 62-day treatment standard with a variance of common cause and an assurance rating of hit or miss.

The waiting list size was larger than planned and has a variation of special cause of a concerning nature, but an assurance rating of pass. The waiting list size has come down and the variance off plan, has reduced. The percentage of patients on the waiting list that have been waiting over 52 weeks is better than plan but with an assurance rating of fail, with the waiting list size bigger than plan. Performance against the two 18 week standards both met the plan, with waits for first activity having an assurance rating of hit or miss and the total 18 week incomplete standard, with an assurance rating of fail.

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For all Urgent and Emergency Care (UEC) metrics, the assurance rating is hit or miss, apart from bed occupancy which is fail and 4-hour performance and 12 hour waits, which both has an assurance rating of pass. The trust continues to see a high levels of no reason to reside and as a result, length of stay is higher than plan. This has resulted in a delay to bed reduction plans, as part of the wider bed reduction plan.

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

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

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5) People dashboard

Metric Group	Metric	Group	Latest Month	Value	Target	Variance to Target	Mean	PY - Month Value	YTD Value	Variation	Assurance
Growing for our Future	Essential Skill Rate	0 - Total	Jun-25	88%	90%	-2.00%	88.73%	89%	88%		
Looking After our People	Appraisal rate	0 - Total	Jun-25	74.81%	90%	-15.19%	75.86%	73.2...	74.81%		
Looking After our People	Sickness Rate (1 month in arrears)	0 - Total	May-25	4.04%	3.75%	0.29%	4.06%	3.72%	4.04%		
Looking After our People	Staff Turnover Rate	0 - Total	Jun-25	9.2%	12%	-2.80%	9.66%	9.38%	9.2%		
Looking After our People	Vacancy Rate	0 - Total	Jun-25	5.9%	5%	0.90%	6.33%	3.33%	5.9%		

- Essential skills rate remained at 88% and 2% below target
- Appraisal rate reduced minimally to 78.4% from 79.12% and remains below target. The table above shows 74.81%, this is a timing issue with when the report was run. It is 78.4%. All other metrics are correct.
- Vacancy rate increased from 4.19% to 5.9% and remains better than the target
- Turnover decreased marginally from 9.3% to 9.2% and remains better than target
- Sickness rate reduced to 4.04% from 4.19%, and remains above target

Essential skills remained at 88%; 2% short of achieving the target. At present this is special cause variation of a concerning nature and an assurance rating of fail without process redesign. Recovery plans are underway in the five training elements where individual compliance is under 80%. 'Get me green' support days are being launched from Month 4. The overall appraisal rate reduced minimally. The assurance classification remains as fail, without process redesign. Feedback relating to the quality of appraisals remains good, both in the appraisee follow up survey and the relevant staff survey questions. Appraisals (both compliance and effectiveness) have been identified by several divisions as an area of action in response to the 2024 Staff Survey results. In response to this a ‘Meaningful Appraisal’ module has been added to the Management Matters training offer. Both the turnover and vacancy rates remain largely unchanged in month, these indicators remain special cause of an improving nature, with processes capable of consistently passing the target for turnover but hit or miss for vacancy rate. The overall sickness percentage has decreased for five consecutive months, decreasing in month 2 (May) by 0.01% to 4.04%. Long term absence decreased in month by 0.19% to 1.90%. Short term absence increased by 0.15% to 2.14%. The rolling year sickness figure has reduced from 4.6% to 4.4%.

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**Narrative provided by Cathrine Youers, Head of People Services*

6) Finance dashboard

Metric Group	Metric	Group	Latest Month	Value	Target	Variance to Target	Mean	PY - Month Value	YTD Value	Variation	Assurance
Capital	Capital Expenditure	0 - Total	Jun-25	2254	1860	394.00	1959.57	1602	4870		
Capital	Cash Position	0 - Total	Jun-25	24550	15653	8,897.00	13183.53	9660	24550		
Revenue	Adjusted Financial Position	0 - Total	Jun-25	-2297	-2292	-5.00	-15.48	-1535	-3145		
Sustainability	Local Supplier % of Catering Spend	0 - Total	Jun-25	16.44%	25%	-8.56%	21.42%	25.46%	16.44%		
Sustainability	Local Supplier % of Total Spend	0 - Total	Jun-25	7.1%	30%	-22.90%	6.55%	6.22%	7.1%		
Value Board	Agency Spend	0 - Total	Jun-25	367.21	456	-88.79	893.16	536	1017.18		
Value Board	Efficiency Delivery	0 - Total	Jun-25	944	1163	-219.00	464.08	632	2696		
Value Board	Off Framework Agency Spend	0 - Total	Jun-25	1	0	1.00	73.63	14	73		

- **Adjusted Financial Position (against control total)**
  £7k ahead of YTD plan - underspends seen in non pay pending review ahead of release to CIP linked to timing of activity invoices and implementation/roll out of new Inventory Management System. £22.4k of Yeovil maternity costs are included in the position offset by income at this stage.

- **Agency Spend**
  Agency underspend vs plan of £390k YTD - continued strong performance across nursing and medical spend down from prior months. Total agency as % of pay at 1.5% in month

- **Off Framework Agency Spend**
  Off framework usage in SCBU, paeds Kingfisher, Mary Anning, and critical care - daily safe staff meeting to break glass in exceptional circumstances

- **Efficiency Delivery**
  KEY ACTION AREA. Undelivered must be recovered - detailed weekly reporting to JEMT and Value Delivery Board oversight with weekly support meetings in place with key areas. Non recurrent delivery areas under review ahead of releasing to CIP.

- **Cash**
  Receipt of NR £13m NHSE funding, ICB and HEE funding plus careful cash management. Continued risk of cash shortfall expected to be challenging during H2 with system conversations ongoing.

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- **Capital expenditure (total)**
  Ahead of plan timing of expenditure digital and medical equipment replacement, along with Digital EHR and stroke works design fees.

*Narrative provided by Claire Abraham, Deputy Chief Financial Officer

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7) All metric glossary

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

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Report to	DCH Board of Directors	
Date of Meeting	12th August 2025	
Report Title	DCH Finance Report – Month 3 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 three delivered a deficit of £2.297 million after technical adjustments, being £0.005 million worse than plan of £2.292 million deficit. The year to date position sees the Trust £0.008 million ahead of its £7.709 million deficit planned position.

Within this position, £22.4k 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.

Agency expenditure has continued at lower than budgeted levels, with total month spend of £0.362 million being £0.094m better than plan in month and £0.4m better year to date. This is an ongoing improvement area which is being extended to medical agency.

Increased bank usage has been seen in ED, Mary Anning and Ilchester wards, along with SCBU, Kingfisher and Theatres. Clinical coding and Estates and Facilities, in particular catering and security have also seen ongoing high this month. 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 c.£1m overspend against plan (including expected phased CIP reductions) year to date.

Break glass Off Framework expenditure is being incurred each month, with £0.001 million incurred in month three taking the year to date expenditure to £0.052 million, with NHS England expecting nil Off Framework spend from July 2024.

The Trust wide efficiency target for the year stands at £29.1 million and is circa 8.7% of expenditure budgets in line with peers and national planning expectations.

Year to date, the Trust has delivered £2.7 million against the £3 million plan, being 9% of total target delivered. The total schemes identified stand at £24.5 million with £4.5 million of unidentified schemes (15%). 40% of schemes are classed as high risk at £11.5m, £5.7m as medium risk being 20% and the remaining £2.7 million classed as low risk at 16%.

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.

Weekly meetings have been established for all areas off plan noting essential to remain on track for the year.
Efficiency delivery remains a significant challenge and key focus area for the Trust with a further detailed report being presented to the Committee this month.

The cash position as at 30 June was £24.6million, £8.9 million 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 Q1 Health Education 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 3 spend totaling £2.3 million, which is ahead of plan by £0.4 million.
Externally funded projects are £0.8 million ahead of plan due timing of expenditure in the New Hospital Programme (NHP) construction works.
Included in the capital plan are bids that the Trust has made to NHS England for Critical Infrastructure 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.

Key Actions
Whilst the Trust remained within the planned position for quarter three, 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. Further Executive led oversight is in place in conjunction with proposed further interventions detailed in a separate report to Committee to help ensure delivery of plans as the year progresses.

Recommendation

The Board is recommended to:

1) Receive the month three financial position for the financial year 2025/26 for **assurance**.

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Financial Position Update 2025/26

June 2025 - Month 3

Chris Hearn
Chief Financial Officer

Healthier lives Empowered citizens Thriving communities

Financial Position Update - June 2025

Executive Summary

A summary of progress is presented for the period of June 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 June 2025, Dorset County Hospital NHS Foundation Trust (DCHFT) has delivered a deficit of £2.3 million after technical adjustments, an adverse performance of £0.005 million against plan. Year to date, the Trust is £0.008 million favourable to a planned deficit of £7.7 million. Within this position, £22.4k 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.

DCH has achieved £2.7 million YTD of the planned £3 million efficiency target at month 3, with the remaining £0.3 million slippage driven by a number of areas largely relating to Estates & Facilities schemes behind plan; timing of drugs spend and bank reduction CIP schemes behind plan.

The Trust wide efficiency target for the year stands at £29.1 million and is roughly 9% of expenditure budgets. While Exec led meetings are driving the efficiency schemes forward, £4.5 million remains unidentified. Of the £24.6 million of identified schemes, £11.5 million are rated high risk and there is significant work being prioritised at pace to lower this risk. Updates on this key workstream is being reported to Committee this month.

Agency expenditure has continued to maintain a reduction against plan for M3 and is £94k below planned levels for June 2025 and £0.4m under year to date. Medical agency reduction is a strong focus for the Trust alongside continued work on Nursing agency. Reduction in bank expenditure is also a key focus area nationally with Workforce engagement in place in this area looking to deliver enhanced controls across the Trust and align as appropriate with Dorset HealthCare procedures.

The Trust is progressing with the capital programme for 2025/26 with month 3 YTD spend totalling £4.9 million, which is behind plan by £0.1 million. Externally funded projects are £0.8 million behind plan due to timing of expenditure in the New Hospital Programme (NHP) construction works with internally funded schemes and donated schemes ahead of plan by £0.7 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 form NHS England in June 2025 and is awaiting the outcome from NHS England of submitting business cases for the Constitutional Standard Bids.

The cash position as at 30 June was £24.6 million, £2.9 million behind 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 (£2.9) million is due to net impact of timing of PDC drawdown (£3.2) million offset by funding for depreciation £0.3 million received from Dorset ICB. Cash remains a significant focus area for the Trust with daily monitoring in place for active mitigations where appropriate.

Financial Position Update - June 2025

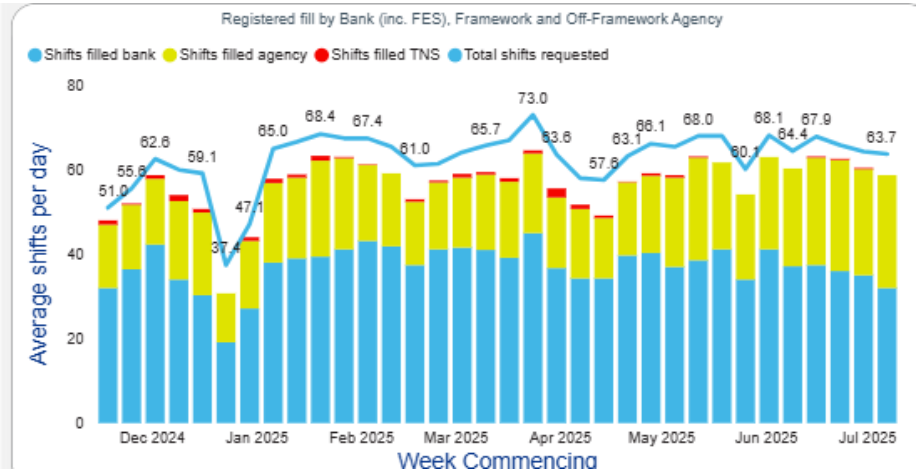
Key Risks

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 redcution 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 largely achieve this, 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 maintaining 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 3 due to continued approach to utilise bank before resorting to agency noting cover for vacancies,sickness, maternity and operational pressures. Further workstreams have been requested to ensure bank is utilised under the appropriate circumstances, rosteris 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.

Financial Position Update - June 2025

Key Risks

Red Risks:

Financial Forecast Risk

There is a risk of delivering the break even position due to the challenging financial envelopes and significant efficiency plan levels. The Trust is actively deploying targeted support towards achievement, led by the CFO and supported by the wider Executive team in order to mitigate the risk to financial balance with stretch targets agreed for efficiencies, productivity, bank and agency to the end of the financial year.

System Elective Services Recovery - income performance

The Elective Services Recovery Funding (ESRF) available to each Integrated Care Board (ICBs) has been included in contract envelopes for 2025/26. The financial year 2025/26 national target is to see a 27% reduction in the elective activity levels seen in 2024/25 and is consistent with the operational plan. While providers are technically still on full ERF contracts, NHSE has imposed ERF caps at ICB levels and so it is crucial the Trust work within these constraints to deliver our system position.

Activity levels will be monitored throughout the year to ensure the Trust stays in line with the operational plan.

Cash Position

There is a risk to cash levels throughout the year due to 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.

NHS
Dorset County Hospital
NHS Foundation Trust

Key Risks

Amber Risk:

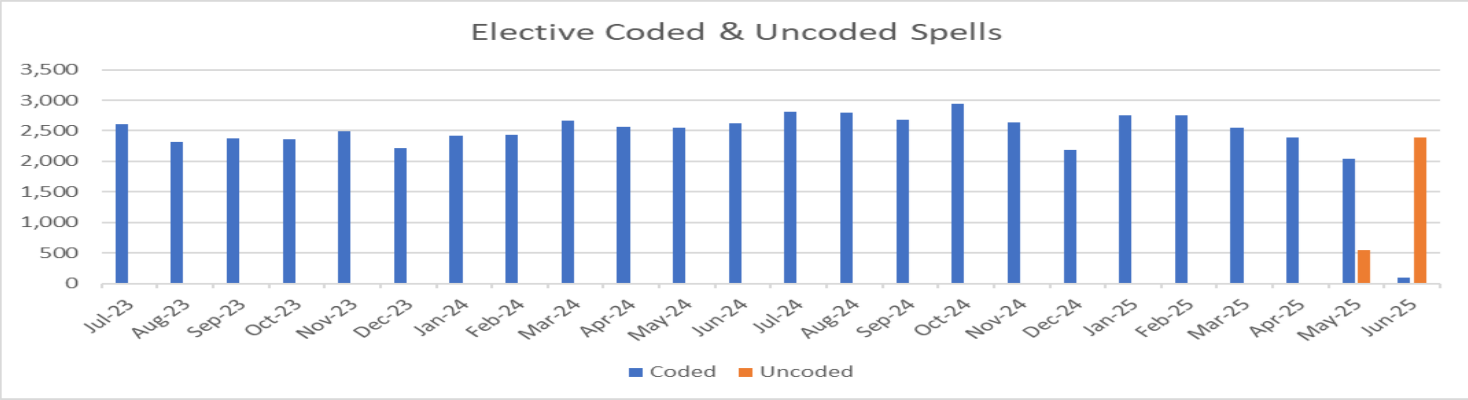
From 2023/24 NHS England introduced the Aligned Payment and Incentive (API) approach to all NHS standard contracts. This approach splits the payment mechanism for the majority of NHS contracts into two envelopes, Fixed and Variable.

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

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

The tariff for each patient is calculated based on their clinical coding assessment. Coding is operated on a flex/freeze model where final coding must be completed by the freeze date to qualify for payment. The freeze date is typically 7 weeks after the end of the month in which the activity occurred, the full timetable is included for information. Any elective activity that remains uncoded after the applicable freeze date represents a loss of income for the Trust.

As at June 2025, the Trust has 2,945 uncoded elective spells & 4,918 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.

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Financial Position Update - June 2025

Key Focus Actions

'**Focus on delivery of existing plans – weekly focus and rigour**
- DCH Recovery Group re-established with CEO Chair
- Essential not to lose pace on non pay & income efficiency delivery noting focus on pay elements
- Productivity analysis, development and embedding per efficiency scheme, utilising GIRFT, Model Hospital, relevant benchmarking
- Interdependencies required for all schemes to understand and prioritise resources effectively
- EEQIA focus linked to all relevant efficiency schemes

Close the unidentified gap
- Revisit all system workstreams clarity & pace, including unpalatables
- Consider bringing forward schemes at pace/acceleration
- WF enhanced controls – essential (bank/rostering/job planning/targeted freeze or delays)
- Wider grip & control focus – controllable spend and overspending mitigations essential to remain in budget
- Critical not to lose sight of underlying recovery required

Dorset County - non delivery impact on cash shortfall H2 – essential Trust action in hand

Key KPIs for weekly reporting to Joint Executive Management Team/Recovery Group/Dorset System:
- Activity key performance against plan - focus on escalated bed numbers
- Workforce performance against plan – WTE & £ reduction, focus on further controls implemented 25/26
- Efficiency delivery/unidentified – fully developed/plans in progress/opportunities/unidentified reporting
- Monthly financial performance vs plan & forecast trajectory
- Cash (noting daily cash reporting to CEO/CFO)

Financial Position Update - June 2025
Income & Expenditure

Dorset County Hospital NHS Foundation Trust

Income and Expenditure

The overall revenue position of the Trust in Month 3 is a deficit of £2.297 million after technical adjustments, an adverse performance of £0.005 million against a plan of £2.292 million deficit. Year to date, the Trust is £0.008 favourable (£7.702 million deficit) to a planned deficit of £7.709 million.

The Trust has seen an increase in both emergency attendances and non elective admission in June, with high levels of no criteria to reside patients (see Performance report). Included within the substantive pay overspend (offset by vacancies) is c.£0.595m 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 largley 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.

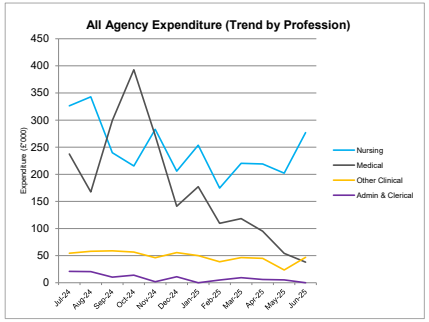
The Trust has a challenging plan for 2025/26, including current CIP plans of £29.1m (approx 9% of expenditure budgets). This includes mandated guidance on reducing Agency spend by a further 30%, Bank Spend by a further 10% with the Trust driving a further push to 20%, and with NHSE focused corporate cost savings of c.£3.5m.

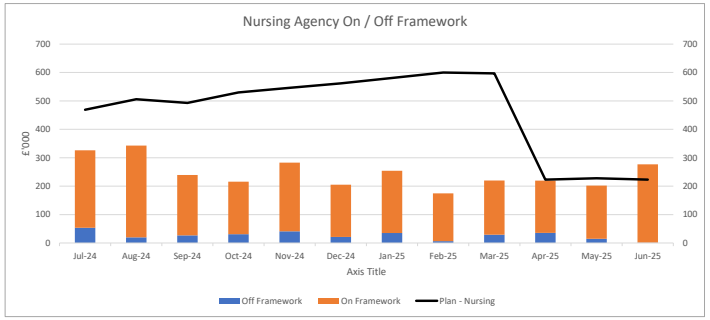
Statement of comprehensive income	In Month			YTD		
	Current Plan £'000	Actual £'000	Variance £'000	Current Plan £'000	Actual £'000	Variance £'000
Employee expenses:						
- Substantive	(16,255)	(16,592)	(337)	(49,654)	(49,791)	(137)
- Bank	(795)	(1,191)	(395)	(2,481)	(3,553)	(1,072)
- Agency	(456)	(367)	89	(1,407)	(1,017)	390
Operating expenses excluding employee expenses	(9,601)	(8,845)	756	(28,858)	(27,792)	1,066
FINANCE COSTS						
Finance income	119	126	7	150	405	255
Finance expense	(65)	(61)	4	(183)	(183)	(0)
PDC dividend expense	(412)	(417)	(6)	(1,251)	(1,252)	(1)
NET FINANCE COSTS	**(357)**	**(352)**	**5**	**(1,284)**	**(1,031)**	**253**
Corporation tax expense	(2)	(2)	0	(7)	(7)	1
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**(2,288)**	**(2,106)**	**182**	**(7,696)**	**(7,427)**	**270**

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	(2,288)	(2,106)	182	(7,696)	(7,427)	270
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	**(2,288)**	**(2,106)**	**182**	**(7,696)**	**(7,427)**	**270**
Retain impact of DEL I&E (impairments)/reversals	0	0	0	0	0	0
Remove capital donations/grants/peppercorn lease I&E impact	(4)	(191)	(187)	(13)	(275)	(262)
Adjusted financial performance surplus/(deficit)	**(2,292)**	**(2,297)**	**(5)**	**(7,709)**	**(7,702)**	**8**

Financial Position Update - June 2025
Trust Wide Performance: Agency

Pay Analysis - Agency
Agency costs in month 3 were £0.362 million against a plan of £0.456 million. This is an improvement against spend in June last year (£536k) however a deterioration against prior months spend by £77k. 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 improvement against Medical agency spend compared to last month following 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 May 2025, worsening by £75k linked to 1-2-1 staffing requirements for mental health patients and increased activity linked to ED attendances.





Agency Spend by Profession (£'000)	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Nursing	326	343	240	215	283	206	254	175	220	219	202	277
Medical	238	167	299	393	271	141	177	110	118	95	54	38
Other Clinical	54	58	59	56	46	56	50	39	46	45	24	47
Admin & Clerical	21	21	10	14	2	11	0	5	9	6	5	0
Total	**639**	**589**	**608**	**679**	**602**	**414**	**481**	**328**	**394**	**365**	**285**	**362**
Plan - Total Agency	*807*	*833*	*807*	*833*	*833*	*833*	*833*	*833*	*810*	*464*	*487*	*456*
Variance to Plan	**168**	**244**	**199**	**154**	**231**	**419**	**352**	**505**	**416**	**99**	**202**	**94**

Nursing Agency Category	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Off Framework	*54*	*20*	*27*	*31*	*41*	*21*	*35*	*7*	*29*	*36*	*15*	*1*
On Framework	272	323	212	185	242	184	219	168	191	184	187	276
Total	**326**	**343**	**240**	**215**	**283**	**206**	**254**	**175**	**220**	**219**	**202**	**277**
Plan - Nursing	*469*	*506*	*493*	*530*	*546*	*562*	*581*	*600*	*597*	*223*	*228*	*223*
Variance to Plan - Nursing	**143**	**163**	**253**	**315**	**263**	**356**	**327**	**425**	**377**	**4**	**26**	**(54)**

YTD Actual	YTD Plan	Variance
698	673	(25)
187	628	441
116	106	(10)
11	0	(11)
1,012	**1,407**	**395**

Pay Metrics	In Month Actual	YTD Actual
Agency expenditure as % of total pay	2.0%	1.9%
Off framework expenditure as % of total agency	0.3%	5.1%

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

Area	Off Framework	On Framework	of which: RNMH	Total Nursing Agency	%
Emergency Dept Main Dept	128	0		128	**18%**
Purbeck Wd	85	1		86	**12%**
Moreton Ward - Respiratory	59	0		59	**8%**
Scbu	57	0		57	**8%**
Surge Area	43	0		43	**6%**
Day Surgery Unit	40	0	4	40	**6%**
Ilchester Integrated Assessment	0	39		40	**6%**
Lulworth Ward	39	0		39	**6%**
The Mary Anning Unit	35	1		36	**5%**
Fortuneswell Ward	32	0		32	**5%**
Crcu	27	1		28	**4%**
Ridgeway Wd	18	8		26	**4%**
Stroke Unit	22	0		22	**3%**
Abbotsbury Ward	21	0		21	**3%**
Kingfisher Ward	9	0	3	9	**1%**
Prince Of Wales	9	0		9	**1%**
Cardiology Care Ward	6	1		7	**1%**
Emergency Dept Nurse Practners	7	0		7	**1%**
Frailty Sdec	6	0		6	**1%**
Evershot Ward	3	0		3	**0%**
Sdec	1	0		1	**0%**
Nurse Bank	0	0		0	**0%**
Discharge Team	0	0		0	**0%**
Bank Nurses	0	0		0	**0%**
Total Nursing Agency YTD	**646**	**52**	**7**	**698**	

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Financial Position Update - June 2025
Trust Wide Performance: Bank

NHS Dorset County Hospital NHS Foundation Trust

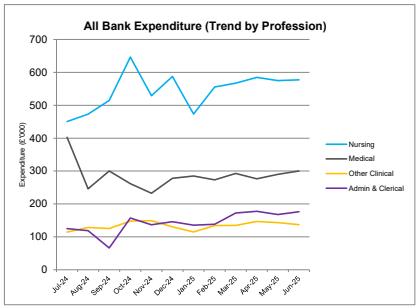
Pay Analysis - Bank

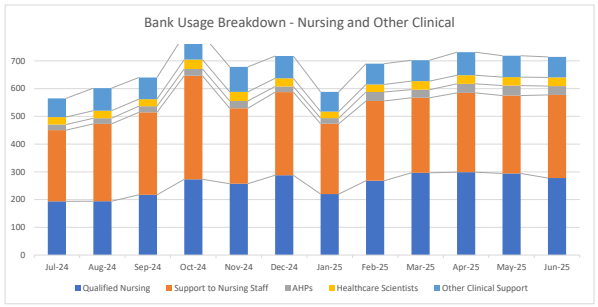
Bank costs in month 3 were £1.190 million against a plan of £0.801 million, similar to the levels seen in prior months, remaining relatively consistent across the past year.

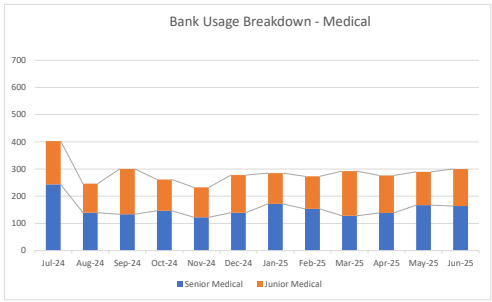
Reduction in bank expenditure is a key focus area nationally, with a minimum of 10% cost reduction expected. As part of 2025/26 planning round, the Trust stretched this target to 20% equating to a cost reduction of c. £2.4m.

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)	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Nursing	450	473	515	646	529	587	473	555	567	585	575	577
Medical	403	246	300	262	233	278	285	273	293	277	290	300
Other Clinical	115	128	126	148	149	130	115	134	135	147	143	137
Admin & Clerical	125	119	66	157	137	146	135	138	173	178	168	176
Total	**1,093**	**967**	**1,007**	**1,213**	**1,048**	**1,142**	**1,009**	**1,101**	**1,167**	**1,186**	**1,176**	**1,190**

YTD Actual	YTD Plan	Variance
1,737	1,575	(162)
866	573	(293)
427	146	(281)
522	188	(334)
3,552	**2,482**	**(1,070)**

Bank Category	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Qualified Nursing	194	194	217	273	258	288	220	268	297	299	294	278
Support to Nursing Staff	257	279	297	373	272	300	253	288	270	286	281	299
AHPs	20	20	22	25	27	20	20	33	29	33	36	32
Healthcare Scientists	27	27	25	34	33	29	24	27	31	31	31	32
Other Clinical Support	67	81	78	90	90	81	71	75	75	83	77	73
Management / Admin	125	119	66	157	137	146	135	138	173	178	168	176
Senior Medical	244	139	134	147	123	140	172	154	128	139	167	164
Junior Medical	159	107	166	115	110	138	113	119	165	138	123	136
Total	**1,093**	**967**	**1,007**	**1,213**	**1,048**	**1,142**	**1,009**	**1,101**	**1,167**	**1,186**	**1,176**	**1,190**
Plan	883	876	862	826	776	724	669	611	554	830	851	801
Variance to Plan	**(210)**	**(91)**	**(145)**	**(387)**	**(272)**	**(418)**	**(340)**	**(490)**	**(613)**	**(356)**	**(325)**	**(389)**

Pay Metrics	In Month Actual	YTD Actual
Bank expenditure as % of total pay	6.6%	6.5%

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Financial Position Update - June 2025

Insourcing

Insourcing Narrative
The insourcing budget of £8.0 million is planned to deliver insourcing activity as presented to Committee during the 2025/26 planning round. Year to date financial performance has delivered a £0.007m improvement against year to date plan. The latest forecast trajectory as at month 3 shows total spend of £7.8m which is £0.2m improvement on 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.

	Actual	Actual	Actual	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast		Forecast
	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD	Outturn
Budget:	**658**	**679**	**658**	**679**	**679**	**658**	**679**	**658**	**679**	**679**	**616**	**679**	**1,994**	**8,000**
Spend:														
Breast	13	13	26	13	0	0	13	0	0	13	0	0	52	**91**
Dermatology	144	126	128	118	118	118	118	118	118	118	118	118	398	**1,464**
Endoscopy/Gastro	131	107	48	107	107	107	107	107	107	107	107	107	286	**1,250**
ENT	91	48	11	50	50	50	50	50	50	50	50	50	150	**601**
General Surgery	6	6	(1)	6	6	6	6	6	6	6	6	6	11	**63**
Gynaecology	29	29	28	29	29	29	48	48	48	48	48	48	86	**463**
OMF	147	90	160	75	75	94	75	75	94	75	75	94	396	**1,132**
Ophthalmology	25	24	76	20	20	20	36	36	36	36	36	236	125	**600**
Orthopaedics	83	88	99	83	83	83	83	83	83	83	83	83	271	**1,020**
Urology	11	11	11	11	11	11	11	11	11	11	11	11	34	**138**
Theatre Staffing	0	122	57	89	89	89	89	89	89	89	89	89	179	**976**
Total spend	**680**	**664**	**643**	**603**	**590**	**609**	**637**	**624**	**643**	**637**	**624**	**843**	**1,988**	**7,798**
Surplus/(Deficit)	**(23)**	**15**	**14**	**76**	**89**	**49**	**42**	**34**	**36**	**42**	**(9)**	**(164)**	**7**	**202**

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Financial Position Update - June 2025
Sustainability & Efficiency

NHS Dorset County Hospital NHS Foundation Trust

Efficiency & Sustainability Programme Update

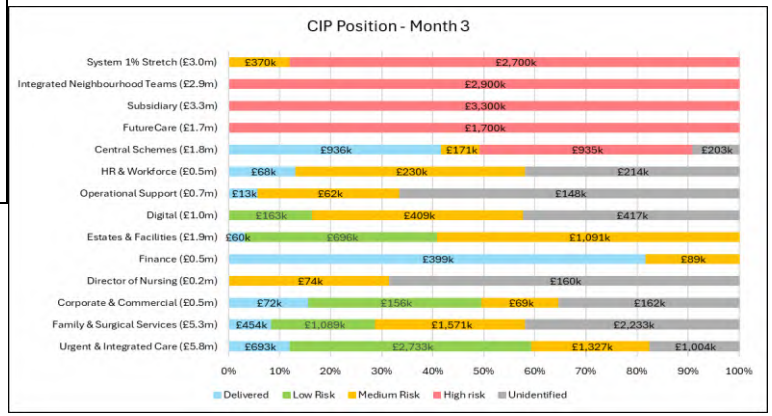
The annual efficiency target for the Trust is £29.1 million, made up of the following elements:
- 5% core annual requirement £18.1 million
- 3% central stretch linked to 2024/25 non-recurrent CIP £7.9 million
- 1% System stretch £3.1 million

In month delivery of c£0.8 million has been achieved, delivered from agency cost reduction of Off Framework and the remainder largely from COVID and finance income (bank interest) and workforce pay savings (vacancies). This is £0.0317 million behind plan YTD, with YTD delivery being £2.695million.

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 teh system to address the full £29.1 million requirement and complete development and delivery of identified projects.

EEQIA monitoring has been established led by the CNO and is required for all relevant schemes with careful assessment in place alongside the overall efficiency programme.

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 £'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	693	776	(83)
Family & Surgical Services	5,347	-	5,347	724	2,390	3,114	2,233	454	486	(32)
Corporate & Commercial	277	183	460	-	298	298	162	72	4	68
Director of Nursing	117	117	234	-	74	74	160	-	1	(1)
Finance	244	244	488	267	220	488	-	399	212	187
Estates & Facilities	942	905	1,847	1,078	769	1,847	-	60	543	(483)
Digital	518	471	989	163	409	572	417	-	72	(72)
Operational Support	223	-	223	-	74	74	149	13	4	9
HR & Workforce	304	208	512	68	230	298	214	68	82	(14)
NR slippage	-	-	-	248	-	248	-	-	-	0
Central Schemes	-	-	2,246	1,796	-	1,796	203	936	832	104
			18,103	**6,340**	**7,221**	**13,562**	**4,542**	**2,695**	**3,012**	**(317)**
Central NR stretch - 3%										
FutureCare - detailed modelling underway			1,700	-	1,700	1,700	-	-	-	-
Subsidiary - indicative			3,300	3,300	-	3,300	-	-	-	-
Integrated Neighbourhood Teams - indicative TBC			2,900	2,900	-	2,900	-	-	-	-
			7,900	**6,200**	**1,700**	**7,900**	**-**	**-**	**-**	**-**
System Stretch - 1%										
System - WorkStream 4 - RMC			1,300	1,300	-	1,300	-	-	-	-
System - WorkStream 4 - Revisit unpalatable list			100	100	-	100	-	-	-	-
System - WorkStream 4 - Commissioning for sustainability			600	600	-	600	-	-	-	-
System - WorkStream 4 - Virtual wards			200	200	-	200	-	-	-	-
System - WorkStream 4 - Balance sheet release			370	-	370	370	-	-	-	-
System - WorkStream 4 - system transformation/technical adjustments			500	500	-	500	-	-	-	-
			3,070	**2,700**	**370**	**3,070**	**-**	**-**	**-**	**-**
Totals			**29,073**	**15,240**	**9,291**	**24,532**	**4,542**	**2,695**	**3,012**	**(317)**



	Pay £'000	Non Pay £'000	Income £'000	Total £'000	R £'000	NR £'000
High Risk	1,700	14,277	100	**16,077**	8,835	7,242
Medium Risk	4,853	791	71	**5,715**	3,239	2,476
Low Risk	3,396	2,614	1,271	**7,281**	4,777	2,504
Total Efficiencies	**9,949**	**17,682**	**1,442**	**29,073**	**16,852**	**12,222**
Delivered	1,347	902	447	**2,695**	947	1,748
Fully Developed	2,193	1,255	680	**4,128**	3,252	875
Plans in Progress	6,409	3,079	216	**9,704**	7,348	2,356
Opportunity	0	7,904	100	**8,004**	5,304	2,700
Unidentified	0	4,542	0	**4,542**	0	4,542
Total Efficiencies	**9,949**	**17,682**	**1,442**	**29,073**	**16,852**	**12,222**
% of Total Schemes (excl unidentified)	30%	42%	3%		55%	20%

Cost Avoidance Schemes	£ Avoidance YTD
Income	-
Pay	-
Non-Pay	-
Grand Total	-

Financial Position Update - June 2025

Cash

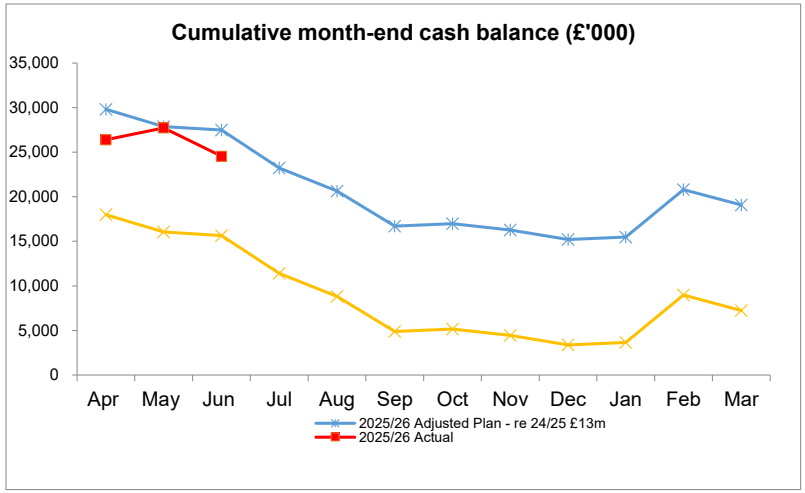
Cash Balance incl Forecast

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 £24.6 million at end of June, which is behind the plan-adjusted forecasted position of £27.5 million due to net impact of the timing of PDC drawdown (£3.2) million offset funding for depreciation £0.3 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)	0.99
Quick Ratio (As above excluding Inventories from current assets)	0.89
Creditor Days (Average days to pay creditors)	145
Debtor Days (Average days to receive payment for debtor invoices)	23
Inventory Holding Days (Average days inventory is held)	22

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 - re 24/25 £13m	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									

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Financial Position Update - June 2025

Capital

Capital Programme Narrative
Capital expenditure year to date to the end of June was £4.9 million and behind plan by £0.1 million. Internally Funded schemes and donated schemes are overall ahead of plan at the end of June by £0.4 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 £0.8 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. 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 is awaiting the outcome of business cases submitted to NHSE for the Constitutional Standards Bids.

CAPITAL	CURRENT MONTH			YEAR TO DATE			FULL YEAR 2025/26			
	Plan	Actual	Variance	Plan	Actual	Variance	Committed Spend	Forecast	Annual Plan	Variance
Estates	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Generator	-	21	- 21	-	10	- 10	94	800	800	-
High Acute Stroke Unit (HASU)	50	29	21	150	167	- 17	342	757	757	-
Estates Schemes	71	164	- 93	211	459	- 248	784	1,111	1,111	-
Digital Services										
EHR Matched Funding	-	36	- 36	-	123	- 123	457	1,781	1,781	-
IT Schemes	134	122	12	388	334	54	974	1,219	1,219	-
Equipment										
Other Equipment	25	31	- 6	25	32	- 7	287	1,557	1,557	-
Sub-Total Internally Funded Expenditure	**280**	**404**	**- 124**	**774**	**1,125**	**- 351**	**2,938**	**7,225**	**7,225**	**-**
Donated										
Other Donations	-	-	-	-	-	-	-	-	-	-
Chemotherapy Unit Refurbishment	40	227	- 187	120	384	- 264	389	480	480	-
Sub-Total Planned Donated Expenditure	**40**	**227**	**- 187**	**120**	**384**	**- 264**	**389**	**480**	**480**	**-**
IFRS 16 Lease Additions										
Admin Offices	-	-	-	-	-	-	-	1,500	1,500	-
MSCP Lease remeasurement	-	-	-	-	-	-	-	500	500	-
CEF Lease remeasurement	-	-	-	-	-	-	-	400	400	-
One Dorset Pathology	-	-	-	-	-	-	-	750	750	-
Other Leases	-	-	-	-	-	-	-	600	600	-
Accommodation & Vehicle Lease Additions	-	-	-	-	-	-	-	382	382	-
Sub-Total Planned IFRS 16 Expenditure	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**4,132**	**4,132**	**-**
Total Internal & Leased Capital Expenditure	**320**	**631**	**- 311**	**894**	**1,509**	**- 615**	**3,327**	**11,837**	**11,837**	**-**
Additional funded schemes										
NHP Works	1,500	1,623	- 123	4,000	3,361	639	27,789	27,789	27,789	-
Digital EHR Funding	40		40	120		120	-	5,482	5,482	-
CIR Funding - Generator	-	-	-	-	-	-	-	1,800	1,800	-
CIR Funding - Renal OP Unit	-	-	-	-	-	-	-	600	600	-
CIR Funding - SSD Plant	-	-	-	-	-	-	-	302	302	-
Constitutional Standards - Diagnostics	-	-	-	-	-	-	-	550	550	-
Constitutional Standards - Elective	-	-	-	-	-	-	-	869	869	-
Constitutional Standards - UEC	-	-	-	-	-	-	-	2,850	2,850	-
Total Externally Funded Capital Expenditure	**1,540**	**1,623**	**- 83**	**4,120**	**3,361**	**759**	**27,789**	**40,242**	**40,242**	**-**
Total Capital Expenditure	**1,860**	**2,254**	**- 394**	**5,014**	**4,870**	**144**	**31,116**	**52,079**	**52,079**	**-**
Expenditure as a % of Plan			121%			97%				100%

Baker, Abi
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Healthier lives Empowered citizens Thriving communities

Report to	DCH Board of Directors	
Date of Meeting	12th August 2025	
Report Title	Operational resilience and capacity plan (Winter) 2025/26	
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, FPCIC and Quality Committee	
Action Required	**Approval**	X
	Assurance	-
	Information	-

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	

Implications	Describe the implications of this paper for the areas below.
Board Assurance Framework	Referenced specifically under SR4 Capacity, Demand
Financial	Intention to indicate good use of resources through a surge period in line with financial planning
Statutory & Regulatory	Support meeting agreed unplanned and planned service standards throughout the surge period
Equality, Diversity & Inclusion	Impact on ED&I considered
Co-production & Partnership	Admission Avoidance and effective Discharge processes require working in partnership with other health and social care partners and closely aligned to VCSE support offers. DCH plan forms part of the NHS Dorset Plan alongside all other System partners and associated workstreams

Executive Summary

The Operational Resilience and Capacity Plan (Winter) 2025/26 outlines Dorset County Hospital's (DCH) comprehensive strategy to manage the anticipated seasonal pressures during the winter period. Developed in alignment with NHS England's Urgent and Emergency Care (UEC) Plan 2025/26, the document addresses increased demand due to respiratory illnesses, infection control challenges, and capacity constraints.

Key components of the plan include:

System-Wide Coordination: The plan is integrated with the Dorset Integrated Care System (ICS) and aligns with system partners to ensure a unified response, particularly around discharge planning, admission avoidance, and infection prevention. The key delivery areas, of the system plan can be found in appendix 4.

Service Delivery Enhancements: Targeted improvements focus on Same Day Emergency Care (SDEC), Transfer of Care Hubs, and front-door interventions to reduce admissions and length of stay.

Governance and Communication: A robust governance framework ensures oversight through daily and weekly operational meetings, supported by a communications strategy to keep staff informed and engaged.

Infection Prevention and Control (IPC): A detailed IPC surge plan includes vaccination strategies, cohorting protocols, and PPE readiness to manage outbreaks of COVID-19, flu, and RSV.

Operational Readiness: Escalation protocols, elective surgery adjustments, and surge testing capabilities are in place to maintain patient flow and safety.

Workforce and Resilience: Measures to address staffing challenges include proactive recruitment, mental health support, and flexible deployment during critical periods.

Key Risks and Mitigations: The plan identifies and addresses risks such as overcrowding, delayed discharges, and system-wide pressures, with clear mitigation strategies and escalation pathways. Demand in Q1, measured by attendances and admissions, has exceeded the operating plan. The proportion of admitted patients subsequently classified as NCTR is also higher than projected.

Joint analysis with system partners found no demographic shifts (e.g., age or location) to explain the increase, confirming it as a genuine rise in demand. Collaborative efforts are now focused on reducing NCTR rates and length of stay for CTR patients ahead of winter. Failure to deliver poses a risk to the bed reconfiguration plan.

The Winter Plan does not include specific bed escalation numbers, as these are now governed by the revised Bed Management Policy. This policy, which will have been ratified at the Senior Leadership Group meeting prior to Finance and Performance Cttee approval in September 2025, outlines the use of escalation spaces and associated processes. The updated approach has been informed by a comprehensive audit of escalation areas, benchmarked against the Care Quality Commission (CQC) Fundamental Standards of Care, ensuring alignment with regulatory expectations and best practice.

Recommendation

The Board is asked to approve the Winter Plan, confirming that appropriate assurance has been provided.

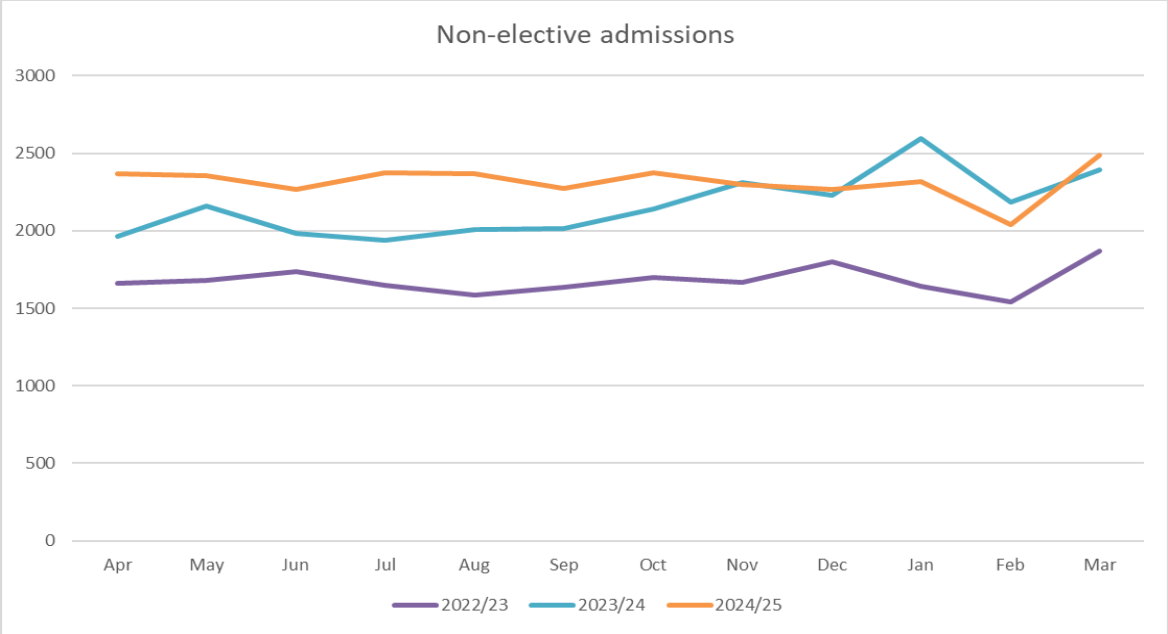
Table of contents

1. Introduction

1.1 Winter is not classified as an emergency or an unusual occurrence; rather, it is a recognised period of heightened operational pressure. This is driven by increased clinical acuity among patients and significant capacity demands on resources across the Trust. Proactive planning and coordinated response strategies are essential to manage the seasonal surge effectively.

1.2 Winter typically results in increased demand due to seasonally affected conditions. This seasonal surge elevates the risk of infection prevention and control (IPC) challenges, particularly with heightened transmission of influenza, COVID-19, and Respiratory Syncytial Virus (RSV). These risks necessitate robust IPC measures and proactive surveillance to mitigate potential outbreaks and maintain patient and staff safety

1.3 This has been particularly evident in the last two years, with admission rates peaking from December through to March.



1.4 To ensure the Trust maintains essential Urgent and Emergency Care (UEC) services, meets the requirements of the Operating Plan for both Elective and UEC services, and safeguards the wellbeing of patients and staff, the development and implementation of a robust Winter Plan is imperative.

1.5 Ahead of the 10-year plan, NHS England (NHSE) published the Urgent and emergency care plan 2025/26, in June 2025. The Urgent and emergency care plan 2025/26 has identified 7 priorities that will have the biggest impact on UEC improvement this coming winter, these are:

1) Patients who are categorised as Category 2 – such as those with a stroke, heart attack, sepsis or major trauma – receive an ambulance within 30 minutes
2) Eradicating last winter's lengthy ambulance handover delays to a maximum handover time of 45 minutes
3) A minimum of 78% of patients who attend an A&E to be admitted, transferred or discharged within 4 hours
4) Reducing the number of patients waiting over 12 hours for admission or discharge from an emergency department compared to 2024/25, so that this occurs less than 10% of the time
5) Reducing the number of patients who remain in an emergency department for longer than 24 hours while awaiting a mental health admission. This will provide faster care for thousands of people in crisis every month
6) Tackling the delays in patients waiting once they are ready to be discharged – starting with reducing the 30,000 patients staying 21 days over their discharge-ready-date
7) Seeing more children within 4 hours, resulting in thousands of children receiving more timely care than in 2024/25

1.6 The Care plan sets out the roles and responsibilities of each system partner, with the expectation that trusts winter plans:

a) Demonstrate plans to improve vaccination rates in health and care workers.
b) Have an accessible occupational health vaccination offer to staff throughout the entire flu campaign window, including onsite bookable and walk-in appointments.
c) Acute trusts to establish a defined improvement trajectory towards achieving the 15-minute hospital handover target.
d) To achieve the target of more children being seen within 4 hours, deliver effective utilisation of UTCs, children and young people's specific services and standards.
e) Acute trusts to set stretching local performance targets for daily pathway 0 discharges and profile them through the week.
f) Acute trusts and local authorities to set local performance targets for pathway 1, 2 and 3 patients.
g) Demonstrate effective use of capacity across the full system by reviewing bed usage, returning people to home-based care where possible, and providing surge capacity alongside IPC, cohorting where it is effective and appropriate to do so.

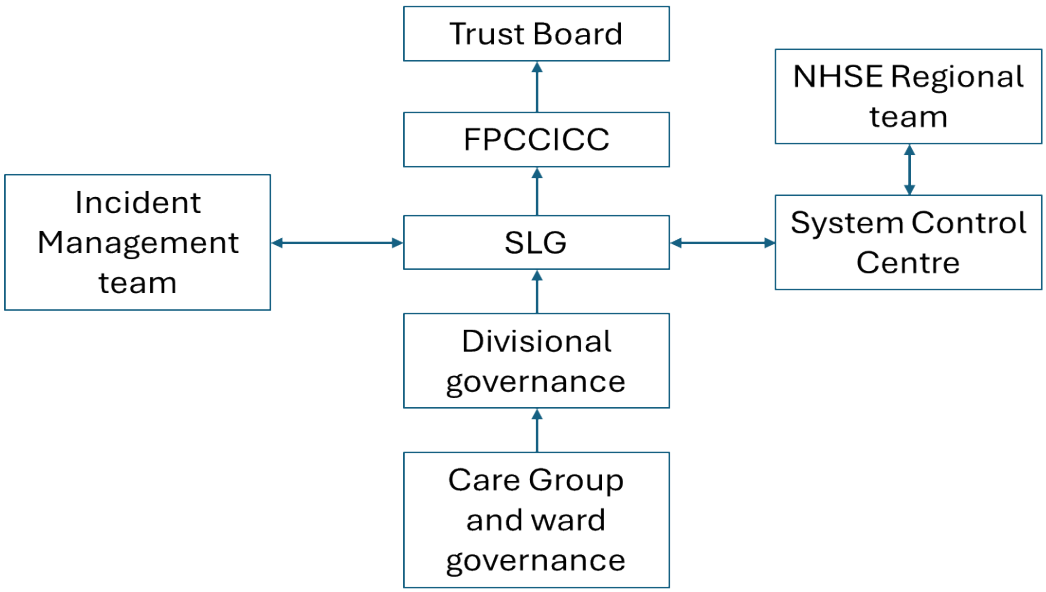
1.7 The DCH operational resilience and capacity plan (winter) will provide assurance against the applicable priorities (for an acute) and against the 7 responsibilities for an acute provider. This will form part of the Dorset ICS system plan.

2 Governance

2.1 All staff without exception have a shared responsibility to ensure that at times of heightened emergency activity, patient safety is not compromised.

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

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



2.4 The winter plan will be shared with staff across the organisation via divisional, departmental, and professional meetings for awareness and feedback.

2.5 Monitoring and control will be provided through:

- Flow (bed) meetings (throughout the day)
- Weekly Ward huddles
- Daily Tactical Resilience Group (TRG) (twice weekly)
- Strategic Resilience Group (SRG) - Stood up as required.
- Existing governance processes (risks, incidents, complaints, staff survey)

3 Winter schemes that address the priorities, roles, and responsibilities of the UEC care plan 2025/26

3.1 In collaboration with system partners, the FutureCare programme, and Operational teams at DCH, the table below outlines the live schemes of work planned for 2025/26. These initiatives are aligned with the priorities of the Urgent and Emergency Care (UEC) Plan 2025/26 and are designed to support the Trust in delivering safe, effective, and responsive services throughout the winter period.

3.2 This plan has grouped together the 7 priorities and the 7 roles and responsibilities for an acute trust, into 4 categories, these are Ambulance handover, ED performance, discharge planning and Infection Prevention and Control.

<table>
<tr><th>Category</th><th>Objective from the UEC Care plan 2025/26</th><th>Action (DCH response)</th><th>Timescale</th><th>Rag</th></tr>
<tr><td>Ambulance handovers</td><td>• Patients who are categorised as Category 2 – such as those with a stroke, heart attack, sepsis, or major trauma – receive an ambulance within 30 minutes (SWAST)
• Eradicating last winter's lengthy ambulance handover delays to a maximum handover time of 45 minutes
• Acute trusts to establish a defined improvement trajectory towards achieving the 15-minute hospital handover target.</td><td>• Timely handover process (THP) implementation systemwide
- This means at 30mins, SWAST starts to handover the patient, with the crew leaving at 45miins and the provides assuming all care requirements.
- To support this, DCH has launched "your next patient" which boards a suitable patient, in a holding space within the ward, rather than holding all risk in ED. Pilots are running throughout the summer to test this.
• Intelligent conveying dashboard across DCH
• Clinical dependency meetings and plan due to CSR and NHP building moves
• Pre-video tirage across extended specialties
• Call before convey using consultant connect for advice and direct admission/ SDEC
• SWAST/DCH data perfect week/ continued process for reducing human error
• Mean handover time submitted as part of the Operating plan, does not deliver
• The mean ambulance handover trajectory, as per the operating plan submission is below. While it does not achieve the 15min, it is an improvement on 2024/25 and therefore meets the ask of the UEC care 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><th>Sep-25</th><th>Oct-25</th><th>Nov-25</th><th>Dec-25</th><th>Jan-26</th><th>Feb-26</th><th>Mar-26</th></tr><tr><td rowspan="3">*Ambulance handover: mean handover time</td><td>plan</td><td>00:16:57</td><td>00:16:34</td><td>00:21:11</td><td>00:17:27</td><td>00:18:00</td><td>00:19:22</td><td>00:19:49</td><td>00:18:57</td><td>00:26:42</td><td>00:26:39</td><td>00:20:07</td><td>00:20:07</td></tr><tr><td>actual</td><td>00:21:57</td><td>00:18:59</td><td>00:16:59</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>variance</td><td>00:05:00</td><td>00:02:25</td><td>00:04:12</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table></td><td>June-September and then ongoing throughout the winter period</td><td></td></tr>
<tr><td>ED performance</td><td>• A minimum of 78% of patients who attend an A&E to be admitted, transferred or discharged within 4 hours
• Reducing the number of patients waiting over 12 hours for admission or discharge from an emergency department compared to 2024/25, so that this occurs less than 10% of the time
• Reducing the number of patients who remain in an emergency department for longer</td><td>• Progress the new ED front door into a UTC model with streaming and redirection pathways and tool.
• GP expected patients arriving through SDEC when appropriate- improved booking process where GPs can book through cons connect and think SDEC first
• Newton flow improvement- improved frailty pathway from ED to SDEC/ Portesham avoiding admission in EDAU
• Newton work focusing on admission avoidance- short stay and SDEC pathways
• Improved pathways for specialty specific SDECs such as orthopaedics
• Pathway implementation between front door services with entry through future UTC
• Joint working with DHC MH team to improve pathways and implement future mental health UTC
• Clinical supervision and training to address inconsistency
• Staff workforce skill review and educational plan
• Out of hours support plan
• Ambulance tracker and check in</td><td>September -November and then ongoing throughout the winter period</td><td></td></tr>
</table>

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<td></td>
<td>than 24 hours while awaiting a mental health admission.
• Seeing more children within 4 hours, resulting in thousands of children receiving more timely care than in 2024/25
• To achieve the target of more children being seen within 4 hours, deliver effective utilisation of UTCs, children and young people's specific services and standards.</td>
<td>• MAUD moved to Evershot and 30%-40% of patients are now surgical. Further expansion to larger footprint to implement pathways to embed AAU model in August 2027 (captured here to ensure reflected in 2026/27 winter plan)
• Implementation of hot clinics across all specialties to protect emergency capacity in SDEC
• Specialty pathway day in September to reduce admissions through ED
• CQC- review patient first and paediatric long term plan for ED
• Implementation of Trust wide PIC/MID line service
• Increase use of step down/ community H@H from front door services
• Increase use of AH@H from ED/SDEC
• Expand Altogether Care front door pilot into TOC Hub
• DCH / Healthwatch long term condition prevention intervention
• Dorset X-Ray Car to reduce number of falls patients conveyed for imaging
• System work with UEC leads to reduce Acute Trust attendance
• Expand community pathways through VW and Future Care work
• Systemwide UTC plan
• Streaming and Redirection tool implementation
• Professional standards document /MOU describing mutual expectations and behaviour of all specialties operating in the ED and front door services
• Trajectories for the 4 hour standard and % of 12 hour breaches can be found below, with actual achievement for Q1

<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><th>Sep-25</th><th>Oct-25</th><th>Nov-25</th><th>Dec-25</th><th>Jan-26</th><th>Feb-26</th><th>Mar-26</th></tr>
<tr><td rowspan="3">A&E: 4 hour wait % (all)</td><td>plan</td><td>81.80%</td><td>79.64%</td><td>78.18%</td><td>76.89%</td><td>81.43%</td><td>82.22%</td><td>79.03%</td><td>79.12%</td><td>74.91%</td><td>75.17%</td><td>78.87%</td><td>78.88%</td></tr>
<tr><td>actual</td><td>82.00%</td><td>83.7%</td><td>83.4%</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>variance</td><td>0.20%</td><td>4.05%</td><td>5.22%</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td rowspan="3">Percentage of A&E attendances over 12 hours</td><td>plan</td><td>6.57%</td><td>6.96%</td><td>11.52%</td><td>8.30%</td><td>6.97%</td><td>7.38%</td><td>8.22%</td><td>7.58%</td><td>11.91%</td><td>16.28%</td><td>9.09%</td><td>9.09%</td></tr>
<tr><td>actual</td><td>6.72%</td><td>6.45%</td><td>6.16%</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>variance</td><td>0.15%</td><td>-0.51%</td><td>-5.36%</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
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• MH CYP pathways review and process to prevent CYP patients waiting in ED for longer than necessary
• Focus on pre hospital prevention and plan for hospital attendance to ensure patient is accessing the right service
• Work with SWAST to prevent unnecessary attendance for MH patients
• Design and model the new designated MH UTC collocated to the front door with DHC and system partners</td>
<td></td>
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<tr>
<td>discharge planning</td>
<td>• Tackling the delays in patients waiting once they are ready to be discharged – starting with reducing the 30,000</td>
<td>• Full implementation and optimisation of the integrated, Transfer of Care Hub function, this will mean:
-Implement early discharge planning and adopt the same process for people leaving intermediate care
-Improve model of discharge planning for people with complex needs.</td>
<td>May-November and then ongoing throughout</td>
<td></td>
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</table>

	patients staying 21 days over their discharge-ready-date • Acute trusts to set stretching local performance targets for daily pathway 0 discharges and profile them through the week. • Acute trusts and local authorities to set local performance targets for pathway 1, 2 and 3 patients.	-Improve patient level tracking and visibility of discharge timelines, next steps and outcomes from acute and community settings, giving a single point of truth to manage individual people and the wider system. -Review and reduce the number of triage points, assessments, and handovers in the discharge processes from acute and community settings. -Implement a full D2A model to minimise long-term care assessments happening in hospital. -Standardise and redesign where necessary required discharge information and forms to minimise duplication and manual recording of information. -Improve ways of working to increase the capacity for and timeliness of Care Act Assessments in community settings. Q1 has seen an increase in demand (attendances and admissions) above the level of the operating plan. The proportion of patients that are being admitted, that go on to be NCTR is higher than modelled. Analysis with system partners have found no underlying reason for the increase, with patient demographic (age and home address) not changing, concluding it is a genuine increase in demand, beyond that expected. Focus, with system partners if reducing the NCTR and LoS for CTR ahead of winter. The risk of non-delivery is to the bed reconfiguration plan.	the winter period	
Infection Prevention and Control	• Demonstrate plans to improve vaccination rates in health and care workers. • Have an accessible occupational health vaccination offer to staff throughout the entire flu campaign window, including onsite bookable and walk-in appointments. • Demonstrate effective use of capacity across the full system by reviewing bed usage, returning people to home-based care where possible, and providing surge capacity alongside IPC, cohorting where it is effective and appropriate to do so.	• DCH are expecting to offer Flu vaccine only, with a mixture of peer vaccination and pop up clinic in Damers • plan to have consistent days across the campaign so the comms message is more straight forward • Setting up a vaccination steering group, and operational group reporting through Meds Comm • Will reach out to staff network leads to explore specific offers for certain groups e.g. night staff • Will target large training events for a mass vaccination approach Please see appendix 1 for IPC arrangements over the winter, including system working and cohorting plans, where effective and appropriate to do so.	September -November and then ongoing throughout the winter period	

4 Operational nuances to the winter season

4.1 During periods of operational pressure, escalation protocols for the Emergency Department (ED), Inpatient Wards, and Critical Care must be followed without exception. The escalation procedures applicable during the winter period remain consistent with those in place throughout the year. Full details can be found in the recently updated Bed Management Policy.

4.2 All approval processes for the use of escalation spaces, requests for additional staffing, and management of mixed-sex breaches remain unchanged during the winter period. These processes are clearly outlined in the Trust's Bed Management Policy.

4.3 The Bed Management policy supports the management and operation of the hospital site and related functions, in accordance with Operational Pressure Escalation Level (OPEL) framework (appendix 2).

4.4 Mitigations are in place to ensure safe staffing levels across the Emergency Department (ED), inpatient ward areas, and designated escalation areas. Twice-daily safe staffing meetings are held to assess current staffing levels, patient occupancy, acuity, and dependency. These meetings enable timely mitigation actions, including the redeployment of staff to areas of greatest need. Temporary staffing support is available seven days a week to maintain service continuity and patient safety.

4.5 In extremis action card in place to support when the Trust is in critical incident and a break glass procedure is in place should extra staff be required via off framework agencies where all other options have failed.

Elective Surgery

4.6 All non-urgent inpatient elective surgery will stop from Wednesday, 24 December 2025 until Friday, 2 January 2026.

4.7 From 5 January 2026, non-urgent inpatient elective surgery will be phased in to build up to normal levels of activity from the 19 January 2026. Phasing will be specific to accommodate individual requirements and will be based on plans at the time.

4.8 The Trust will continue with day case and 0 length of stay as appropriate.

4.9 Elective activity will continue through the winter period.

Pathology

4.10 The winter months see an increase in cases of Flu, Covid and other respiratory infections. To minimise the impact on patient flow, rapid testing for COVID, Flu A/B and RSV is available from a single patient swab processed on the GeneXpert platform based in ED and Paediatrics 24/7.

4.11 Surge capacity is available on the GeneXpert platform in the Microbiology Laboratory with sufficient stock of the GeneXpert testing equipment in preparing for a surge in respiratory cases available.

4.12 Post analytical processes have been optimised to ensure that results are made available as early as possible to help inform decisions to admit, discharge or cohort patients.

4.13 Staff are reminded to refresh their knowledge and follow the latest Trust Policy for COVID, Flu and RSV testing to ensure appropriate testing and avoid unnecessary costs.

Maternity

4.14 In the event that increasing demand may increase the risk of closure of the Maternity Department at DCH, the Maternity Lead will arrange a resilience meeting with departments from neighbouring Trusts, University Hospitals Dorset NHS Foundation Trust, Yeovil District Hospital (if they are re-opened - to be reviewed in November), Royal Devon & Exeter General Hospital and Salisbury District Hospital to discuss operational and patient safety risks, agree a plan for the following 24 hours and set a timescale for review. DCH may offer reciprocal support to other Trusts' who may be in a similar position.

Bank Holiday Arrangements

4.15 The divisional staffing plans for the bank holiday period will be submitted by 5th December 2025 and held by operational teams for reference. A copy will be held centrally on SharePoint for wider reference.

4.16 Emphasis is placed on managing annual leave requests in line with Trust policy, to ensure core services are adequately covered, with expected periods of increased activity around the Christmas and New Year period.

Links to the system plan

4.17 The winter plan reflects and is part of the Dorset ICS approach to managing 'system discharge' and flow.

4.18 The System Leadership Board, Senior Executive Group/Integrated Neighbourhood Oversight Group; Urgent and Emergency Care Board (UEC); and Home First Board; all take responsibility for delivery of partnership arrangements to deliver flow.

4.19 Operationally, the Single Point of Access and Locality Clusters will continue to support hospital discharge and the assessment of patients in their own homes or in a community hospital, where patients require a period of rehabilitation prior to their return home.

5.0 Appendix 1 Infection Prevention Management (IPM) Surge Plan

The IPM team (IPMT) carryout daily ward rounds to support a risk-based approach for the use of isolation cubicles across the trust. The team link closely with the Clinical Site Team to ensure clear plans on which patients can be moved out of single rooms using the ICNet isolation list (our clinical surveillance system). The team support staff to practice standard infection prevention and control precautions at all times, this will support a reduction in transmissions of infections. Every Friday the IPM team send out a weekend handover for the executives and on call managers, this is also forwarded to the consultant microbiologists, including the Salisbury team who are part of the on-call rota, and this covers any IPM data and any concerns when the IPM team are not working.

The team, supported by the communications team, provide regular communication to ensure staff are aware of the need to stay at home if they have symptoms of Diarrhoea and Vomiting for 48 hours after last symptom.

The IPM team will support all outbreak management processes with clear weekend plans, trust wide communications and weekend IPM cover as deemed necessary.

The National Infection Prevention and Control Manual contains useful information, particularly relevant to winter planning is the isolation prioritisation tool. Although not currently used within the trust because the IPM team closely risk assess each cubicle across the trust throughout the week days. It is a tool that could be used in situations of extreme. The isolation prioritisation tool is intended to provide a systematic framework that can be used by healthcare in organisations to assist in the prioritisation of isolation rooms for infection prevention and control. It is recommended that the tool is used as part of a multidisciplinary approach (including IPM, medical, nursing, operations and facilities teams) to collaboratively develop clinical pathways and contingencies based on local risk assessments. Document found in this link:NHS England » National infection prevention and control

Maintaining high staff vaccine rates is crucial to support patient safety and is part of trust winter planning. As part of a targeted approach for staff vaccinations, the use of peer vaccinators particularly in areas expected to have high infection prevalence will help support increased staff vaccine rates. The trust should particularly aim to target Moreton, Ilchester and Mary Anning unit with the use of peer vaccinators.

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

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

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

The decision to cohort infected patients is based on:

- Number of COVID19+/Flu/RSV patients requiring admission / already in hospital
- Presenting need on admission
- The safe and effective isolation of patients, including patients with other infections.
- Both Moreton and Ilchester could be considered as the most appropriate respiratory cohort areas. However, it is important to allow Moreton to have enough space to allow for non-infected admissions. The Mary Anning unit is not an advisable respiratory cohort area due to the specialism, unless healthcare associated cases are declared in a specific bay.
- Capability to support Adult, ITU and Paediatric surge plans independently or simultaneously.
- The subsequent plan to reallocate staffing resources (4.5) is a key consideration in delivering the plan arising from the decision.
- The trust can consider putting COVID-19 recovered patients in empty beds in restricted Covid-19 bays/wards (must have been positive in last 4 weeks). Exemptions to this are high risk immunocompromised patients.
- ED and Paediatric point of care testing will help to reduce the incidence of nosocomial infection.
- The IPM team will ensure prompt daily reviews and medical de-escalation of cases to support flow within the hospital

It is important that procurement maintain a reasonable supply of personal protective equipment (PPE) ready for a surge in respiratory cases during the winter. This is closely monitored, linking to the national availability of stock. The microbiology lab lead should also ensure we have a reasonable supply of GeneXpert testing stock ready for a surge in the testing of patients at the front door in the emergency department and the paediatric ward.

The trust has a designated fit test coordinator to support the national priority risk categorisation for fit testing with FFP3 respirators. Fit mask testing is available within departments throughout the year. When staff do not have up to date FFP3 respirator fit mask testing or are unable to wear FFP3 mask the trust has a supply of FFP3 respirator hoods.

Respiratory Protective Equipment (RPE) i.e. a filtering face piece (FFP), must be considered when a patient is admitted with a known/suspected infectious agent/disease spread wholly or partly by the airborne route and when carrying out aerosol generating procedures (AGPs) on patients with a known/suspected infectious agent spread wholly or partly by the airborne or droplet route.

The decision to wear an FFP3 respirator/hood should be based on clinical risk assessment, e.g., task being undertaken, the presenting symptoms, the infectious state of the patient, risk of acquisition and the availability of treatment for the infectious agent. The link below to the National IPC manual for England contains useful information.

NHS England » National infection prevention and control

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

When wards have more than 2 cohorted respiratory bays and the trust is seeing an increase in respiratory cases using epidemiological data The IPM team with discussion with the DIPC and may recommend that staff move into fluid resistant surgical face masks (FRSM) within specific ward areas or the emergency department. These should be changed when leaving the respiratory designated bays, as part of transmission-based precautions.

Dorset County Hospital (DCH) Infection Prevention Control IPC team collaboration with Dorset Health Care (DHC):
To support flow within the trust and wider community trust, Dorset Health Care IPC lead has agreed several IPC actions:

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

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

The IPMT can support and advise the medical teams to review and de-escalate depending on symptoms and the guidance below:

De-escalation of inpatient Covid 19 – Continue isolation for 5 full days after onset and then review de-escalation with medical team, who will look at resolution of fever and symptoms, unless the patient is immunosuppressed. If immunosuppressed, the patient will require initially a repeat 14-day covid PCR and then weekly covid PCR swabs, until covid PCR negative, please discuss with IPC/micro as required.

De-escalation of inpatient Flu - Continue isolation for 24 hours after resolution of fever and respiratory symptoms, minimum 5 days after onset.

If symptoms persist, isolation can be discontinued 7 days after onset unless the patient is immunosuppressed. If immunosuppressed, then discuss with IPC/ Micro.

De-escalation of inpatient RSV: For duration of respiratory symptoms, particularly if coughing. If symptoms persist, isolation can be discontinued 7 days after onset, unless the patient is immunosuppressed. Immunosuppressed patients may remain infectious for a longer time period. They should be discussed with the IPC team and will need two sets of negative RSV swabs (nose and throat) at least 24 hours apart before isolation restrictions are lifted.

Outbreak Plans

The Infection Prevention Management team (IPMT) will continue to maintain daily ward rounds and will assess patients with known infections accordingly.

Outbreaks will be managed by the IPMT in close co-operation with the operational and clinical site management teams in line with national and local policy.

Information relating to Respiratory infection prevalence in the hospital will continue to be fed through the hospital Incident Management Team (IMT) structure and during each bed meeting. The COVID19 outbreak plan is available on the Trusts' SharePoint site: -

dchftnhs.sharepoint.com/sites/ClinicalGuidance/CG docs1/Forms/Live Documents.aspx?id=%2Fsites%2FClinicalGuidance%2FCG docs1%2F2005-COVID-19-Outbreak-policy%2Epdf&parent=%2Fsites%2FClinicalGuidance%2FCG docs1

IPC weekend working

During the winter months, and to be agreed by the IPM lead specialist nurse, the IPM team will cover reduced hours over the weekend, this will commence when deemed necessary and depend on the latest epidemiological data from UKHSA.

6.0 Appendix 2 The Operational Pressure Escalation Level (OPEL)

The Operational Pressure Escalation Level (OPEL) is an indicator of the pressure that the Trust is under and will rise and fall in a controlled manner based on prevailing and anticipated 4 levels of pressure.

Reference to escalation points, action cards and different levels- Useful EPRR Documents - All Documents

DCH	Average ambulance handover since midnight	Current 4-Hour performance	Current ED majors and resus occupancy	Current median time to treatment since midnight	Patients in ED >12 Hours	Patients in ED referred to service	Bed Occupancy	Patients no longer meeting criteria to reside	Patients discharged	Beds closed due to infection prevention and control
0 points	<15mins	>95%	<=80%	<=60min	<=2%	<=2%	<=85%	<=10%	>30%	<=0.5%
1 point	>=15mins <=30mins	>78% <=95%	>80% <=90%	>60min <=120min	>2% <=5%	>2% <=5%	>85% <=92%	>10% <=15%	>20% <=30%	>0.5% <=2.5%
2 points	>30mins <=60mins	>60% <=78%	>90% <=100%	>120min <=240min	>5% <=10%	>5% <=8%	>92% <=98%	>15% <=20%	>10% <=20%	>2.5% <=5%
3 points	>60mins	<=60%	>100%	>240min	>10%	>8%	>98%	>20%	<=10%	>5%

Score Thresholds	
OPEL 1	0 - 15
OPEL 2	16 - 40
OPEL 3	41 - 70
OPEL 4	71 - 100

7.0 Appendix 3- Winter plan key risk summary

The winter plan is an iterative process, and models are in development. There remain a number of risks to service:

Risk	Mitigation
IPM • COVID19 • Flu • RSV Norovirus	COVID19/Flu/RSV IPM plans and supporting arrangements are well tested through the pandemic. Bed meetings/IPM will trigger the escalation response based on current predicted inpatient demand. ED, Critical Care, Paediatric and Adult inpatient ward escalation plans are in place. Ensure 75% uptake of vaccine for staff (flu). Maintaining high staff vaccine rates is crucial to support patient safety. A targeted approach for staff vaccinations and the use of peer vaccinators particularly in areas expected to have high prevalence, will help support and increase staff vaccinations figures. The trust should particularly aim to target Moreton, Ilchester and Mary Anning unit with the use of peer vaccinators. Ensure all frontline staff continue to adhere to IPC guidelines and Personal Protective Equipment (PPE) is available. It is important that procurement maintain the reasonable supply of personal protective equipment (PPE) ready for a surge in respiratory cases during the winter. This is closely monitored, linking to the national availability of stock. The microbiology lab lead should also ensure we have a reasonable supply of GeneXpert testing stock ready for a surge in testing patients at the front door in the emergency department and the paediatric ward. Escalate to COVID19 / Flu Policy as directed by UKHSA. Risk assessment of patients in ED remains crucial for admission avoidance. IPMT will re-enforce infection control practice to inform clinical staff in the lead up to winter. Daily ward rounds and monitoring for increased incidence of loose stools will continue. Direct communication from ICB/S & UKHSA and neighbouring trusts will be shared for awareness and appropriate action will be taken by DCHFT. The Trust will work with providers to prevent the risk of infection to community hospitals and care homes. The IPM team will support all outbreak management processes with clear weekend plans, trust wide communications and weekend cover as deemed necessary. Cohorting of infectious patients with the same confirmed respiratory infection can be considered when single rooms are in short supply. Infectious patients who must not be cohorted with others include: • Those at increased risk of acquisition and adverse outcomes resulting from infection (e.g. immunocompromised). • Individuals who are unlikely to comply with Transmission Based Precautions in a cohort setting.

	The decision to cohort infected patients is based on: - • Number of COVID19+/Flu/RSV patients requiring admission / already in hospital • Presenting need on admission • The safe and effective isolation of patients, including patients with other infections. • Both Moreton and Ilchester could be considered as the most appropriate respiratory cohort areas. However, it is important to allow Moreton to have enough space to allow for non-infected admissions. The Mary Anning unit is not an advisable respiratory cohort area due to the specialism, unless healthcare associated cases are declared in a specific bay. • Capability to support Adult, ITU and Paediatric surge plans independently or simultaneously. • The subsequent plan to reallocate staffing resources (4.5) is a key consideration in delivering the plan arising from the decision. • The trust can consider putting COVID recovered patients in empty beds in restricted covid bays/wards (must have been positive in last 4 weeks). Exemptions to this are high risk immunocompromised patients. • ED and Paediatric point of care testing will help to reduce the incidence of nosocomial infection. • The IPM team will ensure prompt daily reviews and medical de-escalation of cases to support flow within the hospital Currently there is no requirement for the of wearing a surgical mask as part of normal working, unless caring for a patient requiring respiratory or protective precautions. As we move towards winter, the trust may need to change current mask wearing guidance. The guidance changes will depend on Nationally, Regionally and NHS Dorset system wide agreed triggers and follow a standardised approach. We will aim to align any guidance changes as a Dorset Integrated Care System, although this may not always be achievable depending on our own risk assessments and hierarchy of controls. When wards have more than 2 cohorted respiratory bays and the trust is seeing an increase in respiratory cases using epidemiological data. The IPM team with discussion with the DIPC and may recommend that staff move into fluid resistant surgical face masks (FRSM) within specific ward areas or the emergency department. These should be changed when leaving the respiratory designated bays, as part of transmission-based precautions.
Workforce vacancies and sickness	The People Division will support operational teams with management of sudden sickness and access to temporary staffing. Planning of agency and locum clinicians will include planning for gaps arising from vacancies, planned absence and sickness, including forecast gaps arising from a COIVID19 surge. Use of locum spend should be minimised wherever possible in favour of • Proactive recruitment to vacancies • Recruitment of non-traditional roles to mitigate risks

	• Short-term incentivisation for groups of staff to provide resilience for anticipated period of pressure Wellbeing services and processes continue to be promoted throughout the Trust. Increase in mental health first aiders to support staff. Teams operating at risk or in business continuity continue to be monitored and reviewed by service leads and immediately escalated through divisional structures if the risk worsens.
Admission numbers continue to grow & outstrip bed capacity (limited escalation capacity to extend bed base)	Increase of direct specialty patients through SDEC and Evershot avoiding ED. SWAST call before convey and video triage pathways improvement. Winter schemes and Home First programme to deliver improvements to reduce length of stay/increase out of hospital capacity to support flow. To improve community and primary care provision for suitable patients to avoid conveyance to ED. The Future Care program to reduce admissions through appropriate pathways such as SDEC and AH@h. Implementation of community pathways out of ED, SDEC and frailty SDEC. Unplanned Escalation areas in extreme or serious pressure (OPEL 3 /4) require executive approval
High numbers of patients who do not meet the reason to reside criteria	Instigate OPEL 3 / 4 Serious Pressure Response Actions Internal improvements identified to reduce internal delays. Supporting information already available through the Patient Action Tracker and Business Intelligence reports. Daily escalation meetings in place
High numbers of patient presenting to ED with mental health conditions (no physical health needs)	Plan is in place for the use of EDAU to support the process and care for patients requiring mental health support or placement. Robust Psychiatric Liaison cover is imperative. Care coordination hubs to improve access to the right care in the right place avoiding ED. Improved triage from ED to the retreat and mental health services.
System-wide failure pushes pressures from neighbouring acute trusts Baker,Abi 07/08/2025 09:06:48	Joint working through system wide UEC Board and supporting action plans across the system through the ICS via resilience calls and actions. Escalation plan includes triggers for escalation through Divisions to Executive and then System discussions up to and including closure of ED to new presentations. UHD and DCH working jointly with SWAST to ensure patients are conveyed to the correct Trust as services reconfigure through NHP service redesign. Clear plan of movement of services across Dorset to plan for patient access and reduce patients accessing services in the wrong place.

Overcrowding in ED	The split ED front door has improved crowding in ED by reducing minors patients in the area, work continues to improve urgent pathways and turn the new ED front door model into a UTC. Streaming and redirection to other services. Your next patient (YNP) to improve flow through ED with escalation for Timely Handover Process (THP).
Measles and Pertussis standard Operating procedures (SOP)	Please find below both the standard Operating procedure for Measles and pertussis. Nationally cases have been increasing during 2024, therefore these SOP's have been produced to support patient pathway and management of suspected and confirmed cases. dchftnhs.sharepoint.com/sites/ClinicalGuidance/CG docs1/Forms/LiveDocuments.aspx?id=%2Fsites%2FClinicalGuidance%2FCG docs1%2F2248-SOP-Measles%2Epdf&parent=%2Fsites%2FClinicalGuidance%2FCG docs1 dchftnhs.sharepoint.com/sites/ClinicalGuidance/CG docs1/Forms/LiveDocuments.aspx?id=%2Fsites%2FClinicalGuidance%2FCG docs1%2F2266-SOP-Pertussis%2Epdf&parent=%2Fsites%2FClinicalGuidance%2FCG docs1
Severe weather	Review local business continuity plans for staff and communicate plans in line with national guidance on expected weather conditions. Include weather warnings in bed meetings where appropriate.

8.0 Appendix 4- NHS Dorset system's key deliverables- winter plan

Impact	Plans Received (Y/P/N)	Key Delivery Areas
Increased vaccinations	**Partial**	**Perinatal Vaccinations** • Ensure perinatal vaccinations are consistently offered as part of routine maternal care delivered by DHC. **AW25 Programme Engagement** • Collaborate with senior leadership teams to prioritise the AW25 programme. • Focus on securing workforce engagement and buy-in through clear communication and alignment with organisational priorities.
More patients being treated in the community	**Yes**	**Direct Access Pathways to OPS SDEC** • SWAST and DCH to collaboratively develop a direct access pathway for OPS SDEC. • Implement direct referral protocols between SWAST and DHC SPoA for referrals to Hospital at Home (HaH) and Urgent Community Response (UCR). • Pilot direct ambulance-to-SDEC referrals with DCH in August, with the intention to expand to other providers by winter. **Frailty and Pre-hospital Pathways** • Develop and embed "Call Before Convey" frailty pathways with SWAST to improve decision-making and reduce unnecessary conveyance. **Alternative Care Locations** • **Community Front Rooms**: Identify and procure alternative locations based on the outcome of the recent service review. **Mental Health Response** • **Mental Health Response Vehicles (MHRVs)**: West MHRV to launch on 15 August. • **Street Triage**: Now integrated with *Connections*, with a priority call line available for pre-Section 136 situations.
Better use of Primary Care / Neighbourhood Health teams	**Partial**	**Pharmacy First Utilisation** • Strengthen collaboration between General Practice and Community Pharmacy to increase patient uptake and utilisation of Pharmacy First services. **Outbreak Management** • Implement the new Outbreak Management Plan in partnership with UKHSA, ensuring clear roles, responsibilities, and escalation processes are in place.
Safe emergency care	**Partial**	**Timely Handover Plan** • Deliver the THP Improvement Plan to ensure the Dorset system consistently meets the 15-minute patient handover target across all sites. • Monitor progress through regular system-level reviews and implement rapid escalation measures if delays arise.

Impact	Plans Received (Y/P/N)	Key Delivery Areas

Improved Flow Through Hospitals	**Partial**	**Poole 24/7 UTC Implementation**
		• Implement the 24/7 Urgent Treatment Centre (UTC) at Poole by November 26, ensuring staffing, pathways, and communication plans are fully established.
		SDEC Utilisation
		• Increase the utilisation of Same Day Emergency Care (SDEC) across acute trusts by:
		  • Aligning SDEC criteria consistently across all trusts.
		  • Enhancing patient flow from ED into SDEC, supported by clear referral pathways and clinical engagement.

Improvements in Mental Health patient flow	**Partial**	**Out-of-Area (OOA) Placements** • Reduce OOA placements to zero by 31 August 2025, supported by the work of the DHC Recovery Group which is already established and leading this initiative. **Bed Reconfiguration** • Enact the reconfiguration plan to create a 12-bedded discharge ward, ensuring 100% utilisation of local beds to reduce delays and support timely patient flow. **Paediatric Memorandum of Understanding (MOU)** • Develop and finalise a Paediatric MOU to clarify roles, responsibilities, and escalation processes across the system. **System-Wide Escalation Policy** • Develop and implement a system-wide escalation policy with clearly defined KPIs, ensuring consistent responses to capacity pressures.
Improved patient discharge across the whole system.	**Partial**	**P2 Transitional Beds** • Reduce the number of P2 transitional beds at Figbury Lodge from 20 to 10, ensuring the remaining capacity is optimised. **Enhanced Bed Reconfiguration** • Reconfigure the 10 remaining beds with additional enhanced resources to support a cohort of patients with increased complexity. **Reablement App Deployment** • Deploy the Reablement App across two HBIC providers by October 2025, improving coordination and service efficiency. **P1 Flow Management** • Deliver improvements to P1 flow management and oversight, supported by new capacity management tools to be rolled out by Winter 2025.
Utilisation of new NHS digital solutions to improve operations management	**No**	• N/A

9.0 Appendix 5- EQIA analysis

Quality Impact Assessment	major change	moderate change	minor change	no change	minor change	moderate change	major change
Patient Safety				X			
Clinical Outcomes				X			
Patient pathways				X			
Patient Experience				X			
Accessibility				X			
Staff				X			
Equality				X			
	Negative			Neutral	Positive		

Summary of anticipated impact	Mitigating actions against impact
Increased risk of harm due to overcrowding, delayed ambulance handovers, and infection transmission during peak winter pressures.	Risk assessments in place for escalation areas Patient safety and quality dashboards in place to identify emerging themes PSIRF methodology across organisation supporting a poractive and proportionate response to incidents IPC surge plan and cohorting protocols PPE readiness and fit testing Escalation pathways for critical incidents Real-time monitoring via bed meetings and tactical groups
Potential for delayed treatment, increased length of stay, and reduced access to timely interventions, particularly for high-acuity patients.	Any adverse events are reported and investigated inline with PSIRF. "Your Next Patient" initiative Specialty-specific SDEC pathways Transfer of Care Hub optimisation Community and virtual ward models
Disruption to standard pathways due to escalation measures, bed pressures, and service reconfiguration. Risk of inconsistent access to appropriate care settings.	UTC model at ED front door Mental health UTC planning Integrated discharge pathways Hot clinics and ambulatory models
Longer waits, reduced privacy (e.g. mixed-sex breaches), and increased anxiety due to service pressures and infection control measures.	Pt exp & Public Eng team are monitoring themes from complaints/PALS and proactively working with identified teams to offier targeted support where indicated Reduction in 12-hour ED breaches Healthwatch engagement Weekend IPM handovers Discharge visibility tools
Risk of reduced access to elective care and diagnostics services. Vulnerable groups may face additional barriers.	Prioritisation of day case and 0 LOS elective activity Maternity resilience planning Community-based care models Rapid diagnostics
Increased workload, stress, and sickness absence due to sustained operational pressure. Risk of burnout and reduced morale.	Recognise potentialfor addiotnal impact on staff , aware of wellbeing offers and appropriate KPIs regarding roster planning Twice-daily staffing reviews Temporary staffing 7 days/week Mental health first aiders Incentivisation and recruitment
Potential for disproportionate impact on older adults, disabled people, and those with language or cultural barriers if services are not adapted appropriately.	PALS/complaints and incidents will be monitored as above to identify any emerging themes Inclusive communication Reasonable adjustments Cohorting based on clinical risk VCSE and community partnerships

Equality Impact Assessment	major change	moderate change	minor change	no change	minor change	moderate change	major change	Summary of anticipated impact	Mitigating actions against impact
Age				X				Older adults and children are more likely to be affected by winter illnesses and service pressures	Specific pathways for frailty, paediatrics, and mental health are included. Prioritisation of vaccination and discharge planning supports these groups
Disability				X				Patients with physical, sensory, or learning disabilities may face barriers in accessing services or understanding changes.	Communication strategies, accessible formats, and reasonable adjustments are part of operational planning.
Gender Reassignment				X				Single rooms will be prioritised to support pateint flow and IPM requirements.	Ensure inclusive care and privacy in all settings, including escalation areas. Acknowledge risk of mixed sex accommodaiton breaches.
Marriage & Civil Partnership				X				No direct impact identified.	N/A
Pregnancy & Maternity				X				Maternity escalation plans are in place to ensure continuity of care and safety. Changes at YDH means greater demand expected at DCH.	Note unplanned additional activity due to YDH pausing maternity services has been met with increased workforce being put in place.
Race				X				Language barriers or cultural differences may affect access to care or understanding of IPC guidance.	Use of interpreters and culturally appropriate communication is encouraged.
Religion or Belief				X				Religious observances may be impacted by changes in service delivery or visiting policies	Flexibility in care planning and staff awareness is promoted.
Sex				X				No disproportionate impact identified.	Mixed sex accommodation policy in place
Sexual Orientation				X				No direct impact identified.	Maintain inclusive and respectful care environments.
Human Rights				X				No direct impact identified.	N/A
Other group				X				No direct impact identified.	N/A
	Negative			Neutral	Positive				

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Winter Planning 25/26

Board Assurance Statement (BAS)

NHS Trust

Introduction

1. Purpose

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the CEO and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please double-click on the template header and add the Trust's name.

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 25/26 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 25/26 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2025.**

Provider:	Dorset County Hospital NHS Foundation Trust

Section A: Board Assurance Statement

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has assured the Trust Winter Plan for 2025/26.	Yes	Via Finance and Performance committee and Quality committee, prior to presenting it to Board on the 12th August 2025.
A robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes	Included in appendix 5 of the plan and with sign off from the Nursing Directorate.
The Trust's plan was developed with appropriate input from and engagement with all system partners.	Yes	The system plan process has run alongside the trusts. The key deliverables of the system plan, which includes aspects of the DCH plan, can be found in appendix 4.
The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes	Attended the South West Regional winter planning event 23/07/25
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	Yes	Anita Thomas, Chief Operating Officer and AEO.
Plan content and delivery		
The Board is assured that the Trust's plan addresses the key actions outlined in Section B.	Yes	As detailed below
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.	Yes	Detailed risk analysis is included within the WP
The Board has reviewed its 4 and 12 hour, and RTT, trajectories, and is assured the Winter Plan will mitigate any risks to ensure delivery against the	Yes	The trajectories submitted as part of the 2025/26 planning round, are

Provider:	Dorset County Hospital NHS Foundation Trust

trajectories already signed off and returned to NHS England in April 2025.		compliant with the national ask for winter planning and reported via Finance and Performance Cttee.

Provider CEO name	Date	Provider Chair name	Date

Section B: 25/26 Winter Plan checklist

Checklist	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Prevention		
1. There is a plan in place to achieve at least a 5 percentage point improvement on last year's flu vaccination rate for frontline staff by the start of flu season.	Yes	With a fixed day of the week offering, consistently through the period and proactive engagement with the staff networks group.
Capacity		
2. The profile of likely winter-related patient demand is modelled and understood, and plans are in place to respond to base, moderate, and extreme surges in demand.	Yes	Referenced within the WP and further strengthened by the Bed management plan revised and approved by the Senior Leadership team and the Finance and Performance Cttee in September 2025. This includes clears escalation plans for surges. Modelling completed as part of the system response.
3. Rotas have been reviewed to ensure there is maximum decision-making capacity at times of peak pressure, including weekends.	Yes	As an on-going task, with twice a day staffing meetings throughout winter
4. Seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with local authorities for the number of P0, P1, P2 and P3 discharges.	Yes	Current profiles are under review, given the increase in demand seen at DCH. These may be increased.
5. Elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	Yes	As modelled in the operating plan 2025/26 and reported via the

			Finance and Performance Cttee.
Infection Prevention and Control (IPC)			
6.	IPC colleagues have been engaged in the development of the plan and are confident in the planned actions.	Yes	And signed off the plan, prior to presenting it to Board
7.	Fit testing has taken place for all relevant staff groups with the outcome recorded on ESR, and all relevant PPE stock and flow is in place for periods of high demand.	Yes	As a rolling programme
8.	A patient cohorting plan including risk-based escalation is in place and understood by site management teams, ready to be activated as needed.	Yes	Is reflected in the recently updated Bed Management Policy
Leadership			
9.	On-call arrangements are in place, including medical and nurse leaders, and have been tested.	Yes	In place all year round, with winter rota's now published. Where possible, clinical and non-clinic Exec and Manager have been placed together
10.	Plans are in place to monitor and report real-time pressures utilising the OPEL framework.	Yes	Via the system control system
Specific actions for Mental Health Trusts			
11.	A plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.		
12.	Any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.		

Dorset County Hospital
Dorset HealthCare

People and Culture Committee in Common Assurance Report for the meeting held on Monday 28 July 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	• Review of the Board Assurance Framework and Corporate Risk Register, as detailed below • 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.

Key issues / matters discussed at the meeting

The committee received, discussed and noted the following reports:

Board Assurance Framework (DCH/DHC)
No changes to the two strategic risks for which the committee is responsible. There was one overdue action for SR2 Culture, but that matter was considered later in the meeting. No overdue actions for SR3 Workforce. Key metrics would be added to the Board Assurance Framework in due course and work was underway to refresh risk appetite statements.

Committee discussed the impact of the 10yr plan, WTE reduction and the impact on financial delivery. The latter was reviewed regularly by executive colleagues and would be considered as a deep dive in September. It was not felt necessary to include this in the Board Assurance Framework at this stage.

Corporate Risk Register (DCH/DHC)
For Dorset County Hospital the highest risks related to:

- Digital staffing: the Chief Digital Information Officer (BB) had started in post, was reviewing staffing risks and was appointing to essential roles. She has offered a meeting to update the Committee on the availability of resources across all three Dorset trusts.
- Maternity staffing. an area of particular focus especially since the temporary closure of Yeovil maternity unit. Staff had been made available from Yeovil and additional paediatricians were being recruited. The risk was well mitigated and anecdotal evidence was shared of greater confidence in the level of maternity staffing.

Dorset Healthcare:

- A number of risk outstanding, with updates overdue. These need to be updated more regularly and is well-recognised by executive colleagues.
- While some risks were 'red' there were none that were causing significant concern
- Recognition that some services had reduced as a solution to a risk. Discussion indicated that the Quality Committee was well sighted on the risks and so did not need to be formally referred to the committee.

For both Trusts, the Committee reflected on the extent to which the committee (Board) is fully, clearly understanding it's corporate risks and on the clarity of articulation of risks and mitigations. The new joint risk lead is due in post soon.

Workforce KPI Dashboard (Joint)

- The DCH and DHC reports were considered alongside each other.
- Key metrics were largely unchanged from the last report.
- The vacancy rate was slowly climbing in line with the whole-time equivalent reduction work. DHC reductions were being made in line with plan. For DCH the picture was more complex and covered in more detail in the agency reduction item.
- Work was underway re supreme court ruling around the meaning of sex in the Equality Act 2010. A task and finish group were exploring the implications for the trusts, pending formal guidance from Equality and Human Rights Commission.
- Discussion around the impact of health and wellbeing work and whether this was having the intended effect on staff.

Response to letter from Secretary of State and Sir James Mackey on Agency Spend (Joint), outlining the work to date to reduce agency and bank spend, the focus on improving rostering efficiencies and the plans to utilise the national bank. The national bank was not yet being considered for DCH whilst bed reconfigurations took place but would be considered in the coming months.

Committee members highlighted the importance of remaining focussed on safe staffing levels, whilst reducing WTE and bank/agency usage. The trusts should also consider whether any marginalised groups might be affected by the need to reduce bank usage.

Improving Staff Survey Engagement (Joint) presentation detailing the work undertaken to understand what helps increase staff engagement and proposals presented to the committee. The importance of targeted interventions was discussed.

Joint People Plan - Delivery Framework (Joint) was approved.

Medical Appraisal and Revalidation Annual Report (DCH/DHC)

- Positive assurance received that no medics at DCH or DHC had not been revalidated, and no concerns to raise.
- The two teams across DCH and DHC would be aligned over the coming year.

	• A correction to the DCH report; the front sheet said 20 Drs had been revalidated, whilst the report said this number was 81. The correct number is 81. **Apprenticeship Update (DHC)** The report detailed the high level of activity in both organisations, and their social value obligations as anchor institutions. The two widening participation and apprenticeship teams would be combined in due course. DCH was starting a skills bootcamp in September and was going through the accreditation process at present. This would also be an income generating programme. **Assurance reports from below sub-groups of the People and Culture Committee in Common** DCH: • Partnership Forum • Equality, Diversity, Inclusion and Belonging Steering Group • Local Negotiating Committee DHC: • Trade Union Partnership Forum • Workforce Wellbeing Group **AOB** the trusts were in formal dispute with Unison regarding subsidiary company plans. Development of those plans had been paused for four weeks to allow more detailed conversations with Unison to take place; those were proceeding at present.
Decisions made at the meeting	• Approval of the Joint People Plan Delivery Framework • Approval of the Joint Culture and Belonging Group Terms of Reference • Recommendation to board to approve Medical Appraisal and Revalidation Annual Report for DCH and DHC.
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				
Frances West	A	Y				
Suresh Arularatnam	Y	Y				
Margaret Blankson	Y	Y				
Dawn Dawson	Y	Y				
Eiri Jones	Y	Y				

Lucy Knight	Y	Y				
Nicola Plumb	A	Y				
Rachel Wharton	A	A				

NHS
Dorset County Hospital
NHS Foundation Trust

Report to	DCH Board of Directors	
Date of Meeting	12 August 2025	
Report Title	Medical Revalidation Annual Report	
Prepared By	Rachel Wharton, Chief Medical Officer	
Approved by Accountable Executive	Rachel Wharton, Chief Medical Officer	
Previously Considered By	People and Culture Committee in Common, 28/07/2025	
Action Required	**Approval**	Y
	Assurance	N
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	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 implications.	
Statutory & Regulatory	Statement of Compliance to be signed by CEO once approved in preparation for submission to NHSE/I. RO holds statutory role in medical regulation.	
Equality, Diversity & Inclusion	A review of our case investigation and management systems to support EDI and 'Just Culture' / 'Fair to Refer' will be completed in year 25/26.	
Co-production & Partnership	Appraisal and revalidation are mandated by the GMC and opportunities for co-production and partnership are limited.	

Executive Summary

In line with the Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation the Trust is required to submit an annual report and statement of compliance, approved by the Trust Board and signed by the CEO prior to submission to NHSE/I.
This report is relevant to all Doctors excluding Doctors in Training.

The Trust continues to meet all statutory duties in relation to medical revalidation and Responsible Officer regulations.

Revalidation is a 5 yearly requirement and informs the decision from the GMC to issue a licence to practice. Without a successful revalidation a doctor risks having their licence to practice revoked.

81 Doctors revalidated. Two were deferred and rescheduled dates have been set. There were no non-engagement recommendations.

Revalidation is informed by medical appraisal. All doctors are required to have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for work carried out in the organisation and for work carried out for any other body in the appraisal period & for which they need a licence to practice), including information about complaints, significant events and outlying clinical outcomes. The overall appraisal rate is ~97%

Areas of focus for 2025/ 2026:

• Review working arrangements for Responsible Officer functions to determine if this arrangement best meets the needs of the organisations
• A review of our case investigation and management systems to support EDI and 'Just Culture' / 'Fair to Refer'
• Evaluate value of the newly established Responsible Officer Advisory Group. This is a discussion forum set up across the Federation as part of the actions advised by the Higher Level Responsible Officer in his visit in 2024. At this forum specific Fitness to Practice cases are discussed to ensure a fair and proportionate response.

Recommendation

Board are requested to:

- **Approve** the Medical Revalidation Report.

Designated Body Annual Board Report and Statement of Compliance

Period covered: 1 April 2024 – 31 March 2025

Report author: Dr Julie Doherty, RO & Deputy CMO during period covered by report

Reviewed and updated by: Dr Rachel Wharton Deputy RO from 1st April 2025.

The report sets out the information and metrics that a designated body is expected to report upwards, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

The content of the template is updated periodically (latest version found at NHS England » Quality assurance).

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

1A – General

The board/executive management team of **Dorset County Hospital NHS Foundation Trust** can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:	Options for RO role being presented to Board 31 July 2024
Comments:	Dr Julie Doherty was the RO for DCHFT until 1 April 2025. DCHFT had a split Chief Medical Officer (CMO) / RO role during the period of this report. There was good communication and regular 1:1 meetings between the CMO and RO. We are aware of the comments within the Morecambe Bay report relating to RO / CMO functions & responsibilities. Professor Alastair Hutchison was the CMO. He also had access to GMC Connect which provided resilience within the team should the RO be on unexpected or extended leave.

	Upon the retirement of the CMO and stepping down of the RO, Dr L Knight (Dorset Health Care) is the Responsible Officer with Dr Rachel Wharton as CMO and site RO for DCHFT.
Action for next year:	Review working arrangements for Responsible Office functions to determine if this arrangement best meets the needs of the organisations.

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes / No:	Yes & remains under regular review
Action from last year:	Ongoing recruitment drive to attract & retain appraisers. Discussion at Board on 31 July 2024 regarding resource allocation to RO
Comments:	In – house consultants and Specialist Drs as appraisers + recruitment of appraisers from a pool of retired consultants. Admin support to RO is under regular review is challenging as the medical workforce continues to increase. Additional administrative support of 0.4WTE has recently been added to increase resilience. Total administration support now 1 WTE. We are continually looking to recruit new appraisers within divisions as some relinquish such duties or leave post. Divisional directors supportive and have put forward appraisers.
Action for next year:	Review administrative processes to ensure maximum productivity. Dorset wide review of PA allowance to appraisers

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Action from last year:	Nil
Comments:	Compliant. The revalidation administrator supports the maintenance of an accurate record of connections to DCHFT. Prescribed connections are checked for accuracy & appropriateness. Discussions are held with RO and on occasions the GMC if there is any doubt regarding whether a Dr has a prescribed connection.
Action for next year:	Nil

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:	Nil
Comments:	Medical appraisal policy reviewed, updated & ratified. Published on intranet 13/03/24. Review date 1 Dec 2026.
Action for next year:	Nil unless changes identified.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Action from last year:	To invite the HLRO to conduct a visit during 2024 / 25
Comments:	Informal visit arranged with the new HLRO in July 2025
Action for next year:	Create action plan from informal HLRO visit in July 2025

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	Nil
Comments:	Locum / short term placement Drs are given an introduction to departments. Drs are encouraged & supported to engage in departmental governance & educational meetings. There is no provision for clinical or educational supervision of locums Internal Scope of Practice form available to support provision of feedback for locums. Medical Appraisal Policy updated in respect of appraisal offers and

	requirements for connection to DCHFT as their designated body
Action for next year	To work with the LED tutor to ensure that locums who are connected to DCHFT are allocated a supervisor and that this supervisor will receive the standard PA allowance of 0.125 in their job plan.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:	Consider ways to reduce the approved incomplete / missed appraisal rate.
Comments:	All Drs connected to DCHFT are expected to hold an annual appraisal. Appraisal rates are monitored with a view to continued improvement and a target of >90%. Reasons for missed / postponed appraisals are recorded (Appendix 1). Appraisal inputs & outputs are quality assured via audit. The overall appraisal rate is ~97% Of the 349 Drs with a prescribed connection to DCHFT during this appraisal year, 323 were due to hold an appraisal in the time they were connected to us (26 left the Trust prior to their appraisal anniversary). Of these 323 doctors, 281 had a completed appraisal in line with their appraisal anniversary or within 28 days of such (Grade 1 = 87%). 35 had an approved incomplete or missed appraisal (Grade 2 = 10.8%). This figure includes approved postponements and doctors new to the Trust (including from overseas) who did not provide an appraisal history for the previous year & will have been provided with an appraisal anniversary date on employ at DCHFT. 7 doctors were classed as having an unapproved incomplete or missed appraisal (2.2%) Examining by grade of Dr we can see that there is for improvement required in completed appraisal LED / Trust Dr category Complete Approved missed Unapproved missed Substantive Consultant: 94.2% 4.5% 1.3% Substantive SAS 86.4% 11.9% 1.7% Temp / STC: Consultant 81% 9.5% 9.5% SAS 83.3% 16.7% 0 Trust / LED 75.3% 22.1% 2.6%

Action for next year:	Work with the LED Tutor to support timely appraisal of Locally Employed Doctors which is supported by regular supervision meetings with named supervisors.

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year	Liaison with divisional directors to improve management of postponement of appraisal relating to workforce capacity or absence of appraisers. Support doctors within local investigation processes to hold an appraisal in line with their appraisal anniversary.
Comments:	Compliance with annual appraisal monitored and reviewed at the monthly appraisal meetings attended by the RO / CMO and appraisal lead. QA and governance overseen at RAGG. Reasons for missed / postponed appraisals are recorded via postponement forms with requests scrutinised via the RO or appraisal lead. Quarterly appraiser meetings held. Topics discussed include earlier booking of appraisals to try to avoid clashes with clinical commitments or facilitate rescheduling of clinical work.
Action for next year:	Divisional Managers will receive monthly updates of appraisal compliance for earlier identification of those at risk of missing appraisal anniversaries

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:	Nil unless changes required prior to Dec 2026
Comments:	Medical appraisal policy reviewed, updated & ratified. Published on intranet 13/03/24. Review date 1 Dec 2026.
Action for next year:	nil

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance

Action from last year:	Continued enlistment of support from Divisional Directors (DDs) to identify medical appraisers from departments & encourage consultants / specialist Drs to take on the role.
Comments:	New appraisers sought and in post.There are currently 39 appraisers (July 2025) There is still a turnover of medical appraisers such that we need to continue our drive to recruit and retain new appraisers. As a general guide, each appraiser is allocated 6 appraisals per annum.
Action for next year:	Undertake a review with DHC of appraiser capacity to investigate whether appraisals could be carried out across the Federation

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Action from last year:	Provision of ongoing peer support & CPD opportunities for medical appraisers
Comments:	We hold quarterly appraiser meetings for peer support. The meetings are supplemented by a newsletter which includes updates from ROAN meetings and the GMC ELA. Appraisers attend formal update training every 3 years (with reminders when expired). The RO and appraisal lead conduct audits for QA (inputs and outputs) with feedback to appraisers individually. Appraisers are invited to meet with the RO should they wish face to face feedback or if there are any concerns regarding performance or feedback from appraisees. ASPAT (tool used to measure quality of appraisal outputs): Outcome of audit of quality of appraisal discussed at RAGG and quarterly appraiser meeting. Resource limitations within digital team such that unable to progress IT / AI solutions to support appraisal at the current time.
Action for next year:	Continue provision of ongoing peer support & CPD opportunities for medical appraisers

between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:	Ongoing monitoring & QA of appraisal. The HLRO visit for peer review will provide another source of QA
Comments:	Inputs and outputs from Appraisal are quality assured as noted above. The Board receive an annual report on medical appraisal and revalidation. RAGG meetings scheduled twice a year. The group conducts self-assessment against the Principles of Effective Clinical Governance for the Medical Profession. Outcomes from QA of appraisal are discussed. Summaries of meetings available.
Action for next year:	The HLRO visit for peer review will provide another source of QA

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Action from last year:	Continue to submit recommendations to the GMC on time.
Comments:	All but one recommendation made on time. One was delayed as waiting for further information which was expected within days of the recommendation due date hence considered more appropriate to delay than defer. Number of Doctors revalidated this year: 81 (includes 9 Drs whose revalidation date was after 31/3/25) + 1 Dr from Weldmar HospiceCare Number of deferrals: 2 (including 1 Dr whose revalidation date was June 2025) Number of non-engagement recommendations: 0 (1 x REV 6 notification submitted due to concerns regarding poor engagement with appraisal – not in year of revalidation due date). Decisions are recorded and recommendations notified to the Dr.
Action for next year:	Nil

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Action from last year:	Nil
Comments:	Doctors are informed of RO recommendations via email to the doctor at the time of submission via GMC Connect or PReP IT. Recommendations to defer are discussed with the doctor either face to face or via email well before that recommendation is submitted. Deferrals may be a joint agreement between Dr and RO depending on the reason for deferral. Reasons for deferral and actions the doctor needs to complete to enable a recommendation to revalidate to be made are set out clearly and provided in writing (usually via email).
Action for next year:	Nil

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:	Continue self -assessment at RAGG and take steps to complete actions identified
Comments:	We engage in self-assessment (with lay member challenge at RAGG) against the Principles set out in 'Effective Clinical Governance for the Medical Profession'. Copies of self – assessments available.
Action for next year:	Nil

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Action from last year:	Produce & agree final TOR for a DMG +/- PAG (Performance Advisory Group)

	Establish and evaluate the DMG Introduction of an Employer Relations Report to Board
Comments:	Systems are in place for monitoring the conduct and performance of all doctors working at DCHFT. Concerns regarding conduct / performance are identified and managed at departmental or divisional level and escalation pathways are in place. FtP concerns are discussed with the GMC ELA and PPA as appropriate. The Trust has local polices (such as disciplinary, whistleblowing, grievance, bullying) and uses MHPS. There is a weekly Medical HR meeting involving the Head of People Services, CMO, RO and DDs where concerns are discussed and summaries recorded. Joint Responsible Officer Advisory Group established with DHC Quality Surveillance Group developed with Board level reporting.
Action for next year:	Evaluate ROAG function in September 2025

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Action from last year:	Nil
Comments:	Guidance on supporting information provided to appraisees by appraiser, appraisal lead, RO and administrator for revalidation. Risk data, complaints & compliments available from the Trust. Scope of Practice (internal and external available) to support information sharing.
Action for next year:	Work with the Risk/ Complaints and Legal team to reduce their workload in conducting manual searches of Datix for each doctor. A new system should be able to give automated outputs for appraisal which are also more accurate.

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:	Nil
Comments:	Maintaining High Professional Standards is the approved policy used for responding to concerns. Fitness to Practice issues are discussed at the RO / CMO / GMC ELA meetings which are held quarterly. The GMC ELA is available for informal / formal discussion by MS Teams / telephone between meetings. Practitioner Performance Advice (PPA) service is an additional support for the CMO / deputy CMO (RO). Regular meetings are scheduled with the Trust's allocated advisor from PPA
Action for next year:	Nil

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Action from last year:	Peer support for case investigators – carry over Analysis of PPA Organisational Report
Comments:	Case investigator training took place in March 2024. We have yet to establish a per support group. PPA produced an organisational report which was discussed with relevant staff. Further work around EDI and a fair culture with benchmarking against SAS Charter planned (RO, SAS +/- LED lead)
Action for next year:	Site RO to carry out ED and I audit of doctors involved in case investigations.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation

and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year:	Nil
Comments:	MPIT forms (national process) are used. Telephone conversations or virtual meetings via MS Teams have occurred where there were higher level concerns potentially likely to impact on patient safety / outcomes. There is documented evidence of discussions and decision making / outcomes kept by the medical HR team.
Action for next year:	Nil

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year:	Analysis of PPA organisational report
Comments:	HR policies include an Equal Opportunities Impact Assessment & statement. We are working through self -assessment of the Principles in the GMC handbook as outlined above at RAGG There is discussion and challenge at the RO/CMO/ GMC ELA meetings. PPA organisational report analysed & discussed. Further work around EDI and Fair Culture as above
Action for next year:	Site RO to conduct an EDI audit of doctors undergoing formal MHPS processes and produce an action plan based on the findings.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Action from last year:	Integrate learning from ROAN and national reviews into practice

Comments:	Learning from national events e.g. Letby & Morecambe Bay. ROA established with TOR (see comments 1D ii) Action plan in progress relating to local learning opportunities from Morecambe Bay.
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:	Embedding of Quality Surveillance Evaluation of leadership programmes across the Trust
Comments:	See 1Dii which encompasses all healthcare professionals with regards Quality Surveillance Group (QSG) & Close working relationships being established for leaders across Dorset Health Trusts to achieve consistency in policies where appropriate. The Trust has an established leadership development programme. This gives due regard to EDI. The Trust employs 2 Physicians Associates and 2 Anaesthetic Associates who hold voluntary registration with the GMC.
Action for next year:	Monitor GMC requirements for appraisal and revalidation of Physicians Associates and Anaesthetic Associates.

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:	Nil
Comments:	In addition to pre-employment check there are systems to share information once a doctor has been offered a contract with DCHFT: Sharing of information regarding new doctors entering employ occurs via MPIT forms from RO to RO.

	Such forms are also used to share concerns (RO to RO) which arise during employment at DCHFT of any doctors who also practice elsewhere (e.g locum doctors; doctors with private practice) HPANs (Health Professional Alert Notices) may also be used to share significant concerns about a doctor who has disconnected from DCHFT and not yet made a connection to a new Designated Body. GMC processes also allow appropriate information sharing when there are Fitness to Practice concerns. Information sharing processes adhere to Caldicott principles. The site Responsible Officer is the Caldicott guardian and attends relevant update training. (GMC handbook Principles 4e & f). Resident doctors in training posts have educational and clinical supervisors and follow specialty specific training programmes. Substantively employed LEDs have clinical supervisors and are expected to attend local teaching. They also hold a study budget and are entitled to 10 days per year of study leave
Action for next year:	LED tutor to submit a business case to secure self development time for Locally Employed Doctors to support skills and knowledge acquisition

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Action from last year:	Consider leadership support in promoting positive clinical environments and actioning recommendations from culture survey analysis
Comments:	The Trust values and organisational culture support a strive for excellence in clinical care. Success is celebrated weekly with the “celebrating success” update sent to all staff.
Action for next year:	Ongoing promotion of positive clinical environment & culture New staff recognition scheme being introduced across the federated Trusts in 2025/26

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Action from last year:	As per 1Fi
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 Launch of online reporting portal ‘Work in Confidence’
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.

Action from last year:	N/A
Comments:	Promoted within Trust values and within policies. Behaviours not aligned with Trust values are challenged. Learning culture demonstrated in a variety of ways including outputs from PSIRF investigations, departmental morbidity and mortality meetings and escalation reports to the Guardian of Safe Working. Freedom to Speak Up Guardian in post.
Action for next year:	Nil

1F(iv) Mechanisms exist that support feedback about the organisation’ professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Action from last year:	N/A
Comments:	Feedback from connected doctors occurs in a number of ways including exit interviews, complaints and appeals processes & procedures. Drs may speak with their allocated supervisors / FSUG etc

	For doctors there has been informal feedback from those going through performance management and Fitness to Practice processes. We are aware that delays in such processes contribute to feelings of anxiety & uncertainty. With this in mind the Trust has trained additional case investigators.
Action for next year:	nil

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Action from last year:	N/A
Comments:	PPA Organisational report discussed and analysed to provide further information on E&D issues.
Action for next year:	RO to audit EDI data of doctors involved in Fitness to Practice concerns and produce an action plan based on findings

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Action from last year:	To be determined pending outcome of HLRO peer review
Comments:	Newly appointed HLRO visiting Trust in July. RO, CMO and appraisal lead engage in ROAG meetings.
Action for next year:	Working group to be set up with UHD and DHC to share learning and benchmark RO processes including appraisal.

Section 2 – metrics

Year covered by this report and statement: 1April 2024 - 31March 2025.

All data points are in reference to this period unless stated otherwise.

2A General
The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 31 March 2025 = **349**	

2B – Appraisal

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions is as recorded in the table below.

Total number of appraisals completed	**281**
Total number of appraisals approved missed	**61** (includes 26 leavers who were not scheduled to hold an appraisal prior to leaving; some drs new to Trust and who had appraised prior to arriving or new drs who had not provided an appraisal history for the past year and who were allocated a new appraisal anniversary)
Total number of unapproved missed	**7**

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	84
Total number of late recommendations	1
Total number of positive recommendations	81 (+1 for Weldmar Hospice Care
Total number of deferrals made	2
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	2

2D – Governance

Total number of trained case investigators	14
Total number of trained case managers	3
Total number of new concerns registered	3
Total number of concerns processes completed	1
Longest duration of concerns process of those open on 31 March	12 months
Median duration of concerns processes closed	6 months
Total number of doctors excluded/suspended	1
Total number of doctors referred to GMC	1 (1 Dr was referred by a member of nursing staff. Dr is no longer employed by Trust.

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation	142
Number of new employment checks completed before commencement of employment	142

2F Organisational culture

Total number claims made to employment tribunals by doctors	0
Number of these claims upheld	0
Total number of appeals against the designated body's professional standards processes made by doctors	0
Number of these appeals upheld	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
CMO and RO split role reviewed and roles combined following appointment of Dr Wharton as the 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
Establish a peer support group for case investigators at DCHFT – this should be across the Dorset wide system Conduct an EDI audit of doctors involved in Fitness to Practice case investigations.
Current issues
Retention and replacement of medical appraisers remains a challenge. Remuneration for appraisal under review (Current 0.188 PA with proposal for 0.25PA per 6 appraisals per annum to align with University Hospitals Dorset) We continue to audit inputs and outputs from medical appraisal. Feedback from appraisal is positive for the majority. To ensure that we have a fair culture at DCHFT for appraisal & revalidation and supporting Doctors.
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
1. Review working arrangements for Responsible Office functions to determine if this arrangement best meets the needs of the organisations. 2. Review administrative processes to ensure maximum productivity. Dorset wide review of PA allowance to appraisers as there is a discrepancy between 0.18 PAs and 0.5 PAs. 3. Create action plan from informal HLRO visit in July 2025. 4. Evaluate ROAG function in September 2025 5. Undertake a review with DHC of appraiser capacity to investigate whether appraisals could be carried out across the Federation 6. Continue provision of ongoing peer support & CPD opportunities for medical appraisers

7. Work with the Risk/ Complaints and Legal team to reduce their workload in conducting manual searches of Datix for each doctor. A new system should be able to give automated outputs for appraisal which are also more accurate. 8. Site RO to conduct an EDI audit of doctors undergoing formal MHPS processes and produce an action plan based on the findings. 9. Monitor GMC requirements for appraisal and revalidation of Physicians Associates and Anaesthetic Associates. 10. LED tutor to submit a business case to secure self development time for Locally Employed Doctors to support skills and knowledge acquisition 11. Working group set up with UHD and DHC to be set up to share learning and benchmark RO processes including appraisal.
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/ site Responsible Officer (Dr Rachel Wharton) 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.The existing Medical HR weekly meeting functions effectively to ensure that Fitness Practice concerns are regularly reviewed by the Deputy Responsible Officer, the senior clinical Leadership team with HR advice.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	Dorset County Hospital NHS Foundation trust

Name:	Matthew Bryant
Role:	CEO
Signed:	
Date:	

Dorset County Hospital
Dorset HealthCare

Strategy Transformation and Partnerships Committee Assurance Report for the meeting held on Monday 28 July 2025

Chair	David Clayton-Smith, Chair
Executive Lead	Nick Johnson, Joint Chief Strategy, Transformation and Partnerships Officer
Quoracy met?	Yes
Purpose of the report	To provide assurance on the main items discussed and, if necessary, escalate any matter(s) of concern or urgent business.
Recommendation	To receive the report for **assurance**

Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework	• Frailty Service – strategy in action to be shared with Board • Plan in place to ensure that the risk register is updated and DTI to undertake a review of all digital risks • Joint Strategy aligns with the 10-year plan • MacMillan funding to start filtering in from 01.08.2025 • Positive progress against the Social Value Plan • Green Strategy Annual Report – reported to Board • Six Facets Survey – reported to Board

Key issues / matters discussed at the meeting

The committee received, discussed and noted the following reports:

Strategy in Action
Received a presentation on a QI project, which was around frailty pathways. The project had improved the patient experience, resulting in many of the patients being able to remain at home for treatment, avoiding hospital admission, and saving GP and district nursing time. The service is now looking at capturing the learning, and how this connects to the bigger picture and what learning can be shared with other services. Great feedback had been received from patients, carers and families, DNs and GPs and patients are requesting to be cared for in their own homes. It was noted that this work would link in with INTs.

Corporate Risk Register Assigned Risks
It was noted that one of the risks assigned to STP was in relation to a lease expiry that the Committee felt should sit with FPC. Noted a significant change in relation to talking therapies, the contract had been awarded to a new provider, and an exit plan was currently being worked through.

It was noted that 6 out of the 12 risks reported related to DTI and support. There were a number of overdue risks. Committee were not assured, advised that a recovery plan was in place to address this. It was noted that the last 3 Joint Transformation Improvement Boards had been cancelled. Review of the risk registers relating to digital to take place. Noted DTI were taking a more aligned approach across all three providers, and were

currently looking at joint teams and roles, alongside a large-scale programme of work.

Board Assurance Framework Assigned Risks
There were no changes to the scoring across both organisations. Revised dates had been provided for the outstanding actions. Committee were made aware that a Risk Appetite survey would shortly be circulated to both Boards.

Key metrics will be reviewed in light of the Performance Assessment Framework and the 10-year plan.

CYP mental health programme remained a national priority and required continued focus and resources also highlighted the significance of securing social capital funding for the integrated neighbourhood teams (INT) business case.

10 Year Plan – Initial Assessment
Received an initial assessment on the 10-year plan against the Trust's Joint Strategy. It was noted that we aligned well, and that Dorset was well positioned to make the most of any opportunities. The 10-year plan also covered all voluntary and support sectors as well.

Committee noted the importance of maintaining the patient's voice and public engagement, and the need to align resources with strategic priorities and that we needed to ensure that we invest in the areas of transformation and improvement where we would make the most impact. Locally we will want to make closer contacts with the public and reflect the DASH report. The next steps would be to assess the gaps against the plan and look at the national implementation dates.

Strategic Framework and Plan on a Page 25/26
Received a graphic that detailed on a page how the strategy came together. It was noted that the CYP and MH workstreams needed to be added as an organisational priority. Noted that there were also service and directorate plans sitting under the operational priorities, discussed whether the diagram should be inverted as the biggest section should be healthier lives.

One Transformation Approach Highlight Report
Received a highlight report, which covered key progress in the transformation and improvement work ongoing across the organisations. These included bed reconfigurations at DCH, admin and clerical review at DCH and mental health beds at DHC.

The team are working on aligning processes around prioritisation, with an emphasis on impact. This will be discussed further in the September meeting.

It was noted that amber areas were around the enabling plans and the strategy dashboard. The plan is to launch key metrics alongside the plan. It was noted that the Improving Together programme was now in the development stage.

Integrated Neighbourhood Teams

Received an update on the integrated neighbourhood teams, highlighting the recent funding agreement with MacMillan, some of which will be released from 01.08.2025 to support the set up and framework. We also have two proposals being submitted for Dorset and BCP areas for a national neighbourhood health programme. We should find out if we have been included within this cohort early September. The team were looking at how we use themes from the data to assist with the redesign of pathways, and this included benefit tracking and activation measures.

Progress Against Social Value Plan

SP presented the six-monthly report. Team were working on a joint social value operational plan, and they were currently mapping this out. Local investment spend was on an upward trajectory as was the local catering spend. Similarly local employment and training figures were also up. Tilbury Douglas have provided quarterly social value reports. Patient and public engagement work was ongoing. Volunteers had given 15000 hours of time to the organisation.

Working Together Programme Progress Against Original Aims and Ambitions

Reported that we are still making good progress with the federation working and in progress we had:

- INTs
- Our Dorset Provider Collaborative
- Future Care
- Electronic health records
- NHP
- Digital
- CYP MMH access to wellbeing.

Provider Collaborative Update – Clinical Services Work

Received updated on the provider collaborative's focus on fragile services, including ophthalmology, OMF, interventional radiology, and dermatology. There is a need for a refreshed clinical strategy.

Green Strategy Annual Report

Received the net zero strategy annual report, highlighting progress in reducing emissions and future priorities. We had been successful with a number of bids to support this work. DCH now also had in place a sustainability ranger.

	Cyber Security and Risks Updates Received an update on both organisations. **Six Facet Survey Results – Estates Maintenance Backlog and Critical Infrastructure Risk** Noted that this was a key enabler for the Estates Strategy. The last survey was completed 7 years ago approx. Noted cost of addressing work and level of backlog maintenance which has increased. We have engaged with NHSE and NHSD. Cost of the backlog is forecast to rise. Highest areas of risk outlined and focus will be given to patient's areas first. **Consent Items** Committee received all consent items
Decisions made at the meeting	• None
Issues / actions referred to other committees / groups	• Risk Register Item 1924 to be re-allocated to FPC.

Quoracy and Attendance					
	28/05/2025	28/07/2025			
Quorate?	Y	Y			
David Clayton-Smith	Y	Y			
Frances West	Y	Y			
Dave Underwood	Y	Y			
Andreas Haimbock-Tichy	Y	Y			
Claire Lehman	Y	Y			
Nick Johnson	Y	Apols			
Chris Hearn	Y	Y			
Dawn Dawson	Y	Y			
Nicola Plumb	N	Y til 11			

Dorset County Hospital
NHS Foundation Trust

Audit Committee Assurance Report
for the meeting held on 04 August 2025

Chair	Stuart Parsons
Executive Lead	Chris Hearn, Chief Finance Officer
Quoracy met?	Yes
Purpose of the report	To provide assurance on the main items discussed and, if necessary, escalate any matter(s) of concern or urgent business.
Recommendation	To receive the report for **assurance**

Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework	• Review of the Board Assurance Framework and Corporate Risk Register, as detailed below. Risk score of SR5: Estates has increased from 16 to 20, due to increased likelihood reflecting the results of the six facets survey • Board Assurance Framework and Corporate Risk Register continue to highlight digital and finance as the highest risks for the trust. • Positive support had been received from DHC colleagues to improve the trust's FOI position; thanks were extended to the team.

Key issues / matters discussed at the meeting	The committee received, discussed and noted the following reports:
	• Further to an action from a previous meeting the purchase order exclusion list was reviewed, with no unusual findings.
	• Board Assurance Framework, noting that:
	  ○ All strategic risks had been reviewed at committees over the last week
	  ○ The highest scoring risks continue to be SR3: Workforce Capacity; SR5: Estates; SR6: Finance and SR9: Digital Infrastructure (each with a score of 15 or more).
	  ○ Risk score of SR5: Estates has increased from 16 to 20, due to increased likelihood reflecting the results of the six facets survey
	  ○ Actions which were past their original scheduled date would be updated to reflect they were behind schedule
	  ○ Discussion around ensuring regular Joint Transformation Improvement Board (JTIB) meetings were scheduled (re SR7: Collaboration)
	• Corporate Risk Register, noting that:
	  ○ Risk appetite review work was ongoing.
	  ○ An updated platform for risk management was being procured across DCH and DHC.
	  ○ A new joint head of risk was expected to be in post by the end of the summer.
	  ○ All high-scoring risks had been reviewed at committees over the last week

- Three of the four new highest scoring risks related to digital and finance, reflecting the highest scoring areas in the Board Assurance Framework
- Reflection from committee members that mitigations and actions needed to be SMART. The new joint manager would monitor and improve this.

- Tender Waiver Report, detailing the use of single tender waivers (STW), including three waivers >£100k and the reasons for these. Potential emerging factors that could lead to an increase in STW in the coming year and the steps to ensure these were handled appropriately. The STW process and level of challenge was considered by external auditors as part of their Value for Money audit. The report was approved.
- Internal Audit progress reports, noting:
  - The audit plan was on track, with two amendments to the plan agreed by the committee, prioritising a quality impact assessment audit and an audit of maternity incentive scheme compliance.
  - Cyber security supply chain management audit with moderate assurance re design and effectiveness.
- Internal Audit follow up reports, noting updates to outstanding actions. One action update (re joint strategy) had been received shortly before the meeting and would be included in the next report.
- Counter Fraud Progress Report, noting:
  - The handover from TiAA had been completed in May. Four fraud referrals had been received to date this year, reflecting 70% of last year's referral rate.
  - The 2024/25 Counter Fraud Annual Report presented to the June 2025 meeting of the Audit Committee did not contain a fully completed functional standard return nor a signed statement of assurance, meaning the trust was non-compliant in this regard. This would be returned to the next Audit Committee meeting to rectify the position.
- Freedom of Information Request Compliance showing improved compliance. 79% of requests were completed by the deadline, but this was still below the target set by the ICO. Work was ongoing to escalated delayed responses. Positive support had been received from DHC colleagues to improve the trust's FOI position; thanks were extended to the team.
- Data Security and Protection Annual Compliance, confirming that this was submitted by the deadline. An internal audit by BDO identified how compliance could be improved. New requirements for the DSPT were noted this year and the trust had been cautious in it's self-assessment.

Decisions made at the meeting

- Approval of the Tender Waiver Report

Issues / actions referred to other committees / groups	• Nil

Quoracy and Attendance						
	02 Jun 2025	25 Jun 2025	04 Aug 2025	01 Dec 2025	02 Feb 2026	30 Mar 2026
Quorate?	Y	Y	Y			
Stuart Parsons	Y	Y	Y			
Stephen Tilton	Y	A	Y			
Dave Underwood	Y	Y	Y			

Dorset County Hospital
NHS Foundation Trust

DCH Charitable Funds Committee Assurance Report for the meeting held on 22.7.2025

Chair	Name Dave Underwood
Executive Lead	Name Nicholas Johnson
Quoracy met?	**Yes**
Purpose of the report	To provide assurance on the main items discussed and, if necessary, escalate any matter(s) of concern or urgent business.
Recommendation	To receive the report for **assurance**

Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework	• Major legacy (est. value c.£835K) – interim distribution of £780,000 received 21.7.25.
Key issues / matters discussed at the meeting	The committee received, discussed and noted the following reports: • **CFC Minutes (20.5.25)** – approved as an accurate record. • **CFC Actions (20.5.25)** – All actions completed or in progress. • **DCH Charity Financial Reports 25/26 (M2)** – reports were received. Total income as of end May 2025 £45,425**.** Unrestricted funds were £394,247 providing a surplus of £121,247 against the newly approved reserves target of £273,000. Major legacy (est. value c.£835K) – interim distribution of £780,000 received 21.7.25. • **DCHC Reserves Policy (updated)** – the committee approved the target amount of Reserves to be held as £273,000. • **£2.5M Capital Appeal (ED/CrCU) report (Jun 2025)** – report received. £1,145,580 income and pledges received to date. • **Fundraising & Communications report** – overview of current key fundraising activities and communications. • **Lillian Martin legacy -** sale of land completed end Mar 2025. DCHC share initially advised as £31,416, may now be higher, awaiting final confirmation prior to receipt of funds.
Decisions made at the meeting	**DCHC Reserves Policy:** the committee approved the target amount of Reserves to be held as £273,000.
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**	
Quorate?	Y	Y	Y	Y	Y	
Committee member name	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	
Committee member name	Y Jo Howarth	Y Jo Howarth	N Jo Howarth	Y Jo Howarth	Y Jo Howarth	
Committee member name	Y Anita Thomas	Y Anita Thomas	Y Anita Thomas	Y Anita Thomas	Y Anita Thomas	
Committee member name	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	

Dorset HealthCare University
NHS Foundation Trust

Mental Health Legislation Committee in Common (MHLCiC) Assurance Report for the meeting held on 31st July 2025

Chair	Andreas Haimböck-Tichy
Executive Lead	Lucy Knight, Chief Medical Officer
Quoracy met?	DHC – Yes DCH - No
Purpose of the report	To assure the Board on the main items discussed by the Committee and, if necessary, escalate any matter(s) of concern or urgent business which the Committee is unable to conclude.
Recommendation	To receive the report for **assurance**

Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework	• Positive outcomes to recent CQC visits, particularly Glendinning Ward. • The Committee agreed more work is required to understand the declining use of the mental health act to help flag any risks, areas of concern and inform corrective action. • First committee in common meeting where full attendance was challenging. • Mental Health Legislation Annual report for DHC received.
Key issues / matters discussed at the meeting	**Corporate Risk Register Assigned Risks - DHC** There are currently two assigned risks to the newly formed MHLCiC relating to DOLS legislation and Right Care, Right Person both with a risk score of 12. The committee agreed further clarification is needed on the controls and mitigation that are in place, and further assurance required that there are no wider risk related themes relating to Mental Health Legislation that need to be considered for committee oversight. **Mental Health Legislation Assurance Dashboard – DHC (Including training rates)** Report highlights were presented covering Q1. The key points conveyed to the committee were: - One section was deemed invalid in the reporting period. - Declining trend in use of the mental health act continues. A more recent reduction is also noted within the acute hospitals, this is particularly evident within Poole Hospital. - A spike is noted in May 25 with regards to number of section 136 detainees. However, total numbers of section detainees continue to sit at much lower level . As total numbers of section 136 reduce, more persons are being assessed within the 3-hour threshold. Considerable and varied discussion on various aspects of the report including possible drivers behind the reduction in section 136 detainees, extracting any learning from the findings of the report and greater clarity

and summary of actions and areas of concerns for the committee to consider in the future.

Mental Health Legislation Assurance Dashboard – DCH (Including training rates)
The committee recognised that DCH does not have the same level of scrutiny around application of the mental health legislation act and mental health CQC standards and therefore the report is currently lighter than the DHC report but will develop over time. DCH has experienced an increasing number of individuals requiring assessment under the Mental Health Act and Mental Capacity Act at initial presentation. Assurance was provided that the teams are working within the boundaries of their statutory responsibilities.

Mental Health Act Care Quality Commission Inspection Assurance Report - DHC
Four services have been reviewed under CQC Mental Health Act Reviews since the start of the year reflecting a notable increase in CQC activity. Seven actions noted and being worked through. A further five actions remain open from the previous year mainly due to awaited improvements/changes to the estate. The extremely positive report on the Glendinning Ward visit for the second time was noted and commended by the committee. The common emerging themes from the review visits in recent months are:

- Treatment authorisations (maintaining them up to date, relevant and appropriate)
- Recording of discussions with patients around consent to treatment and their capacity to consent (and how this may have been supported).
- Management and correct use of Section 62.
- Management of SOAD visits.
- Reading Section 132 rights and keeping people aware of their rights.

Strategic Mental Health Legislation Multi-Agency Group Assurance Report

- Improved contacts with healthcare professionals before invoking section 136 was highlighted as positive.
- Minimal instances recorded of any requirement for mechanical restraint in Quarter 1.
- Positive report on the Mental Health Response Vehicle (MHRV) which launched in April 2025 with 61 contacts in April and 87% of persons treated on the scene. Majority of contacts under 15 minutes, with 11% of persons conveyed to hospital. Second vehicle planned for West Dorset.

Mental Health Legislation Scheme of Delegation - DHC
Deferred

	Mental Health Legislation Annual Report - DHC The paper was summarised with the following highlights: – Reduction in section 136 related to police power to remove persons to a place of safety. Th average number per month in 2024/25 was 19 compared to much higher figures in previous years. – Total use of the Mental Health Act in the acute providers across Dorset has reduced in the past few months. – Useful insights into the trends by the Clinical Director were highlighted. – There has been no requirement to report to the CQC via the notification process due to deaths under the Mental Health Act in Dorset and no under eighteen-year-olds have need to be admitted to an adult ward. – There were 6 instances of a section being allowed to lapse in 2024/25. – Numbers of Hospital Managers hearings organised and held are at the highest they have been for four years, with 273 hearings held and arrangements put in place for 463. This represents an approximate 16% increase on 2023/24, in terms of hearings held Further assurance was requested by the committee in clarifying the key takeaway messages in future reports, the impact of the report findings on patients, and a trend report relating to delays in panel hearings. **Mental Health Legislation Committee Effectiveness Review - DHC** A summary of the report was provided. The Committee formally met four times (April 2024 to March 2025) and discharged its responsibilities in all areas. The response rate was low but the committee effectiveness evaluation was positive.
Decisions made at the meeting	To defer approval of the DHC Scheme of Delegation
Issues / actions referred to other committees / groups	Nil

Quoracy and Attendance				
	24/04/202	**31/07/2025**	**27/11/2025**	**29/01/2026**
Quorate?	Y	DHC Y | DCH N		
Andreas Haimböck-Tichy (DHC)	Y	Y		
Dawn Dawson (or deputy)	N	Y (CS) (JH part)		
Lucy Knight (DHC)	Y	N		
Racehl Wharton (DCH)	N/A	N		
Margaret Blankson (DCH)	Y	N		
Steve Peacock (DHC)	Y	Y		
Suresh Ariaratnam (DHC)	N	Y		

Dorset County Hospital
Dorset HealthCare

Report to	DCH Board of Directors	
Date of Meeting	12 August 2025	
Report Title	Green Plan Annual Report	
Prepared By	Bev Lagden, Patrick McDermott	
Approved by Accountable Executive	David McLaughlin, Joint Director of Estates & Facilities	
Previously Considered By	Strategy, Transformation, and Partnership Committee in Common – 28 July 2025	
Action Required	**Approval**	Y
	Assurance	Y
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	**Yes**	No
Colleagues	**Yes**	No
Communities	**Yes**	No
Sustainability	**Yes**	No
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR5 - Estates	
Financial	Without further resources or funding the trusts are at risk of not meeting their NZC targets. This was an existing challenge exacerbated further by the recent closure of Public Sector Decarbonisation Funding.	
Statutory & Regulatory	The Trusts must have regard to the Environmental targets of the Environment Act 2021, UK net zero emissions target of Climate Change Act 2008 as part of the Health and Care Act 2022 and adapt to any current or predicted impacts of climate change.	
Equality, Diversity & Inclusion	Climate change impacts on people of lower income and ethnic minorities disproportionality. Of the 17 UN Sustainable development goals 5 are concerned with health, equality, poverty, food and inequalities, respectively.	
Co-production & Partnership	Many actions are delivered in partnership, both internally and via external stakeholders and funders/offering social value. This includes Sustainability Champions, Sustainability and Travel Working Group Members and Green theme leads; Greener Communities Fund, Heat Network Development Fund, Dobbies in the Community, Mens' Shed Dorchester, Kingston Maurward College, Dorchester Timber, LST, TD., Devon Wildlife Trust.	

Executive Summary

DCHFT has set a baseline and is making progress towards Net Zero however reaching these targets without further funding or resources means not achieving the target is a risk. The annual target is calculated as: -

NHS Carbon Footprint ($TC0_2e$) =3,321.02 /3 years = 1,1007pa
NHS Carbon Footprint Plus ($TC0_2e$) = 24,817.8/10 years = 2,481.28pa

There has been a range of clinical, estates and staff initiatives including likely carbon emissions avoidance of: -

a. 146,200 kWh and 1,535 $kgCO_2e$ from LED projects
b. 17T of rehoming saving approximately $15kgCO^2e$ to landfill

c. 21.65 $TC0_2$ Dorset NHS Lift share (Scope 3 FP+)

Changes in clinical practice, IPC projects, reduced use of anaesthesia gases, outpatient activity delivered remotely, and a greener theatres team drop in has led to reduced emissions and increased recycling

Achieving Clinical Waste Strategy targets has reduced emissions and costs

Recycling engagement, cup take back scheme and recycling station in Damers with repair to a compactor has increased recycling rate and improved the differential in cost of recycling compared to general waste and reduced emissions.
A range of greenspace initiatives will improve biodiversity, green up grey areas increase carbon sinks and provide areas of respite for patients, staff and visitors. The Dorset Recovery Ranger initiative can improve connections to nature and been shown to encourage environment conscious behaviour[1].

Dorset Health Care Foundation Trust in the 6 years from the baseline 2019/20 to 2024/25, total carbon emissions have decreased significantly, reflecting concerted efforts to reduce energy consumption, transition to cleaner technologies, and implement sustainable practices across our estate and operations.

Total emissions (tonnes CO_2e):

Baseline and Current Year	*Dorset Health Care*	*Dorset County Hospital*
2019/20:	8,016	7,066
2024/25:	4,832	4,609
Reduction	39.7%	33%

Joint Priorities ahead include

i. Expand on site renewable energy generation (e.g. Solar PV)
ii. Continue fleet electrification and promote active staff travel
iii. Deepen carbon literacy and staff engagement at all levels
iv. Develop carbon foot printing across procurement

The requirement for leadership and commitment is strongly linked to achieving net zero.

Recommendation

The Board of Directors is recommended to:

v. Receive the report for **assurance**
vi. **Approve** nzc target risk on the risk register
vii. **Approve** the Technical Economic feasibility study next steps

[1] Yongbo Liu, Anne Cleary, Kelly S. Fielding, Zoe Murray, Anne Roiko, Nature connection, pro-environmental behaviours and wellbeing: Understanding the mediating role of nature contact, Landscape and Urban Planning, Volume 228, 2022, 104550, ISSN 0169-2046, https://doi.org/10.1016/j.landurbplan.2022.104550.

Green Plan, Net Zero Progress and New Initiatives

1. Executive Summary

1.1 DCH has made set a baseline and is making progress towards Net Zero however reaching these targets without further funding or resources means not achieving the target is a risk. The annual target is calculated in Tonnes of Carbon Dioxide emissions equivalent ($tC0_2e$):-

a) NHS Carbon Footprint=3,321.02 /3 years = 1,1007pa
b) NHS Carbon Footprint Plus = 24,817.8/10 years = 2,481.28pa

1.2. There has been a range of clinical, estates and staff initiatives including likely carbon emissions avoidance of: -

a) 146,200 kWh and 1,535 $kgCO_2e$ from LED projects
b) 17T of rehoming saving approximately $15kgCO^2e$ to landfill
c) 21.65 $TC0_2$ Dorset NHS Lift share (Scope 3 FP+)

1.3. Changes in clinical practice, IPC projects, reduced use of anaesthesia gases, outpatient activity delivered remotely, and a greener theatres team drop in has led to reduced emissions and increased recycling

1.4. Achieving Clinical Waste Strategy targets has reduced emissions and costs. Recycling engagement, cup take back scheme and recycling station in Damers with repair to a compactor has increased recycling rate and improved the differential in cost of recycling compared to general waste and reduced emissions.

1.5. DCH now weights Social Value and Sustainability as 10% of scoring in tender decisions, there is an emphasis on local providers to the trust and catering. DHC is developing its Social Value to mirror DCH Social Value programme.

1.6. A range of greenspace initiatives will improve biodiversity, green up grey areas increase carbon sinks and provide areas of respite for patients, staff and visitors. The Dorset Recovery Ranger initiative can improve connections to nature and been shown to encourage environment conscious behaviour[2].

1.7. A DCH decarbonisation plan was developed and a techno-economic feasibility study into ground source and deep geothermal, as building energy makes up 18% of DCH Carbon Footprint (Scope 1&2) 2019/20 carbon emissions footprint. The decarbonisation plan was shared with DCH and UHD and the feasibility study is attached as an appendix. The findings are to discuss potential heat network with DC and develop ASHP with a main ASHP a significant step to nzc, and approach CEF who developed the CHP project on this option.

[2] Yongbo Liu, Anne Cleary, Kelly S. Fielding, Zoe Murray, Anne Roiko, Nature connection, pro-environmental behaviours and wellbeing: Understanding the mediating role of nature contact, Landscape and Urban Planning, Volume 228, 2022, 104550, ISSN 0169-2046, https://doi.org/10.1016/j.landurbplan.2022.104550.

2. Introduction

2.1. The trusts have made progress on green plan and net zero targets and are in process of capturing other initiatives and detail to a Green Plan refresh across DCH, UHD and DHC. The trusts now have carbon footprint and energy baselines and DCH is starting a food waste baseline.

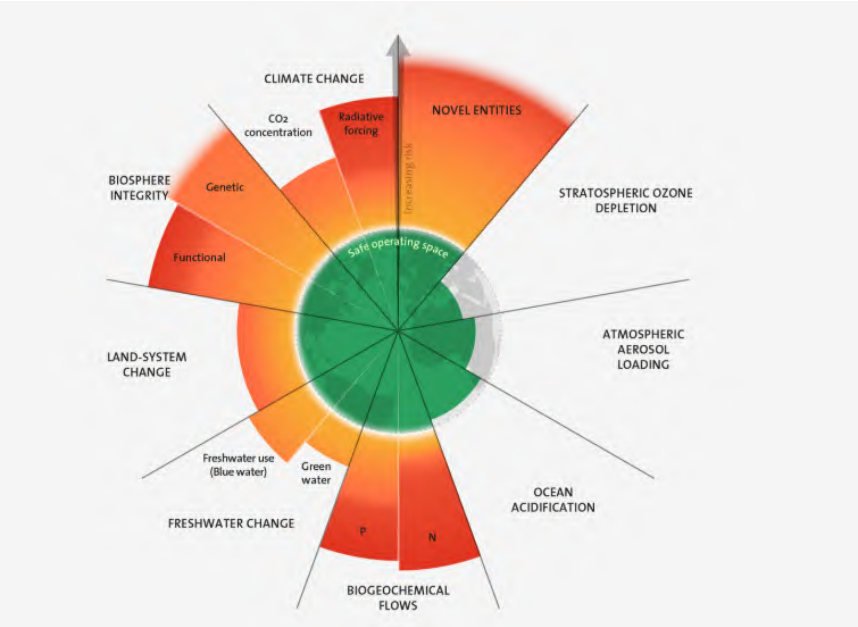
2.2. There is a focus on anaesthetic gases, procurement and options for building energy as these are significant emitters of carbon for the trusts. Social Value, greenspaces and biodiversity are material to addressing healthcare inequalities and adaptation to climate change, such as concurrent droughts.

2.3. With the loss of PSDS funding, and tie into CHP, decarbonisation projects face a funding gap for longer term investment despite some good potential return on investment.

3. Net Zero Carbon (NZC) Progress

Net zero carbon is defined as when Anthropogenic carbon emissions achieve a balance with removals and sinks of greenhouse gases. The NHS is clear that offsetting is a final measure when all carbon emitting activities are reduced as far possible. While offsetting can be useful, it is likely that the planet has a limit that ecological processes can sink carbon emissions, the planetary boundaries of the earth's resilience, Stockholm Resilience Centre (developed in 2009) is an example of mapping this.

Graphic: Stockholmresilience.org Planetary Boundaries 2023 (9 Boundaries assessed, 6 crossed)[3]



[3] The 2023 update to the Planetary boundaries. Licensed under CC BY-NC-ND 3.0. Credit: "Azote for Stockholm Resilience Centre, based on analysis in Richardson et al 2023"

3.1 Carbon Footprint Targets

3.2 The trusts have improved its reporting and carbon emissions tracking from work of the Sustainability team, feeding in Greener NHS quarterly data and ERIC data to NHS England. DCH are updating a local tool that formed part of the 2024 Heat Decarbonisation Plan, with Building energy making up 18% of the tCO_2e emissions. The sustainability team have improved energy, waste and water resource use tracking. The original 1990 baseline data by NHSE is not available so a revised 2019/20 baseline includes data that can be mapped and sets a revised target of

1. Reach net zero NHS Carbon Footprint by 2040, reducing emissions by at least 47% by 2028-2032
2. Reach net zero NHS Carbon Footprint plus by 2045, reducing emissions by at least 73% by 2036-2038

3.3 The NHS has benefitted from decarbonisation of the grid; however, the NHS targets are ambitious compared to the UK target of net zero by 2050.

3.4 Progress to Net Zero against the National Health Service England midway targets since 2019/20 baseline, (DCH Graph 1, Table 1, 2 DHC Table 2).

Graph 1: DCH Carbon Footprint Scope 1 Emissions 2019/20 to 2024/5 against Target

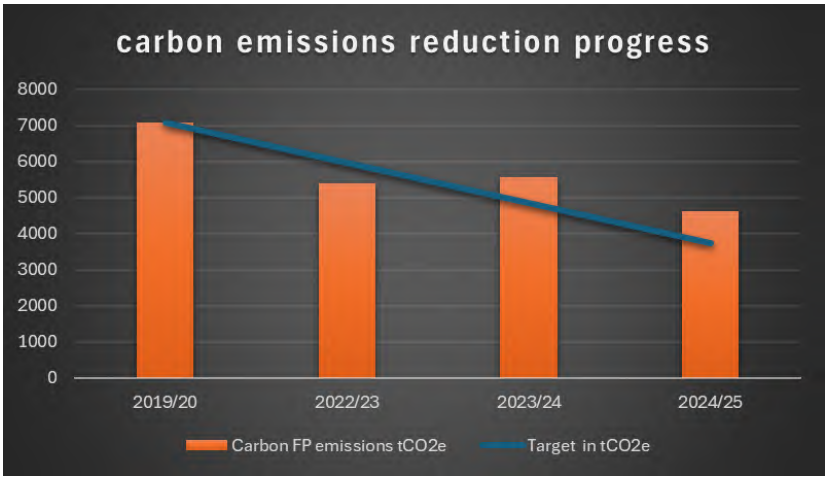


Table 1: DCH Carbon Footprint since baseline (33% reduction in Scope 1 emissions)

Financial Year	2019/20 (baseline)	2022/23	2023/24	2024/25
Target in $tC0_2e$	7066.00	5959.00	4852.00	3745.00
Carbon FP emissions $tC0_2e$	7066.00	5375.58	5571.7	4609.67

4. Table 2: Carbon Scope 1 & 2 main emitters (tCO_2e) since last financial year

Dorset County Hospital Foundation Trust (tCO2e)	2023/24	2024/25
Gas	4194.92	3395.05
Grid electricity	627.00	448.00
Anaesthetics	598.37	655.58*
business travel and fleet (Scope 3)	147.64	108.64

5. While this is an increase overall the Anaesthetic gases have decreased by 17% since 2019/20 (797) due to removal of the Nitrous manifold in 2023 and ceasing use of Desflurane in 2022 and increasing TIVA anaesthesia. Nitrous is used in cylinders in maternity, Kimmeridge Ward and A&E.

6. There has been a slight rise against the downward trend in 2023/4, this is likely to be building energy, using the CHP for electricity for cooling during hot events, with an increase in heatwaves and concurrent heatwaves occurring in 2023/4.[4]

Table 3 DHC Emissions by Scope ($TC0_2e$)

Dorset Health Care Foundation Trust Emissions Scope ($tC0_2e$)	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Scope 1	5,113	3,741	4,319	4,105	4,178	4,223
Scope 2	1,951	1,532	1,260	1,131	1,152	76
Scope 3	951	868	1,224	921	908	533
Total	7,987	6,108	6,754	6,026	5,708	4,702

Scope 2 (purchased electricity) emissions have fallen dramatically for DHC (**96% reduction**) by 2024/25, reflecting the switch to REGO certified clean UK generated renewable energy contracts. DCH did switch to REGO but has since changed due to decarbonisation of the grid and NHSE guidance this wasn't necessary, however scope 2

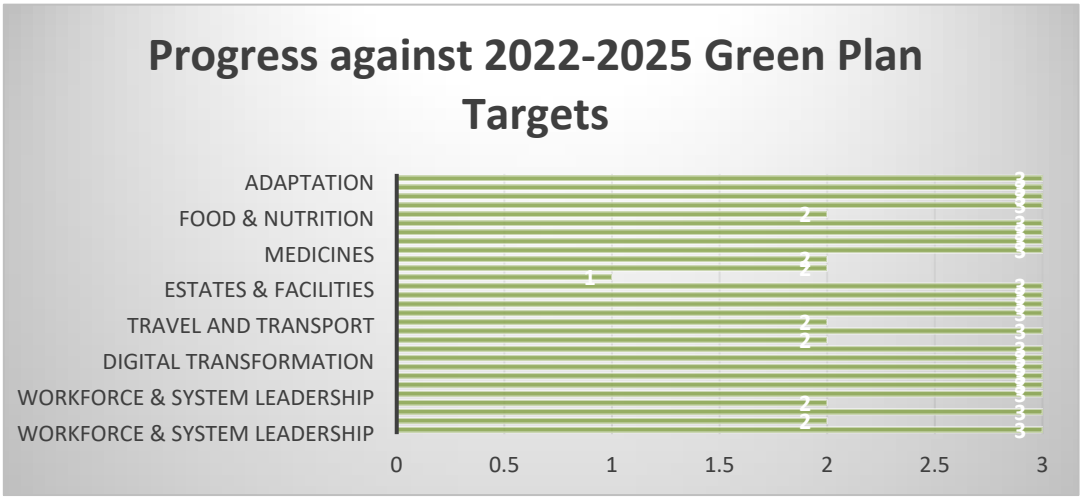
Scope 1 (direct emissions) remain the most persistent challenge due to on-site heating and Trust-owned transport for both trusts and DHC with a gas powered CHP.

Scope 3 (indirect emissions), including procurement, travel, and waste, represent an area with increasing importance for net zero strategies for both trusts.

7. Green Plan Progress

7.1 The DCHFT Green Plan and targets were set from 2022/3-2024/5 and progress was tracked until March 2025 of 72% achieved and anticipating new Green Plan refresh guidance from NHS England. The metrics are broadly qualitative and set within themes of materiality set by NHS England. To track progress targets were assigned 3 – completed, 2 – In progress and 1 not started. 21 actions were completed, 9 need work, such as NHP ambitions for NZ hospital standard.

[4] https://www.metoffice.gov.uk/about-us/news-and-media/media-centre/weather-and-climate-news/2025/annual-climate-stocktake-shows-weather-records-and-extremes-now-the-norm-in-uk-climate



7.2 Further initiatives developed organically and were completed led by Clinical teams in IPC and Greener theatres including re-useable tourniquets, theatre ventilation downtime, early intervention removal of devices, IV to oral switch, gloves off, less waste sterilising in SCBU, recycling in theatres.

7.3 **Waste**

Staff on wards and the Waste Co-ordinator, now part of the DCH Sustainability team, achieved the NHS Clinical Waste targets for the first time. Recycling rates, and repair of a compactor, has meant more recycling, and a greater cost reduction than general waste and the Catering Manager and Sustainability team have established monitoring and a baseline of food waste, a recycling station and new cup provider and cup takeback scheme for many of the 2M cups used each year that were contaminating 15% of recycling loads as they had residue and wax/plastic lining. The Catering team will trial digital food ordering for more tailored patient experience and reduce food waste. There is a leftover plates scheme for staff via wellbeing coaches.

DHC has similarly improved waste segregation and recycling practices and DHC and DCH are investigating together on rehoming and repair initiative. Rehoming at DCH intercepted 17T of items over 2024/5 as a valuable re-use resource with an estimated second-hand value of £252000 and saving 15.78 $TC0_2e$ and £6,000 disposal costs.

7.4 **Energy**

The DCH Sustainability Manager and Sustainability Officer took up free training places with NHSE England and the Energy Institute and will be working in teams with their cohort for energy projects to benefit the trust. There have been 2 LED NEEF funded of £62,000 over 2023/4 & 2024/5 to fund nearly 400 LED light fittings across the main site. This is estimated to lower carbon emissions by 1,960 kilograms a year through avoiding 146,200 kWh and save the Trust money. DHC the Head of Sustainability has led on a successful and even more extensive LED light fitting replacement across large parts of the estate from NEEF funding.

The DCH decarbonisation plan was developed and shared with DHC and UHD. Funding was obtained by HNDU

grant for a techno-economic feasibility study into ground source and deep geothermal, as building energy makes up 18% of DCH Carbon Footprint (Scope 1&2) 2019/20 carbon emissions footprint. The decarbonisation plan was shared with DCH and UHD and the feasibility study is attached as an appendix. The findings are to discuss potential heat network with DC and develop ASHP with a main ASHP a significant step to nzc, and approach CEF who developed the CHP project.

7.5 **Sustainable Procurement**

DCH developed a sustainable procurement policy and 10% weighting for social value and sustainability. Procurement Managers are considering Life Cycle Analysis for some supply changes. Local suppliers are recorded and part of procurement and catering provision where possible.

7.6 Water conservation includes reporting leaks points via Eco Earn the staff eco pledge platform across all 3 Dorset trusts and SWAST. DCH theatre staff scrubbing once then using hand sanitizer.

7.7 **South Walks House refurbishment** and Green Travel Plan was awarded BREEAM Very Good for its environmental and sustainable building practices and travel plan.

78 **Green Travel**

A DCH travel survey was carried out in June-July 2024 with 288 responses and is being organised for July 2025. The Sustainability team worked with Dorset Council travel team with a Beryl e-bikes roll out in Weymouth and Dorchester including spaces each end of the route between South Walks House and DCH main site. Low carbon travel options are available on DCH staffnet and adapted for the public website pending its update. DCH are taking steps to electrify 20% of the fleet and scoping a whole site Green Travel Plann mirroring the successful South Walks House GTP.

DHC has Green Travel plans in place and identifies further fleet electrification and active travel for staff as a propriety for FY 2025/6 and beyond.

7.9 **Climate Change Adaption**

Both trusts and UHD are working with Dorset Council sustainability team and participating in a Dorset Climate Change Risk Assessment. The DCH Climate Change Adaption Plan was shared to the other 2 Dorset Trusts and will be refreshed in 2025 and is aligned with Business Continuity; to date this has included concurrent drought planning and could include tree scape planning following the tree equity score[5].

[5] https://uk.treeequityscore.org/map#14.58/50.71318/-2.44209 ranks tree cover, air pollution, heat disparity, employment, health, income and has shown local cooling and health benefits and this refers to the idea that everyone should have access to these benefits regardless of their location or socioeconomic status

7.10 **Green spaces and Biodiversity**

The trusts are working to improve their greenspaces for health and wellbeing benefits . IN DCH a Greenspaces and a Gardens Group, led by the Director of Nursing, are working to achieve these aims.

- A Greener Communities, Hubbub and Starbucks Charity Award of £50,226 to develop a Sensory Courtyard Garden hard landscaping features completed in June 2025 and a Dobbies in the Community award will design and provide plants
- The Centre for Sustainable HealthCare 'Healthy by Nature' project and National Lotteries Community Fund DCH are 1 of 9 trusts successful to start a CSH Recovery Ranger from summer 2025 · Staff gardens group are meeting monthly with tasks of planting NHSForest hedgerow whips, collect wildflower seeds, cutting back, weeding, planting donated snowdrop and daffodil bulbs. Once activity resources are developed the Ranger will share this across the other Dorset trusts and satellite in demonstration activities.
- DHC, DCH and UHD organised and participated in Dorset Biodiversity Net Gain training with the NHS Dorset Green leads participants across strategic projects, sustainability, estates and fabric teams.
- Installed interpretation board and gate sign for Mark's Meadow funded by DCH Charity
- Regular wildlife sightings by staff added to a Mark's Meadow repurposed whiteboard.
- A bird feeder livestream in Damers restaurant staff area and planned for the Terrace and investigating for Ilchester ward thanks to a hospital charities award.

10. Communication/Engagement of sustainability

9.1 EcoEarn 2024/5 DHC and DCH

- DCH 213 and DHC 411 total number of participants
- Main events include big garden bird watch, Health Bioblitz, Pantry challenge.
- Sustainability team, DCH attended 23 staff induction coffee breaks for promoting Ecoearn and Liftshare, altogether 250 engagements with staff.
- 112,562kg C02e avoided, 249,450 Green points collected by staff and approximately 36,038 coffee cups and bottles avoided: stats considering DCH, DHC, UHD and SWAST. Relates to scope 3 with some tailoring to NHS roles.

9.2 **Sustainability Champions**

- Sustainability champions Drop-in session promoting big garden bird watch was held at Damers restaurant in January 2025; 30 engagements and 12 signed for the sustainability champions bimonthly e-newsletter, 4 signed in for the gardens club.
- Dorset NHS Liftshare
  - 90 members liftsharing across Dorset NHS (DHC, UHD and DCH)
  - Historic savings are £28,657, 21.65 Tonnes of C02 and 98,175 miles saved as a part of liftsharing.
  - Forecasted 12-month savings figures are £11,694, 8 Tonnes of C02 and 40,063 miles to be expected to be saved in next 12 months. This brings in affordability, opportunities for travel where public transport is not aligned to work needs, and

reduced single occupancy vehicles on site, associated local air pollution, and parking availability for the public.

11. Green Plan Refresh

NHS England released Green Plan Guidance in February 2025 with a July deadline, the UHD, DCH and DHC Sustainability leads are working on a combined plan with a structure agreed and content being drawn together. NHSE SW was notified of delays and the desire for a joint approach.

Preliminary Greener and More Sustainable DCH actions were included in the trusts Social Value Action Plan (not yet published) and this will be complemented by DHC's first SVAP in the Autumn.

12. Conclusion

a. As part of the Task Force for Climate-related Disclosure format of the Annual Report there is a focus on trust's leadership and governance on net zero emissions This guidance may change next year as TFCD is withdrawn generally but the requirement for leadership and commitment is strongly linked to achieving net zero.
b. A range of initiatives and progress of the green plan themes and since the start of the green plan can be mapped and has been achieved.
c. While there is good progress, without further resources the trusts are at risk of not meeting net zero, and decarbonisation of building energy is a significant part of the trust's footprint. The government has closed the PSDS grant scheme and grant applications in other areas are competitive.
d. Priorities ahead include
    i. Expand on site renewable energy generation (e.g. Solar PV)
    ii. Continue fleet electrification and promote active staff travel
    iii. Deepen carbon literacy and staff engagement at all levels
    iv. Develop carbon foot printing across procurement

13. Recommendations

a. The Board / Committee is recommended to:
    i. Receive the report and appendix for **information**
    ii. Receive the report for **assurance**
    iii. **Approve** nzc target risk on the risk register
    iv. **Approve** the Technical Economic feasibility study next steps

Name and Title of Author: Bev Lagden, Sustainability Manager DCH with information supplied by Patrick McDermott, Head of Sustainability, DHC.
Date: 14 July 2025

Appendices

Appendix 1: Dorset County Hospital Heat Decarbonisation and Heat Network Feasibility Study

Appendix 2: Methodology of tracking against Carbon emissions targets

9.2 Methodology: Use of NHS England 2019/20 data, Greener NHS Data (Futures Dashboard) and Trust's own Carbon Footprint tracking developed as part of the Decarbonisation Plan. This also contains the midway targets. SOUTH WEST_NHS DORSET ICB_RBD_DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST.pdf

Baseline (2019/20) year emissions:	tCO_2e
Scope 1 & 2	7,066
Scope 3 (Included Sources)	20,248
Total Emissions (Including commute, patient, visitor travel and outside commissioned services)	33,997

14. Midway targets to 2028/29 from NHSE recalculated from 1990 targets and then calculated as an annual target and plotted. Carbon Footprint Plus data is not yet available on Greener NHS Data and would be prohibitive amount of resources to calculate locally.

2019/20	Midway Targets	Annual Target
FP is 7066	2040 NZC 47% of 2019/20 data by 2028/32	3,321.02 /3 years = 1,1007pa
FP+ is 33,997	2045 |NZC 73% of 2019/20 data by 2036/38	24,817.8/10 years = 2,481.28pa

Dorset County Hospital

Heat decarbonisation and heat network feasibility study

July 2025

Source: Esri, Maxar, Earthstar Geographics, and the GIS User Community

ARUP

Document verification

Revision	Date				
		Filename	Dorset Hospital Study Draft		
P01	29th May 2025	**Description**	First Draft for Client Comments		
			Prepared by	**Checked by**	**Approved by**
		Name	Gareth Tucker Isabelle Browne	Alban Leiper	Ann Cousins
		Signature			
P02	1st July 2025	**Filename**	Dorset County Hospital Heat Decarbonisation and Heat Network Feasibility 010725		
		Description	Final version		
			Prepared by	**Checked by**	**Approved by**
		Name	Gareth Tucker Isabelle Browne	Alban Leiper	Ann Cousins
		Signature			
		Filename			
		Description			
			Prepared by	**Checked by**	**Approved by**
		Name			
		Signature			

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ARUP

Structure of report

ARUP

Executive Summary

ARUP

Executive Summary

Dorset County Hospital is seeking to decarbonise its heating supply in order to meet NHS targets to achieve net zero carbon (NZC) and provide a more secure heat supply diversified away from natural gas. Ove Arup and Partners Ltd (Arup) has been commissioned by Dorset County Hospital NHS Foundation Trust (DCH) to undertake a techno-economic evaluation of decarbonising heat on the hospital campus, and for Dorchester more widely. The evaluation includes:

- A review of the existing DCH operations and previous work.
- An appraisal of low carbon heating technologies, including an estimation of ground source and geothermal resource, as well as a plant location appraisal.
- High-level determination of whether a heat network could be feasible both on campus and more widely in Dorchester to serve other public buildings.
- Techno-economic modelling of four decarbonisation scenarios with a comparison against the business-as-usual operations.
- Reporting and recommendations for the next steps.

Existing operations and work to date

The hospital comprises of the main building, with the heating plant being located in the energy centre to the west of the building and a number of smaller buildings, most of which are located on the main hospital campus. The main hospital building is currently heated by three dual fuel boilers, along with heat produced by a gas CHP plant. The CHP reduces the site's heat and electricity costs, but contributes to much higher carbon emissions than would be the case were electricity supplied from the grid and the heat supply decarbonised. The other buildings are heated by individual boilers. The boilers and CHP are operated by Centrica under an EPC contract which started in 2019 and will expire in 2035.

The British Geological Survey (BGS) has undertaken an assessment of the site which showed that ground conditions could support the use of deep geothermal energy or ground source heat pumps. The hospital has also produced an Energy Strategy [1] in 2024, encompassing energy efficiency, security and decarbonisation, which identified heat decarbonisation as a key issue to resolve.

Current energy demand and supply

The main hospital building accounts for 92% of annual heating demand, consuming 9.5GWh/annum, with a peak demand of 5.1MW. While the other hospital buildings appear negligible in comparison, they still have significant heating loads, totalling to 0.8GWh/annum. This total includes Albany Court, which is an situated off-campus. Demand data analysis showed that around 90% of the main hospital building's heat demand could be met by plant with 2MW heat generation capacity.

The CHP plant generates just over 50% of the hospital building's heat consumption and around 76% of the its total electricity consumption.

The main site also includes cooling plants, the largest of which are the main chillers on the roof of the north wing building which are used for air condition and dehumidification. An estimated 1.0 GWh/annum of waste heat is available from the chillers, based on assumptions.

Alongside the DCH campus buildings, several council-owned buildings in Dorchester town have been considered in our analysis. The DCH campus stands out with the highest annual heating demand at 10.1GWh/annum, significantly exceeding each of the other sites, the sum of which was found to be 11.8GWh/annum. There may also be scope to connect other buildings – i.e. those not owned by the council or hospital – to the potential future heat network, these should be considered in any further feasibility analysis.

Future energy supply options

Four different types of low carbon heat supply have been considered at the site; air source heat pump, closed loop ground source heat pump, open loop ground source heat pump and deep geothermal. Heat is distributed currently at 77°C to 80°C. To support heat decarbonisation, and avoid the use of ammonia-based heat pumps, it is recommended that DCH trial a distribution temperature of 75°C over winter to check that this temperature would meet demand.

The overall feasibility of heat supply options is given in Table 0.1, overleaf. The ASHP shows good feasibility against the other options, each of which would need to be combined with an ASHP too in order to meet the required 2MW low carbon plant capacity.

ARUP

Executive summary

Heat networks

To investigate the potential for a heat network for DCH and in Dorchester, we undertook a high-level feasibility assessment. Using Arup's proprietary HeatNet tool, we assessed route options for two scenarios: one connecting only the hospital campus, and another extending to buildings owned by Dorset Council in Dorchester. Future feasibility work should investigate other, non-council owned buildings that could be connected.

For the campus only network, it was found that the heat demand density was below the threshold required to be worthy of further investigation. In other words, the heat demands of the other campus buildings are not high enough to economically support the installation of the heat network pipework necessary to serve each building.

Overall, the extended network connecting other public buildings in Dorchester showed a total annual heat demand of 22 GWh/annum across 7.7 km of pipework, yielding a linear heat density of 2,840 kWh/m. Although this is below the target threshold above which networks become more feasible, the higher densities in individual segments suggest that targeted connections to high-demand buildings could make the off-site network feasible. Additional heat loads / connections than those identified in this study need to be identified to improve feasibility.

The heat supply assessment did not identify a surplus of heat available from the hospital campus, and therefore there is no reason that the energy centre for a Dorchester heat network should be located on site. Further investigation of a network should involve an assessment of potential energy centre locations off the hospital campus.

System	Source temperature	Peak heat output, MW	Annual heat delivered GWh	Time to implement Years	Advantages	Other considerations	Overall feasibility
ASHP	7.5°C (assumed heating season average)	2.0	8.6	1	• Relatively low capex • Relatively simple installation, little civil works • Performance is relatively predictable	• Careful siting needed due to potential for cold pluming in vicinity • Possible acoustic concerns, needs to be taken into account during design • Trial of heating hospital with output temp of 75°C needs to take place before finalising model	High
Closed loop GSHP	13.8°C	0.3	2.2	1	• Relatively simple installation • Little to no maintenance • Performance is relatively predictable	• Careful design and operation to manage ground temperatures • Excavation disruptive during installation • In order to produce sufficient energy, many boreholes need to be installed, covering a substantial part of the site	Medium
Open loop GSHP	16°C	0.2	0.76	3	• Relatively low capex • Relatively simple installation	• Careful design and operation to manage ground temperatures • Low flow rate of 5l/s is expected • Regulatory restrictions due to being within a source protection zone	Low
Deep geothermal	60°C	1.0	6.2	5	• Greater capacity per well • Warmer temperatures, greater heat pump efficiency	• Higher maintenance for boreholes and pumps • High capex • System performance carries greater risk relative to closed loop systems • Could be increased with soft hydraulic stimulation	Medium

Table 0.1: Summary table for potential low carbon heating options at the site

Executive Summary

Technical and economic modelling

Given that an on-campus heat network has been shown to be unfeasible, a range of future heat decarbonisation scenarios have been modelled for the main DCH building only.

As shown through our analysis of geothermal and ground source options, heat output capacities of these technologies are all below the 2MW low carbon plant requirement in order to meet 90% of the heat consumption. Therefore, we have assumed that ASHPs are installed alongside the ground source and geothermal options. We have assumed the existing gas boilers are retained as the peaking plant, delivering the remaining 10% of heat and providing resilience.

If a heat pump is installed, further work should be carried out to understand whether any of the heat currently rejected by the chillers could be captured, or whether the existing chillers would be replaced by reversible heat pumps, capable of delivering both a heating and cooling demand simultaneously from the same plant.

The closed loop GSHP scenario is also found to be expensive compared to the ASHP only, and ASHP plus open loop GSHP options. Similarly to the deep geothermal option, a lot of the reason for this is driven by high costs of drilling associated with the 115no. Boreholes installed to a depth of 250m.

The open loop GSHP option is cheaper because there are only expected to be 2no. boreholes and this drives lower drilling costs than the other geothermal options.

The lowest cost option is the ASHP only scenario, as a result of less drilling and civil works.

In all low carbon options, there is a reduced cost of gas, but an increase in the cost of electricity. This is due to both the CHP being turned off and so the power that is currently generated on site must be imported instead, and as a result of electrifying the heat generation with the use of heat pumps. Despite the CHP being turned off in low carbon options, the EPC loan repayment value remains unchanged, whilst the energy centre maintenance costs are reduced.

The ASHP only option has the highest electricity cost. However, implementing either the closed or open loop GSHP systems only make small changes to that cost, since systems are small, and the remainder of the hospital electricity consumption remains equal, and as the largest proportion.

The deep geothermal option has the lowest operational costs, but compared to the increase in capex of this option over the others, the savings it offers do not justify the extra expenditure. Compared to the ASHP only option, the deep geothermal option supplying the main hospital building would not pay back until beyond 70 years. This period is even longer for both GSHP options.

Furthermore, whilst the deep geothermal *is* the most efficient in operation, the time taken to implement the solution is much longer, hence the cumulative carbon emissions are higher than the other options, as the CHP will be running for longer.

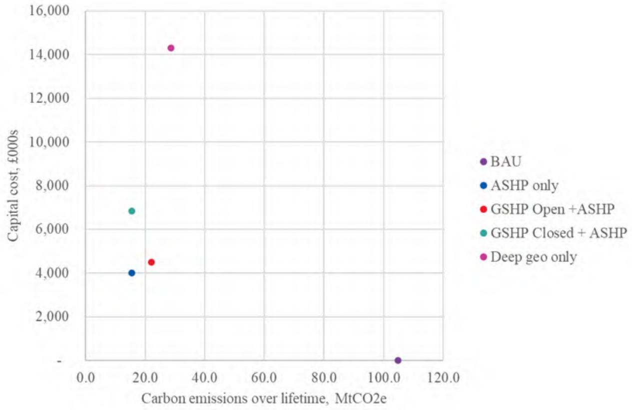

Figure 0.1: Techno-economic results summary with emissions

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Executive Summary

Our recommendations

Our recommendation is that DCH pursues the ASHP only option. This option has some of the lowest carbon emissions, is the lowest cost option, and its operational costs which – although higher – are comparable with the other options. See Figure 6.1.

Our heat network modelling found that an onsite heat network supplying other buildings on the campus from the main site's energy centre is **not economically feasible**, as the heat consumption of the other onsite buildings is too low to support the length of pipe that would be needed. Many of these buildings have a heat source that is over ten years old, and we recommend that these are replaced with low carbon heating sources as each plant reaches the end of its life.

Our heat network modelling found that a heat network in Dorchester serving the hospital and other public buildings, **may be feasible.** There is unlikely to be surplus low carbon heat at the hospital itself, but there are other external locations in the area that could be considered for low carbon heat generation such as deep geothermal or ground source heat pumps.

There is potential for DCH, Dorset Council and other organisations in the area to collaborate in developing a low carbon heat network, and our recommendation is that this is taken forward by Dorset Council, with DCH's cooperation and support as the network's major anchor heat load.

Next Steps

In developing the ASHP for the main hospital building, we recommend:

- Further work to determine the exact location of ASHP.
- Consideration of the risks of cold pluming and noise with specialist assessments carried out at RIBA Stage 2.
- Make an application with the DNO to ascertain an indication of cost for an additional 1MVA of power capacity on site – this is a major risk and needs mitigation before further work is undertaken.
- A programme of low temperature testing, undertaken over winter to check whether the building's heat demand could be satisfied with a heating supply temperature of 75°C. This assessment would reduce the output temperature of the existing heat generation equipment and the building's performance and reaction from tenants monitored.
- The New Hospital Plan will be heated using ASHPs. The connection of the new hospital building into the existing energy centre should be investigated, such that any spare generation capacity in the new hospital's ASHPs can be used for the existing building. This should include a review of the operational characteristics of the new heat pumps, to show what spare capacity there may be.

In operating the existing plant, we recommend that DCH:

- Explores optimisation of the existing plant with Centrica.
- Understands the route to decarbonisation through the lens of the existing EPC contract.
- Avoids contract termination due to the high exit costs.
- Explores, in the long term, the replacement of all gas boilers with either electric or hydrogen boilers.
- Engages with Centrica around the potential for a phased approach for installing the low carbon generation plant along side the CHP.

For the other, smaller, hospital buildings, we recommend that DCH:

- Explores a building-by-building approach to decarbonising each building in turn.
- Considers that this is likely to involve an air source heat pump at each building, with potentially some fabric works.
- Surveys the plant in each building to determine the best phasing approach to decarbonisation.

In relation to a Dorchester-wide heat network, we recommend that DCH:

- Collaborates with Dorset Council in their efforts to develop a heat network, including exploring potential energy centre locations not on the hospital campus.
- Supports heat network development by supplying energy demand data to Dorset Council.
- Recognises their position as a major anchor load for the network, therefore having the most influence in terms of its strategic direction.

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Section 1: Introduction

1.1 Scope summary

This project has investigated heat decarbonisation pathways for Dorset County Hospital, which included a review of low carbon heat supply technologies and the feasibility of a campus-wide, and a Dorchester-wide heat network to support decarbonisation of multiple buildings at a time.

Scope

Ove Arup and Partners Ltd (Arup) has been commissioned by Dorset County Hospital NHS Foundation Trust (DCH) to undertake a techno-economic evaluation of decarbonising heat on the hospital campus. The evaluation includes:

- A review of the existing DCH operations and previous work.
- An appraisal of low carbon heating technologies, including an estimation of ground source and geothermal resource, as well as a plant location appraisal.
- High level determination of whether a heat network could be feasible both on campus and more widely in Dorchester to serve other public buildings.
- Techno-economic modelling of four decarbonisation scenarios.
- Reporting and recommendations for the next steps.

Report use and limitations

This document was prepared by Arup on behalf of DCH to consider the various decarbonisation options. It takes into account the Client's particular instruction and requirements and addresses their priorities at the time of report generation. This report was not intended for, and should not be relied on by, any third party and no responsibility are undertaken to any third party in relation to it.

All reasonable skill, care and diligence have been exercised within the timescale available and in accordance with the technical requirements of the brief.

Site details

Dorset County Hospital (the site, shown in Figure 1.1) is located within the town of Dorchester, on a site that is predominantly covered by hospital buildings and hard standing for roads and parking.

Figure 1.1: Site boundary

1.2 Background and context

The existing buildings are heated by gas, including in the main energy centre where a gas CHP engine generates heat and power simultaneously. The NHS has set a targets in emissions reduction, and the CHP is a major source of on-site carbon emissions.

In 2020 the NHS set carbon emissions targets [2] as follows:

- For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032 (compared to 1990 levels);

- For the emissions we can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039 (compared to 1990 levels).

More recently the NHS has built on these targets, with a further aim for at least a 47% reduction in 2019/20 CO2 emissions by 2028-2032. DCH is therefore seeking to decarbonise its heating supply, and also provide a more secure heating source diversified away from natural gas.

The hospital comprises of the main building, with the heating plant being located in the energy centre to the west of the building and a number of smaller buildings, most of which are located on the main hospital campus. The main hospital building is currently heated by three dual fuel boilers, along with heat produced by the gas CHP plant. The CHP meets 76% of the site's electricity [1], reducing the site's heat and electricity costs, but contributing to much higher carbon emissions than would be the case were electricity supplied from the grid and the heat supply decarbonised. The other buildings are heated by individual boilers. The boilers and CHP are operated by Centrica under an EPC contract which started in 2019 and will expire in 2035.

The British Geological Survey (BGS) has undertaken an assessment of the site which showed that ground conditions could support the use of deep geothermal energy or ground source heat pumps. The hospital has also produced an Energy Strategy [1] in 2024, encompassing energy efficiency, security and decarbonisation, which identified heat decarbonisation as a key issue to resolve.

A new hospital building will be built on the south-west of the site, due to be completed by 2027. The new building will be heated by heat pumps, and has not therefore been included in the analysis.

There are a number of public buildings in the vicinity of the hospital, which also need to be decarbonised. This work explores the potential for a heat network to simultaneously decarbonise the hospital buildings alongside the other public buildings in Dorchester.

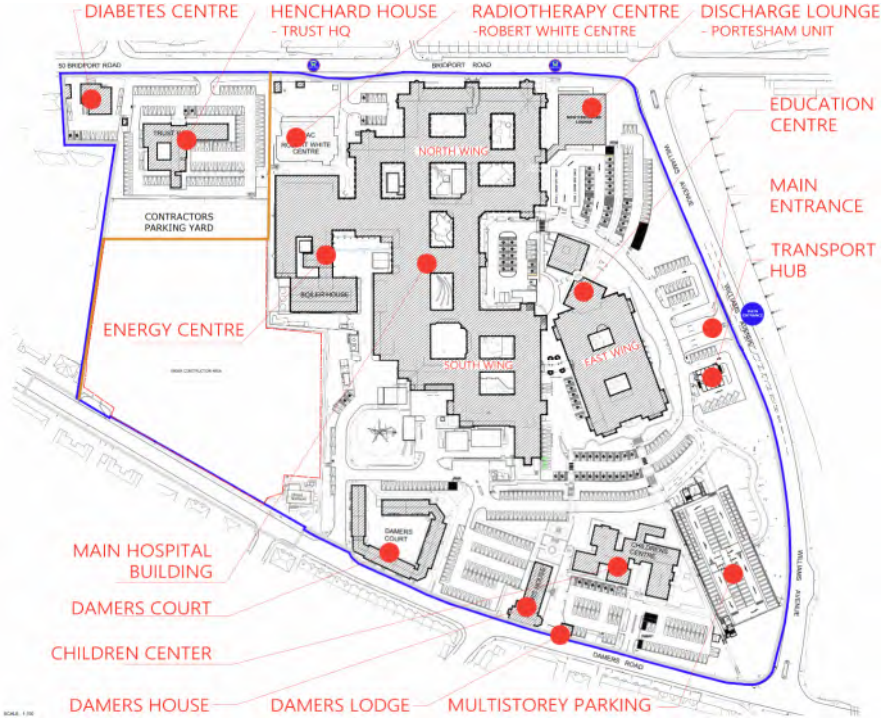

Figure 1.2: Site plan

1.3 Methodology

We have undertaken analysis on the current energy supply and demand on campus, as well as looking at the heat demands of public buildings in Dorchester. The feasibility of heat networks have been explored, and techno-economic analysis has been undertaken for a series of options.

Current energy demand and supply

Meter data from DCH was used to estimate average annual and peak heating demands per building across the hospital campus. Boiler and plant room locations alongside details of the existing heating equipment enabled us to build a baseline understanding of how heat is currently supplied at the hospital. Our analysis of the current heating demand allowed us to estimate the requirements for a future low carbon heating system. Heating demand data for Dorset Council owned buildings was provided for the wider Dorchester area, which gave us a broader view of local energy use.

Future energy supply options

We assessed four low-carbon heating technologies: air source, closed-loop and open-loop ground source heat pumps, and deep geothermal. Our focus was on the potential of ground source heat pumps and geothermal energy, which we sized based on heating demand as described above, as well as local ground conditions. Potential installation sites were identified by a multi-criteria analysis, and technologies were assessed against a range of criteria.

Heat network options

To assess the feasibility of heat networks as a means of decarbonising heat across multiple buildings simultaneously, we explored two heat network scenarios; the first scenario looked at connecting hospital campus buildings only, the second extended to include Dorset Council owned buildings in Dorchester town. We used Arup's HeatNet model combined with a desktop route assessment to identify potential networks. A benchmark for the linear heat density of the networks was used to determine potential feasibility.

Techno-economic analysis

We developed a high-level techno-economic model to compare the cost and carbon impacts of four technology scenarios. Using system efficiencies and demand estimates we calculated gas and electricity requirements for each scenario. These were assessed alongside CAPEX and OPEX estimates to determine overall costs and emissions compared to a business-as-usual baseline scenario.

Data limitations

We based our estimates of future demand on data from July 2022 to July 2023. Note that this therefore assumes that the 2022/2023 period was a typical heating year, and also that any changes to fabric or climate would have an immaterial effect on the heat demand. For the other buildings, where hourly consumption data was not available, peak demand was estimated from typical benchmarks applied to the annual heat consumption in kWh. Costs and other technological assumptions are based as far as possible on data provided by DCH. Where assumptions were needed, these are based on industry standard assumptions or on our experience from similar sites elsewhere

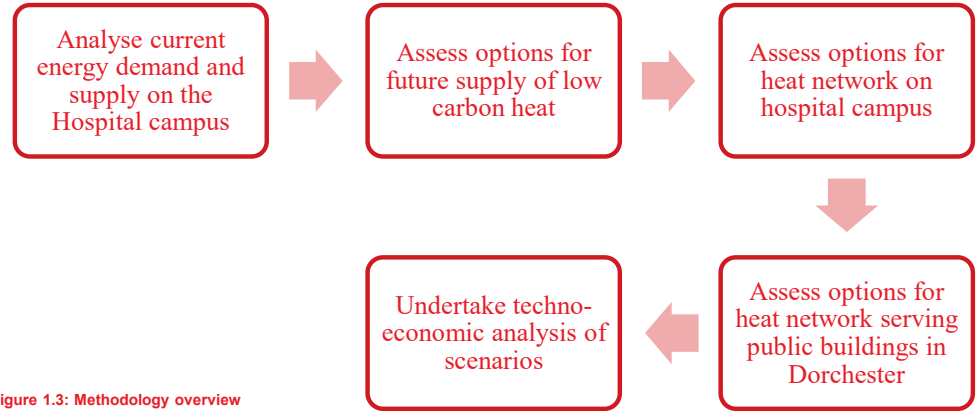

Figure 1.3: Methodology overview

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Section 2: Current energy demand and supply

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2.1 Main hospital building

The main hospital building is heated by dual fuel boilers and gas CHP. Heating plant is operated by Centrica under an EPC Contract that commenced in 2019 and is due to end in 2035. The CHP generates just over 50% of the building's heat consumption, and around 76% of its power consumption.

The Main Hospital Building central heating plant consists of three dual-fuel boilers with a nominal heating capacity of 2,200kW each and one natural gas CHP unit with a useful thermal output of 930kW and electrical output of 850kW. These are all housed in the Energy Centre as shown in Figure 1.2. Typically, the boilers operate using natural gas, with oil being used in emergencies upon the failure of the gas supply, or in the event of an extreme cold weather event due to gas supply pipe diameter not allowing enough flow rate. The CHP and boilers were installed in 2018 with the maintenance contract starting in 2019. They are operated and maintained under an EPC contract by Centrica.

The CHP plant generates just over 50% of the hospital building's heat consumption and around 76% of the its total electricity consumption. In doing so it consumes significant volumes of gas, with high associated carbon emissions. Exiting the CHP contract early incurs costs, which decrease towards the end of the contract. If the CHP is decommissioned in July 2029, i.e. 10 years from the start date, this would incur a cost of c. £1,6m. If terminated around the time of this report (May 2025), the cost would be c. £2.6m.

The main site also includes cooling plant, largest of which are the main chillers on the roof of the north wing building which are used for air condition and dehumidification. An estimated 1.0 GWh/annum of waste heat is available from the chillers, based on assumptions. The other chiller units have not been included in waste heat recovery modelling, as they are significantly smaller in size than the main units.

Metric	Units	Value
Building energy use		
Annual average heat consumption	GWh/annum	9.5
Peak demand	MW	5.1
Annual average electricity consumption	GWh/annum	7.9
Cooling demand	GWh/annum	1.2
Boiler data		
Installed capacity	MW	6.6
Heat generated	GWh/annum	4.6
Gas consumed	GWh/annum	5.5
CHP data		
Installed capacity (heat/electricity)	MW	0.93 / 0.85
Heat generated	GWh/annum	5.0
Heat rejected	GWh/annum	1.5
Electricity generated	GWh/annum	6.2
Parasitic electricity	GWh/annum	0.3
Gas consumed	GWh/annum	17.2

Table 2.1: Energy use breakdown, main hospital building

2.1 Main hospital building

Approximately 90% of the hospitals heat consumed can be delivered by plant under 2MW in capacity. There is 6.6MW of boiler capacity installed in order to meet a peak (in 2022/2023) of 5.1MW.

We analysed half hourly gas consumption and plant operation data, converting this to heat using assumed boiler and CHP efficiencies.

Figure 2.1 shows the load duration curve for the main hospital building. This is the hourly heat load sorted from high to low. The area under the graph is the kWh delivered. As it can be seen, 90% of the kWh consumed are under 2MW in heat demand. The remaining 10% of kWh are above 2MW; the peak heat demand was found to be 5.1MW against an installed boiler capacity of 6.6MW.

Data analysed was from the July 2022 to July 2023, where the peak was recorded on 17th December 2022 at 0200 hours, despite the coldest recorded temperature in Dorchester over the period being March 8th 2023.

The fact that installed capacity exceeds the peak by 1.5MW gives good resilience against periods of extremely cold weather, or the option to increase heat demand, for example by introducing new building area and associated heat demand (for example, the planned new hospital entrance).

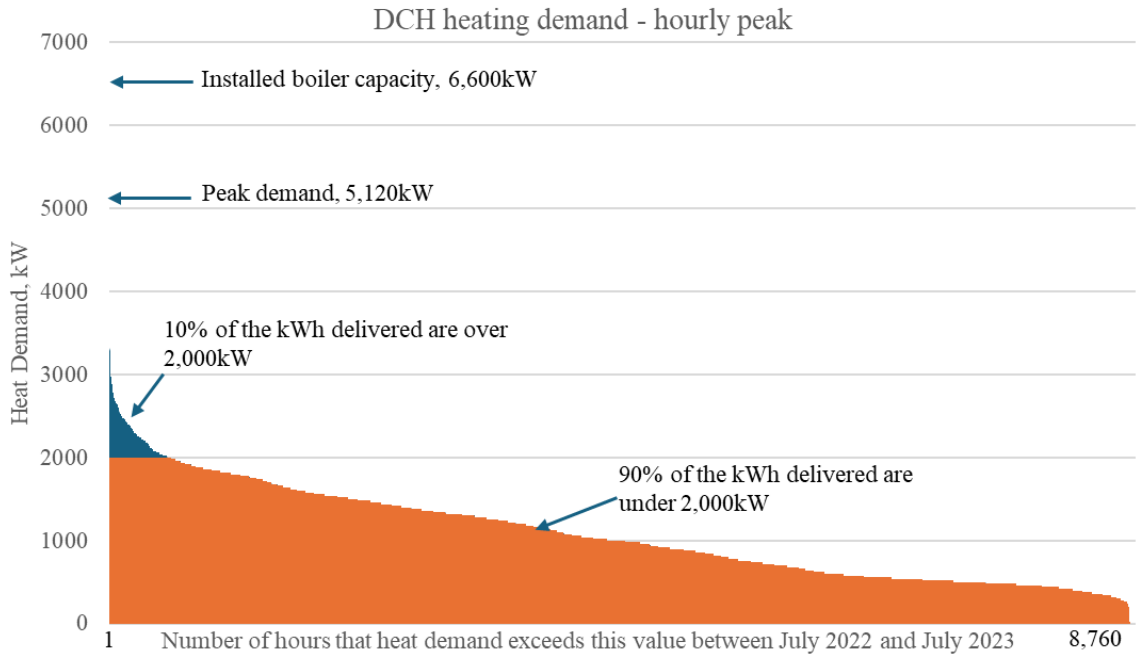

Figure 2.1: Load duration curve for main hospital building

2.2 Hospital campus buildings

The main hospital building makes up over 90% of the hospital campus heat demand. The other buildings are heated by individual boilers, with varying plant life remaining.

The DCH campus consists of the main hospital building along with several smaller ancillary buildings. The annual heating demand and peak heating demand of each of the campus buildings are presented in Table 2.2. For clarification on terminology, Table 2.3 defines which buildings the terms *main hospital building*, *campus buildings*, and *external buildings* refer to throughout this report.

Heating consumption for the main hospital building was calculated using the boiler and CHP gas meter data between July 2022 to July 2023. This was the only year with a complete set of data available for all three boilers and the CHP, making it most representative of the hospital's annual heat requirement. For the remaining hospital campus buildings, heating demand was estimated using averaged values taken from the available gas meter data between 2019 and 2024.

Figure 2.2 illustrates the distribution of heating demand across the hospital campus buildings. The main hospital building accounts for over 90% of annual heating demand, consuming 9.5GWh/annum, with a peak demand of 5.1MW. While the other hospital buildings appear negligible in comparison, they still have significant heating loads, totalling to 0.8GWh/annum.

Henchard house – Trust HQ and the Diabetics centre have estimated annual heating demands of approximately 0.1 and 0.024GWh/annum, respectively. These values have been included in our analysis for this project, with the understanding that the buildings are scheduled for demolition. We assume that the replacement buildings will have a comparable heating demand.

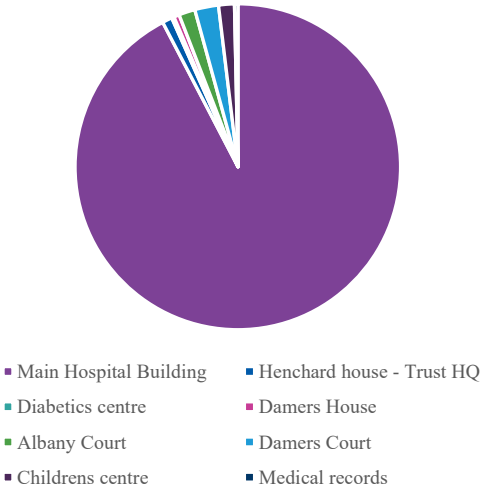

Figure 2.2: Hospital campus buildings heating demand split

Building/ Department Name	Annual heating demand (GWh/annum)	Peak heating demand (kW)
Main Hospital Building	9.5	5,120
Henchard house - Trust HQ	0.10	50
Diabetics centre	0.024	12
Damers House	0.056	28
Albany Court	0.17	84
Damers Court	0.24	121
Children's centre	0.16	80
Medical records	0.036	18
Total	**10.3**	-

Table 2.2: Hospital campus buildings heating demands (Albany Court is not on the main hospital site)

Main building	Campus buildings	External buildings
Main hospital building	The main hospital building and the smaller ancillary hospital buildings, detailed in Table 2.2.	Council-owned buildings in the area, excluding all hospital campus buildings.

Table 2.3: Definition of the building grouping terminology used throughout this report

2.3 Public buildings in Dorchester

DCH has a significantly greater annual heat demand compared to council-owned buildings in Dorchester Town, due to its size and operational requirements.

As well as the DCH campus buildings, several council-owned buildings in Dorchester town have been considered in our analysis. These buildings, alongside values for their annual and peak heating demands as estimated using demand data provided by DCH, are detailed in Table 2.4. The estimations assumed a peak heat demand of 0.05% of annual demand, and boiler efficiency of 85%. Figure 2.3 provides a spatial overview of these demands. The DCH campus stands out with the highest annual heating demand at 10.1GWh/annum, significantly exceeding all other sites (which sum 11.8GWh/annum in total). This reflects its size, operational intensity, and continuous use. Other major consumers include County Hall, Dorchester Sports Centre, and Thomas Hardye School, contributing substantially to local energy use. Smaller sites such as Manor Park First School and the Dorset History Centre have relatively low demands, each under 0.5GWh. The geographic clustering of these buildings within Dorchester may present opportunities for district heating solutions or shared energy infrastructure, particularly among the higher-demand sites. This is explored further in Section 4.

Building/ Department Name	Annual heating demand (GWh/annum)	Peak heating demand (kW)
County Hall Campus	2.7	2,000
South Walks House	1.1	460
Dorset History Centre	0.41	115
Manor Park First School	0.49	240
Dorchester Connect/Area Office	0.33	166
St Osmund's	1.2	576
Thomas Hardye School	2.4	1,216
Dorchester Middle School	0.62	308
Dorchester Sports Centre	2.6	1,300

Table 2.4: Wider Dorchester council-owned building heating demands

Figure 2.3: Annual heating demand of council-owned buildings in Dorchester town

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Section 3: Future energy supply options

3.1 Summary of heat supply options considered

Four different types of low carbon heat supply were considered: Air source heat pump, closed loop ground source heat pump, open loop ground source heat pump and deep geothermal.

Four different types of low carbon heat supply have been considered at the site; air source heat pump, closed loop ground source heat pump, open loop ground source heat pump and deep geothermal. These technologies and their suitability for supplying DCH are outlined in the rest of this section, including a multicriteria analysis to compare possible locations in section 3.8, and an economic model of different heating scenarios in Section 5.

Existing boilers

Regardless of which low carbon heating technology is used, the three existing dual fuel boilers are expected to be retained, both to act as a back-up when other heating sources are not operating, or at times when there is a high peak demand.

Air source heat pump (ASHP)

ASHPs collect heat from the ambient air. To do so, it uses a vapour compression cycle, which uses the ambient air heat to evaporate the working refrigerant, which is then compressed and condenses onto the building heating system at a higher temperature. Fans are used to blow air across the heat collecting evaporator, which can have noise implications. Their coefficient of performance (the amount of useful heat out as a proportion of the electricity used to drive the cycle, typically 2.5 – 4) is higher when it is warmer outside. Therefore, ASHPs are particularly inefficient during winter as the air is typically colder during this period. Since electricity is used to run the cycle, emissions depend on the grid. An ASHP has the potential be the sole low carbon heating source for DCH, or it can be used in conjunction with other heat sources. Further information is provided in Section 3.2.

Closed loop GSHP

A ground source heat pump transfers heat from the ground at lower temperature to the building's distribution system at a higher temperature. The 'closed loop' GSHP system uses a closed network of pipes, containing an aqueous glycol working fluid within flow and return pipework with a U-bend at the bottom, installed in vertical boreholes drilled to depths between 50 and 250m below ground level. A manifold is used to connect the borehole heat exchangers together, feeding heat back to the heat pump in the plant room. They are well suited to dense urban environments as they use less space at ground level. Since ground temperatures are warmer than the air in winter, GSHPs are typically more efficient than ASHPs. Further information, including the area needed, is provided in Section 3.3 and 3.5.

Open loop GSHP

Open loop systems directly extract groundwater from one location, remove heat via a heat exchanger, and reject it into another location. Boreholes are drilled to a depth of 100 – 200m, where water is pumped from the abstraction borehole, usually using an electrical submersible pump (other pumps may be possible for shallow aquifers). The water is piped to the heat exchanger where heat is transferred to the heat pump prior to discharge back into the aquifer. Further information is provided in Section 3.3 and 3.5.

Deep geothermal (>500m)

Deep geothermal is defined in the UK as greater then 500m in depth, In the case of DCH this is likely to be approximately 1.5km deep, where the extractable heat energy may be hot enough to be usable for direct-use space heating. A deep geothermal open loop doublet would be installed which can sustain high flow rates at appropriate temperatures. The water passes through a heat exchanger and temperatures can be raised using a heat pump. Further information is provided in Section 3.3 and 3.6.

Heat generation temperatures

For the current heating system, the water temperature distributed from the central plantroom fluctuates between 77°C and 80°C. If the heat pump output temperature is above 75 °C then an ammonia heat pump is needed which is more expensive, has safety implications and is less efficient than a heat pump with a hydrocarbon refrigerant.

The heat distribution temperature in large buildings can often be reduced by a few degrees, so our analysis based on the assumption that a heat supply temperature of 75°C will be sufficient to meet demand, and a hydrocarbon heat pump being used.

As part of the development of this option in future, we recommend that DCH trial a distribution temperature of 75°C over winter to check that this temperature is still suitable.

3.2 Air Source Heat Pumps

An ASHP of 2MW capacity could meet 90% of the hospital's total heat demand, and would need an external area of around 14m × 18m. We have identified a number of potential locations for the ASHP plant on the hospital campus; these are assessed later in the report via a multicriteria analysis.

Size

As described in Section 2.1, a 2MW ASHP would meet 90% of the hospital building's heat demand. For sizing we have assumed this to be two 1MW modules, each with 3 compressor units and a pumping module located in internal plant space and a fan assisted evaporator located at roof level.

Each 1MW unit is assumed to be 5m by 11.3m (information provided by Solid Energy, a possible supplier), with a manifold of 1.5m on the side of each ASHP. The ASHP requires a buffer of at least 2m buffer around it for access and safety, and because the area immediately around an ASHP can be prone to frost. This gives a total footprint of 14m × 18m, i.e. around 250m^2.

Location

A possible location for an ASHP unit is shown in Figure 3.1. The location shown is not a final recommendation, it is included to indicate the approximate scale of the unit and buffer around it. As ASHP units are modular there may be flexibility with overall shape of the total unit. Proximity to roads, other buildings and residential areas would need to be considered when determining the final location for an ASHP. The suitability of area B and area C/D are compared in the multicriteria analysis on page 29.

An ASHP can be located above GGS boreholes, as the boreholes for shallow GSHP are below the frost level. Its location would however need to be finalised in conjunction with design of the GGS system to allow access to borehole manifolds.

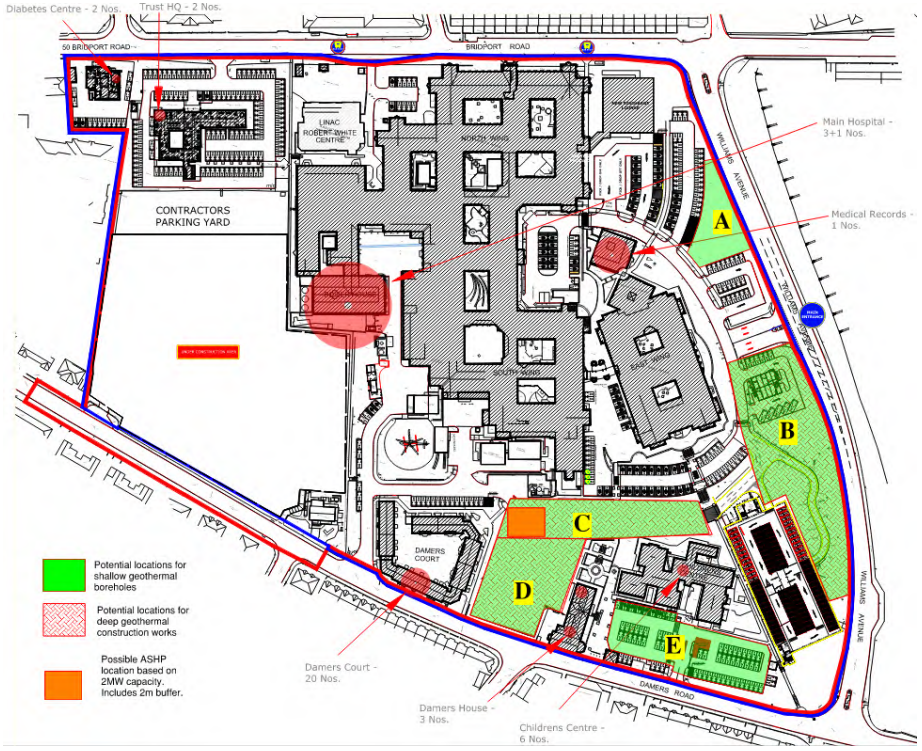

Figure 3.1: Approx size of 2MW ASHP including buffer, and potential location on campus

3.2 Air Source Heat Pumps

Considerations to be taken into account with an ASHP specification and design include refrigerant type, acoustics and cold pluming. These risks can be mitigated but need to be incorporated into the design from early stages of development.

Refrigerant type

Whilst this report is vendor agnostic, ASHPs which use hydrocarbon refrigerants have been selected for costing and sizing the units. A two stage (cascade) cycle is used, with separate isobutane and propane loops and compressors, to achieve the high flow temperature required. These two refrigerants both have a global warming potential (GWP) of 3, which is significantly lower than most available refrigerants. However, they are highly flammable and these risks need to be mitigated effectively, for example allowing sufficient buffer around the ASHP.

Acoustic concerns

The 1MW ASHP units the sizing and costing have been based on each have a sound power level of 79dB(A). During further design stages, an acoustic assessment will be needed to determine the required level of acoustic attenuation, such as an acoustic screen around the units. The acoustic assessment will consider ambient background noise, the sound power levels of the selected plant equipment, and the proximity and sensitivity of nearby noise receptors.

Risks: cold pluming

The potential for cold pluming should be explored to understand the impact on nearby areas and buildings. Air source heat pumps extract heat from the ambient air and reject colder air out. This could result in cold air re-entrainment which lowers the coefficient of performance (COP) of the heat pump, a potential reduction in thermal comfort of the immediate surroundings, visible plumes as the air reaches saturation point, ice formation, and potential harm to nearby planting due to frost.

This risk can be mitigated by ensuring adequate airflow around the evaporators. The location of the ASHP in relation to neighbouring buildings, the prevailing wind direction, and the elevation should be assessed. If required, CFD analysis can be used to determine the extent of the risk to the surrounding area. Drainage routes and external finish should be carefully considered. Significant volumes of condensation are expected from the evaporators which, if not channelled away, can freeze during cold conditions.

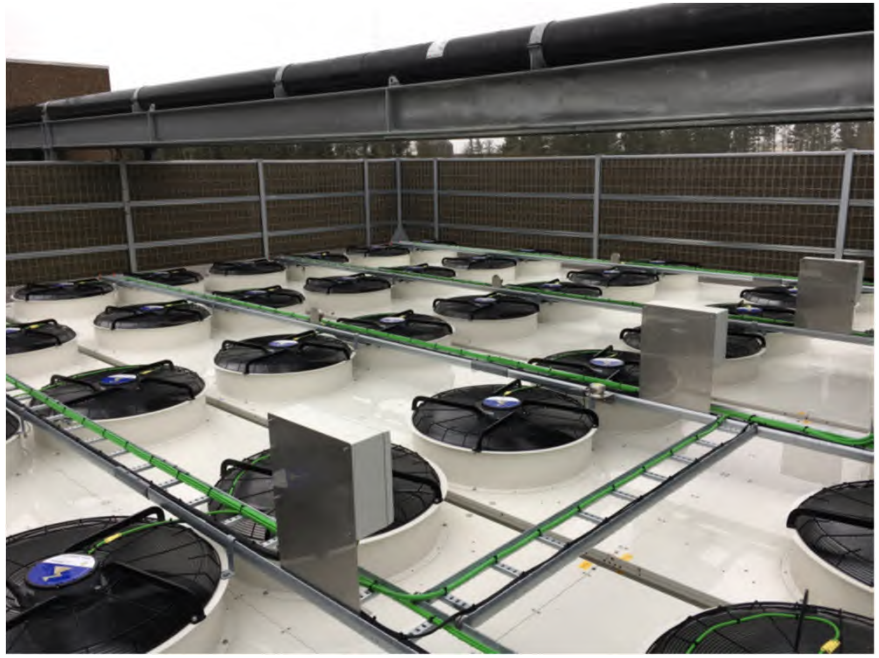

Figure 3.2: Modular ASHP unit (Solid Energy ©)

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3.3 Geothermal systems

Open loop systems require licencing and engagement with regulatory bodies (Environment Agency). Closed loop systems are unlikely to require licencing.

Shallow geothermal (<500m)

Shallow geothermal, or ground energy, systems require a ground source heat pump (GSHP) to modify the energy from the ground to a temperature appropriate for use in buildings. There are two types of configuration:

- Closed loop systems: A closed-loop system is comprised of High-Density Polyethylene (HDPE) tubing that is arranged in either a single or multiple loop configuration typically installed 150-250m vertically into the ground. There are typically many boreholes in a system of this type (as many as can fit inside the available site area). Water (and sometimes an antifreeze additive) is pumped through the piping and the thermal exchange occurs within the boreholes. Where heat to the building is required, the fluid extracts heat from the ground, and where cooling is required, the fluid rejects heat to the ground. For this reason, closed loop systems are typically run in balance between the annual heating and cooling loads.
- Open loop systems: Groundwater is brought to the ground surface where heat is transferred at a heat exchanger before being returned to the ground. Open loop systems require certain ground conditions to provide sufficient water to the ground surface and careful design to minimise risks such as thermal interference and borehole deterioration over time. Open loop systems are generally more cost effective than closed loop systems however there are additional regulatory requirements for licencing.

Deep geothermal (>500m)

Heat energy increases with depth. The UK Government has adopted the term ‘deep geothermal’ to refer to below ground heat resources from depths greater than 500m. At depths greater than 1km the heat energy begins to be hot enough to be usable for direct-use space heating.

For larger capacity projects such as DCH a deep geothermal open loop doublet is usually required which can sustain high flow rates at appropriate temperatures. The water passes through a heat exchanger and temperatures can be raised using a heat pump. Where deep geothermal open loop doublets are unsuitable, single deep standing column wells can be installed. Cooling using a deep geothermal system requires an adsorption chiller which may not be cost effective.

Regulatory requirements

Under current legislation, closed loop systems are often exempt from licencing [3]. Open loop systems and deep geothermal systems interact with groundwater and therefore require licencing. For these systems, early engagement with regulatory bodies (Environment Agency) is recommended.

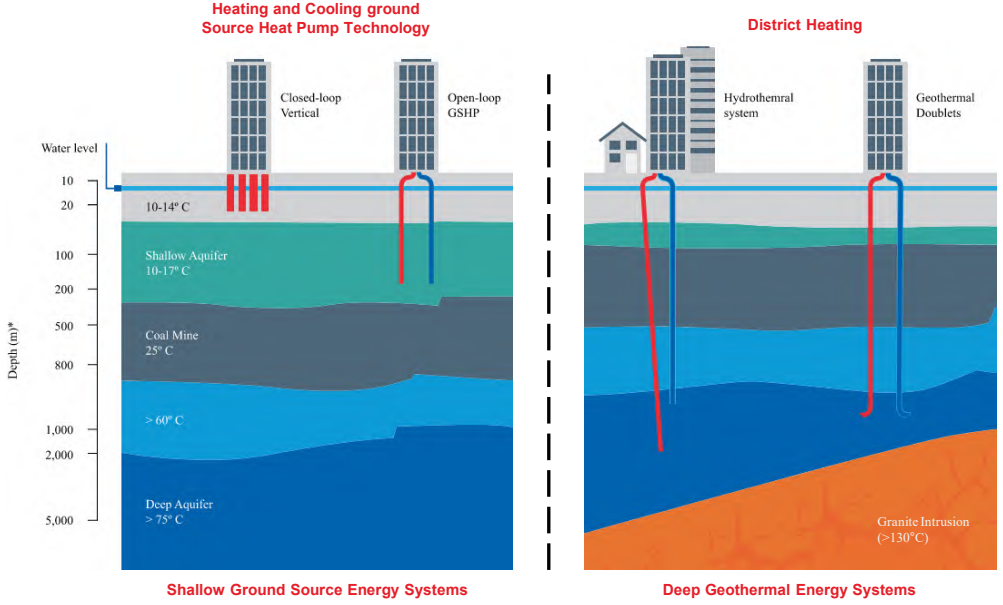

Figure 3.3: Illustration of typical geothermal project types (Arup ©)

3.4 Ground conditions

The bedrock beneath the site is considered to include two potentially productive stratigraphies – the Chalk Group and Sherwood Sandstone Group. Open and closed loop GSHPs would deliver water at around 20°C, deep geothermal at around 60°C. Heat supply at the hospital is over 77°C.

Geology

The Site is underlain by a thin (~2m thick) covering of made ground and natural superficial deposits, which overlies the bedrock. BGS geological maps show the bedrock beneath the site to be the Portsdown Chalk Formation of the Chalk Group [4].

Two key sources of information have been used in assessing the deeper geological stratigraphy:

- Seismic lines B90-33 and B90-35, located c.100m east of the site and immediately north of the site [5]
- West Stafford 1 borehole, located around 5km southeast of the site [6]

The BGS report [7] includes an interpretation of the seismic lines. Based on the information from these records, two potentially productive geological layers have been identified:

- The Chalk group, which extends from surface to a depth of c. 300mbgl (meters below ground level)
- The Sherwood Sandstone Formation at roughly 1400 – 1600mbgl

Hydrogeology

The Chalk Group is designated a Principal Aquifer by the Environment Agency and the Hospital has a groundwater abstraction well which extends to 160mbgl. Due to this groundwater abstraction well, the Site is within a Source Protection Zone (SPZ) [8], see Figure 3.4.

The BGS report [7] includes details on various pump tests and borehole yields in the Chalk from across Dorset. Pumping test results varied, however the BGS generally concluded by stating that flow rates of greater than 5 l/s are unlikely.

The BGS's estimation of the permeability of the Sherwood Sandstone is largely based on the porosity-permeability relationships for the Sherwood Sandstone in the West Stafford 1 borehole [9]. This derived permeability values between 10 and 1000mD, with a median of 52mD.

Thermogeology

Based on a geothermal gradient of 30°C per km and an average surface temperature of 11°C, the temperature at 300mbgl (the base of the Chalk) is estimated to be about 20°C. Similarly, the ground temperature at 1600mbgl (base of the Sherwood Sandstone Formation) would be about 60°C.

Licencing

Closed loop systems are exempt from permitting if they are located outside of Source Protection Zone 1 (SPZ1) [8], red area in Figure 3.4 which outlines a 50m buffer from a water abstraction well. Open loop and deep geothermal systems may require permits to investigate and operate as they interact with groundwater.

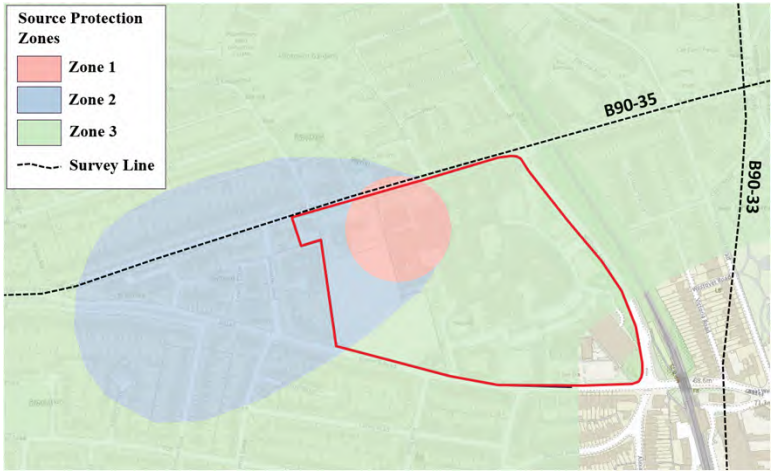

Figure 3.4: Groundwater Source Protection Zones (SPZ) [8] and seismic reflection surveys near site [5]

3.5 Shallow ground energy options

The chalk aquifer is anticipated to yield low flow rates of less than 5 l/s. These flow rates are below what would be targeted for a feasible open loop GSHP system. 250m of spacing is required between the abstraction and injection wells.

Open loop

The chalk aquifer is around 250m thick. Based on a review of available data, flow rates are anticipated to be below 5 l/s. Typical open loop systems target around 20 l/s for good economic feasibility.

The capacity of open loop systems are highly sensitive to flow rate. A single open loop doublet system (one injection well, and one abstraction well) is estimated to provide around 130kW peak, and around 730MWh heating and 480MWh cooling annually using the following assumptions:

- A flow rate of 5 l/s
- The system is used for heating and cooling through the year
- 250m spacing between wells

It is also worth noting that an open loop system within the chalk aquifer (principal aquifer) and source protection zone, would need more assessments to meet environmental regulations (relative to closed loop systems).

Based on the relatively low thermal capacity of a potential open loop system, regulatory requirements, and source protection zone identified, we consider it unlikely that an open loop system at the site would be feasible.

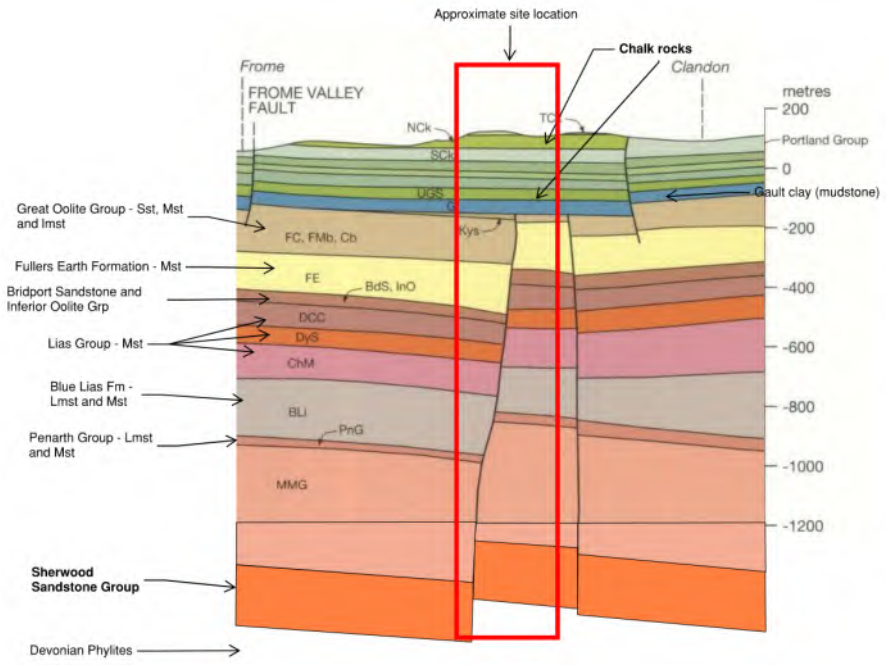

Figure 3.5: Modified cross section based on Section 1 of BGS map sheet 328

3.5 Shallow ground energy options

The thermal energy demand of the main hospital building is heavily weighted towards heating over cooling. As such greater spacing is required between boreholes, and the amount of heat that can be extracted is lower so as not to deplete the ground energy reserves too quickly.

Ground energy assessment

Closed loop ground energy options can be scaled to maximise heating and cooling from the areas of the site that area available for geothermal development. Annual heating demands (including assumed 15% distribution losses) are inferred to be around 9GWh and annual cooling demands around 0.8GWh (i.e., imbalanced thermal loads). As previously outlined, balanced heating and cooling loads allow for more efficient systems. This is demonstrated in the following sections comparing, a balanced heating/cooling system and a heating dominated system.

Closed loop boreholes are typically installed in grids and could be installed in the car parking areas and beneath landscaping areas.

It is noted that the groundwater well (ID: SY69/41) present on the site and associated SPZ1 (50m radius from wells) can impact on closed loop permitting [3]. Closed loop systems located within 50m the well would likely be subject to permitting requirements [3]. Other areas are likely to be exempt, based on the permitting requirements. Based on an assessment of available closed loop borefield locations (as discussed on the following page) it is unlikely the closed loop systems would require regulatory permits.

Closed loop – balanced heating and cooling

Closed loop boreholes in a balanced heating/cooling system can be installed with 6m spacing between boreholes. Each borehole is estimated to produce around 13.3kW baseload, c. 58MWh per year, based on the following assumptions:

- Annual operation of 6 months of heating;
- Thermal capacity (baseload) of the ground is 40W/m of installed borehole;
- Peak capacity of the ground is 65W/m of installed borehole;
- Borehole depth is 250m (to the base of the chalk)

Closed loop – heating dominated

If the boreholes are used for predominantly for heating, the spacing of the boreholes will need to be increased to 12m, so as not to deplete the heat form the ground too quickly. Each borehole would still produce around 13.3kW baseload and 58MWh per year, however, given the greater spacing requirements, the overall borefield would be less energy dense (i.e., fewer boreholes can fit within a given area). It is noted that tighter spacing is possible, however the efficiency of each borehole reduces and therefore overall cost per energy supply with increase.

Borefield

The exact area where boreholes can be installed is yet to be determined and therefore the total number of closed loop boreholes is uncertain. Therefore, our assessment highlights the number of boreholes which could be installed on existing car parks across the site and the potential thermal energy production of each area. Some possible locations are considered in the MCA on in section 3.8.

Its worth noting, that whilst construction activities can be disruptive, all disturbed ground would be reinstated (e.g., car parks repaved) and the borefields would be entirely buried and out-of-sight, enabling car parks to be reused following completion.

3.5 Shallow ground energy options

A number of potential areas on site were investigated for the installation of GSHPs. The heat output expected is lower than for a building with a balanced thermal energy demand as the system will be predominantly heating led and greater spacing between boreholes is needed.

Closed loop ground energy assessment

Based on the assumptions for a closed loop system included on the previous page, the potential energy that could be harnessed from borehole arrays installed across the site are included in Table 3.1. The zones included in this assessment are shown in Figure 3.6. Note that when used for heating only, fewer boreholes can be in any given site, reducing the thermal capacity of the system. These areas are not located in an SPZ1 and therefore unlikely to require permitting.

Zone	Area m²	Equal heating and cooling (6m spacings)			Heating only (12m spacing)		
		No Boreholes	Base load (MW)	6-month thermal energy (GWh)	No Boreholes	Base load (MW)	6-month thermal energy (GWh)
A	850	34	0.44	1.9	12	0.16	0.7
B	3950	132	1.72	7.5	39	0.51	2.2
C	1900	68	0.88	3.9	21	0.27	1.2
D	1900	68	0.88	3.9	21	0.27	1.2
E	2000	71	0.92	4.0	22	0.29	1.3

Table 3.1: Thermal energy assessment of the five shortlisted zones

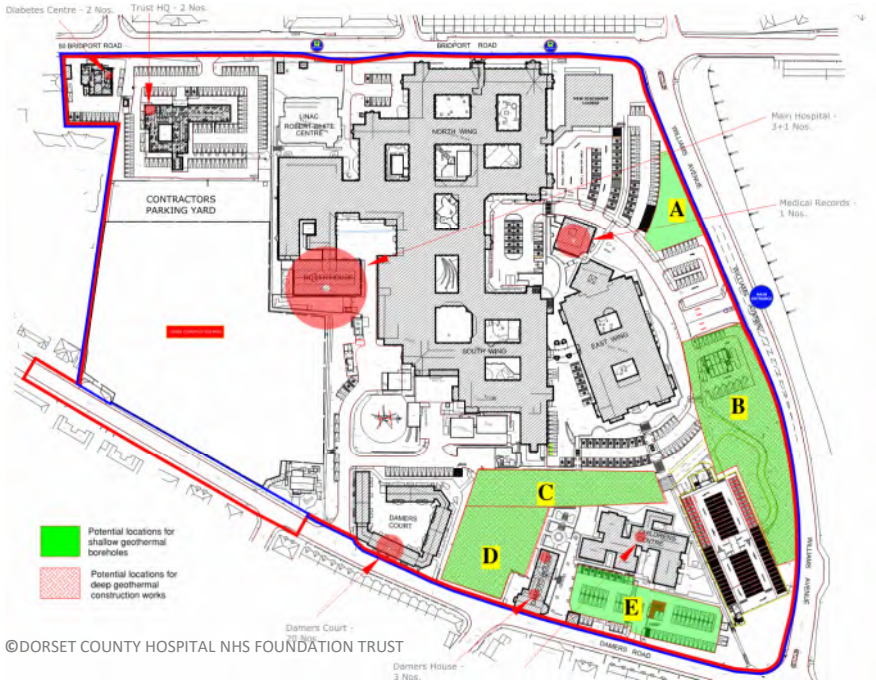

Figure 3.6: Zones considered where it may be feasible to install closed loop boreholes (Table 1)

3.5 Shallow ground energy options

Ground Loop Design (GLD) was used to refine energy output estimates for the closed loop GSHP option. We found 115 boreholes could be installed, with an annual generation of 0.76Gwh, against a heat demand of 9.5GWh. This is lower than the BGS report findings.

Ground Loop Design

We have used Ground Loop Design (GLD), a widely used commercially available GSHP sizing tool, to refine borefield sizing. This was done because of the heating imbalanced loading at the site which typically constrains borefield capacity relative to theoretical values (see previous page).

Geological data, borefield design, and energy loads (heating: 3.9MW peak, 9.5GWh annual, cooling: 0.4MW peak, 0.8GWh annual) were used to inform the assessment. The modelling work included trimming of heating loads until a sustainable ground temperature was achieved for the life of the project. Load trimming is required to ensure that the borefield does not extract too much energy over a given annual period, resulting in thermal degradation and subsequent reduction in efficiency over time.

Our model assumed 115No. boreholes to 250m depth with a 12m spacing (sum of areas: A, B, C, D, E). The BGS also did GLD modelling, with 162No boreholes with 8m spacing, and 108No. boreholes with 10m spacing. The BGS model also included options for heat recovery from CHP, which we did not explore in the Arup model at this design stage. The findings are presented in Table 3.2.

Assessment	No Boreholes	Spacing	Heat Recovery?	Heating load supplied (MWh) (%)	Cooling load supplied (MWh) (%)
Arup	115	12	N	2,230 (24%)	762 (100%)
BGS	162	8	Y	3,896 (50%)	937 (100%)
BGS	162	8	N	2,561 (33%)	937 (100%)
BGS	108	10	Y	3,192 (41%)	937 (100%)
BGS	108	10	N	2,395 (30%)	937 (100%)

Table 3.2: Comparison between the Arup and BGS models of the target area

Our assessment is consistent with the BGS no heat recovery scenarios. Our assessment did not include modelled thermal influence of groundwater flow within the chalk aquifer. Therefore, the modelled results are likely conservative, as groundwater flow can benefit thermal recharge of borefields.

Our assessment required the trimming of peak heat pump output of 260kW, due to the fact that the building is heating led and there is a lack of heat replenishment in the ground by heat recovered from the cooling system.

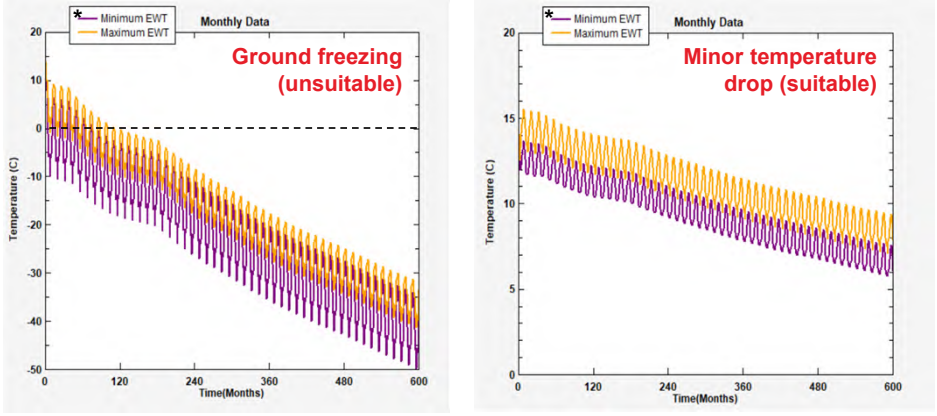

Figure 3.7: Left: GLD model output without load trimming (significant ground freezing), Right: GLD model output with load trimming (sustainable ground cooling over life of model)

*EWT: Entering water temperature (analogous for ground temperatures). Thermal limits for short and long periods are required for a sustainably operated system

3.6 Deep geothermal energy

Deep geothermal systems are expensive and carry more risk. Estimates of the potential system size and output vary, with the average output expected to be 1MW, generating 6.2GWh of heat over a year. A heat pump is needed to increase the temperature from 60°C to the hospital required 77°C.

Ground energy assessment

Deep geothermal systems require suitable hydrogeological conditions to allow for sustainably high flow rates for the life of the system. The Sherwood Sandstone Group, at around 1,400 to 1,600 metres below ground level (MBGL) depth, has been identified as a favourable deep geothermal target.

To estimate the capacity of a potential deep geothermal system, we have used the commercially available DoubletCalc tool, which outputs probabilistic capacity curves, enabling low, medium, and high estimates.

It is estimated that a deep geothermal system targeting the Sherwood Sandstone Group could provide between 0.2 to 3.5MW peak from the ground, and 0.3 to 5.2MW with use of high temperature heat pumps. Annual production assuming 6000hrs of annual use is estimated at 1.8GWh to 31GWh. Average estimates are 1MW peak, and 6.2GWh annual.

These results are based on the following key assumptions:

- Permeability range of 1/52/500mD (Min/Ave/Max)
- A geothermal gradient of 33°C/km. Produced fluids are estimated to be around 60°C.

The wider site area, including Rifle Field is around 600m wide. Deep doublets require around 1 to 2km spacing at depth, therefore, there is sufficient space for a single deep doublet only (rather than multiple).

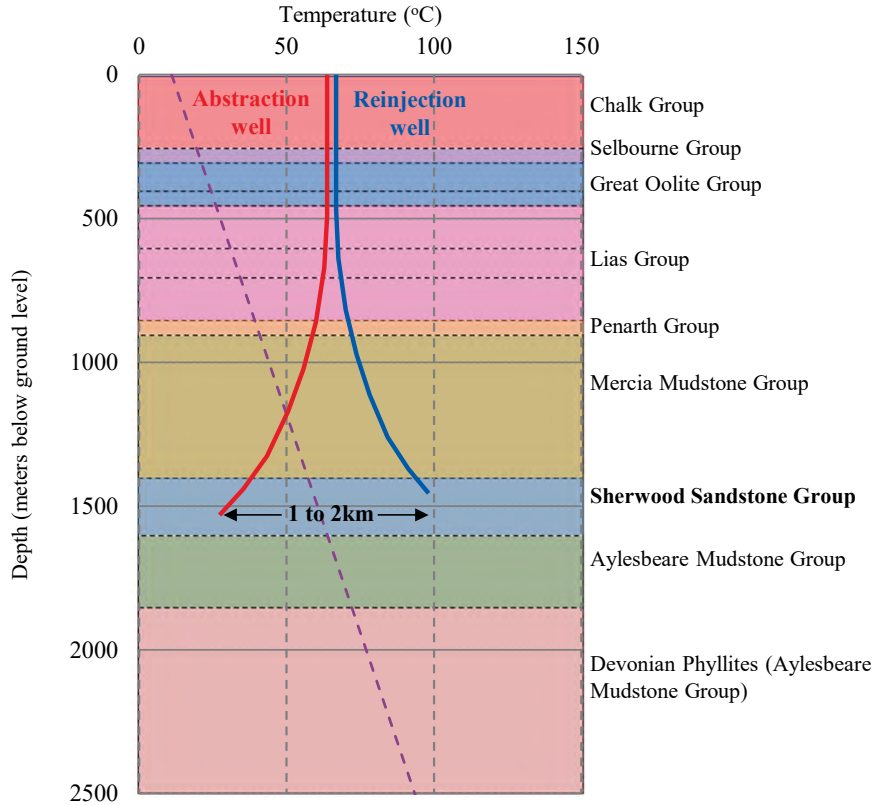

Figure 3.8: Simplified geological stratigraphy and geothermal gradient

3.6 Deep geothermal energy

End of life abandonment costs also need to be considered for a deep geothermal system, and can range from £0.5 – 1.5m. Abandonment is regulated by the North Sea Transition Authority.

Abandonment costs

We have assumed a 25-year deep geothermal system life. This is a standard global benchmark, which reflects the point at which an individual well doublet may become uneconomical to run. This may be the result of reservoir pressure loss, or increased maintenance costs from an aging asset. These can increase operational costs to exceed revenue returns from heat sales. However, it is worth noting that there are numerous examples where deep geothermal systems have been continually operational for more than 40 years (e.g. Southampton, and Po Basin, France), and dependent on brine chemistry, well construction, and ground conditions, the well assets themselves could be suitable for decades.

At the end of life, the deep geothermal wells require abandonment. This is currently regulated by the North Sea Transition Authority (NSTA). The regulator will keep track of aging assets and ensure the asset owner has sufficient financial retention to abandon the wells to sufficient standard. From experience, we estimate the cost to abandon a deep geothermal well ranges from £500k to £1.5 million.

Figure 3.9: Deep geothermal wellhead ©Sanjack Petro

3.7 Offsite potential for geothermal solutions

An alternative site off the hospital campus, Rifles Field, has been considered as a possible location for geothermal heating. This site could potentially supply the hospital with heat as part of a wider heat network.

Offsite overview

DCH has suggested that Rifles Field, part of an Army Reserve Centre, located around 300m northeast of the hospital site, could potentially be used as a geothermal development site. The field is around 8300m^2 (see Figure 3.10), and is the offsite location considered in the multicriteria analysis in Table 3.4.

Closed loop ground energy assessment

Based on a site area of 8300m^2, and based on the a 12m spacing, 74no. boreholes could fit in this area. Proportionally scaled to the GLD model findings, this could provide around 1,450MWh of heating, and 760MWh of cooling annually.

Deep Geothermal Option

As outlined in Section 6.3, deep geothermal doublets require sufficient spacing between the abstraction and reinjection wells to avoid 'thermal short-circuiting'. Generally, 1km to 2km spacing is required. Rifles Field is only 300m from the Hospital and therefore it is assumed that only a single deep geothermal well pair could be installed at the site, rather than multiple deep pairs.

Given the small distance between the Hospital and Rifles Field, the ground conditions are considered to be comparable, and therefore a deep geothermal system located at either site could provide the same capacity, of around 6.2GWh annually.

Figure 3.10: Location of Rifles Field

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3.8 Multicriteria analysis

A multicriteria analysis looked at both on and offsite locations, scoring against weighted technical, delivery, commercial, social and environmental factors. The weighting of factors was agreed with DCH.

We undertook a multicriteria analysis to qualitatively assess possible locations for low carbon heating plant. We scored locations against technical, delivery, commercial, social and environmental factors, and gave each a waiting agreed with DCH. These factors and their weightings are described in Table 3.3.

An onsite location and an offsite location at Rifles Field (see Figure 3.10) were compared for all GGS technologies. For deep geothermal and ASHP two different onsite locations were compared, area B and area C/D as shown in Figure 3.6.

For closed and open loop GSHP shallow geothermal and closed loop GSHP, onsite locations have not been compared. Closed loop GSHP has been sized assuming boreholes are on all suitable areas of the site, and an open loop system would need both an abstraction well and a rejection well spaced >200m apart, which limits possible siting options, and would for example would need plant on both areas B and area C/D.

Conclusions

The multicriteria analysis is shown overleaf in Table 3.4. It found that Area C on the main site was likely to be the best location. This location allows the heat source to be closer to the energy centre where heat is distributed, lowering installation costs and reducing losses. It also avoids loss of green space on the site, which reduces environmental and social impacts. The cost assumptions in the economic modelling have been based on area C/D being used.

	Weighting	Score 1 description	Score 5 description
Technical	25%	The location may be technically unfeasible. It cannot meet the full site load, is hard to maintain and inefficient in operation.	The location is technically feasible and provides significant technical benefits, such as being able to meet the full site load efficiently and being easy to access and maintain.
Delivery	20%	This location is high cost and/or there may be difficulty transporting heat to site, stakeholders may be opposed to its use, there are regulatory barriers.	The location is economically feasible and highly practical and deliverable. Full stakeholder buy-in exists and there are minimal regulatory barriers.
Commercial	25%	This location is unlikely to be considered 'bankable' by investors.	This location is likely to attract investment and other funding streams.
Social	15%	Use of this location would receive significant opposition from the heat users and other local stakeholders. It may not meet comfort needs, be disruptive and/or costly for users in operation.	The location provides wider benefits to users on such as reduced disruption, providing high levels of comfort and cheap for users in operation. It has minimal adverse impact on local stakeholders.
Environmental	15%	The location is detrimental to the local environment.	The location provides significant environmental benefits with minimal disbenefits.

Table 3.3: Multicriteria analysis criteria weightings and descriptions

3.8 Multicriteria analysis

The multicriteria analysis found that Area C/D on the main site was likely to be the best location, due to their proximity to the energy centre and potential loss of green space on other locations.

Weighting:	Technical 25%	Delivery 20%	Commercial 25%	Social 15%	Environmental 15%	Total score	Comment
Deep Geothermal - Main, Area C/D	4	3	3	3	3	3.25	The construction works will take up a large amount of space and make some noise, so there will be some disruption to the hospital site (although once constructed it takes up very little space).
Deep Geothermal - Main, Area B	4	3	3	2	2	2.95	The construction works will take up a large amount of space and make some noise, so there will be some disruption to the hospital site (although once constructed it takes up very little space). This site would also lead to possible loss of green space.
Deep Geothermal - Rifle Field	3	2	2	2	3	2.4	Assumed loss of heat due to the distance from site, though less disruptive to the hospital. There could be objections from users of this field and from road users/residents that are affected by the installation of pipes in the streets.
ASHP - Main site, Area C/D	4	4	4	3	3	3.7	This is the closest area suitable for ASHPs (sized as the hospitals main energy source) to the energy centre.
ASHP - Main site, Area B	4	2	3	2	2	2.75	This area is further from the energy centre where the heat will be distributed. It would also lead to possible loss of green space on the site.
Closed Loop - Main site	4	3	4	3	3	3.5	A closed loop system is typically cheaper than a deep geothermal system. The construction works will take up some of the hospital space and make some noise, so there will be some disruption to the hospital site (although once constructed it takes up very little space).
Closed Loop - Rifle Field	3	2	3	2	2	2.5	Assumed loss of heat due to the distance from site. Larger site could make it more economically viable and less disruptive to the hospital. There could be objections from users of this field and from road users/residents that are affected by the installation of pipes in the streets. A closed loop system appears to have a lower cost for the energy output compared to a deep geothermal system.
Open Loop - Main site	1	2	3	3	2	2.15	Produces the least heat. Installation is cheap and has little disturbance. Implications of being within an SPZ would need to be resolved.
Open Loop - Rifle Field	1	1	2	2	2	1.55	Produces the least heat. Installation is cheap. Implications of being within an SPZ would need to be resolved.

Table 3.4: System installation site multicriteria analysis results

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3.9 Geothermal options overview

All geothermal and ground source options would require coupling with an ASHP in order to meet the hospital heating demands. The capacity of these systems found in our calculations are lower than those found in the BGS' assessment.

As described in Section 2, 2MW of low carbon heat generation plant is required to deliver 90% of the main hospital building's heat demand. All geothermal and ground source options fall short of delivering 2MW, and as such would all need coupling with an ASHP to decarbonise the main hospital building. Whilst closet loop GSHP comes a close second in the multicriteria analysis, it would still require nearly 2MW of ASHP being installed alongside it, in order to meet 90% of the consumption. ASHP is therefore considered the most favourable option as it reduces cost and risk.

The boilers and CHP currently in use generate and distribute heat at a temperature that fluctuates between 77°C and 80°C [1]. This distribution temperature will need to be reduced to 75°C for the low carbon heating to avoid using an ammonia ASHP. In all geothermal and ground source options, a heat pump will be therefore needed to generate heat at 75°C. The higher the source temperature, the more efficient the heat pump will be (i.e. it will operate at a higher COP).

Closed loop GSHP systems and deep geothermal systems are suitable options for the site. For the closed loop GSHP systems to produce a significant amount of heat, many boreholes need to be installed across the site. It could be possible to use a combination of these solutions to meet the annual heating demand of the building. An open loop GSHP system within the chalk would also likely work, but due to low flow rates in the chalk at this depth, as well as the location being within a Source Protection Zone which will mean additional scrutiny by the environment agency, the system capacity is likely to be much lower than the other two options.

System	Depth (m)	Footprint required or no. of boreholes	Temperature from ground, i.e. source temperature	Arup calculated heat to buildings	BGS calculated heat to buildings	Field testing
Closed loop boreholes – Chalk aquifer (Modelled 115No. boreholes)	250m	12m spacing, c. 10,600m^2	13.8°C	Peak: 0.26MW Annual: 2.2 GWh (Based on GLD model)	Baseload: 1MW Annual: 4.4 GWh (6 months heating) (scaled to 100 boreholes)	Thermal response test
Open loop – Chalk aquifer	250m	c. 1m^2 per well (one injection, one abstraction well assumed)	16°C	Peak: 0.17MW Baseload: 0.13MW Annual: 0.76 GWh (6 months heating)	NA – "Open loop GSHP prospects do not appear to be geologically favourable"	Drilling and testing
Deep geothermal – Sherwood Sandstone Group	1500m	c. 1m^2 per well (one injection, one abstraction well assumed)	60°C	Peak/Baseload: 1.0MW Annual: 6.2 GWh (6000hrs heating)	Peak/Baseload: 1.23MW Annual: 5.4 GWh (6 months heating)	Drilling and testing

Table 3.5: Summary table for the potential geothermal options at the site

3.10 Low carbon heat generation plant summary

Of the low carbon heating options, an ASHP has the potential to supply the hospitals heat. All GGS options would need to work with an ASHP to meet 90% of the hospitals demand.

Requirement for ASHPs

Our modelling found that all GGS options will still need an ASHP to meet the hospital demand. An ASHP would supply the majority of the heat for both closed and open loop GSHPs. The addition of GSHP would therefor make very little difference to the size of ASHP units required, and at that scale are unlikely to be a viable addition to the heating system.

Grid Connection Requirements

If 2MW heat pumps are installed, then assuming a COP of 2 (a conservative estimate) then 1MVA of additional power capacity on site will be needed. We understand power capacity availability to be an issue in the area, so this is a risk that needs mitigating later. For both the GSHP options, approximate 1MVA grid connection would be needed, and a new connection would still be needed for deep geothermal. Grid connection costs can vary significantly, and an application with the DNO to get an indication of cost is recommended. Based on anecdotal evidence from meetings with the council and the hospital, connection costs could be prohibitively high and so this is a major project risk across all options.

Development timescales

The different technologies considered have different development timescales, as outlined in table 3.8. There may be potential for a phased approach with the CHP when introducing low carbon heating options, and we recommend that DCH discuss this option with the existing EPC contractor.

System	Source temperature	Peak heat output, MW	Annual heat delivered GWh	Time to implement Years	Advantages	Other considerations	Overall feasibility
ASHP	7.5°C (assumed heating season average)	2.0	8.6	1	• Relatively low capex • Relatively simple installation, little civil works • Performance is relatively predictable	• Careful siting needed due to potential for cold pluming in vicinity • Possible acoustic concerns, needs to be taken into account during design • Trial of heating hospital with output temp of 75°C needs to take place before finalising model	High
Closed loop GSHP	13.8°C	0.3	2.2	1	• Relatively simple installation • Little to no maintenance • Performance is relatively predictable	• Careful design and operation to manage ground temperatures • Excavation disruptive during installation • In order to produce sufficient energy, many boreholes need to be installed, covering a substantial part of the site	Medium
Open loop GSHP	16°C	0.2	0.76	3	• Relatively low capex • Relatively simple installation	• Careful design and operation to manage ground temperatures • Low flow rate of 5l/s is expected • Regulatory restrictions due to being within a source protection zone	Low
Deep geothermal	60°C	1.0	6.2	5	• Greater capacity per well • Warmer temperatures, greater heat pump efficiency	• Higher maintenance for boreholes and pumps • High capex • System performance carries greater risk relative to closed loop systems • Could be increased with soft hydraulic stimulation	Medium

Table 3.6: Summary table for potential low carbon heating options at the site

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Section 4: Heat network options

4.1 Heat network study: methodology

Two heat network scenarios have been explored as a low carbon heating solution for DCH. To assess the viability of the proposed networks, we have undertaken high level analysis to investigate the feasibility of connecting buildings within the area.

What are heat networks?

Heat networks supply heat to a collection of buildings via a network of buried hot water pipes connected to a centralised heat source. Low carbon heat networks may use heat pumps, hydrogen boilers, or waste heat as their source of heat generation. In certain cases, where the heat demand density in an area is high enough, heat networks can offer the lowest cost, lowest carbon route to heat decarbonisation at scale. They also offer other benefits such as reducing electricity infrastructure requirements and costs by enabling use of higher temperature heat sources at specific locations, which increase heat pump COP, and by offering thermal storage, helping reduce peak power demands by shifting electricity demand. Heat networks can be complex projects to deliver; pipework is expensive to install; land is needed to host the energy centre(s); and, long term heat supply contracts are needed with customers to derisk projects.

How were heat networks modelled?

To investigate the potential for a heat network for DCH and in Dorchester, we undertook a high-level feasibility assessment as outlined in Figure 4.1. Using Arup's proprietary HeatNet tool, we assessed route options for two scenarios: one connecting only the hospital campus, and another extending to buildings owned by Dorset Council in Dorchester. Future feasibility work should investigate other, non-council buildings that could be connected.

The HeatNet tool uses a digital map of the local road network and an algorithm which evaluates the combination of pipework routes and connected heat loads that maximises the amount of connected demand while minimising pipework length. The initial network map generated by HeatNet was reviewed against the hospital site development plan, which includes new buildings planned across the campus. Due to limitations in the tool's accuracy for the hospital campus, manual adjustments were necessary. The roads between hospital buildings are not part of the local road network dataset used by HeatNet, making the initial network unrealistic.

After finalising the two network scenarios, we calculated the linear heat density for each network pipe length. Where there is a linear heat density above a threshold of 3,000kWh/m, this indicates that the network may be worthy of further investigation.

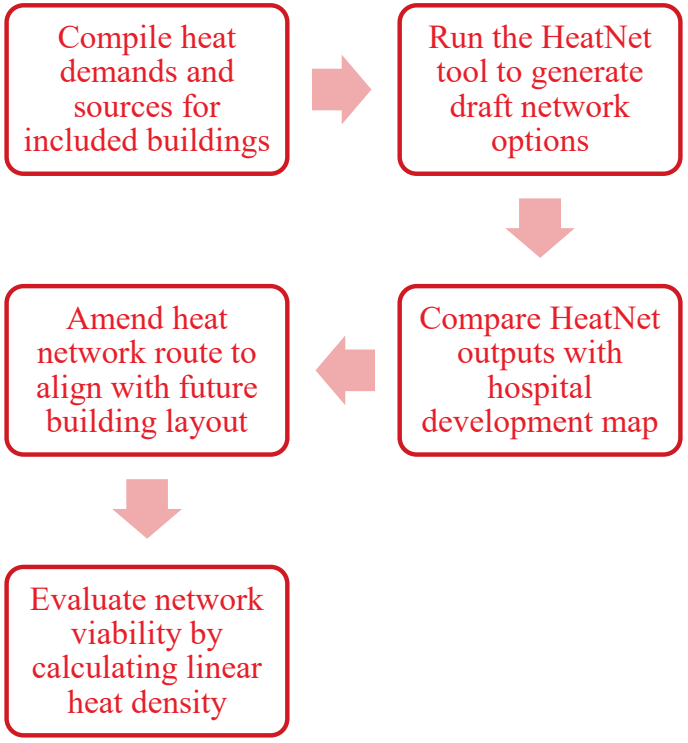

Figure 4.1: Process flow diagram of heat network viability assessment

4.2 Campus wide network

The low linear heat density of campus building network connections suggests that a campus-level heat network is unfeasible, showing that individual decarbonised heating solutions should be prioritised instead.

Campus wide network results

To test the feasibility of a heat network on campus, we investigated what pipework would be necessary to supply buildings. Using satellite imagery, we identified a potential network route, shown in Figure 4.2. While Trust HQ and the Diabetics centre are shown on the map as having a current annual heating demand, they have been excluded from the network due to their planned demolition.

Figure 4.2 shows a potential network starting from the Energy Centre, connecting also to the chillers at the main hospital building to capture waste heat. The first segment, South East 1, connects Damers Court and Damers House. The network extends from South East 1 to reach the children's centre and medical records building on the East side via the road which circles the site's perimeter.

The connected buildings have an annual heat demand of 0.5GWh/annum, resulting in a linear heat density of 440kWh/m, as detailed in Table 4.1. This is significantly below the 3000kWh/m benchmark for feasibility. Given that the heat demand of the hospital campus buildings is only about 5% of the main hospital's demand, connecting these buildings to a heat network is unlikely to offer significant benefits compared to providing individual decarbonised heating solutions.

Network segment name	Pipe length (m)	Annual heat demand (GWh)	Linear heat density (kWh/m)
South East 1	470	0.3	630
South East 2	490	0.2	400
Chiller connection	150	n/a	n/a
Total network*	1,110	0.5	440

Table 4.1: campus-wide heat network analysis

*The main hospital heat demand has been excluded from this calculation as it is already supplied by the energy centre, meaning it does not require a network connection.

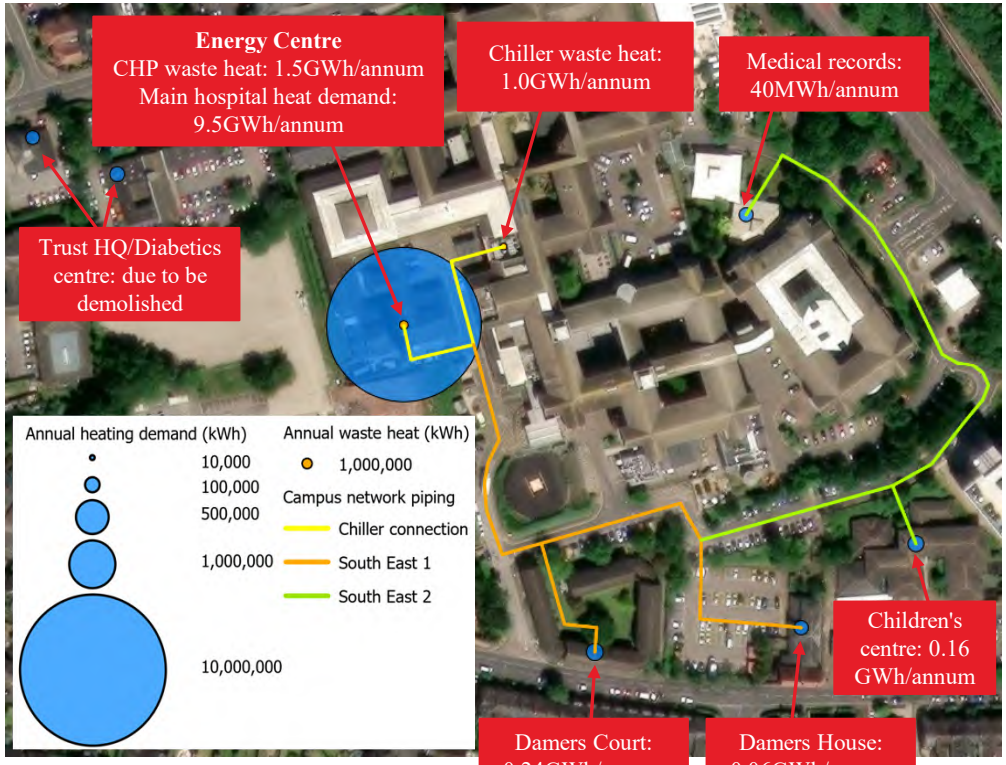

Figure 4.2: Potential campus-wide heat network

4.3 Dorchester town network

Extending the hospital campus heat network to council-owned buildings in the wider Dorchester area showed higher potential than a campus-only network, but the total linear heat density still fell below the viability threshold.

Dorset town network results

In the second scenario, we explored extending the hospital campus heat network to buildings in the wider Dorset area. The potential network route, shown in Figure 4.3, includes the hospital campus network from Figure 4.2 as highlighted in the centre. This extended network aimed to connect larger demand sources such as Thomas Hardye School, Dorchester Sports Centre, and County Hall Campus. South Walks House, a building currently leased by the hospital from Dorset Council was included in the analysis for the wider Dorchester heat network, and excluded from the hospital campus heat network.

Some of the extended network segments, notably the South West and North East 1 segments, demonstrated significantly higher linear heat densities compared to the campus-only scenario, as detailed in Table 4.2. The South West segment has a linear heat density above the 3,000 kWh/m benchmark, indicating possible feasibility. Conversely, segments North East 2 and South East 3 on the East side of the network showed poorer viability due to their relatively low annual heat compared to the required pipe length.

Overall, the extended network connecting the wider Dorset area showed a total annual heat demand of 22 GWh/annum across 7.7 km of pipework, yielding a linear heat density of 2,840 kWh/m. Although this is below the target threshold above which networks become more likely to be feasible, the higher densities in individual segments suggest that targeted connections to high-demand buildings could make the network feasible. This approach leverages economies of scale, making it a more promising solution than the campus-only network.

Network segment name	Pipe length (m)	Annual heat demand (GWh)	Linear heat density (kWh/m)	Buildings connected
South West	1,650	5.8	3,530	Albany Court, Dorchester Sports Centre, Dorchester Middle School, Thomas Hardye School
North East 1	1,440	3.1	2,120	Dorset History Centre, County Hall Campus
North East 2	1,030	1.4	1,380	Dorchester Connect/Area Office, South Walks House
South East 3	2,490	1.6	660	St Osmund's, Manor Park First School
Total network	7,720	22.0	2,840	All buildings, including the main hospital heat demand but excluding the diabetics centre and Trust HQ

Table 4.2: campus-wide heat network analysis

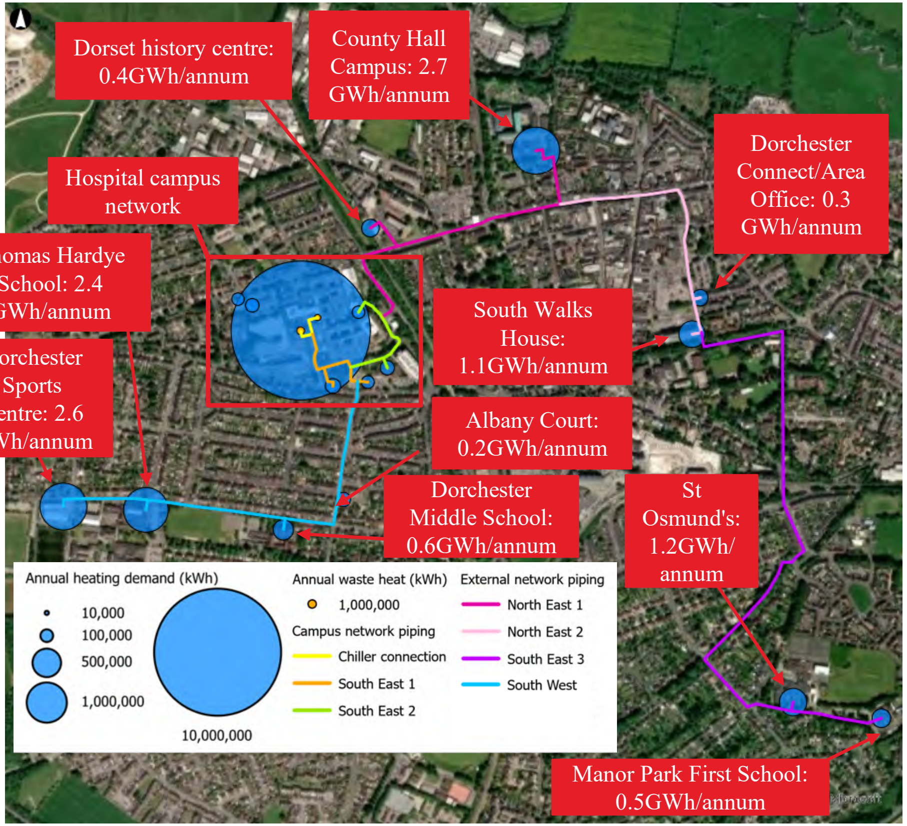

Figure 4.3: Potential wider Dorset area heat network

4.4 Heat network study: conclusions

The two heat network scenarios explored in this analysis were discounted due to linear heat densities falling below the feasibility benchmark. Future studies should consider a more detailed analysis of the potential benefits of a broader Dorchester heat network.

Conclusions on heat network opportunities

Our analysis concluded that a heat network on the hospital campus is not viable due to the insufficient heat loads of individual buildings relative to the cost of the necessary pipework. The linear heat density of the campus-only network was much lower than the benchmark at 440kWh/m, making a heat network economically unfeasible. Instead, we recommend a building-by-building approach to decarbonisation, focusing on the main hospital building and the existing energy centre.

However, there is some potential for a heat network in Dorchester Town, leveraging the hospital as a significant anchor load. This extended network could connect larger demand sources such as Thomas Hardye School, Dorchester Sports Centre, and County Hall Campus. The council should explore this opportunity further by identifying suitable locations for energy centres, planning pipework routing, and engaging early with potential heat offtakers. Additional heat loads / connections than those identified in this study need to be identified to improve feasibility.

Figure 4.4 shows a summary of the linear heat densities of each network segment that was assessed in our analysis, as previously shown in Table 4.2. The network segments are colour coded using green lines where the network is viable (linear heat density greater than 3,000kWh/m), orange where the viability is near the threshold (linear heat density between 2,000 and 3,000kWh/m), and red where the network is not viable (linear heat density less than 2,000kWh/m). The only part of the network with a linear heat density greater than 3,000kWh/m is the South West segment.

Future studies should include a more detailed economic analysis to assess the viability of a heat network. This analysis should explore each building's counterfactual low carbon heat costs, potential energy tariffs on the network, connection costs, and associated investment metrics. Such comprehensive evaluation will provide a clearer picture of the financial feasibility and benefits of a heat network in the area. Sites in Dorchester Town not on the hospital campus could also be considered as possible energy centre locations. The space needed for these would depend on the heating technology used. The closer these locations are to the heat demand the less losses there will be and the more likely the network is to be viable.

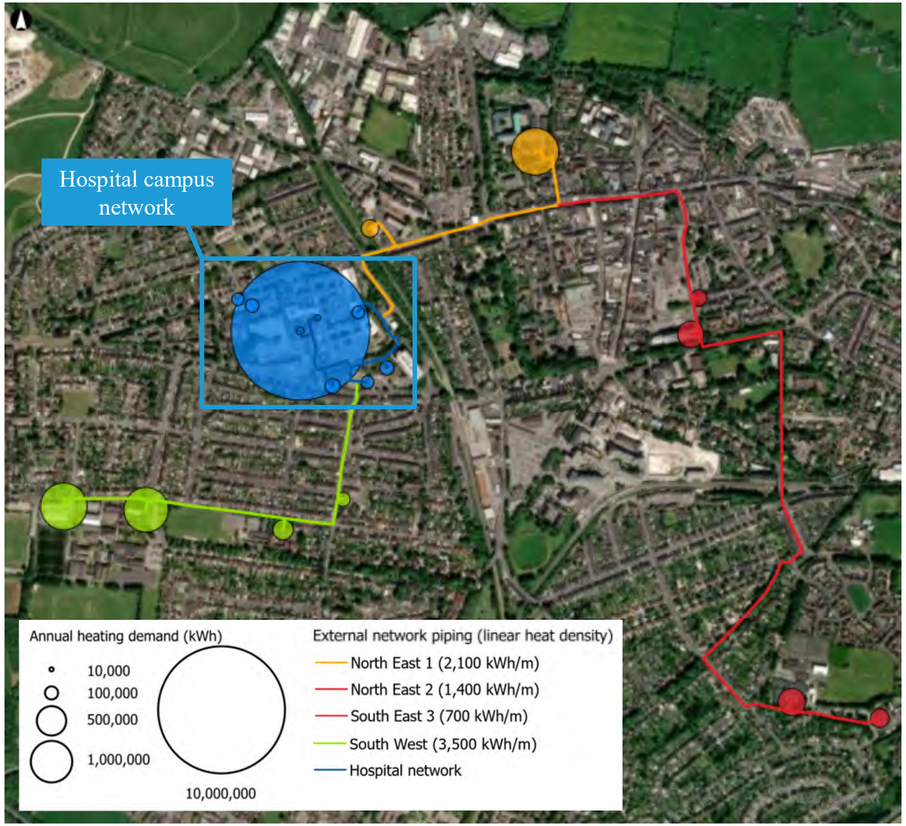

Figure 4.4: Red-amber-green rating of the viability of the wider Dorchester heat network

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Section 5: Economic analysis and results

5.1 Modelled scenario plant sizes and building energy balance

Four low carbon scenarios have been compared against the BAU. We recommend that initially the existing gas boilers are retained, recognising a longer term plan to replace them with electric boilers in future. ASHPs are present in all scenarios to top up the heat delivered from low carbon plant to be 90%.

Given that an on-campus heat network has been shown to be unfeasible, a range of future heat decarbonisation scenarios have been modelled for the main DCH building only. As described in Section 2.1, 90% of the heat consumption of the building can be met with low carbon plant capacity of 2MW.

As shown through our analysis of geothermal and ground source options, heat output capacities of these technologies are all below 2MW. Therefore, in all scenarios, we have assumed that ASHPs are installed alongside the ground source and geothermal options, such that 90% of the heat consumption of the main hospital building can be decarbonised.

At times of heat demand above 2MW, the existing dual fuel boilers will be used to top up the low carbon heat source, supplying about 10% of the heat consumption annually. They will also serve as a back up in the event of a loss of gas or electricity.

The economic modelling and recommendations of the report focuses on heat as that is the greater demand, and reducing use of the CHP system is a priority in order to meet decarbonisation targets. Retaining the dual fuel boilers whilst installing an electric heat source also provides greater energy security to the hospital, and potentially the wider area.

If a heat pump is installed, further work should be carried out to understand whether any of the heat currently rejected by the chillers could be captured, or whether the existing chillers would be replaced by reversible heat pumps, capable of delivering both a heating and cooling demand simultaneously from the same plant.

Table 5.1 summarises the plant sizing across each modelled scenario, and the corresponding energy balance for the building.

Item		Unit	BAU	ASHP only	GSHP Closed + ASHP	GSHP Open +ASHP	Deep geo + ASHP
Plant capacities	Dual fuel boiler capacity	MWth	6.6	6.6	6.6	6.6	6.6
	CHP Capacity	MWth	0.93	-	-	-	-
	ASHP Capacity	MWth	-	2	1.7	1.8	1.0
	GSHP Closed loop capacity	MWth	-	-	0.3	-	-
	GSHP Open loop capacity	MWth	-	-	-	0.2	-
	Deep geothermal capacity	MWth	-	-	-	-	1.0
Energy balance	Hospital heat demand	GWh/annum	9.5	9.5	9.5	9.5	9.5
	Hospital electricity demand (excluding heat related electricity)	GWh/annum	7.9	7.9	7.9	7.9	7.9
	Annual gas consumption	GWh/annum	22.7	1.2	1.2	1.2	1.2
	Low carbon technology electricity demand	GWh/annum	-	3.3	3.2	3.3	2.1
	Annual electricity imported	GWh/annum	2.0	11.3	11.1	11.2	10.0
	Annual CHP electricity generation	GWh/annum	6.2	-	-	-	-

Table 5.1: Plant sizing and energy balance breakdown per scenario

5.2 Capital costs of scenarios

The deep geothermal option represents the highest cost option, driven by the high cost of drilling. Closed loop GSHP also has high comparative costs driven by drilling costs. The ASHP only option is the cheapest.

Table 5.2 shows a breakdown of the estimated capital cost for each low carbon scenario. Allowances have been made for each of the low carbon technologies, as well as for supporting works to facilitate their installation and deployment. As it can be seen from the results, the deep geothermal option is significantly more expensive than the others. This is driven primarily by the high costs of drilling associated with the technology.

The closed loop GSHP scenario is also found to be expensive compared to the ASHP only, and ASHP plus open loop GSHP options. Similarly to the deep geothermal option, a lot of the reason for this is driven by high costs of drilling associated with the 115no. Boreholes installed to a depth of 250m.

The open loop GSHP option is cheaper because there are only expected to be 2no. Boreholes and this drives lower drilling costs than the other geothermal options.

The lowest cost option is the ASHP only scenario, as a result of less drilling and civil works.

The cost estimates are commensurate with the RIBA Stage 1 level of design, i.e. they are accurate to +/- 50%. Many of the costs for supporting works are assumed to be similar across different options – this will not be the case in reality. Costs are presented as 2025 values, and no allowance has been made for inflation as a result of installation later than 2025. A quantity surveyor should be engaged at RIBA Stage 2 onwards to give great cost certainty.

Costs, £'000s (2025)		Quantity	Unit	ASHP only	GSHP Closed + ASHP	GSHP Open +ASHP	Deep geo + ASHP
Energy centre costs	Air Source Heat Pumps	*Varies (see table 5.1)*	*MW*	2,220	1,931	2,027	1,071
	Geothermal / ground source predevelopment costs	*0.3*	*MW*		30	80	787
	Geothermal / ground source drilling costs	*0.2*	*MW*		2,444	381	7,104
	Geothermal / ground source plant costs	*1.0*	*MW*		220	147	1,969
	Mechanical upgrades to energy centre			359	359	359	359
	Electrical upgrades to energy centre			76	76	76	76
	BMS system upgrades			86	86	86	86
	Builder's work in connection with energy centre	*3%*		82	154	95	344
	Testing and commissioning	*2.5%*		71	132	81	295
	M&E Subcontractor preliminaries	*12%*		347	652	400	1,451
External works	Thermal stores; 333m^3, 6mx12m high	*1*	*No*	120	120	120	120
	Incoming 11kV cable	*50*	*m*	13	13	13	13
	Pre-insulated buried pipework	*200*	*m*	400	400	400	400
	Additional electrical connection	*1*	*MW*	200	200	200	200
	Testing and commissioning	*2%*		15	15	15	15
	Builder's work in connection with external works	*3%*		22	22	22	22
Total				**4,010**	**6,853**	**4,501**	**14,310**

Table 5.2: Capital cost comparison for all scenarios

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5.3 Summary of results

The deep geothermal option is lowest cost in operation, but the payback over the ASHP option is beyond 70 years. The payback of the GSHP options when compared to the ASHP only option is even longer. Due to how quickly an ASHP can be implemented, its carbon emissions are the lowest.

A summary of the operational and capital costs of options, alongside their carbon emissions, is given in Table 5.3. For a discussion on capital expenditure, see Section 5.2.

In all low carbon options, there is a reduced cost of gas, but an increase in the cost of electricity. This is due to both the CHP being turned off and so the power that is currently generated on site must be imported instead, and as a result of electrifying the heat generation with the use of heat pumps. Despite the CHP being turned off in low carbon options, the EPC loan repayment value remains unchanged, whilst the energy centre maintenance costs are reduced (costs provided in email from CEF to DCH on May 6th 2025).

It can be seen that the ASHP only option has the highest electricity cost. However, implementing either the closed or open loop GSHP systems only make small changes to that cost, since systems are small, and the remainder of the hospital electricity consumption remains equal, and as the largest proportion.

The deep geothermal option has the lowest operational costs, but compared to the increase in capex of this option over the others, the savings it offers do not justify the extra expenditure. Compared to the ASHP only option, the deep geothermal option would not pay back until beyond 70 years. This period is even longer for both GSHP options.

Furthermore, whilst the deep geothermal *is* the most efficient in operation, the time taken to implement the solution is much longer, hence the cumulative carbon emissions are higher than the other options, as the CHP will be running for longer.

		Quantity	BAU	ASHP only	GSHP Closed + ASHP	GSHP Open +ASHP	Deep geo + ASHP
Operational costs	Cost of gas	£k/annum	£858	£44	£44	£44	£44
	Cost of electricity	£k/annum	£252	£1,431	£1,416	£1,426	£1,272
	Maintenance costs energy centre, including boiler/CHP	£k/annum	£215	£51	£51	£51	£51
	Maintenance costs, low carbon technology	£k/annum	n/a	£22	£22	£24	£46
	EPC Loan repayment	£k/annum	£213	£213	£213	£213	£213
	Total OPEX	**£k/annum**	**£1,539**	**£2,465**	**£2,450**	**£2,462**	**£2,331**
Capital costs	**Total CAPEX**	**£**	**n/a**	**4,010**	**6,853**	**4,501**	**14,310**
Carbon emissions	Annual emissions (2035 emissions factor)	MtCO2e/annum (2035)	4.2	0.4	0.4	0.4	0.4
	Total cumulative emissions 2026-2050	**MtCO2e**	**104.9**	**15.4**	**15.4**	**22.1**	**28.6**

Table 5.3: Techno-economic results summary

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Section 6: Conclusions and next steps

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6 Conclusions and next steps

DCH's current Scope 2 carbon emissions are largely attributed to the CHP engine located in the main energy centre. Whilst all low carbon options are more expensive to install and run than the CHP, the ASHP provides the best value.

This report has investigated how to decarbonise heat for the DCH campus in Dorchester. The heat demand of the main hospital building is met by gas boilers and a CHP engine, operated by Centrica under an EPC contract since 2019. The CHP plant is a major source of carbon emissions, and its continued operation will make meeting the NHS targets to achieve net zero carbon (NZC) very difficult. This contract will expire in 2034 and has high exit costs (£1.6m to exit the contract in 2029, for example). We recommend that rather than terminating the contract, a plan is made to transition the main heat supply away from the CHP, which would subsequently be turned off.

The CHP plant currently generates about 76% of the hospital building's electricity demand, inferring much higher operating costs were it to be switched off.

This study has investigated a series of decarbonisation options:

- Installing new, low carbon heat generation equipment in place of the gas boilers and CHP.
- Connecting the hospital buildings together via a campus wide heat network.
- Connecting the hospital campus onto a wider Dorchester heat network.

Future heat generation

From a purely economic perspective, none of the low carbon heating options modelled are as viable as the current heating system.

Around 2MW of low carbon heat generation is needed to meet 90% of the main hospital building's heat demand. It was found that all geothermal and ground source heating options would fall short of this 2MW requirement, meaning each of them would need to be installed alongside an ASHP to make up the difference. Compared to the ASHP, the geothermal and GSHP options would take longer to implement, and there would be high CHP-related emissions during this project development phase.

Our recommendation is that DCH pursues the ASHP only option. This option has some of the lowest carbon emissions, is the lowest cost option, and its operational costs which – although higher – are comparable with the other options. See Figure 6.1.

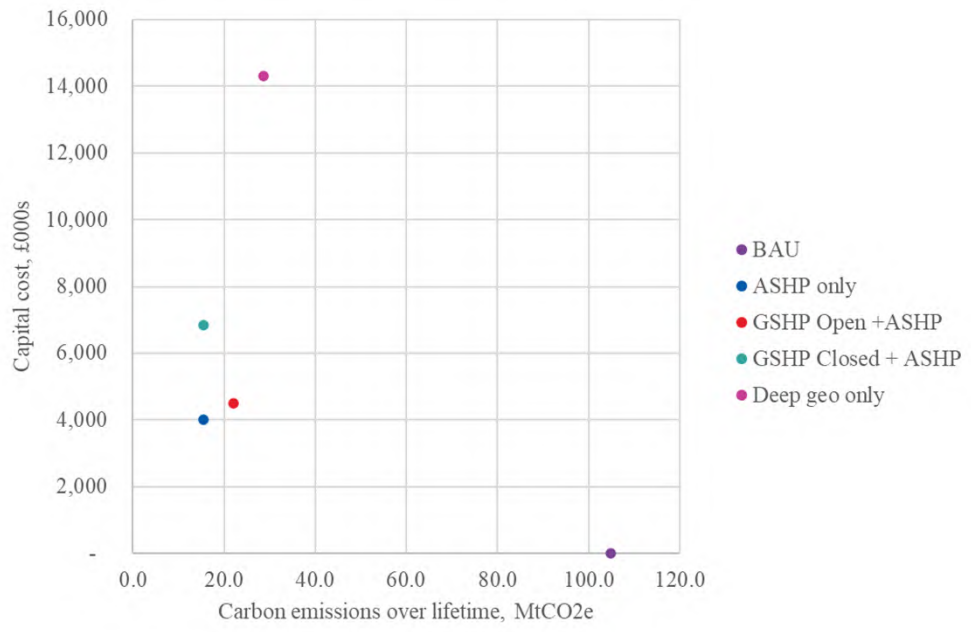

Figure 6.1: Techno-economic results summary with emissions

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6 Conclusions and next steps

We recommend further work to determine details of an ASHP, and liaison with Dorset Council to explore an external heat network.

Campus only heat network

Our heat network modelling found that an onsite heat network supplying other buildings on the campus from the main site's energy centre is **not economically feasible**, as the heat consumption of the other onsite buildings is too low to support the length of pipe that would be needed. Many of these buildings have a heat source that is over ten years old, and we recommend that these are replaced with low carbon heating sources as each plant reaches the end of its life.

Dorchester wide heat network

Our heat network modelling found that a heat network in Dorchester serving the hospital and other public buildings, **may be feasible.** There is unlikely to be surplus low carbon heat at the hospital itself, but there are other external locations in the area that could be considered for low carbon heat generation such as deep geothermal or ground source heat pumps.

There is potential for DCH, Dorset Council and other organisations in the area to collaborate in developing a low carbon heat network, and our recommendation is that this is taken forward by Dorset Council, with DCH's cooperation and support as the networks major anchor heat load. Additional heat loads / connections than those identified in this study need to be identified to improve feasibility.

Next Steps

In developing the ASHP for the main hospital building, we recommend:

- Further work to determine the exact location.
- Consideration of the risks of cold pluming and noise with specialist assessments carried out at RIBA Stage 2.
- Make an application with the DNO to ascertain an indication of cost for an additional 1MVA of power capacity on site – this is a major risk to the project and needs mitigation prior to further work being undertaken.
- A programme of low temperature testing, undertaken over winter to check whether the building's heat demand could be satisfied with a heating supply temperature of 75°C. This assessment would reduce the output temperature of the existing heat generation equipment and the building's performance and reaction from tenants monitored.
- The New Hospital Plan will be heated using ASHPs. The connection of the new hospital building into the existing energy centre should be investigated, such that any spare generation capacity in the New Hospital ASHPs can be used for the existing building. This should include a review of the operational characteristics of the new heat pumps, to show what spare capacity there may be.

In operating the existing plant, we recommend that DCH:

- Explores optimisation of the existing plant with Centrica.
- Understands the route to decarbonisation through the lens of the existing EPC contract.
- Avoids contract termination due to the high exit costs.
- Explores, in the long term, the replacement of all gas boilers with either electric or hydrogen boilers.
- Engages with Centrica around the potential for a phased approach for installing the low carbon generation plant along side the CHP.

For the other, smaller, hospital buildings, we recommend that DCH:

- Explores a building-by-building approach to decarbonising each building in turn.
- Considers that this is likely to involve an air source heat pump at each building, with potentially some fabric works.
- Surveys the plant in each building to determine the best phasing approach to decarbonisation.

In relation to a Dorchester-wide heat network, we recommend that DCH:

- Collaborates with Dorset Council in their efforts to develop a heat network, including exploring potential energy centre locations not on the hospital campus.
- Supports heat network development by supplying energy demand data to Dorset Council.
- Recognise their position as a major anchor load for the network, therefore having the most influence in terms of its strategic direction.

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Section 7: References

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Dorset County Hospital
NHS Foundation Trust

Report to	Trust Board	
Date of Meeting	12 August 2025	
Report Title	DCH Social Value Report (6mth)	
Prepared By	Simon Pearson, Head of Charity & Social Value	
Approved by Accountable Executive	Nicholas Johnson, DCH Deputy Chief Executive	
Previously Considered By		
Action Required	**Approval**	N
	Assurance	Y
	Information	N

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

Executive Summary

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

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

- Joint Social Value approach (DCH/DHC)
- Local Investment
- Local Employment/Training/Widening Participation
- Greener & Sustainable
- Estates Capital Projects: incl. Enc 1. Tilbury Douglas DCH NHP Social Value report
- Involving our Community: incl. Volunteering
- Civic Partnerships: DCH Charity/Enc 2. Arts in Hospital
- Enc 3. Social Value Activity Report 2024/25

Recommendation

Members are requested to:

- Receive the report for **assurance.**

DCH Social Value Programme: Progress Report (6 month) August 2025

Our Social Value Pledge

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

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

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

Joint DCH/DHC Social Value approach: In line with our federated model and Joint Strategy we have commenced plans for embedding an approach to social value delivery at DHC, in line with DCH's social value programme. An initial workshop of the Joint Social Value Operational Group was held with DCH and DHC colleagues on 14.5.25, with a further meeting held on 24.7.25. Work will now be taken forward to map DHC's key social value workstreams (ie. Local Investment; Local Employment, Green/Sustainable et al), mirroring DCH's social value commitments and approach. The current DCH Social Value Programme Group will develop into a joint oversight group. The primary objective is to develop a joint Social Value Annual Plan for 2026/27. We look forward to reporting progress as this work advances.

Local Investment:

We commit to maximise local investment, recognising the social, economic and environmental benefits of buying locally when procuring goods and services. The table below presents the Trust's spend with local businesses, catering and 3rd sector suppliers for 23/24 and 24/25 (12mth):

Social Value pledge	Social Value activity	Measure (23/24)	Measure (24/25)
Maximise Local Investment	Local Supplier (DT) spend	£6,869,068	£7,356,058
Maximise Local Investment	Local Catering spend	£1,119,818	£1,181,624
Maximise Local Investment	3rd Sector spend	£181,800	£160,354

Local supplier and local catering spend for 24/25 has grown in comparison to the 23/24 spend. There has been a slight decline in 3rd sector spend year on year. There is a considered approach

to how the Trust's social value goals are balanced against the benefits of economies of scale through local, regional, and national aggregated volumes. Despite work to utilise national frameworks to benefit from aggregated volumes, the Trust has managed to influence the areas of spend where there is limited opportunity in this regard. The Trust continues to receive enquiries from SME's who are interested in working with the Trust and these are followed up and considered where viable opportunities exist. Categories of spend where this applies heavily are Estates Minor works, Facilities Services and Catering suppliers.

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

Social Value pledge	Social Value activity	Measure (23/24)	Measure (24/25)
Increase Local Employment	Local Residents Employed	3,590	3,091 (out of 3,799)
Increase Local Employment	Total Employees - % Local (DT) (Target 80%)_	81%	81%
Champion equality, diversity and inclusion	No. BAME Employees	799	905
Champion equality, diversity and inclusion	No. Disabled Employees	190	236
Increase Training opportunities	Apprentices Trained	196	200
Increase Training opportunities	Work Experience Placements	113	250

Widening Participation:

During the last 12 months the Widening Participation team at Dorset County Hospital have continued to develop initiatives with innovation and creativity to support the delivery of our organisational social value principles. We endeavour to enable local individuals, especially those from a disadvantaged background and underrepresented groups, to experience education, training and employment opportunities. Aligned with our social value pledge, we have implemented the following initiatives:

Work Experience – Our current workstream offering supports students in Year 10 (14,15 years old), Sixth Form and College students (16,17,18 years old) and undergraduate and postgraduate students. We have had a significant increase in the number of placements we are able to offer local schools. We have seen a 257% increase in young people attending work experience programmes in the organisation, with 70 placements in 2023/24 compared to 250 in

2024/2025. We have increased host departments to showcase the variety of NHS careers on offer at Dorset County Hospital. Our increase in capacity has enabled us to support all areas of education, including our local special educational needs and disabilities provisions to offer equitable opportunities to all students.

Supported Internships – We continue to work with Weymouth College as well as our new provider, Southwest Regional Assessment Centre to host supported internships. These 32 week-long placements are designed for young people with special educational needs and disabilities. In the last year we have hosted six supported interns with successful employment for four the students that have completed the programme so far.

T levels – Dorset County Hospital have now successfully completed our first T Level industry placement in partnership with Kingston Maurward and Weymouth College. We are now hosting placements for Yeovil College and are planning further placements in the new academic year.

Functional Skills English and Maths – Aligned with our social value good employer principles to develop our people and further their careers, we continue to offer Functional Skills English and maths, as well as Digital skills, numeracy and literacy classes. We currently have 33 learners enrolled to our functional skills programme delivered in partnership with Skills and Learning. 62 learners have completed their skills course and 14 have passed a level 2 qualification in English or Maths.

Employability Sessions – We have held career development/employability sessions for internal staff members and individuals within our community to support the development with their NHS career. Since April 2024, we have met with 114 individuals who are looking to gain employment or further their career. We have also attended sessions at the Department of Working Pensions to support individuals returning to work with a long-term health condition. Alongside this we have also engaged with members of the Afghan refugee community, with the aim of inspiring and supporting them with their career journey following settlement within Dorset.

School Engagement – The Apprenticeship and Widening Participation team have been proactively visiting primary, middle and senior schools within Dorset and Somerset, as well as further education providers. We have visited nine schools to promote NHS careers, the wide variety of educational opportunities within healthcare and to promote the supportive environment at Dorset County Hospital. The Widening Participation team are passionate about inspiring the next generation to consider a future in healthcare. We have attended five specialist schools to promote the inclusivity and diversity embedded within the organisation's values.

This year we had the pleasure of hosting **Teacher Encounters** in partnership with Dorset Chamber. This involved inviting 18 teachers from a variety of schools to come and take part in elements of work experience with the goal of gaining a better understanding of the many routes

into the NHS. We were able to showcase that the NHS is more than doctors and nurses and were able to promote the 350 careers.

Young people engagement - As part of as sustainable future for employment within our local community, we have continued to grow our engagement with people in the area. We have attended multiple career events in local schools engaging with several hundred students from ages 10-18.

This year also saw our first **Introduction to Nursing Programme**. This involved inviting thirty local young people, with an interest in a nursing career, to spend 3 days in the organisation learning about the vital role of nursing. This has been delivered in partnership with the Healthcare Support Worker Development Team and Dorset Healthcare.

We also welcomed students from Wey Valley School in Weymouth to The Education Centre. This initiative, in partnership with The Jon Egging Trust, allowed 28 young students to explore many of the careers on offer at Dorset County Hospital. The Jon Egging Trust supports students that are facing significant life challenges or lack positive role models. This programme has supported the students to build teamwork, leadership and communication skills and raise aspirations.

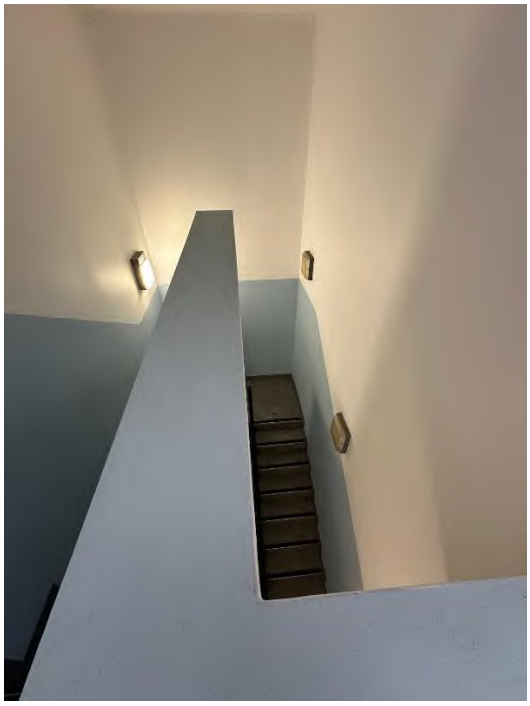
Greener & Sustainable:

Eco earn and Sustainability champions drop-in session

We hosted in-person drop-in sessions with our sustainability champions to discuss the Green Plan and Green Travel Plan updates. We gained 9 sustainability champions in last 6 months across various wards/departments of hospital

- Total number of Ecoearn participants: 218
- Approximately 10 staff inductions and 150 engagements made with new staff as a part of their induction.

National energy efficiency funding Emergency LED project



We are delighted to have received an additional £42,000 from the NHS National Energy Efficiency Fund (NEEF) as part of a project to replace our lights with LEDs. The Trust has received a total of £62,000 over the last two years to fund nearly 400 LED light fittings across our main site. This will lower our carbon emissions by 1,960 kilograms a year and save the Trust money.

The trust was also successful with a small £25,000 submetering project that is hoped to identify areas of high use and potential impacts of energy reduction initiatives.

Further work and funding application preparation for energy projects is underway, following the Trust's Decarbonisation Plan and Energy Strategy (commissioned in 2023) and successful funding application to Heat Network Development Fund in April 2024 to investigate feasibility of heat pumps and networks.

Net Zero Clinical transformation

The Greener theatres group and Sustainability team have undertaken engagement on recycling and bin placement in theatres and continue to reduce use of desflurane and nitrous with alternatives and compiling a report into lower carbon anaesthetic practices and the Intercollegiate Greener Theatres Checklist second iteration.

Infection Prevention Management and clinical teams have worked on a range of sustainability initiatives including:

- Theatre ventilation downtime to save energy
- Re-useable tourniquets

- Gloves off (on ward round for example, to save money and reduce waste)
- Early intervention removal of devices to prevent infection
- Sterilising facilities in SCBU
- IV to Oral switch to enable patients to go home sooner

Clinical Waste Targets

In February 2025 the Trust achieved the NHS Clinical Waste Strategy targets of '60:20:20' (*60% OW (Offensive Waste); 20% HTI (High-Temperature Incineration); 20% AT (Alternative Treatment)) for the first time, thanks largely to engagement by the Waste Co-ordinator and effective understanding and use of the correct waste streams across all areas by staff of the trust. This is anticipated to contribute to a reduction of 15% clinical waste by 2030 to the NHS overall and significantly reduces carbon emissions from waste.

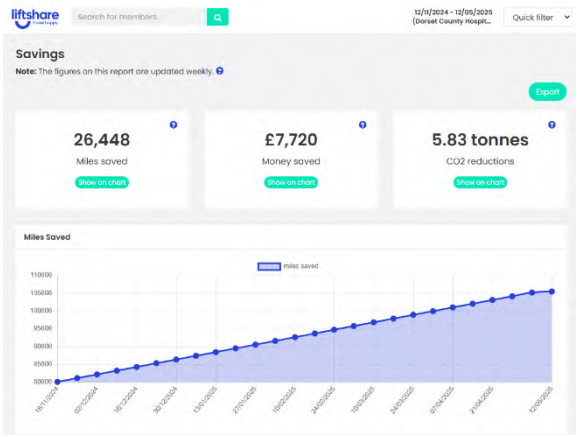
Low Carbon Travel

As a part of developing the green travel plan for the trust main site, and building on the green travel plan for South Walks House, a staff travel survey was conducted in Summer 2024 with more than 300 responses. An FAQ document on staff low carbon and active sustainable travel was produced focusing on reducing the amount of single occupancy vehicles (SEV) to the trust, this is now available on staff net for trust staff. Work has begun on updating the Hospital website to align on low carbon travel option information for outpatients, visitors, general public and for new recruitment for both hospital locations of Williams Avenue and South Walks House. The trust is in discussions with Dorset Council around potential cycle route from Poundbury and welcomed the addition of Beryl bikes located near South Walks House and Damers Road for potential travel between the sites.

Part of low carbon travel was to engage and in future build on the Dorset NHS lift share platform.

Dorset NHS Liftshare

- Total number of members: 84
- 9% growth in members in past 6 months
- Miles saved since last 6 months (from 12/11/2024): 26,448
- Money saved: £7,720
- 5.83 Tonnes of C02e reduced as a part of liftsharing and reducing the number of Single occupancy vehicles.



Greenspaces and Healthy by Nature

The Sustainability Manager and Greenspaces team secured £50,226 grant from the NHS Charities Together Greener Communities Fund in April 2024. We are working with Horticultural students from Kingston Maurward College to design a suitable landscaping and planting scheme, with Dorchester Men's Sheds to work on planters and design accessible planters, a range of stakeholder engagement and Capital Projects team managing transformation of a neglected courtyard into a Sensory Courtyard Garden, which opened on 10th June 2025.

The trust, together with 8 other trusts, supported a successful application by Centre for Sustainable Healthcare 'Healthy by Nature' project to National Lottery Community Fund in 2024/5. A CSH Nature Recovery Ranger (4 days/week) has started at DCH to run nature-based activities with staff, patients and visitors from June 2025 to March 2027.

The Sustainability team of Bev Lagden (Sustainability Manager), Gokul Ramendran (Sustainability Officer) and Darren Hallet (Waste Co-Ordinator) would like to thank Green Plan Theme leads, sustainability champions and colleagues that make possible continuous sustainability improvements contributing to a Greener and More Sustainable DCH.

Estate Capital Projects:

Tilbury Douglas – DCH NHP Social Value report

Tilbury Douglas have provided their Q2 2025 Social Value report for DCH's NHP project, relating to the new build Emergency Department and Critical Care Unit. Please see Enc 1. report enclosed.

Tilbury Douglas's key Social Value KPIs and measures for Q2 2025 are presented in the table below:

Theme	Code	Measure	Unit	TD figure
SME/VCSE	P1	Contract spend with SME/VCSEs - total	£	£5,139,347
	P2	No of contracts with SME/VCSEs	No.	78
	P3	Contact spend with SME/VCSEs - % of total contract spend	%	83.00%
	P4	Local Spend - Businesses registered within 25 miles of Project - % of total spend	%	6.40%
	P5	Local Spend - Total amount spent through local SMEs	£	£396,076.00
Apprenticeships	P6	Apprenticeships on Project	Weeks	238
	P7	Apprenticeships - New Starts	No.	6
Local Employment	P8	Directly Employed Staff - Main and Subcontractors	No.	13

	P9	No. of local direct employees (FTE) hired or retained (for re-tendered contracts) on contract for one year or the whole duration of the contract, whichever is shorter. / No. of local people (FTE) on contract for one year or the whole duration of the contract, whichever is shorter, employed through the supply chain as a result of your procurement requirements.	No.	14
	P10	Direct Employment - % of total workforce	%	80.00%
Community	P11	More working with the Community	Hours	1,091

Measurement of the DCH NHP project's social value return on investment will continue throughout the project construction period.

Involve our Community:

A key principle of delivering social value is engagement with our stakeholders. Through its Patient and Public Engagement activity, DCH has an active role in engaging with our local community by listening to them, involving them and acknowledging their contributions.

Our commitment to involving our community includes:

- Engage with local residents and service users. To promote opportunities for gathering views, including those not heard or voiced.
- To provide feedback to the local community so they can see the results of their involvement.
- Ensure communities receive timely and appropriate information and communication.

Examples of this over the last 12 months include:

- A conversation cafe with representatives from our Deaf Community held in January 2025. This brought staff from across the Trust together with the representatives from the deaf community to learn, with the support of British Sign Language interpreters, about the experiences and challenges they faced when coming into our hospital. Key findings and recommendations from the cafe have since been developed into an action plan which will be delivered through our Accessible Information Standards group over 25/26 with continued engagement with the Deaf community.
- Continued work with the Armed Forces Community which was recognised through reaccreditation as a Veteran Aware trust with the Veterans Covenant Healthcare Alliance in October 24.

- Engagement with Carers groups in Weymouth and Portland and through closer working with PCNs across the county to learn where we can support carers better when they come into hospital to support those they care for.

Volunteer Services

Our Volunteer service continues to thrive. Our volunteers have given over 15000 hours of their time this year to support the Trust, (this figure is for our direct volunteers only and does not currently include our Friends of DCH or the YFW Blood Bikes who we also support within the Trust through our volunteer services.)

We continue to deliver our Young Volunteer programme with opportunities to volunteer primarily in Ward based roles. We have continued to deliver our outreach work this year, as part of this programme, working with schools and youth organisations to support with healthcare related projects and to pilot the NHS Young People's Health challenge.

Over the last 12 months the voluntary services team have also supported Ukrainian refugees into volunteering roles within the hospital. These volunteers are actively volunteering in roles across the hospital with the majority coming to us with healthcare qualifications. They have approached us for volunteering opportunities to improve their English and gain experience working in UK healthcare settings and we have been able to support them through adapting our training to remove language barriers and buddy them up with other volunteers to provide support as they learn their volunteer role.

As part of our Volunteer service, we continue to support our voluntary sector partners delivering services within the hospital. This includes The Friends of Dorset County Hospital who continue to deliver a daily trolley shop service around the hospital alongside their fundraising activities. We also support the YFW Blood Bikes who offer a free 24/7 service to transport emergency samples and equipment via their blood bikes to and from other healthcare providers. This year they have extended their services to include transporting medications to patients who have been discharged home. This evening service means that some patients can be discharged earlier in the day and no longer have to wait for medications to be ready before they can go home.

Civic Partnerships:
Promote partnerships between DCH and our civic community, implementing local activities which contribute to reducing inequalities and improving health and wellbeing for all.

DCH Charity
DCH Charity's purpose is to raise funds to enhance patient care and staff welfare.
The Charity's current major focus is its £2.5M Emergency and Critical Care Appeal which will fund enhancements in the new Emergency Department and Critical Care Unit such as, Critical Care paediatric bed space; Child & Adolescent Mental Health suite; Critical Care patient garden; medical equipment; staff rest facilities and artistic elements for both new units. The Appeal target has recently achieved a major milestone reaching over £1M.

Arts in Hospital
Arts in Hospital delivers social value by promoting civic partnerships between DCH, artists and our community. Please see Enc 2. the Arts in Hospital & Social Value report enclosed.

DCH Social Value Activity Report (2024/25): DCH's annual Social Value Activity Report 2024/25 provides a broad range of social value related articles and images. Please see Enc 3 enclosed.

Simon Pearson MCIOF
Head of Charity & Social Value

Tilbury Douglas

Emergency Department Dorset County Hospital(Dorchester) Report

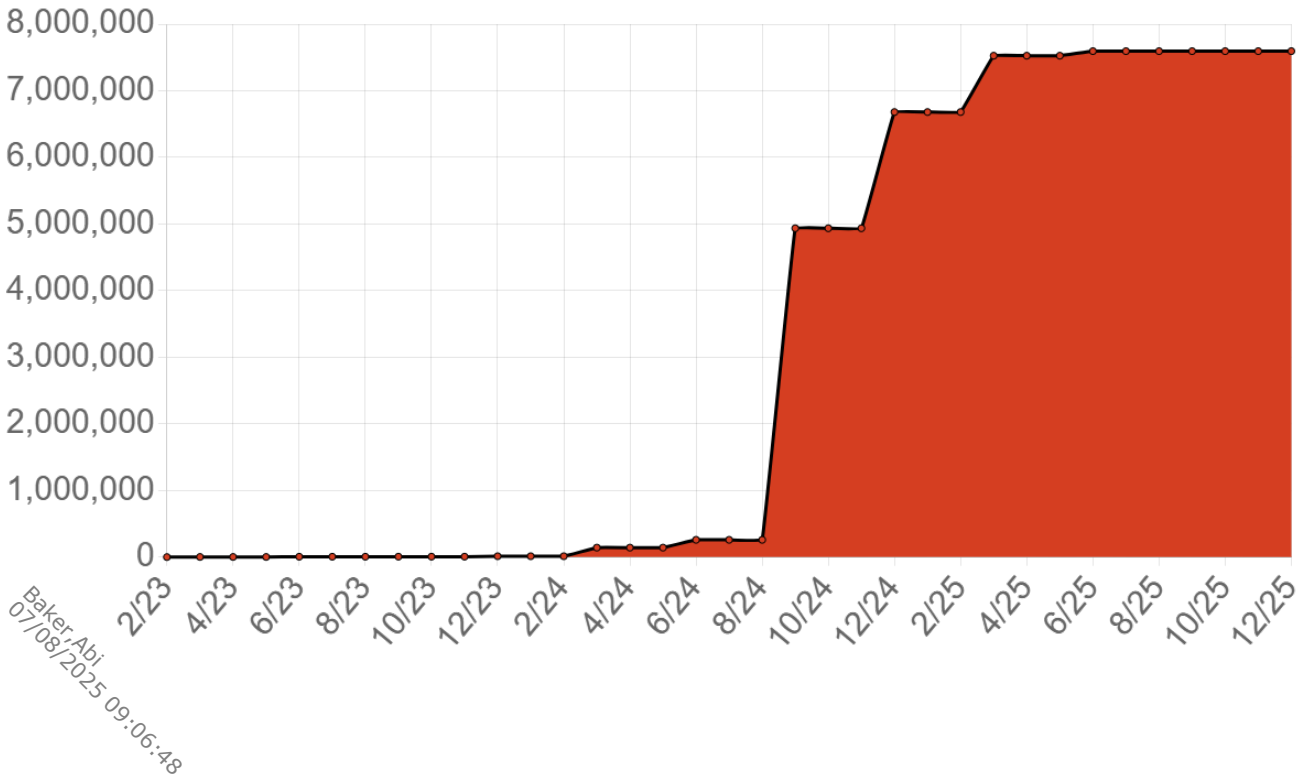
Contents

Introduction

This is a Social Value report for the New Emergency Department and Critical Care Unit at Dorset County Hospital detailing the progress to date Q2 2025.

Social Value: £7,594,460.01 STEV: 12% SLEV: 12%

Social Value Generated By Project



IM45	4,259,940 The value of contract opportunities awarded in £ spent to LOCAL suppliers	£5,963,916.00 Social Value
IM48	4,714,366 The value of contract opportunities awarded in £ spent to Small & Medium Enterprises (MSMEs)	£1,084,304.18 Social Value
IM19	7.3 Number of LOCAL full time equivalent (FTE) employment opportunities created	£280,129.04 Social Value
IM28	238 Number of apprenticeship weeks completed	£172,133.33 Social Value
IM119	0.4 Number of full time equivalent (FTE) hires of those who were CARE LEAVERS	£23,356.46 Social Value

Project Images

Team Tilbury T Rex before setting off from Corfe Castle on the DCH Jurassic Challenge 2025.

Impact Evaluation Standard

Tackling economic inequality

Metric Name	Social Value	Achieved	Target	Comment	%
(IM26): Number of apprenticeship opportunities (Level 2, 3, and 4+) created	£0.00	4			

Metric Name	Social Value	Achieved	Target	Comment	%
(IM28): Number of apprenticeship weeks completed	£172,133.33	238			

Metric Name	Social Value	Achieved	Target	Comment	%
(IM32): Number of weeks of work experience (WEX) placements completed	£108.22	0		Collaboration with the DCH Early Careers Team. A morning with the project team for two local young people.	

Metric Name	Social Value	Achieved	Target	Comment	%
(IM119): Number of full time equivalent (FTE) hires of those who were CARE LEAVERS	£23,356.46	0			

Create new businesses, new jobs and new skills

Metric Name	Social Value	Achieved	Target	Comment	%
(IM19): Number of LOCAL full time equivalent (FTE) employment opportunities created	£280,129.04	7	12	New hires include Charlie Durrant, Assistant Site Manager	61%

Metric Name	Social Value	Achieved	Target	Comment	%
(IM34): Number of hours of mentoring received by mentee/s	£3,473.10	90			

Metric Name	Social Value	Achieved	Target	Comment	%
(IM35): Number of hours of mock interviews, CV writing support, and career advice received by beneficiaries.	£20,618.20	558			

Metric Name	Social Value	Achieved	Target	Comment	%
(IM38): Number of hours of health, safety and wellbeing training received by beneficiaries - such as employee inductions, tool box talks.	£10,935.35	276		Two safety stand downs led by David Langrish, and Diversity and Inclusion Training led by the DCH EDI lead Jan Wagner	

Metric Name	Social Value	Achieved	Target	Comment	%
(IM48): The value of contract opportunities awarded in £ spent to Small & Medium Enterprises (MSMEs)	£1,084,304.18	4,714,366	57600000		8.2%

Metric Name	Social Value	Achieved	Target	Comment	%
(IM51): Total spend with local businesses, expressed as a percentage of total spend		78.49%			

Metric Name	Social Value	Achieved	Target	Comment	%
(IM53): Total spend with Small & Medium Enterprises (MSMEs), expressed as a percentage of total spend		80.75%			

Increase supply chain resilience and capacity

Metric Name	Social Value	Achieved	Target	Comment	%
(IM45): The value of contract opportunities awarded in £ spent to LOCAL suppliers	£5,963,916.00	4,259,940	44800000		9.5%

Wellbeing

Metric Name	Social Value	Achieved	Target	Comment	%
(IM103): Number of employees trained as Mental Health First Aiders	£2,663.77	2		David Langrish and Phoebe Gale	

Metric Name	Social Value	Achieved	Target	Comment	%
(IM113): Donations (£) - Cash & Products	£15,475.50	7,738			

Metric Name	Social Value	Achieved	Target	Comment	%
(IM114): Donations (£) - Fundraising	£1,917.50	959		DCH Jurassic Challenge 2025, project team involvement raised £908.75	

Metric Name	Social Value	Achieved	Target	Comment	%
(IM106A): Number of hours spent on Educational Engagement activities	£5,128.92	149		Activities include 2 workshops delivered at the Compass Alternative Provider School in Weymouth, and STEM Skill workshops delivered to 22 children at St Mary's School in Dorchester	

Improve community integration

Metric Name	Social Value	Achieved	Target	Comment	%
(IM111): Number of hours spent on activities that demonstrate a collaborative way to work with businesses as part of the supply chain	£0.00	23			

Metric Name	Social Value	Achieved	Target	Comment	%
(IM109A): Number of hours spent by employees on volunteering schemes	£10,300.43	294	112		260%

Project Name	Social Value
BSO-P22- Emergency Department Dorset County Hospital(Dorchester)	£7,594,460.01

Arts in Hospital and Social Value

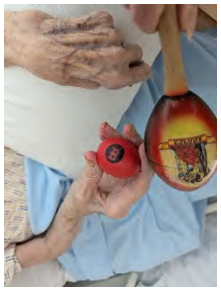
Arts in Hospital is continuing to contribute to and promote civic partnerships between DCH and our community, implementing local activities which promote the reduction of inequalities, increasing opportunities and improving health and wellbeing for all.

1. Our Art collection is a valued cultural resource, used by local schools and colleges to inform them of the use of Creative Health within the hospital environment. We recently gave a tour of the collection to 15 Weymouth College Fine Art degree students, one of which joined us to help hang our latest exhibition, *Biophilia*, gaining valuable curatorial experience. We also currently have a Thomas Hardye sixth form A level Art student here with us on work experience during Creativity and Wellbeing week, as well as a degree student as 'Artist in Residence' producing work for the discharge lounge. These opportunities give real life work experience for students, equipping them with skills for employment within the healthcare, creative, and creative health industries.

2. The *Biophilia* exhibition is a collaboration between with two community art organisations, *Dorset Visual Arts* and the *Arborealists*, adding to our cultural offer and supporting the artistic community through promoting and sharing their work as part of our temporary exhibition programme. All work displayed is for sale, including an economic benefit. In addition, we have a regular slot writing for local magazine, the *Sherborne Times,* where we promote our activity and share the importance of Creative Health.

3. We employ and commission local and regional artists to produce work and deliver workshops, engaging with community outreach where possible. Our most recent example is an Open Call to artists in the region to submit applications for a paid commission to produce work for SCBU. This is in collaboration with the Maiden Castle Sunflower Trail, long term supporters of DCH Charity.

4.One of our long-term collaborative projects is our partnership with Bournemouth Symphony Orchestra (BSO). We are working with them on a long-term plan to deliver activity across patient pathways and to focus on prevention within the wider community. As well as delivering interactive sessions on our acute site, they are also working in the Alderney (DHC) and plans are for them to perform in the Neighbourhood Hubs in the very near future.



5. Community intervention with our Creative Health Specialist working with patients with dementia and their families continues, reducing strain on staff, carers and increasing wellbeing. This includes recruiting and training volunteer ‘Creative Health Ambassadors’(CHA). Providing skills training and wellbeing benefits for members of the wider community. Our team of CHA is flourishing and contributing to our work experience for young people.

6. Our future project to work with Portland Prison and their learning facilitators is progressing, our aim being to engage another hard-to-reach demographic within Dorset. Through this project we hope to facilitate prisoner engagement with the arts, building bridges between prisoners and community, with a focus on the wellbeing of individuals and communities as well as potential economic benefits. We have engaged an artist of national significance, who is also an ex-prisoner, to work on this project, which we hope will begin in 2026. Artwork from this project will be exhibited within the hospital and hopefully tour DHC’s community hospitals. We are also working with an artist who has received Arts Council funding for engaging overseas staff on a national level to support their inclusion and wellbeing.

Suzy Rushbrook, DCH Arts in Hospital Manager June 2025

Social Value Activity Report

2024-2025

We are very pleased to publish our latest edition of the Dorset County Hospital Social Value Activity Report.

Dorset County Hospital is committed to maximising the positive social value impact we have on our local communities, contributing to improving the economic, social and environmental wellbeing of the local population.

The report highlights a few of the wide-ranging initiatives as part of the hospital's ongoing social value programme.

The Trust's Social Value Pledge is available on our website at www.dchft.nhs.uk/about-us/social-value

For more information about DCH's social value commitments and how you can contribute and make a difference, please contact Simon Pearson, Head of Charity and Social Value, at simon.pearson@dchft.nhs.uk

Our Social Value Pledge

NHS
Dorset County Hospital
NHS Foundation Trust

Volunteer Activities

Our Volunteer Activity team provide opportunities for patients to engage in activities which can lead to improvements in their own wellbeing and potentially help them to leave hospital sooner.
Activities include bingo, cooking, a game of cards or a friendly chat and we are lucky enough to have five Pets as Therapy dogs visiting patients.

The team launched a book trolley service and our volunteers have also been supporting the Arts in Hospital team to expand their creative health programme which uses art to improve patients' wellbeing.

Our Young Volunteer Programme is open to students over the age of 16 and is a fantastic way to support gain valuable experience. Many of our young volunteers go on to pursue a career in healthcare.

Improving Tumbledown Farm

Members of our Strategic Estates team joined staff from our building contractors Tilbury Douglas and Blanchard Wells Ltd to volunteer at Tumbledown Farm in Weymouth. The team helped to improve their raised bed area and make it more accessible for people with mobility issues.

Our Social Value Pledge

NHS
Dorset County Hospital
NHS Foundation Trust

Sustainability

Our Sustainability Team worked with local students and organisations to transform a neglected courtyard into a sensory garden so our patients, staff and visitors can take a moment away from the busy hospital environment. The £50K project was funded through the NHS Charities Together Greener Communities Fund.

Kingston Maurward College students designed the garden as part of their course - a great opportunity to put their learning into practice.

Plants were provided by the local Dobbies Garden Centre and LST Projects, who have refurbished our Ridgeway and Fortuneswell units. Their involvement was voluntary and was provided as a result of Social Value commitments made within our Trust Procurement process. It is a nice example of the circular nature of social value and the direct benefits it can bring to the Trust, its staff and wider users of the space.

The Centre for Sustainable Healthcare (CSH) has chosen us to be part of the national Healthy by Nature project. Funded by the National Lottery Community fund, a Nature Recovery Ranger will be based at DCH to help improve our spaces and deliver activities with local community groups for hospital patients and visitors who might otherwise have limited access to nature. Our programme of activities start in summer 2025.

The Trust achieved the NHS Clinical Waste Strategy targets of '60:20:20' for the first time, thanks largely to engagement by the Waste Co-ordinator and effective understanding and use of the correct waste streams across all areas by staff. This is anticipated to contribute to a 15% reduction of clinical waste by 2030 to the NHS overall, and significantly reduces carbon emissions from waste at DCH.

Our Social Value Pledge

NHS
Dorset County Hospital
NHS Foundation Trust

DCH Charity hits Emergency and Critical Care Appeal milestone

In May 2025, the Dorset County Hospital Charity announced it had raised £1.1M for its Emergency and Critical Care Appeal. Donations will fund equipment and facilities for the new Emergency Department and Critical Care Unit at DCH, which is currently under construction.

The total target for the appeal is £2.5M which will provide fund elements such as a new child and adolescent mental health suite, dedicated relatives' rooms, paediatric critical care bed space and equipment. Many local organisations, businesses and people are supporters of the appeal, helping to raise money.

Supporting carers

The Patient Experience team have been engaging with local people at various Primary Care Networks drop in and wellbeing events. They have been promoting the Carer's Passport for unpaid carers when their cared for person becomes an inpatient to ensure carers are identified and their rights observed and supported.

Widening participation and employability programmes

The Widening Participation team finished its fifth healthcare support worker scholarship in July 2024. The two-week programme includes an introduction to the care certificate, ward visits, clinical skills and values and employability sessions. They have supported 41 individuals into employment.

In the Spotlight: Supporting future talent

Jiya Nixon, a dedicated A-Level student from Thomas Hardye School, has long aspired to become a nurse, inspired by her mother's career in healthcare. Jiya participated in the Introduction to Nursing programme in February 2025, a decision that proved pivotal in shaping her future. Jiya has now secured a place on the Registered Nurse Degree Apprenticeship - a significant milestone in her journey toward becoming a nurse. Her journey illustrates the impact that structured work experience and employability programmes can have on young people.

Supported Internships

The Trust supported two cohorts of internship students in partnership with Weymouth College. 66% gained employment following their placement at DCH. We are also offering placements to a second education provider in the area, the Southwest Regional Assessment Centre, to help young people with a special educational need or disability gain valuable experience in a workplace.

Apprentice Awards

Over 200 staff are undertaking apprenticeships across a wide range of roles and levels at local and regional colleges and universities. The Apprenticeship Team held a special awards ceremony in February 2025. The awards recognised individuals hard work and commitment, and helps promote apprenticeship opportunities at DCH.

English and Maths

Our functional skills offering has now evolved to include virtual learning so we can support even more staff at DCH. The first staff members are now starting to undertake and pass their exams. We are also working together with Dorset HealthCare to provide places for their staff in our classes at DCH with individuals signed up to both courses.

T Levels

We commenced our first Health T Level industry placement with Weymouth College. Students spend time on the wards as part of their course.

Arts in Hospital

Arts in Hospital is continuing to contribute to and promote civic partnerships between DCH and our community, implementing local activities which promote the reduction of inequalities, increasing opportunities and improving health and wellbeing for all.

Our Art collection is a valued cultural resource, used by local schools and colleges . The team has also offered work experience opportunities and welcomed a degree student as 'Artist in Residence' These opportunities give real life work experience for students, equipping them with skills for employment

As part of our temporary exhibition programme, Biophilia is a collaboration between Dorset Visual Arts and the Arborealists. We are promoting and sharing their work, which is displayed is for sale, benefitting the local economy.

The team has partnered with Bournemouth Symphony Orchestra (BSO). We are working with them on a long-term plan to deliver activity across patient pathways and to focus on prevention within the wider community.

A Creative Health Specialist has been working with patients with dementia and their families , reducing strain on staff, carers and increasing wellbeing. This includes recruiting and training volunteer Creative Health Ambassadors, providing skills training and wellbeing benefits for members of the wider community.

Report to	DCH Board of Directors	
Date of Meeting	12th August 2025	
Report Title	National Cost Collection Post-Submission Report	
Prepared By	Chris Badminton, Head of Income and Costing DHC; Fred Day, Head of Income and Costing DCH	
Approved by Accountable Executive	Chris Hearn, Chief Financial Officer	
Previously Considered By	Finance and Performance Committee in Common, 30/07/2025	
Action Required	**Approval**	Y
	Assurance	N
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	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 submit an annual National Cost Collection we break the terms of our Provider Licence.*	
Financial	As above	
Statutory & Regulatory	Statutory Requirement	
Equality, Diversity & Inclusion	No Implication	
Co-production & Partnership	Yes linked to federated working	

Executive Summary

The National Cost Collection (NCC) is an NHS England annual requirement. All NHS Trusts are required to submit actual costs for care delivered at patient level, as detailed in the Approved Costing Guidance publication.

The Costing teams from both Dorset HealthCare (DHC) and Dorset County Hospital (DCH) are responsible for submitting the NHSE mandated NCC on behalf of their respective organisations.

A pre-submission report was shared with FPC and board on 29th May detailing the timeline and process for the 2024-25 collection in line with Approved Costing Guidance. The next stage of this process is a final report confirming adherence to the Approved Costing Guidance and signed-off submission of the National Cost Collection.

For the 2024-25 collection both Trusts followed the Approved Costing Guidance in calculation of their respective submissions, noting the following:

- All data validations have been reviewed and verified
- Activity has been reconciled to national datasets
- Financial quantum's have been reconciled to the final audited accounts
- All minimum standards in the costing guidance have been delivered, recognising appendix 1 highlights areas where each organisation has identified improvements beyond the minimum standard for subsequent submissions.

The Chief Finance Officer (CFO) reviewed both submissions on the 25th June 2025 and they were agreed and successfully submitted to NHSE ahead of the 4th July 2025 deadline.

Recognising both Trusts have followed the Approved Costing Guidance and with sign-off from the CFO, this paper confirms the process was followed to successfully submit the NCC submission. It is recommended the Committee approve the 2024-25 NCC submissions for both organisations, ahead of approval at the respective Trust boards on 12th August (DCH) & 13th August (DHC).

Recommendation

Board are requested to:

- **Approve** the National Cost Collection submission for 2024-25 for DCH

National Cost Collection Post-Submission Report

1. Executive Summary

1.1. The Finance and Performance Committee in Common is asked to review and approve the National Cost Collections for Dorset HealthCare and Dorset County hospital for 2024-25 ahead of board final approval.

1.2. The data collected is the source data for work by the Model Health System. Therefore, the board assurance process has been updated to reflect the importance of cost submissions and raise the profile of costing across the organisations, especially at a senior level.

1.3. The Approved Costing Guidance requires an increased level of board assurance. This is the second of two reports taken to the Finance and Performance Committee in Common on the process for producing the National Cost Collection, required under the NHS Provider Licence. The first report updated the Committee on the plan for completing the submission.

1.4. This final report confirms the plan in the pre-submission report was followed and that the submissions were made adhering to the Approved Costing Guidance.

2. Introduction

2.1. The National Cost Collection is an NHS England annual requirement for all NHS Trusts to submit actual costs for care delivered at patient level.

2.2. The Chief Financial Officer is the executive lead sponsor for all work undertaken by the Costing Teams. The CFO is included in the submission for validation and sign-off purposes.

2.3. The 2024-25 collection covers the financial period 1st April 2024 – 31st March 2025.

2.4. The collection period for this year's National Cost Collection runs from the 9th of June 2025 until 4th July 2025 and submissions were sent on time.

3. Main narrative

3.1. The Committee is asked to note:

a. The costing submission has been completed in line with the Approved Costing Guidance:
   3.1.a.1. All data validation engine (DVE) failures and warnings have been reviewed and verified.
   3.1.a.2. The information included in the submission – both cost and activity – is being reviewed and verified with services and has been reconciled on the submission of activity to national datasets.
   3.1.a.3. The quantum of costs has been reconciled to the audited financial accounts and other exclusions have been verified with NHS England.

3.2. Appendix 1 includes a summary of improvements we have identified for future collections, and we will bring an update to this Committee on progress against these requirements in the pre-submission report for the 2025-26 National Cost Collection.

4. Conclusion

4.1. The Board is being asked to approve this report

5. Recommendations

5.1. The Board / Committee is recommended to:

a. Approve the process in place as sufficient to provide assurance to the board on the plan to complete the mandated costing submissions for 2024/2025.

Name and Title of Author: Chris Badminton & Fred Day
Date: 16th July 2025

6. Appendices

6.1. Appendix 1 - Areas where the Trusts can improve upon quality of National Cost Collection

Trust	Costing Standard	Issue	Raised with NHS England	Actions this year	Plan for future submissions
DHC	Mental Health & Community Services	Mental Health Provider Spells, Mental	No	a) Develop the implementation of currencies into the national datasets.	a) Monitor development in national datasets and where data isn't collected as

		Health Care Contacts, IAPT and Community Health Services currencies were mandated for 2025, which meant that a currency had to be assigned to each patient activity for these services. This was not done in the way prescribed due to the MHSDS and CDS not having this data populated.			prescribed then continue to use default coding.
DHC	Exclusions	There are four services which we request for exclusion from the submission each year due to absence of patient level activity data, these are – Veterans, Retreats and Community Front Rooms,	No	a) Wheelchairs is now a mandated dataset so this will be imminently made available for costing. b) Veterans is collected on AWP's EHR instance, so I will be	A) Wheelchairs and Veterans to be included and fully costed for next submission. B) MedTOP, Retreats and CFR's will be understood and a plan in place to

		Wheelchairs and Medical Termination of Pregnancy.		progressing a link or manual dataset. c) Unclear on how we progress the other two datasets at this point, due to the way they are collected in source systems.	address for future returns.
DCH	Acute	The costing standard for allocation of nonpay consumables is based on an average cost across all patients within a speciality. With the introduction of the Inventory Management System (IMS) in procurement, nonpay consumables are now listed at patient level for certain services.		a) Identify and reconcile patient level consumable reports to the finance ledger. b) Implement patient level allocation of nonpay consumables within the cost model.	a) Implement patient level consumable allocations for all areas where IMS is recording this data.
DCH & DHC	Integrated	Allocations within the cost model are agreed with services on an ad hoc basis.		a) Develop a combined allocation sign-off template for use within the Trusts.	a) Begin roll-out of allocation sign-off process for 2025-26. b) Embedded roll-out

		Implementation of a formal sign-off for allocations will increase accuracy and devolve ownership to services.		b) Develop a combined sign-off process for use within the Trusts.	across the Trusts for the 2026-27 collection.