

Board of Directors in Common Part 1

~ 09/11/2025

Tue 09 December 2025, 09:30 - 15:10

Training Room 1&2, Sentinel House, Poole, and via MS Teams

Agenda

- 09:30 - 09:50
20 min

1. Staff Story
Presentation
- 09:50 - 10:00
10 min

2. Formalities
 - Agenda BoD in Common - Part 1 - December 2025.pdf (4 pages)
 - 2b Declarations of interest.pdf (2 pages)
 - 2bi DHC Minutes ~ BoD Part 1 13 August JH.pdf (19 pages)
 - 2bii BoDiC Minutes Part 1 07 10 25 - DCS.pdf (23 pages)
 - 2c BoDiC Action Tracker - Part 1 Dec 25.pdf (2 pages)
- 10:00 - 10:05
5 min

3. Chair's Comments
Verbal
- 10:05 - 10:15
10 min

4. CEO Report
 - 4. CEO Report Dec 2025 Final.pdf (7 pages)
- 10:15 - 10:25
10 min

5. Board Assurance Framework and Risk Appetite Statement Review
 - 5a DHC Board Assurance Framework Q2 Board Dec 25 and Appendix.pdf (16 pages)
 - 5b DCH Board Assurance Framework Q2 Board Dec 25.pdf (3 pages)
 - 5b Appendix A BAF DCH Q2 DCH Board Dec 25.pdf (13 pages)
 - 5c. Risk Appetite Statements Board 9 December 2025.pdf (11 pages)
- 10:25 - 10:35
10 min

6. Corporate Risk Register
 - 6a. DHC Risk Report updated Nov 2025 revised final.pdf (11 pages)
 - 6ai. Risks 15+ 19.11.2025.pdf (3 pages)
 - 6bi DCH Corporate Risk Register Front Sheet Nov 25.pdf (4 pages)
 - 6bii DCH Corporate Risks Quarter 2 15 and above Final.pdf (14 pages)
- 10:35 - 10:45
10 min

7. Quality Committee Assurance Report
 - 7.1 Assurance Report QCIC November 2025 EJ.pdf (5 pages)
- 10:45 - 10:55
10 min

8. Maternity Safety Report
 - 7.2a front sheet Maternity Neonatal Report November 2025 Board.pdf (2 pages)
 - 7.2b Maternity neonatal safety quality report Sept and October Trust Board 2025.pdf (20 pages)
- 10:55 - 11:10
15 min

9. Annual Safe Staffing Report
 - 7.3a DHC Mental Health Inpatient Annual Safe Staffing Review.pdf (46 pages)

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- 7.3ai DHC Community Hospital Inpatient Annual Establishment Review.pdf (37 pages)
- 7.3b Front sheet DCH Safe Staffing Annual Report November 2025.pdf (2 pages)
- 7.3bi DCH Annual Safe Staffing Report Nov 2025 Final.pdf (13 pages)

11:10 - 11:20 10. Learning From Deaths Report

10 min

- 7.4a DHC Learning from Deaths Report - Q2 2025-26.pdf (13 pages)
- 7.4b DCH 25-26 Q2 Learning from Deaths Report.pdf (17 pages)

11:20 - 11:30 11. Complaints Annual Report

10 min

- 7.5a DHC Patient Experience Annual Report 202425.pdf (13 pages)
- 7.5ai DHC Complaints and PALS Annual Report 2024-25.pdf (21 pages)
- 7.5b DCH Front Sheet Patient Experience ANNUAL REPORT 2425.pdf (3 pages)
- 7.5bi DCH 202425 Patient Experience Annual Report.pdf (31 pages)

11:30 - 11:40 Coffee Break

10 min

11:40 - 11:50 12. Finance and Performance Committee Assurance Report

10 min

- 8.1 Assurance Report November 2025 FPCIC V3.pdf (5 pages)

11:50 - 12:05 13. Integrated Performance Report

15 min

- 8.2a DHC ICD - Dec 25 (Oct data).pdf (76 pages)
- 8.2ai DHC ICD Appendix - ICS Oct 2025 Final.pdf (1 pages)
- 8.2aii DHC ICD Appendix - CYP MHLN Nov_25 (Oct_25 data).pdf (2 pages)
- 8.2b DCH Integrated Board performance report December 2025.pdf (23 pages)

12:05 - 12:20 14. Finance Reports

15 min

- 8.3a DHC Finance Report Month 7 October 2025 FPC.pdf (21 pages)
- 8.3b DCH Finance Report.pdf (3 pages)
- 8.3bi DCH Finance Report M7.pdf (13 pages)

12:20 - 12:30 15. People and Culture Committee Assurance Report

10 min

- 9.1 PCCIC November 25 Assurance Report.pdf (5 pages)

12:30 - 12:40 16. Freedom to Speak Up Report

10 min

- 9.2a. DHC FTSU Quarter 12 November 2025 Final.pdf (18 pages)
- 9.2b. DCH FTSU Quarter 12 November 2025 Final.pdf (9 pages)

12:40 - 12:50 17. Annual GMC National Training Survey Results and Action Plan

10 min

- 9.3a DHC GMC survey results and action plan 2025 for Board 09-12-2025.pdf (5 pages)
- 9.3b DCH GMC Survey for Board Front Sheet Nov 25.pdf (2 pages)
- 9.3bi DCH 2025 GMC for Board 2025.pdf (27 pages)

12:50 - 14:00 Lunch Break

70 min

14:00 - 14:10 18. Strategy, Transformation and Partnership Committee Assurance Report

10 min

- 10.1 Assurance Report November 2025 STPCIC.pdf (4 pages)

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14:10 - 14:25 19. Digital Strategy

15 min

- 📄 10.2a Our Dorset Digital Strategy Front Sheet.pdf (1 pages)
- 📄 10.2b Our Dorset Digital Strategy 2025.pdf (37 pages)

14:25 - 14:35 20. Advanced Foundation Trust Update

10 min

- 📄 10.3 DHC Board Advanced Foundation Trust Board Dec 25.pdf (4 pages)

14:35 - 14:45 21. Audit Committee Assurance Reports

10 min

- 📄 11.1a DHC Audit Committee Assurance Report November 2025.pdf (3 pages)
- 📄 11.1b Assurance Report DCH Audit Committee 01 December 2025.pdf (3 pages)

14:45 - 14:55 22. Mental Health Legislation Committee in Common Assurance Report

10 min

- 📄 11.2 Assurance Report November 2025 MHLIC v3.pdf (2 pages)

14:55 - 15:05 23. Scheme of Delegation

10 min

- 📄 11.3a Board Front Sheet Scheme of Delegation - DHC.pdf (3 pages)
- 📄 11.3b Scheme of Delegation DHC Final Draft.pdf (29 pages)
- 📄 11.3c Scheme of Delegation and Reservation of Powers to the Board.pdf (5 pages)

15:05 - 15:05 24. Consent Section

0 min

24.1. Quarterly Guardian of Safe Working Report

- 📄 12.1a DHC GOSW Report Q2 25-26 for Board 09-12-2025.pdf (4 pages)
- 📄 12.1b DCH GoSW Board Report Q2.pdf (5 pages)

24.2. Emergency Planning, Response and Resilience

- 📄 12.2a DHC Trust Board EPRR Annual Report - Dec 2025.pdf (20 pages)
- 📄 12.2b DCH EPRR ICB Review Outcome November 2025.pdf (1 pages)
- 📄 12.2bi ICB to DCH Outcome Letter 2025.pdf (4 pages)

24.3. Provider Capability Assessment

- 📄 12.3a DHC Board Confirmed Provider Capability Assessment Final Dec 25.pdf (16 pages)
- 📄 12.3b DCH Board Confirmed Provider Capability Assessment Report Dec 25.pdf (15 pages)

24.4. DCH SubCo Ltd Assurance and Performance Report

- 📄 12.4b DCH SubCo Assurance Report 03 11 2025.pdf (1 pages)
- 📄 12.4a DCH SubCo Performance Report Oct 2025 v2.pdf (4 pages)

24.5. Charitable Funds Committee Assurance Report

- 📄 12.5 Assurance Report - DCH Charitable Funds Committee (18.11.25).pdf (2 pages)

24.6. Mental Health Act Panel Member Re-Approval

- 📄 12.6 MHA panel member re-approval for MHLIC - Nov 2025.pdf (3 pages)

24.7. Mental Health Legislation Committee in Common Terms of Reference

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 12.7 MHLIC Terms of Reference.pdf (9 pages)

24.8. Review of Memorandum of Understanding

 12.8a MOU Review Front Sheet Board Dec 25.pdf (2 pages)

 12.8b MoU Final Dec 25 Board.pdf (7 pages)

15:05 - 15:10 **25. Questions from the Public**
5 min

15:10 - 15:10 **26. Any Other Business**
0 min

**Meeting of the Boards of Directors (Part 1) of
Dorset County Hospital NHS Foundation Trust
and
Dorset HealthCare University NHS Foundation Trust
Tuesday 09 December 2025 at 9.30am to 3.10pm
Training room 1&2, Sentinel House, Poole and via MS Teams**

AGENDA

Ref	Item	Trust	Format	Lead	Purpose	Timing
1.	Staff Story • Presentation • Comment & Questions	DCH	Presentation	Dawn Dawson (Paul Lewis)	Information	9:30-9:40 9:40-9:50
2.	FORMALITIES to declare the meeting open.		Verbal	David Clayton-Smith Trust Chair	Information	9:50-10:00
	a) Apologies for Absence	Joint	Verbal	David Clayton-Smith	Information	
	b) Conflicts of Interests	Joint	Verbal	David Clayton-Smith	Information	
	c) Minutes of the Meeting: • 13 August 2025 (DHC) • 07 October 2025 (Joint)	Joint	Enclosure	David Clayton-Smith	Approve	
	d) Matters Arising: Action Log	Joint	Enclosure	David Clayton-Smith	Approve	
	e) Board workplan	Joint	Enclosure	David Clayton-Smith	Information	
3.	Chair's Comments	Joint	Verbal	David Clayton-Smith	Information	10:00-10:05
4.	CEO Report	Joint	Enclosure	Dawn Dawson	Information	10:05-10:15
5.	Board Assurance Framework (BAF) • DHC BAF • DCH BAF And Risk Appetite Statement Review • DHC Statement • DCH Statement (Dec/Nov Audit Committees)	DHC DCH DHC DCH	Enclosure	Jenny Horrabin	Assurance Approval	10:15-10:25
6.	Corporate Risk Register • DHC Risk Register • DCH Risk Register (Dec/Nov Audit Committees)	DHC DCH	Enclosure	Dawn Dawson	Assurance	10:25-10:35
7.	Quality					
7.1.	Quality Committee Assurance Report	Joint	Enclosure	Eiri Jones	Assurance	10:35-10:45
7.2.	Maternity Safety Report (November QC)	DCH	Enclosure	Dawn Dawson (Jo Hartley)	Assurance	10:45-10:55
7.3.	Annual Safe Staffing Report • DHC - Mental Health • DHC - Community • DCH - Acute	DHC DHC DCH	Enclosure	Dawn Dawson	Approval	10:55-11:10



Healthier lives



Empowered citizens



Thriving communities

	(November QC)					
7.4.	Learning from Deaths Report • DHC LFD Q2 • DCH LFD Q2 (November QC)	DHC DCH	Enclosure	Lucy Knight Rachel Wharton	Approval	11:10-11:20
7.5.	Complaints Annual Report • DHC Patient Experience Report • DHC Complaints Report • DCH Patient Experience and Complaints Report (November QC)	DHC DHC DCH	Enclosure	Dawn Dawson	Approval	11:20-11:30
Coffee Break 11:30-11:40						
8.	Finance and Performance					
8.1.	Finance and Performance Committee Assurance Report	Joint	Enclosure	Dave Underwood	Assurance	11:40-11:50
8.2.	Integrated Performance Report • DHC Report • DCH Report	DHC DCH	Enclosure	Chris Hearn Anita Thomas	Assurance	11:50-12:05
8.3.	Finance • DHC Finance Report • DCH Finance Report (November FPC)	DHC DCH	Enclosure	Chris Hearn	Assurance	12:05-12:20
9.	People and Culture					
9.1.	People and Culture Committee Assurance Report	Joint	Enclosure	Frances West	Assurance	12:20-12:30
9.2.	Freedom to Speak Up Report • DHC Report • DCH Report (November PCC)	DHC DCH	Enclosure	Nicola Plumb (Anne Hiscock) (Lynn Paterson)	Assurance	12:30-12:40
9.3.	Annual GMC National Training Survey Results and Action Plan • DHC Report • DCH Report (November PCC)	DHC DCH	Enclosure	Rachel Wharton Lucy Knight	Assurance	12:40-12:50
Lunch Break 12:50-14:00						
10.	Strategy, Transformation and Partnership					
10.1.	Strategy, Transformation and Partnership Committee Assurance Report	Joint	Enclosure	David Clayton-Smith	Assurance	14:00-14:10
10.2.	Digital Strategy (November STP)	Joint	Enclosure	Beverly Bryant	Approval	14:10-14:25
10.3.	Advanced Foundation Trust Update	DHC	Enclosure	Jenny Horrabin	Assurance	14:25-14:35
11.	Audit and Governance					
11.1.	Audit Committee		Enclosure		Assurance	14:35-14:45

	- DHC Assurance Report - DCH Assurance Report	DHC DCH		Steve Peacock Stuart Parsons		
11.2.	Mental Health Legislation Committee in Common Assurance Report	Joint	Enclosure	Andreas Haimbock-Tichy	Assurance	14:45-14:55
11.3.	Scheme of Delegation (DHC November Audit Committee)	DHC	Enclosure	Jenny Horrabin	Approval	14:55-15:05
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.	Quarterly Guardian of Safe Working Report - DHC GOSW - DCH GOSW (November PCC)	DHC DCH	Enclosure	Lucy Knight Rachel Wharton	Assurance	
12.2.	Emergency Planning, Response and Resilience: - DHC Annual Assurance Report - DCH ICB Outcome Letter (November FPC)	DHC DCH	Enclosure	Rachel Small Anita Thomas	Assurance	
12.3.	Provider Capability Assessment	DHC DCH	Enclosure	Jenny Horrabin	Information	
12.4.	DCH SubCo Ltd Assurance and Performance Report (November FPC)	DCH	Enclosure	Anita Thomas	Assurance	
12.5.	Charitable Funds Committee Assurance Report	DCH	Enclosure	Dave Underwood	Assurance	
12.6.	Mental Health Act Panel Member Re-approval (November MHLIC)	DHC	Enclosure	Lucy Knight	Approval	
12.7.	Mental Health Legislation Committee in Common Terms of Reference (December MHLIC)	DHC DCH	Enclosure	Jenny Horrabin	Approval	
12.8.	Review of Memorandum of Understanding (November STPC)	Joint	Enclosure	Jenny Horrabin	Approval	
13.	Questions from the Public	All	Verbal	David Clayton-Smith		15:05-15:10
	In addition to being able to ask questions about discussion at the meeting, members of the public are also able to submit any other questions they may have about the trust in advance of the meeting to Abigail.baker@dchft.nhs.uk or jim.bailey2@nhs.net					
14.	Any Other Business Nil notified	All	Verbal	David Clayton-Smith	Information	15:10
15.	Date and Time of Next Meeting					
	The next part one (public) Boards of Directors' meeting of Dorset County Hospital NHS Foundation Trust and Dorset HealthCare University NHS Foundation Trust will take place at 9.30am on Tuesday 10 February 2026 in venue to be confirmed.					
	Resolution Regarding Press, Public and Others:					

To agree, as permitted by the National Health Service Act 2006 (as amended), the Trust's Constitution and the Standing Orders of the Board of Directors, that representatives of the press, members of the public and others not invited to attend to the next part of the meeting be excluded due to the confidential nature of the business to be transacted.

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

Quorum:

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

Voting rights:

The Board of Directors is to comprise:

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

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

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

Part 2 Items

- Chair's Comments
- CEO Update
- Medium-Term Financial Plan
- Technology Roadmap
- Consent Section:
 - o One Dorset Provider Collaborative Minutes
 - o Successful Bids Report
 - o Fortrus Contract Re-set
 - o Extension of Internal Auditors
 - o Key Worker Housing

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04/12/2025 09:14:16

					Type of Interest				Date of Interest	
First Name	Surname	Trust	Current Position Held	Declared Interest (Name of the Organisation and nature of the business)	Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest	Indirect	Declared	Date to
David	Clayton-Smith	Joint	Joint Trust Chair	Role is a joint role with Dorset HealthCare and Dorset County Hospital NHS Foundation Trust Chair		✓			11/03/2025	Current
				Unity Insights Ltd, Director and Chair		✓			11/03/2025	Current
				National Centre for Creative Health		✓			11/03/2025	Current
Matthew	Bryant	Joint	Joint Chief Executive Officer	Role is a joint role with Dorset HealthCare and Dorset County Hospital NHS Foundation Trust		✓			28/02/2025	Current
				Member of Dorset Integrated Care Board (Mental Health Partner Representative).		✓			28/02/2025	Current
				Trustee, NHS Providers		✓			28/02/2025	Current
Dawn	Dawson	Joint	Joint Chief Nursing Officer and Deputy CEO for Dorset HealthCare	Role is a joint role with Dorset HealthCare and Dorset County Hospital NHS Foundation Trust		✓			27/02/2025	Current
				Son is a sales representative for Stryker IVS South & Southwest				✓	27/02/2025	Current
				Daughter is Associate Director of People & Transformation in NHS Somerset				✓	27/02/2025	Current
				Daughter in law is Assistant Divisional Management Accountant at Royal Devon and Exeter NHS Foundation Trust				✓	27/02/2025	Current
				Son in law is a registered nurse degree apprentice in Dorset Healthcare				✓	27/02/2025	Current
Chris	Hearn	Joint	Joint Chief Finance Officer	Role is a joint role with Dorset HealthCare and Dorset County Hospital NHS Foundation Trust		✓			04/03/2025	Current
Jenny	Horrabin	Joint	Joint Executive Director of Corporate Affairs	Role is a joint role with Dorset HealthCare and Dorset County Hospital NHS Foundation Trust		✓			24/02/2025	Current
				Trustee – Coventry Sports Foundation			✓		24/02/2025	Current
				Independent Audit Committee Member - Citizen Housing	✓				24/02/2025	Current
Nicola	Plumb	Joint	Joint Chief People Officer	Role is a joint role with Dorset HealthCare and Dorset County Hospital NHS Foundation Trust		✓			17/04/2025	Current
Anita	Thomas	Dorset County Hospital	Chief Operating Officer	Director at DCH Pharmacy SubCo Ltd		✓			05/09/2025	Current
Rachel	Wharton	Dorset County Hospital	Chief Medical Officer	Nil					03/02/2025	Current
Lucy	Knight	Dorset HealthCare	Chief Medical Officer	Nil					25/03/2025	Current
Rachel	Small	Dorset HealthCare	Chief Operating Officer	Magistrate in HM Courts and Tribunals Service			✓		25/03/2025	Current
				Sister-in-Law works as a district nurse in Bournemouth team				✓	25/03/2025	Current
Eiri	Jones	Joint	Joint Non-Executive Director	Role is a joint role with Dorset HealthCare and Dorset County Hospital NHS Foundation Trust		✓			16/04/2025	Current
				Non-Executive Director at Salisbury NHS Foundation Trust	✓				16/04/2025	01/07/2025
				Interim Chair at Salisbury NHS Foundation Trust	✓				01/07/2025	Current
Claire	Lehman	Joint	Joint Non-Executive Director	Role is a joint role with Dorset HealthCare and Dorset County Hospital NHS Foundation Trust		✓			18/05/2025	Current
				Non-Executive Director at Southwest Ambulance	✓				25/03/2025	Current
				Non-Executive Director at Great Western Hospital Advocacy for Parkinson's Disease	✓			✓	25/03/2025	30/04/2025 Current
Dave	Underwood	Joint	Joint Non-Executive Director	Role is a joint role with Dorset HealthCare and Dorset County Hospital NHS Foundation Trust		✓			25/03/2025	Current
				Chair of Royal British Legion Club West Hill Ltd Registered IP23677R on the FCA Mutuals Public Register			✓		25/03/2025	Current
				Policy Board member of the SW Business Council - The economic partnership for the South West of the UK			✓		25/03/2025	Current
				Member of the University of Exeter Digital Advisory Network			✓		25/03/2025	Current
Frances	West	Joint	Joint Non-Executive Director	Role is a joint role with Dorset HealthCare and Dorset County Hospital NHS Foundation Trust		✓			11/03/2025	Current
				Non-Executive Director - Westward Housing Group	✓				11/03/2025	Current
Margaret	Blankson	Dorset County Hospital	Non-Executive Director	Nil					04/03/2025	Current
Stuart	Parsons	Dorset County Hospital	Non-Executive Director	Nil					27/02/2025	Current

First Name	Surname	Trust	Current Position Held	Declared Interest (Name of the Organisation and nature of the business)	Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest	Indirect	Declared	Date to
Stephen	Tilton	Dorset County Hospital	Non-Executive Director	Director and Chairman of DCH Pharmacy SubCo Ltd		✓			05/04/2025	Current
Suresh	Ariaratnam	Dorset HealthCare	Non-Executive Director	Director, Sprung Sultan	✓				24/03/2025	Current
				Director, Norland College			✓		24/03/2025	Current
				Non-Executive Director, NHS Somerset	✓				24/03/2025	Current
				Trustee, Trussell			✓		24/03/2025	Current
				Honorary Fellow, Royal Society of Literature			✓		24/03/2025	Current
				Member, Advisory Council of The British Library			✓		24/03/2025	Current
				Trustee, Literature Works South West			✓		24/03/2025	Current
				Deputy Lieutenant, Somerset Lieutenancy			✓		24/03/2025	Current
Andreas	Haimböeck-Tichy	Dorset HealthCare	Non-Executive Director	Director, Harbour View (Swanage) Management Company Ltd	✓				25/03/2025	Current
				Managing Director and shareholder of Accenture Plc	✓				25/03/2025	Current
				Wife is HR Director for DJO Ltd, a Medical Device Company				✓	25/03/2025	13/08/2025
				Wife is HR Director for ThermoFisher Scientific				✓	07/09/2025	Current
Steven	Peacock	Dorset HealthCare	Non-Executive Director	Chief Finance Officer at National Trust	✓				01/02/2025	Current

Definitions

Category	Description	Example
Financial interests	Where the individual may gain direct financial benefit from a decision (through financial gain or the avoidance of financial loss) or where an individual is in receipt of regular payment (salary or allowance) from an organisation. An unpaid role for which reimbursement of costs such as travel would not necessarily qualify as a financial interest.	Outside paid employment
Non-financial professional interests	Where there is no financial gain but there is a professional interest to the organisation. This will generally be the case where the business of the organisation is in the same or similar sector to the individual's profession(s), or where the individual could gain professionally or reputationally as a result of a decision that may be made.	Unpaid appointment to a body which is within the same or similar sector
Non-financial personal interests	Where there is no financial gain and no relationship to the individual's profession(s). An interest may have the potential for the organisation in which the individual has a personal interest to gain from a decision, or where the individual could gain personally.	Unpaid appointment to a body which has no link to the individual's professional role
Indirect interests	Where the individual does not have a relationship with the named organisation, but where a person who they have a close relationship with does have such a relationship and that person could gain from a decision that is made.	Close friend in paid employment of another organisation within the same or similar sector

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

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

BoD25/088	Patient Story	Action
Setchell, Ryan 04/12/2025 09:14:16	The Board received the patient story introduced by DD. The patient story related to a patient's experience with the Dermatology service. It centred around the waiting times to access the service from referral, and the lack of information provided, which led to a lack of confidence with the service.	
	Service Lead advised that there are improvements that the team are working on. The dermatology team agreed they could do more about advising patients regarding waiting times if patients are concerned. They are also developing a new website to look at how we provide more information regarding where patients could be directed. We have committed to work with the patient to review the letters, and to have an open partnership with patients, to be open about waiting times and offer support. We agreed to look at the service as a whole and look to give the best services to patient with the resource that we have available. We will pick up the communication issues and look at other areas where we have	



	long waits, to make sure people were supported properly and were kept informed. The patient did reflect that if the patients were seen, or Artificial Intelligence (AI) was used, they may not need to be seen again after the first consultation. If patients were triaged in primary care, the hospital could then concentrate on seeing those patients that needed to be seen. Patient did advise he had been referred to the service again in November 2024 and again had heard nothing since. However, his wife had been referred to dermatology had a different experience and had been seen quickly. FW stated that it resonated with her that patients are going to appointments that they may not necessarily need, because they are worried about how long it will take to get back into the system if they do not. DU added that how we are communicating with patients was causing uncertainty. We needed to think about the process before implementing anything as a technical solution. SP thanked colleagues for sharing a story where we have not got things right, it felt like time mattered for the patient and that SP had reflected on the visible and invisible quality of care. EJ noted that we provide a service, and it is how we support staff to provide good 'customer care' and this was evident in the Dash report, experience is important. It is an area that we should focus on. ACTION: RS to provide an update on waiting lists and the development of correspondence at the next Board.	RS
	Resolved: that the Patient Story be heard and noted.	
BoD25/089	Meeting open	
	The Chair welcomed members to the meeting. DCS highlighted that this was NJ's last Board meeting with DHC as he would be leaving the Trust at the end of the month to become Managing Director at Salisbury NHS Foundation Trust. DCS thanked NJ for his work over the years at DCH, in his many roles, including acting as CEO at Dorset County Hospital NHS Foundation Trust (DHC) for a period.	
BoD25/090	Apologies	
	Apologies were received from Nicola Plumb, Joint Chief People Officer (Catherine Granville in attendance) and Claire Lehman, Joint Non-Executive Director.	
BoD25/091	Conflicts of interest	
Setchell, Ryan 04/12/2025 09:14:16	It was confirmed that there were no declarations of interest relating to the items for consideration at the meeting. The register of interest included in the paper was highlighted; EJ noted that she was the Interim Chair of Salisbury NHS Foundation Trust from 1st July 2025. FW and SP's, DU's interest also needed to be amended. However it was confirmed that there were no conflicts related to agenda items today.	

BoD25/092	Minutes of the Meeting held on 11 June 2025	
	The minutes of the meeting dated 11 June 2025 were agreed as an accurate record.	
BoD25/093	Matters Arising: Action Log	
	<u>Action 52</u> - noted this action dated back to August 2024. The Digital Strategy will be prepared for November, which will include the fully costed and deliverable plan to the end of March 2026. Regular updates are provided via the Strategy Transformation and Partnership Committee (STP). Proposal to review the action in November when we have the digital strategy to review to ensure it addresses what we are expecting it to address. SP commented on the delay and AHT asked if November was realistic. MBr advised that part of the reason for the delay was the senior digital leadership focus on the EHR business case. To support delivery Beverley Bryant (BB), Joint Chief Digital Officer, is in the process of putting her senior team in place. NJ confirmed that this had been discussed at STP Committee, and the strategy was in development and had been co-produced across the system. JeH noted that a report on the development of the strategy had been reported STP Committee in May 2025. FW advised that BB had offered to come and speak to the People and Culture Committee (PCC) about the availability of resources, which is demonstrating the matrix working now in place. ACTION: JeH to circulate the paper on the development of the Digital Strategy that had been presented to the May STP Committee to Board Members. <u>Action 63</u> – not yet due. This has been moved to December as that is when the next FTSU report is scheduled. <u>Action 67</u>- This action related to an internal audit review of system governance. It had been escalated to DCS and MBr to meet with SP to agree required steps. DCS advised that the ICB were currently undergoing a reorganisation. Action to remain open. <u>Action 68</u> – Terms of reference for MHALAC had been circulated – Agreed to be closed Two additional actions had been referred to other Committees, both of which had been completed. Actions to be closed. The Business Calendar had been shared for information. SP added that it was very helpful to see it laid out in that format and suggested asking the Staff Networks to present when a staff story was considered.	JeH

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	DD noted that there was a broader point around how we increase the time that the Board can spend with those staff network chairs. It was noted that the Staff Network Conference is to be held in Swanage, on 5 September, which would be a fantastic opportunity for the Board to spend some time with those groups. ACTION: Invite to event to be shared with Board members.	JeH / Jan Wagner
	Resolved: that the action log be received, updates noted, and approval be given for the removal of completed actions.	
BoD25/094	Chair's Comments	
	The board received a verbal update which included the following highlights: • The Trust was compliant with the Fit and Proper person test (FPPT) submissions which have all been completed. • NED appraisals are nearly all completed. • Visits to services including: • Children's Hospice, Julia's House • Herm ward with the Bournemouth Symphony Orchestra • Several Quality Walkarounds • Working with the system partners. There has been a considerable focus on finances across the system. • Working with local authority colleagues in Bournemouth Christchurch and Poole and Dorset County Council.	
	Resolved: that the Chair's Update be received for information.	
BoD25/095	CEO Report	
	MBr took the report as read and highlighted the following: • The 10-year plan has been published and is significant for the Board. There is a focus on out of hospital care and integration with a high degree of alignment between our own strategy and the plan. • Focus on neighbourhood care, with invitations to bid to be neighbourhood health pilots. Two bids had been submitted. • Public finances remain constrained and there will be challenges with the technological revolution of health care and how it is delivered with more use of AI. The national agenda will develop as it moves from the plan into delivery. • Penny Dash report detailed the approach to quality within the NHS, and we welcome that focus. • At a national level, we are anticipating industrial action. MBr passed on his thanks to all involved in the planning for that period. • ICB cluster arrangements are being developed. This will be significant for us and the way we are working in Dorset. We will be working across Dorset, Somerset, and Wiltshire. This will require us to reflect on our partnerships with our providers, and it is important that we reach out to the provider organisations within that cluster. • EHR has received Cabinet Office approval and the case for Community and Mental Health Services is progressing.	

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	• CQC remain active and visiting our services. A second positive report was received for Glendinning. • Update provided on the proposal to create an NHS Shared service (Estate and facilities, procurement, and sterile services), recognising the strength of feeling around this. There remain concerns about terms and conditions, and NHS pension, which we have been clear from the start will be retained for staff and any new staff joining the organisation. It is very much a wholly owned NHS company. Following a formal dispute being lodged by Unison, work had been paused from July to the start of August. A process for hearing that dispute has been agreed. It is hoped this will take place by the first week in September. This work and engagement were now recommencing. MBr reiterated that this was still a proposal at this stage, and it will need to come back to a future Board to move from a proposal. FW noted that EHR was primarily a project that delivered funding for Somerset and Dorset County, this position had since changed, and FW asked for clarification. NJ advised that the business case for Somerset and the acute trusts within Dorset was approved by the Cabinet Office. Dorset Healthcare was moved out of scope of that original business case because of funding restraints. The original case has now commenced the procurement phase. In parallel there was an opportunity to secure additional funding for Dorset HealthCare of £10m, so we have developed a business case which is now with the national teams for approval. The intention is as and when we secure that approval it is to dovetail Dorset HealthCare back into the procurement process.	
	Resolved: that the CEO's Update be received for information.	
BoD25/096	Board Assurance Framework (BAF)	
Setchell, Ryan 04/12/2025 09:14:16	JeH provided an update on the BAF and reported that all Committees had reviewed their BAF, with the full BAF being presented at Audit Committee. There were no changes reported to the highest scoring risks which were SR3 Workforce, SR6 Finance, and SR9 Digital, which is consistent with the discussions throughout Committees and Board. There are 10 overdue actions across the 10 risks, 5 of which relate to SR9 and SR10 Cybersecurity. SP commented that the BAF was well received and that committees were finding it easier to work with and there is greater connectivity. The next stage would be to complete the risk appetite review. It was noted that there would be a Board workshop on this in September. SP also noted the number of overdue actions and that we need to maintain focus, particularly if some are repeatedly overdue. There are significant overlaps between workforce, finance, quality and digital, so at some point it would be good to spend some time looking at those interdependencies. JeH explained that the actions had increased from 5 to 10 outstanding, as the SR9 risks had been discussed at Finance and Performance Committee (FPC) and a decision was taken to move the actions to behind schedule rather than to plan where dates had been amended, which moved us from 5 to 10 actions outstanding.	

	DU advised that under Finance and Performance Committee (FPC) and STP there had also been discussions about SR9 and SR10. DU felt that the mitigated score of 9 did not reflect the infrastructure. DU asked that SR10 be reviewed at the Q2 review to ascertain whether the mitigated score was as good as stated. EJ provided assurance that the Committees she sat on did consider where else the risks would impact. In terms of SR7 Collaboration, EJ asked if we should be more reflective of the changes within NHSE and the ICB as they move to cluster arrangements alongside Somerset and noted that we would be a key player in terms of community and mental health services. We must focus our ability to influence within the system space and focus on what is being commissioned. It was also noted that there would be movement in the BAF the following quarter. FW added that the network of interdependence between Committees has become apparent, and they are informing workstreams. FW gave the example of People and Culture Committee (PCC) where there were undertaking a review of the Whole Time Equivalent reduction, which is linked to the financial plan. MBr noted that we are getting to a place where the BAF is an important strategic document that helps to guide and focus Committee discussions, and that is real progress from a year ago. It was noted that after the Board Workshop on Risk Appetite, it may be beneficial to ask Lead Executives to look at their assigned risks and consider if we are in the right place and whether we have anything missing. AHT queried the digital risks and asked if it would be better to have one place where this had oversight. JeH confirmed that this was STP but that there would be cross over to FPC, particularly where financial values in terms of the strategic piece were being agreed. AHT felt that this should be prominent on the agenda, as the focus had been on transformation.	
	Resolved: that the Board Assurance Framework be received for information.	
BoD25/097	Corporate Risk Register	
Setchell, Ryan 04/12/2025 09:14:16	DD advised that the data in the report was extracted on 26 July 2025 and reminded the Board that register was dynamic, live, and reviewed daily, so there would have been movement since the report was produced. At time the data was extracted, there were 11 risks that were scoring 15 or above, which were detailed within the report. One risk in relation to hydrotherapy provision had increased, and there were three risks where the score had reduced. DD noted that there had been significant work within DHC around overdue risks and thanked executive colleagues for supporting this work within their committees. As at time of the Board, only 4 risks remained overdue, and some had recently been updated. DD updated on changes within the risk function: Currently in procurement stages for the new risk management system or software. We currently have a different system in each organisation,	

Setchell, Ryan 04/12/2025 09:14:16	and we want to move to the same one across Dorset. This should assist with how we manage and oversee risks across the Federation. • We are in the process of recruiting a joint Head of Risk so we can bring the same reports and use the same reporting mechanisms. • An audit will be undertaken on some of the risks that have been on the system for an extended period. That is being undertaken across both organisations, and a report will be provided in due course. SP said it was encouraging to see the move to improve consistency across both trusts, which would help the Audit Committees moving forward. It would be helpful to the Board to understand the strategic oversight that the executive and others input into the risk. We should understand the themes and trends over time. For example, there was a theme in IT, a theme around maintenance, and a general staffing theme. The more we can start to explain and talk about themes rather than individual risks, it will assist us in having strategic conversations. DD advised that those discussions happen within the individual committees, but we need to be more explicit within the report to Board around the conversations. SP agreed that would be helpful for the Audit Committee as they are trying to give assurance around the risk management framework and the oversight. CH advised that in terms of the Estates risk we were currently undertaking a 6-facet survey to understand the critical infrastructure risk across the estate, which will be fed into the risks when we receive the report. EJ reflected that at DCH Board, the Board heard a patient's story in relation to hydrotherapy, and we have an increased risk at DHC where there has been a commissioning decision to pause the service for the people under the care of DHC. EJ suggested we could use the patient stories and the risks to guide system discussions. EJ added that the ICB have established a new Quality and Commissioning Group, where she will be representing the Trust and advised that she will write to the Chair of the Group to ask about Equality Impact Assessments (EIAs) and request that they are included within the Committee structure using the hydrotherapy as an example. It was acknowledged that this was outside of the normal escalation, but it is an ideal opportunity with a NED Committee being established to review quality and commissioning decisions that it would be an appropriate action, noting the long-term adverse impact this could have on patients, it is significant. DCS agreed that commissioning should be collaborative. RS informed the Board that this decision was made by the ICB under personalised commissioning, which is a different issue to the provision of hydrotherapy in general. RS advised she had escalated this to her counterpart at the ICB around the Quality Impact Assessment (QIA) on changes for Continuing Health Care (CHC) commissioning, which includes the impact on learning disability patients. MBr summarised that it had been a helpful conversation, and we needed to, in terms of governance, do the right this for our population, to ensure	

	the risk is recognised in the right place and the system is the place that can take the action.	
	Resolved: that the Corporate Risk Register be received for information.	
BoD25/098	Quality Committee Assurance Report	
	EJ presented the assurance report and highlighted: General: • 10- year plan had two key implications for the Committee with an increased focus on the patient's voice and enhanced transparency an openness around quality metrics, including league tables • Penny Dash report. DHC: • Reflected on the BAF and the Corporate Risk Register, noting movements and actions taken. • LK was now the senior responsible officer for Integrated Neighbourhood teams (INTs) at DHC. • Discussions around a restraint on Children and Young People (CYP) • Intermediate care had undergone an external peer review noting an over reliance on bank medical staff. It was noted that the clinical governance arrangements in the service were good, and lessons will be shared wider across other services. • Strong assurance around regulatory compliance • Some challenges in arranging quality walkarounds • Approval of the Joint Nutrition Strategy.	
	Resolved: that the Quality Committee Assurance Report be received for assurance.	
BoD25/099	Joint Food and Drink Strategy	
	DD advised the strategy had been via QC and DCH Board. It had been developed to meet national standards. A wide range of engagement had taken place in its development. A request from DCH Board was that we considered explicitly detailing the income generation that can be gained from food and drink and the links to social value, and sustainability. JeH noted that we were required to have a named lead, which would be DD. AHT queried if we had a baseline we are working from to demonstrate the impact the strategy has had. DD responded that we have annual PLACE surveys undertaken in addition to the staff survey. We have baseline data for each organisation that we would be looking to improve. CG noted that the staff side representatives had raised concerns about Shared Services, as this was one of the services that would move over. CG asked how we would ensure that the strategy was maintained within the Shared Services organisation. CH responded that there is joint leadership across both organisations, who were consistently reviewing	

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	how the catering provision is delivered for staff and patients. This has already been factored into discussions. If the proposal progresses around the shared services company, it enables us to deliver this strategy, and we are confident that food, nutrition, and hydration are fundamental to well-being, so it is something we must provide well to our patients and to our staff. We would like to see what opportunities there are for hotel services to really improve. Board approved the strategy.	
	Resolved: that the Joint Food and Drink Strategy be received for Approval.	
BoD25/100	Safeguarding Adults and Children Annual Report	
	DD presented the Annual Report. and noted that it provides assurance that we are achieving all our statutory requirements to safeguard and protect child and adults at risk of harm. This has been considered via the required governance routes before being presented to Board. EJ confirmed this had been via Quality Committee (QC) and that it was important that staff had the time to undertake and complete the training. SP asked if the Board needed sight of the annual child death report. LK advised that it comes through as part of the Learning from Deaths Report and added that she was working to improve the quality and the content of the information that comes alongside the child deaths, as often we are just given numbers. SP agreed it would be good to show the learning.	
	Resolved: that the Safeguarding Adults and Children Annual Report be received for Assurance.	
BoD25/101	Infection Prevention and Control Annual Report.	
	DD presented the mandated annual report. EJ noted the importance of the mandatory training and how we manage and learn from IPC incidents. CG asked if we were seeing an improvement year on year. DD replied we were but not in all areas. We had a theme of E coli infections, which were often related to indwelling catheters where people got UTIs. There is a piece of work ongoing to look at this. Part of this would be making sure people drink well, which would tie in with the nutrition and hydration strategy and having a drinks menu to offer patients. DU raised a question about the introduction of tiered training and asked what the timeline was for that. DD agreed to respond directly to DU. ACTION: DD to respond to DU around the timeline for tiered training	DD
	Resolved: that the Infection Prevention and Control Annual report be received for Assurance.	

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BoD25/102	Finance and Performance Committee Assurance Report	
	DU presented the report and highlighted: • The Committee received a presentation on the financial recovery review report. The report was well received and commended by the Committee; however, they recognise that there is a significant risk in delivery of our financial plans across both Trusts. Whilst the plans are robust, they are incredibly demanding. • The Committee was pleased to hear about the improvements made in the early intervention and psychosis service, and the out of area placement reductions. • The Committee received the winter plan for the first time; these had previously been reviewed at a more tactical level. He acknowledged the work that had gone into producing this within a short timeframe due to compressed timelines. • Corporate risk register was reviewed and noted the work that needs to continue to ensure updates and mitigations are timely to ensure the appropriate management of risks identified at a strategic level. • Performance framework has been published and is being reviewed by both Trusts to make sure we have the appropriate performance assessments in place and consider how that is reported through to Board to ensure we meet the needs of the new framework. • Health and safety compliance report was received, with no areas of concern raised. • The Committee approved the radiological service transfer and agreement to increase the updated cost plan in regard to the Nuffield Road site. This was because we did not have full access to the site prior to procurement and we have since discovered several significant works that need to be undertaken. EJ asked if the increase would have an impact on any savings made by relocating. CH advised that, through our governance processes, we have been able to reallocate some funding via capital and external funding, there is a slight increase in the payback period, but medium to longer term there will be savings.	
	Resolved: that the Finance and Performance Committee Assurance Report be received for assurance.	
BoD25/103	Integrated Corporate Dashboard	
Setchell, Ryan 04/12/2025 09:14:16	CH introduced the report which encompassed quality and operational performance for the first quarter of the year. DD highlighted the following from a quality perspective: • 95.4% compliance with Pressure T, which is the pressure ulcer assessment. This is the ninth month that we have been over the thresholds, which is something to celebrate. • Seclusion in adults has been below the mean for seven months, and supine restraints, occlusion, and rapid tranquilisation for under 18s have also remained below thresholds for the last few months. • Nothing of concern to highlight. CG highlighted the following from a people perspective:	

Setchell, Ryan 04/12/2025 09:14:16	• Mandatory training compliance is slightly up at 93.5%. • Patient safety compliance is up to 95.9%. • Oliver McGowan part 1 training is at 96.4%. • Estates and Faculties compliance is at 76.8% and is being progressed and monitored • Internal review of mandatory training was taking place, but we were awaiting the national framework of mandatory training provision, noting how much staff time is taken up completing mandatory training, some of which may not be relevant to their role. • Soft launch of new appraisal process in August, with the full launch happening in September. Current figures are sitting at 85.2% overall. Estates and Facilities are at 61.4% which is positive. • Turnover is static, and vacancies ate slightly up. Sickness rates were also static for the third month. EJ asked if we had to wait for the national mandatory framework review before we did anything locally. CG advised that it is expected that the national review which will rationalise some of the content around mandatory training and statutory training. We have been encouraged to look at this locally. For example, de-escalation training is delivered to all staff, even support staff, and is that really required. IPC may be another example, do staff that work from home or are always in an office need that training. EJ added that the 85% appraisal rate, meant that 15% were not receiving one, and what was the appetite for improvement in this area. CG responded that we always aim for 95%, but we have to account for people that may be on long term sick, or maternity leave that will not have had an appraisal. We are not outliers in this area, and we are still above the national average. MBr added that we are also considering the quality of the appraisal conversation to ensure that it is meaningful, and asked that PCC look at the issue of the threshold. We would expect the figures to be higher for the doctors and nurses as it is part of their registration and revalidation processes, so it was queried as to whether the numbers were skewed due to that. ACTION: PCC to consider appraisal thresholds. RS presented the performance data and highlighted: • Discussion at previous Board around the recording of ethnicity data, this has improved and is at 91.7%. There was a dataflow issue, and we were under reporting. There is still further work to do in this area. • Plan to have zero out of area placements by the end of August. We are currently down to two. • The community mental health indicator, which has been an important metric over the previous year around the access or being transformation, is no longer measured nationally. We will not be contractually held to that, but we are still working to improve our access.	NP/FW

	• CYP is the area of most national attention, and we are not where we would like to be in this area. We have had the business case approved for investment, but we are now working through a mobilisation plan. • Maintained good performance of virtual wards. • No 52-week breaches within the community waiting lists. We do not have the same lens that the acute services do, because they do not operate on referrals. We do have quite a varied picture across the community provision around waiting times. We have not had a clear sense of the demand capacity modelling to inform the commissioning. We are picking this up throughout commissioning contractor services with the ICB. We are concerned about the growing waits across both community services, and some of our associated bed services. FPC were asked to consider the metrics that should be reported to Board around the community services waiting times. ACTION: Discussion at FPC regarding information to be provided to Board around community Service waits. JeH noted the good progress around the recording of ethnicity data and queried whether the national threshold was 100%.	RS/DU
	Resolved: that the Integrated Corporate Dashboard be received for assurance.	
BoD25/104	Finance Report	
	CH presented the report and the position as at month 3 (end of quarter 1). CH reminded the Board that from a plan perspective, the Trust has a surplus value of £9.8 m based on an efficiency target of about 8.7%, which equated to £38.5m efficiency, which was significant. FPC had received a detailed analysis of the independent review performed by David Moon and Mark Mansfield around that plan. This would be discussed further in Part 2. At the time the plan was signed off, we did not have a fully identified efficiency programme, recognising the scale of the timeframe associated with that and level of the efficiency was based within the second half of the year. In terms of performance in the first quarter: • Year to date, there is a deficit of £1.44m, which is broadly in line with the plan. • Agency use has reduced, however, expenditure on temporary staffing increased by £323k. It is an area that is being reviewed. • Financial Recovery Board has been established. • Out of Area placements - we are seeing a good trajectory in terms of reduction. We have 10 block booked beds, which enables us to ensure we have value for money. At the end of quarter 1, we had seven patients in other out of area beds. RS reported that stood at 2 as at today. We are continuing to see a downward trend over time, which is positive.	

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Setchell, Ryan 04/12/2025 09:14:16	• Efficiency delivery is slightly ahead of plan at this point in the year. We need to maintain focus in this area to ensure that those areas where we have identified efficiencies can be fully implemented. • Areas where we have unidentified efficiencies continue to be explored. • There is currently in the region on £9.6m risk to that overall efficiency that is largely linked to the transformational element of the plan. We need to determine how we mitigate this. • £4.2m is linked to the NHS Shared Services, so if that is not delivered within year, we will need to find that additional amount from elsewhere. • We are currently slightly ahead with the cash position. • We are slightly behind plan from the capital perspective; however, it is likely that we will catch up with this throughout the course of the year. • Some key elements of expenditure in the year are investing capital in the maintenance back log and digital. • We are in receipt of a significant amount of external funding primarily around our new hospitals programme, and some related to environmental sustainability and we are looking at solar panel installation where appropriate across the estate. • We are also in receipt of funding associated with the critical infrastructure risk, and we were successful in bidding for elements of that funding. SP asked about the agency spend and whether we needed to review the controls in place, and the £9.8m risks around the transformational activity, and whether we needed to undertake some scenario modelling about what that looks like, noting that some elements were outside of our control. FW added that PCC have the WTE review, linked to the financial plan, going to the September meeting, and looking at how they dovetail in with transformation, and the speed at which that happens, that could then impact on the temporary staffing spend. AHT questioned our confidence in the recovery plan and what outcome we are expecting. CH responded that that we are seeing a positive trend in terms of agency spend. There was a huge focus on agency spend and we have seen that decline and we are demonstrating value for money in that space. We are seeing an increase in bank expenditure, which is a cost-effective way of filling gaps as generally they are on agenda for change conditions. This is a key area of focus through the internal Financial Recovery Board to ensure that we have the relevant controls in place, and that we are only using bank to ensure quality and safety. We are currently seeing a high use of bank within Estates and Facilities. Medical agency has always been an area of challenge, and we have plans in place on how we address this. We have an international medical recruitment programme underway and on track. We are expected to be fully recruited within the next 12 months. At the same time, we are implementing a reduction in the rates that we pay on agency locums, and we are fully committed to that. We have improved our year end forecast by around £600k for medical overspend. LK is intending to further reduce this over the next few months.	

Setchell, Ryan 04/12/2025 09:14:16	MBR referred to some more up to date information reviewed that morning that detailed agency spend between months 1 and 4 as £265k less than those 4 months in the previous financial year. Medical, was around £85k higher than we were for the same period in the previous year, but if the run rate is reviewed, this is coming down, which reflects the actions LK had described. CH addressed FW's comments and advised that we need to look at spend in totality. What we have seen is a significant focus on agency which has lowered. There is now a focus on substantive staff, and we have a very robust vacancy review panel to facilitate this. Third element is bank expenditure, which we are seeing increase. We have ensured that we have the relevant controls in place, but ultimately the fundamental part is ensuring that we have the right staffing levels in place at any time to deliver a safe service. CH responded to AHT's question about the sustainability of the savings from the out of area placements. From a financial perspective, the reduction of out of area placements is a positive. We had forecast the year end position with a level of out of area usage above our block contract. We are now getting below this, which gives us room in case we do need to use additional beds. This will not deteriorate the Trust forecast position, however in terms of the wider question as to whether this could be sustained, there is always a risk that we have to place someone out of area due to bed flow. We will see some fluctuations at various points. We have 10 additional out of area beds, block booked, that are constantly in use. Once we get to zero usage, we will need to sustain that position. We will have a large degree of capacity coming online through the new hospital programme over the next few years, which will give us a longer-term sustainability perspective. Reducing out of area usage has more than just a financial implication, it also impacts on patients and their families. In regard to the £9.8m risk, there will be a more detailed conversation in Part 2, but ultimately that figure has been validated by the independent review, in terms of what they perceive to be an unidentified risk. Therefore, this is a material risk for delivery this year. On the 8.7% CIP we have effectively allocated 5% within services' budgets recognising this would be the third year of that level of target. We are committed to achieving that in year. That leaves a residual 3.7% that needs to be delivered by transformation across the system. Conversations with the system are taking place. SP queried whether this should be a topic that goes through FPC to get through the detail, and whether there should be triangulation of hotspots where agency/bank use is high. DD advised this already takes place, and she was aware of the areas of high usage and the rationale for this use. There is a safer staffing group that meets monthly that has representatives from the Nursing and Quality Team, the People Directorate, and the operational directorates so that information can be triangulated. The safer	

	staffing reports come up via the quality governance routes, where the heat maps are reviewed.	
	Resolved: that the Finance Report be received for Assurance.	
BoD25/105	Seasonal Surge (Winter) Plan	
	RS presented the winter plan, which is our tactical plan. We have mapped that against the new Urgent and Emergency care (UEC) guidance which details the 'must do' areas for community mental health trusts around winter planning and then detailed some other areas we would expect to consider as part of surge planning. Within the pack, RS had also included the Standard Operating Procedures (SOPs) because there are somethings that are routine and repeat throughout the winter, which are not tactical, but they have been provided so the Board has full sight, noting this was more information that the Board required. This will be refined moving forward. This is a new process for DHC, and it is also significant earlier than usual. It was noted that there is no additional funding for winter surge planning this year which in itself does not necessarily increase the risk of the winter plan as in previous years as a community Trust we have struggled to utilise available funds because of the nature of the workforce that we employ and difficulties getting short term workforce for surge periods. The plan had been via FPC and QC already to look at the resilience and equality issues and no issues were raised. To note is the requirement around staff vaccinations, based on response rate last year. We are putting in place additional measures to increase vaccination uptake this year, recognising the role that plays. DU commented that he was impressed by what had been achieved in three weeks to produce the plans and noted that the issue of no additional funding being available would be more of a significant issue for acute services. MBr asked whether the papers included the Chair and CEO declaration. They did not and RS advised that these need to be submitted post Board. The QIA and EQIA needed to go via Panel to agree, and there was a request to share this with Board members as DCS and MBr would be signing on behalf of the Board. RS advised that we had complied the best we could at this stage, and identified the gaps, but that the template included some standards that are acute only. JeH explained that we will have a parallel process. At DCH we did receive the Board Assurance Template, which was delegated down to FPC to review due to timings and deadlines at the end of September, when we do not have a Board. We will circulate it to Board members for any comments, and we will take the final version through FPC in the same way. ACTION: Declarations (QIA, EQIA) related to Seasonal (Winter) Surge Plans to be circulated to the Board members with delegation for sign off to FPC.	JeH

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	Resolved: that the Seasonal Surge (Winter) Plan be received for Approval.	
BoD25/106	People and Culture Committee Assurance Report	
	FW presented the report and highlighted: • People Plan is in place, and we have the delivery framework with accountable timeframes sat behind that. • Review of the assigned BAF risks • Deep dive of the WTE reduction is coming to September meeting. • Resourcing and the implication around the people agenda. • Committee discussed the WTE reduction v bank usage implications. • Apprenticeship update for DHC was provided and was a well-received document and linked in with the social value work. It is a good mechanism for delivery in terms of developing people's careers and putting good markers out into the community.	
	Resolved: that the People and Culture Committee Assurance Report be received for assurance.	
BoD25/107	Medical Appraisal and Revalidation Annual Report	
	LK reported that 93.3% of DHC doctors had an appraisal, where appraisals did not take place rationale was provided. The are no doctors that are not engaging with the appraisal process which is a positive. We have adequate appraisal capacity and all actions recommended during the Responsible Officer visit last year have been completed. There were several 'should do's' and all of those had been completed. These actions see the two appraisal and revalidation offices (DCH and DHC) coming together to begin to align training and then approaches, and all the policies and processes. JeH advised that there were two elements that the Board were required to approve. The first was the annual report, and the second was a statement of compliance that must go to NHSE that was not included in the papers that went to PCC or within the Board pack, so the Board can only receive it for assurance today. The document will need to go to September PCC and then October Board to complete the process to approve the statement. We will clarify if the statement can be completed by the Responsible Officer (RO) on behalf of the Board, or if it needs to have Board sign off. JeH confirmed it was in Committee plans but an appendix had been omitted from the DHC report. CG added that a Responsible Officer Advisory Group (ROAG) had been established, and the appraisal programme had been validated via that route, and it was working well. This is chaired by LK, with DCH, and it meets monthly. There is also a more informal Fitness to Practice meeting monthly, where any concerns or complaint that have come up in relation to the doctors are discussed. That is also working well. SP asked if there were any forward programmes for the committees where this could be documented to ensure it was not missed, and to make sure that all external compliance issues were factored in. SP also asked if there	

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	was a threshold for doctors' appraisal as with the other appraisals, and what happened with agency or locum doctors. LK responded that the agency would be responsible for that element and that there are regular contacts made with the agency RO's.	
	Resolved: that the Medical Appraisal and Revalidation Annual Report received for approval.	
BoD25/108	Strategy, Transformation, and Partnership Committee Assurance Report	
	DCS presented the following highlights from the report: • Presentation around the Frailty Service, which demonstrated the Trust strategy in action. The project had improved patient experience and had resulted in a number of patients being able to remain at home, avoiding hospital admission, and saving GP and district nursing time. Learning is being captured so that it can be shared with other services. • Reviewed the BAF, the risk register, and digital risks. • Review of the 10-year plan against the Trust joint strategy, which aligned well. • Funding for the INTs had started coming in from the beginning of August. • Social Value Plan was discussed, and it was noted this had been discussed at DCH Board, and it was felt that there was more that we could do. • Green Strategy annual report was received, and it was noted that there were some impressive figures coming out from the reduction in CO2. • 6 Facet survey for DCH was received and discussed. EJ noted that support for the elderly frail was one of the Trust objectives and queried whether a half day Board Development session, like the CYP one, could be considered. As a result of the project, we are seeing a reduction in hospital admissions and demand on GPs and queried whether this project could be aligned to the Future Care outcomes. SP asked for some clarity around the £9.8m transformation piece as we were stating that there were no changes to the risk and asked if CH was articulating that there was a broader transformation risk. CH confirmed that the overall risk to the trust's financial plan was £9.6m and the mitigation of this would be discussed in Part 2. The trust's planned surplus is £9.8m, and the risk identified is £9.6m	
	Resolved: that the Strategy, Transformation and Partnership Committee Assurance Report be received for assurance.	
BoD25/109	Audit Committee Assurance Report	
	SP presented the report and highlighted the following areas: • Presentation received from the executive to bring forward the Equity, Equality and Quality Impact Assessment (EEQIA) internal audit and	

	postpone the Research and Development audit. Committee were supportive of this. - Increased activity coming through around imposter fraud, in terms of volume of activity, volume of events being investigated and the number of people involved. Audit Committee requested that the visibility of the investigations is made available to the Quality Committee and the People and Culture Committee. - Some challenging FOI requests were being received, and not all targets were being met. A request was made to the Executive team to provide support to the FOI team so that they can try to comply with the more complex cases. In response to a question from SP DD advised the Board that we would never be in a situation where a ward would be staffed with 100% agency staff, as that would be a red flag. It was noted that in terms of the identity fraud activity, this was still subject to a live police investigation. QC will be provided with an update on the process of checking staff. SP requested support from DCS and MBr to ensure that the outstanding actions relating to an ICB audit were updated and closed. This has remained open for some time.	
	Resolved: that the Audit Committee Assurance Report be received for assurance.	
BoD25/110	Mental Health Legislation Committee Assurance Report	
	AHT highlighted the following areas: - First Committee in Common, there were no representatives from DCH in attendance, and the meeting was not quorate. - Positive CQC report for Glendinning. This was the second consecutive positive report for that service, and the service should be commended. - Annual Mental Health Legislation report was received. Committee noted that the use of the Act continues to decline. It is unclear whether this is a positive, or if this is a result of how the police are working differently. The team are undertaking some more work to try and understand this. There are some indicators that identify that we are triaging people before they are assessed under the Act, which may also account for lower numbers. - Committee to assure themselves of the quality of the Mental Health Panel members, and the hearings. JeH advised that a debrief had taken place, looking at what did work and what we would do differently moving forward. Membership and quoracy will be reviewed and we will be writing out to those staff to ensure that we have a clear process for people to provide apologies for meetings, so it is consistent, and we know in advance if we are quorate or not. DCS noted that it is a relevant Committee to DCH as well, so we need to ensure representation.	
	Resolved: that the Mental Health Legislation Committee Assurance Report be received for assurance.	

BoD25/111	Consent Section	
	- Annual Health and Safety (including fire and water) Compliance Report (Assurance) - RS noted the award detailed within the report. Report accepted for assurance - Green Strategy Annual Report (Approval) Report accepted for approval. - National Cost Collection Exercise (Approval) Report accepted for approval.	
	Resolved: Consent section received for assurance and approval.	
BoD25/112	Questions from the Public	
	No questions, but Becky Aldridge fed back that it was an interesting meeting and that the level of discussion was good and liked the way the meeting opened with a challenging patient story. There was a thread through the whole meeting around the opportunities for people to have a voice and be more at the centre of their care and design of the NHS in line with the 10-year plan.	
BoD25/113	Any Other Business	
	Nil	
BoD25/114	Date and Time of Next Meeting	
	The next meeting of the Board of Directors will take place on Tuesday 7 October 2025, at Sentinel House.	

Signed by Chair Date

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**Minutes of a public (Part 1) meeting of the Boards of Directors of
Dorset County Hospital NHS Foundation Trust and
Dorset HealthCare University Foundation Trust
held at 9.30am on 7th October 2025 at
Training Room 1-2, Sentinel House, Dorset HealthCare University Foundation Trust
and via MS Teams videoconferencing.**

Present:		
Joint Board Members		
David Clayton-Smith	DCS	Joint Trust Chair (Chair)
Matthew Bryant	MBr	Joint Chief Executive
Chris Hearn	CH	Joint Chief Finance Officer
Jenny Horrabin	JeH	Joint Director of Corporate Affairs
Eiri Jones	EJ	Joint Non-Executive Director (DCH Deputy Chair)
Nicola Plumb	NP	Joint Chief People Officer
David Underwood	DU	Joint Non-Executive Director
Frances West	FW	Joint Non-Executive Director (DHC Deputy Chair)
DCH Board Members		
Margaret Blankson	MBI	Non-Executive Director (DCH) (via videoconference)
Stuart Parsons	SPa	Non-Executive Director (DCH)
Anita Thomas	AT	Chief Operating Officer (DCH)
Stephen Tilton	ST	Non-Executive Director (DCH)
Rachel Wharton	RW	Chief Medical Officer (DCH)
DHC Board Members		
Suresh Ariaratnam	SA	Non-Executive Director (DHC)
Andreas Haimboeck-Tichy	AHT	Non-Executive Director (DHC)
Steve Peacock	SPe	Non-Executive Director (DHC)
Rachel Small	RS	Chief Operating Officer (DHC)
In Attendance:		
Manpreet Aujla-Gudgeon	MAG	Equality, Diversity & Inclusion Lead (DHC) (BoDiC25/035)
Abi Baker	AB	Corporate Governance Manager (DCH) (Minutes to BoDiC25/035)
Jim Bailey	JB	Corporate Governance Manager (DHC) (Minutes from BoDiC25/036)
Trevor Ball	TB	Carer (item BoDiC25/014)
Mel Calderwood	MC	Patient Experience Lead (DHC) (item BoDiC25/014)
Andy Dean	AD	Medical Director and Clinical Director (DHC)
Lauren Farmer	LF	Organisational Development Lead (DHC) (observing)
Ben Holt	BH	ICSD West Team Leader (item BoDiC25/014)
Jo Howarth	JoH	Director of Nursing (Acute Care) (DCH)
Rachael Pankhurst	RP	Patient Experience Facilitator (item BoDiC25/014)
Helena Posnett	HP	Trust Lead for Health Inequalities (DHC)
Ben Print	BP	Senior Programme Manager – Our Dorset Provider Collaborative (observing)
Ryan Setchell	RS	Corporate Governance Officer (item BoDiC25/014)
Cara Southgate	CS	Director of Nursing (Mental Health & Community) (DHC)
Members of the Public (observing via videoconference):		
Macolm Albery	MA	DHC Governor
Becky Aldridge	BA	DHC Governor
Andy Burgen	ABu	DHC Governor
Mike Byatt	MBy	DCH Governor

Judy Crabb	JC	DCH Governor
David Dickson	DDi	DHC Governor
Kathryn Harrison	KH	DCH Lead Governor
Jean-Pierre Lambert	JPL	DCH Governor
Mark Taylor	MT	Public
Jan Wagner	JW	Staff Governor (also present as DCH Equality, Diversity & Inclusion Lead for item BoDiC25/035)
Elizabeth White	EW	DHC Governor
Apologies:		
Dawn Dawson	DD	Joint Chief Nursing Officer
Lucy Knight	LK	Chief Medical Officer (DHC)
Claire Lehman	CL	Joint Non-Executive Director

BoDiC25/014	Patient Story	
	TB, RP, MC, and BH joined the meeting for this item. CS introduced the patient story, highlighting that 982,000 people in the UK lived with dementia, some of whom required the kind of specific care which was provided by the Intensive Community Support for Dementia (ICSD) team. A video was shared in which TB described his experience of caring for his wife, Sarah, who had a diagnosis of unspecified dementia. Following a change in her behaviour and an increase in aggression TB felt that he was not able to cope, but the support offered by the ICSD team had been transformative, giving him another six months at home with Sarah. TB described the team as incredible, that he felt part of the team caring for Sarah and he was kept informed at every stage. Following a deterioration, Sarah did not recognise TB or her home and was placed in a care home. This was initially incredibly challenging for Sarah such that she required one-to-one care in the evenings. This was not sustainable, but the support and interventions offered by the ICSD team were vital in allowing her to stay in the care home. TB described that whilst he had lost the Sarah he used to know he had fallen in love with the new Sarah. The ICSD team offered a remarkable service under incredibly difficult circumstances and were kind, considerate and understanding. He encouraged others in his position to trust the team and use their support and thanked the team for their support. Board members thanked TB for his story and insights, noting their own experiences of caring for loved ones with dementia. Asked whether the trusts were offering equal access of service across the county, or whether this needed further development, RS noted that there could still be challenges with reaching the service and getting the support required. The challenges with dementia diagnosis in the county was noted and RS described that the trust was working with the commissioner to improve access to diagnosis regardless of location. Whilst further work was needed RS was heartened to hear the good experience received from the specialist service.	

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	Resolved by the DCH Board that: the Patient Story be received for information. Resolved by the DHC Board that: the Patient Story be received for information.	
BoDiC25/015	Transition to Board in Common	
	Summarising the key points of the report, JeH highlighted: • Whilst meeting as a Board in Common each Trust retained their own sovereignty and accountability • The agenda was set such that it was clear what items were joint, and which were Dorset County Hospital (DCH) or Dorset HealthCare (DHC) specific • Both Boards had agreed at their last meeting to move a Board in Common and so the meetings would develop iteratively over the coming months • The Corporate Affairs Team had spoken to three other trusts working in similar group arrangements, to learn from their experiences • Appendices to the report outlined the governance structure and future meeting dates • Action trackers had been combined in to one document The Boards discussed the quoracy and voting rights detailed in the report, seeking to understand whether the two were in contradiction of each other, and the nuances of joint and trust specific roles. JeH advised that these were the same as before moving to the Board in Common and that if a vote was needed the Corporate Affairs Team would ensure this was conducted appropriately. There was a further suggestion that the quoracy should be a minimum of two Non-Executive Directors. EJ commended the work undertaken to reach this point and noted that there was no blueprint for how to work in a group model. MBr reflected that on occasion it may be necessary to be clear and separate in how decisions were made, in order to ensure deliberate good governance for each Trust. Similarly, if there was a trust specific issue that required a vote, this would need to be managed separately for each trust. MBr encouraged board members to speak up if they felt that matters were not being handled in this way. DCS noted that the papers were long today at over 600 pages, but that over time these would reduce as there became more opportunity for reports to be combined and the clarity of executive summaries increased. He further reflected that this first Board in Common meeting was the beginning of the next stage in how the trusts provided services to the residents of Dorset, and this would continue to develop.	
Setchell, Ryan 04/12/2025 09:14:16	Resolved by the DCH Board that: the Transition to Board in Common be received for assurance. Resolved by the DHC Board that: the Transition to Board in Common be received for assurance.	

BoDiC25/016	Formalities	
	The Chair declared the meeting open and quorate and welcomed governors to the meeting. Apologies for absence were received from Dawn Dawson, Lucy Knight and Claire Lehman.	
BoDiC25/017	Conflicts of Interest	
	ST and AT noted their professional interest with the DCH SubCo Ltd Performance Report, as directors of the company. There were no other conflicts of interest declared in the business to be transacted on the agenda	
BoDiC25/018	Minutes of the Meeting held on the 10 June 2025 (DCH), 12 August 2025 (DCH) and 13 August 2025 (DHC)	
	The minutes of the meetings of DCH held on 10th June and 12th August were approved without amendments. JeH advised that a new version of the minutes of the DHC meeting held on 13th August had been shared yesterday. The changes included removal of colloquialisms and editing out some details, but there were no changes of substance. All actions on the action tracker remained the same and were in the revised minutes, and there were no issues with the approvals made at the meeting. It was agreed that the minutes of the DHC meeting held on 13th August would be returned to the next Board in Common meeting, once members had had the time to review them. The general length of minutes was noted and members felt this could be reduced.	
	Resolved by the DCH Board: that the Minutes of the Meeting held on the 10 June 2025 (DCH), 12 August 2025 (DCH) be approved Resolved by the DHC Board: that the Minutes of the Meeting held on the 13 August 2025 (DHC) be deferred to the next meeting.	
BoDiC25/019	Matters Arising: Action Log	
	The action log was considered, updates received in the meeting were recorded within the log, and approval was given for the removal of completed items. A corrected update was provided for DHC Action BoD25/068 re request for the Chair's Assistance, noting that a meeting had taken place, a letter drafted and would be sent in the next two weeks. The action was updated to "open – update provided" and would remain on the action tracker until the letter had been sent. DCH Action BoD25/122 Staffing gaps, safety concerns referred to People and Culture Committee in Common had been complete. The committee would continue to monitor and align compliance thresholds.	

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	Resolved by the DCH Board: that updates to the action log be noted with approval given for the removal of completed items. Resolved by the DHC Board: that updates to the action log be noted with approval given for the removal of completed items.	
BoDiC25/020	Board Workplan	
	Responsibility for Nick Johnson's agenda items had not yet been reallocated but would be updated ahead of the next meeting. SPE queried whether it would be useful to indicate in the workplan whether an item focused on current, operational matters, or longer-term strategic issues. JeH was not certain how this would be incorporated in to the workplan but agreed that in developing the agendas it was important to balance assurance and strategic matters.	
	Resolved by the DCH Board: that Board Workplan be received for information. Resolved by the DHC Board: that Board Workplan be received for information.	
BoDiC25/021	Chair's Comments – DCH and DHC	
	DCS stated that today was an important day for the two boards to be working in common. Work would continue to refine and develop the meetings, but this first meeting was the beginning of the next stage of the trusts joint working. The boards would continue to focus on the services provided to residents and patients across the county, but that this was being undertaken with very challenging budget levels which meant there was a need to focus on delivering best value and undertaking activity efficiently. The trusts would therefore need to work with the ICB, in their role as strategic commissioner on behalf of the people of Dorset.	
	Resolved by the DCH Board: that the Chair's comments be received for information. Resolved by the DHC Board: that the Chair's comments be received for information.	
BoDiC25/022	CEO Update – DCH and DHC	
Setchell, Ryan 04/12/2025 09:14:16	MBr provided an update on the development of a shared service company across the three Dorset provider trusts. During the development of the company the trusts had heard clearly that colleagues had concerns about the proposal. The proposal had been to develop an NHS company across the three trusts, to provide some important shared services. Updated guidance had recently been received about the establishment of subsidiary companies in the NHS. This stated that such companies would not be supported by NHS England unless they offered NHS terms and conditions and pensions (which the proposed Dorset company offered and protected for 25 years), and unless there was clear union support to such proposals. The proposed Dorset company was not supported by the unions. As a	

Setchell, Ryan 04/12/2025 09:14:16	result, the trusts had now stopped the development of the proposed company. MBr stressed the immense value placed on all colleagues working in the services affected by the proposal and that the trusts would not be able to offer health services without those individuals. The three trusts now needed to continue conversations about next steps and would continue to engage with and listen to colleagues, unions, and staff side partners to cocreate those next steps. Reflecting on the CEO Report, MBr highlighted the strong focus within the 10-year plan around improving quality issues, including maternity investigations, the working environment, and the 10-point plan to improve resident doctors working lives. He further noted the changes to the regulatory environment, including the establishment of the new ICB cluster arrangements. For Dorset the new ICB cluster included Dorset, Somerset and Wiltshire systems, and the Chair and CEO had been appointment to that cluster. The boards should work to establish and renew relationships within the new structure. Further to this the NHS England regional team would become trusts' primary regulatory for issues that the ICB had previously had a role in, including performance, financial oversight, and segmentation. Within this the ICB would move towards being a strategic commissioner and will oversee the changing healthcare landscape. The trusts continued to focus on performance and planning, with half two (H2) review meetings scheduled with the regional team. Finally, MBr highlighted progress against the delivery of the trusts' strategic goals. Firstly, Dorset had been chosen to be part of the national neighbourhood pilot. Secondly the CQC had published its report following the recent inspection of DCH's maternity unit, with congratulations extended to the team for the positive outcome. Thirdly, the first anniversary of the wellbeing hub at Boscombe which was an important part of changing mental health pathways and reflected the commitment to thriving communities and working with partners across the system. In relation to the 10-point plan to improve the working lives of resident doctors RW outlined that the board needed to appoint a senior doctor representative and a peer resident doctor representative. For DCH RW proposed that she take on the senior role, and that Olivia Young take on the peer role. Olivia was the chief resident doctor, at the end of her training so was a natural choice for the role. The DCH board approved this proposal. FW asked whether the 10-point plan would meet the expectations and address the concerns of resident doctors. RW felt it would go a long way to address their concerns, although understood that resident doctors had a further mandate for industrial action.	

	For DHC, AD advised that names had not yet been agreed for DHC. However, it would be sensible for LK to take on the senior role. The DHC board agreed to delegate responsibility to LK to put arrangements in place and to advise the board who those individuals are. EJ welcomed the 10-point plan and asked that the working environment for all staff, as well as resident doctors, be considered. Asked about the strategic partner referenced in the report, MBr described that proposed scope of work had been discussed at the recent Board to Board to Board meeting with University Hospitals Dorset (UHD) and the GP Alliance. The work commissioned by the ICB to look at the configuration of clinical services in Dorset to meet the needs of the population and provide services in a sustainable way. The work was out to tender at present and further detail would be provided in the coming months. AHT further asked where mental health commissioning would sit within the new ICB arrangements, as there had been previous discussions about DHC taking on this responsibility. MBr noted that the reconfigurations within the NHS were still being shaped. He described the local and regional agenda and that it was important that the trusts were part of both. The boards discussed the work that was needed with unions and colleagues before further coproduction work could take place around alternative solutions to shared services. The value of unions and staff side bodies was highlighted, as well as the fact that the trusts were in a formal dispute process with Unison, but that the ambition was to rebuild the relationship and work together. It was further noted that whilst there was a dispute over this matter, the trusts and Unison were also working together on other matters. Some staff chose not to be part of a union, and it was important to include them in discussions as well. MBr undertook to consider how to learn from the approach and assumptions made in the development of shared services. DU reflected on the need to include the role of the commissioner in performance monitoring and assessment. He further commended the turnaround in DCH maternity unit and celebrated the achievement for the team.	LK MBr
	Resolved by the DCH Board: that the CEO Update be received for information. Resolved by the DHC Board: that the CEO Update be received for information.	
BoD/C25/023	Quality Committee Assurance Report – DCH and DHC	
	EJ highlighted the following key points from the assurance report: The busyness of the committee in having lots of assurance conversations about clinical care	

Setchell, Ryan 04/12/2025 09:14:16	• Issue of quoracy for DHC, noting that dates of future meetings were due to be sent out and requesting that Executives were supported to attend these essential meetings • Good assurance received in a number of areas. Where assurance was not received further detail was sought and often returned to an informal committee meeting, or a workaround was arranged. • Positive report from CQC regarding DCH maternity. Maternity quadrumvirate meetings were positive and although the service had now received a 'good' rating, colleagues recognised there was still further work to do. • Chief Nursing and Chief Medical Officer verbal updates were useful in providing professional intelligence and additional narrative and context • Areas of improvement included tissue viability and the early adoption of new complaints processes at DCH, and the increased focus on learning in the Learning from Deaths report. • Equality quality impact assessments continued to be a focus • Some out-of-date policies but JeH was supporting to progress this. SPe sought further assurance around overdue policies, and training for completing equality quality impact assessments. On the first point EJ noted the thorough discussion at committee. NEDs had challenged that whilst policies were still in place any material change to practice needed to be captured. NEDs would continue to challenge on this matter, and updates would be provided to committee. On the second point, JoH outlined the trusts' adoption of the National Quality Board's new national impact assessment template and the work to embed this in to transformation and finance processes, that could be updated iteratively through a programme's lifecycle. MBI asked how the trust could ensure that Apgar scores were inclusive of babies from all ethnic backgrounds. JoH would provide an update within the maternity agenda item. It was noted that coding appeared to be becoming a concern again. MBr confirmed that work was underway to look in to addressing coding concerns and that CH would provide an update to Finance and Performance Committee in Common, given the importance of the function in terms of finances and contracting, as well as quality. FW added that People and Culture Committee in Common had experienced similar issues with outstanding policies, but that processes in place were to resolve those issues. MBr noted that the matter had been discussed by the executive team with a number of actions in place to improve the position in the coming months. There was a discussion around the Penny Dash report and the return of focus to quality as the combination of safety, experience and effectiveness. The report described the need to view matters in the round; both considering individual care plans and the totality of what was able to be offered, and that difficult decisions would need to be made, supported by equality quality impact assessments.	CH

	Resolved by the DCH Board: that the Quality Committee Assurance Report be received for assurance. Resolved by the DHC Board: that the Quality Committee Assurance Report be received for assurance.	
BoDiC25/024	Maternity Safety Report - DCH	
Setchell, Ryan 04/12/2025 09:14:16	JoH referred to the previously circulated report, noting the high level of scrutiny at committee, and highlighting the following key points: - Positively, the trust remained below the 5% threshold for term babies admitted to the special care baby unit (SCBU) at 4.2%. This remained unchanged despite the increase in number of babies born at DCH following the temporary closure of the Yeovil District Hospital (YDH) maternity unit. - Detail provided in the report regarding cases of neonatal death or late miscarriage. Processes for these cases continued. - Increase in the rate of third- and fourth-degree tears. This remained an area of focus with the thematic review undertaken, but no themes identified to date. 100% compliance in five of the safety standards of the Saving Babies Lives requirements for quarter one. The standard regarding diabetes stood at 67% compliance. - Audit work of Apgar scores was ongoing at present, and JoH would feedback the need to consider the diversity and health inequalities lens MBI previously raised. - The risk score relating to maternity staffing had reduced, due to mutual aid in the form of midwives from YDH and recruitment of eight newly qualified midwives. - An audit of consultant attendance had showed compliance with the national standards as set by the Royal College of Obstetricians and Gynaecologists It was forecast that the trust's annual birth rate would increase from 1,500 to over 2,000 as a result of the YDH closure. As board safety champion EJ noted the upcoming November deadline for Maternity Incentive Scheme (MIS) data and the changing, increasing requirements for the scheme each year. Following a recent maternity quadrumvirate meeting, EJ escalated three matters for the board's attention: - The trust ran an anaesthetic consultant led clinic for high-risk pregnancies and deliveries. An administration gap was causing problems for the delivery of that clinic. - The digital contract for BadgerNet expired in February. EJ had already escalated this to CH. - It was not always possible for partners to stay overnight with the birthing person during a complicated antenatal period, but this was possible in some other trusts. This was an area that came up in complaints. DU sought further detail about carbon monoxide (CO) levels at booking. JoH described the three different measures for smoking in pregnancy,	

	and that the trust's compliance had reduced for monitoring CO levels at booking, partly as a result of women having been booked at YDH and their care since transferred to DCH. Targeted work was being undertaken with women from socio-economically deprived backgrounds who were more likely to smoke during pregnancy. Noting previous discussions about the focus of the board, MBr described that the maternity report was a requirement for boards with a maternity service and this naturally led to operational discussions. MBr further reflected on the future and scale of the DCH service once YDH maternity reopened, and that the board may need to consider the strategic outlook for the maternity service. MBr undertook to arrange a three-way meeting with the ICB and Somerset Foundation Trust to take an overview of maternity services across Yeovil and Dorset to ensure they were sustainable and compliant.	MBr
	Resolved by the DCH Board: that the Maternity Safety Report be received for assurance.	
BoDiC25/025	Learning From Deaths Q1 Report – DCH and DHC	
	<u>Dorset County Hospital</u> RW outlined that the report had bene through the usual governance route and that the Summary level Hospital Mortality Index (SHMI) was in a positive position. It had been identified that there may have been an increase in deaths in patients who suffered fractured neck of femur. This was thought to be a coding issue but was being investigated further and the outcome returned to the next Hospital Mortality Group meeting. SPa noted that the material number of deaths in quarter one of this year compared to last year was being reviewed, in light of a 40% increase in the number of deaths. This would be returned to Quality Committee in Common in the next report. <u>Dorset HealthCare</u> AD outlined the following key points from the report, which had been through the Mortality Governance Group and Quality Committee in Common: • The learning from deaths process was now aligned with the Patient Safety Incident Reporting Plan (PSIRP) • A total of 53 unexpected deaths, and 30 inquests. No regulation 28 notices. • Thematic learning was included in the report. One PSII concluded with positive learning and recommendations • Three child deaths reported, one of which had been identified for a wider investigation. • Eleven deaths of people with learning disabilities, one of which was unexpected EJ noted the lack of medical input in the DHC report and that the report should be medically led.	

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	SPe and AHT reflected that it was difficult to gain assurance when actions and targets were not empirical. EJ understood this but noted that the reports nationally had developed from being data driven to being focused on learning and providing soft intelligence.	
	Resolved by the DCH Board: that the Learning from Deaths Q1 Report be approved.	
	Resolved by the DHC Board: that the Learning from Deaths Q1 Report be approved.	
BoDiC25/026	Implementing the Patient Carer Race Equality Framework: Bi-annual Update – DHC Only	
	HP joined for the item, outlining positive steps taken in progressing the Patient Carer Race Equality Framework (PCREF), including embedding the basics and teams taking ownership of the work. A baseline review of protected characteristics allowed greater monitoring of processes so that improvements could be made. Given the financial position PCREF was not managed as an individual programme. This meant HP was able to work more tactically to support operations to where they needed to be, but it was more difficult to offer check and challenge and to progress matters amongst other competing priorities. HP reflected that PCREF was not well known across the organisation, and that she was spending more time working with teams rather than with senior leaders who could influence the progress of the programme. HP further noted that there was a level of dual reporting with the people directorate who also undertook work similar to PCREF, but that a PCREF working group was now in place. HP reflected on two key issues in the programme. The need for top-down alignment across related programmes in order to move work forward, and the need to understand and celebrate existing work going on across the trust. Board members considered that there was some siloed working between programmes impacting patients (sitting with the quality and nursing teams) and staff (siting with the people directorate). NP reflected on the need to focus resources in the right place and to take a stand against what was being seen more widely in society. HP felt that in a resource constrained environment the way the PCREF programme was structured was creating inefficiencies and duplications, hampering the ability to move forward with the necessary cultural transformation. MBr took assurance from the report that the right steps were being made in the implementation of PCREF and that this needed to be built on to ensure focus on what good looks like. To support this the actions in progress in the report should be converted to specific timescales, and this should be reflected in the next report presented to Quality Committee in Common.	

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	Resolved by the DHC Board: that the Implementing the Patient Carer Race Equality Framework: Bi-annual Update be received for assurance.	
BoDiC25/027	National Inpatient Survey 2024 Report – DCH Only	
	JoH referred to the previously circulated paper, detailing the results of the inpatient survey undertaken for patients who were admitted in November 2024. The trust scored on or above the national average in all domains, although some individual questions scored in the lowest quartile. Areas for improvement included noise at night from patients and staff and a review of care at night had been launched to address this. Information regarding medication on discharge, and length of time on waiting list were also areas for improvement. EJ noted her concern around discharge; this was a national issue, but some trusts were performing well. The findings of the survey reflected feedback she had received from local residents. Quality improvement programmes were being undertaken to improve the areas of concern.	
	Resolved by the DCH Board: that the National Inpatient Survey 2024 Report be received for information.	
BoDiC25/028	Finance and Performance Committee Assurance Report – DCH and DHC	
	DU highlighted the following key points from the report: • 12% increase in activity at DCH in urgent and emergency care pathways in July and August compared to the previous year • Comprehensive plans in place in both trusts for adapting performance reports to the Performance Assessment Framework (PAF) • Approval of winter plan statements for both trusts • Emergency Planning Response and Resilience (EPRR) self-assessments 100% compliant • Revised bed capacity plan for DCH, with associated financial impact • Finances approximately on plan for month five, whilst recognising the challenge remaining for the remainder of the year • Approval of a number of items, as detailed in the report CH updated that there had been changes to the DCH capital plan as the trust had been successful in bidding for critical infrastructure funding which allowed for internal reprioritisation of £1.5m of capital, which would largely be spent on quality items. The trust would continue to apply for external funding as it arose. SPE sought further assurance around the balance of recurrent versus non-recurrent savings, and the possible national move to payment by results. CH confirmed that this was being worked through as part of the medium-term financial plan, which would be presented to Finance and Performance Committee in Common and Board for approval in the coming months. It was clarified that it was not yet clear if payment by results was being implemented nationally.	
	Resolved by the DCH Board: that the Finance and Performance Committee Assurance Report be received for assurance.	

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	Resolved by the DHC Board: that the Finance and Performance Committee Assurance Report be received for assurance.	
BoDiC25/029	Integrated Board Performance Report (DCH)	
	AT took the report as read, noting the balanced scorecard was now known as the Integrated Board Performance Report was the first iteration of the report aligning with the DHC Integrated Corporate Dashboard and the PAF. With reference to page 284 of the papers SPa noted the trust scored well on implied productivity, but low on planned deficit, and did not understand how those two metrics correlated. The matter was referred to Finance and Performance Committee in Common for further analysis. MBr noted that the productivity data was fairly new and variable, and teams were working to understand the data; this should be borne in mind whilst reviewing the information. MBr asked if committees had analysed the indicators included in the report. AT confirmed this had taken place and additional metrics not included in the report could be added at the request of committees. Board members commended the alignment to the PAF and FW commended the trust for being the highest performing trust for E-Coli infections and for being in the top quarter for staff sickness. The meeting heard that learning from positive stories was captured and triangulated with other intelligence.	AT/CH
	Resolved by the DCH Board: that the Integrated Board Performance Report be received for assurance.	
BoDiC25/030	Integrated Corporate Dashboard (DHC)	
	CH echoed AT with regards to the revised metrics to align with the PAF. Executive directors updated the following key points from the report: • A rise in falls in community hospitals with work ongoing to understand the cause, • Two out of area incidents detailed in the report. These were spot purchases of emergency admissions rather than pressure related. • Good initial uptake in the staff flu vaccination campaign and staff survey response rates. • Improved wait times in young people eating disorder service	
	Resolved by the DHC Board: that the Integrated Corporate Dashboard be received for assurance.	
BoDiC25/031	Finance Report – DCH and DHC	
Setchell, Ryan 04/12/2025 09:14:16	CH outlined that there were three reports included in the papers. A DCH paper, a DHC paper, and a broader report of the system position at month five. <u>DCH</u>	

Setchell, Ryan 04/12/2025 09:14:16	CH outlined the trust had a fully year planned deficit of £9.8m with an efficiency target of £21.9m (8.7% of operating expenses), and that there was a significant phasing to the plan with activity increasing in the second half of the year. Outlining the position at month five, CH noted: • £3.2m deficit in month and a year-to-date deficit of £14.3m, both broadly in line with plan. A surplus was needed over the remainder of the year to meet the £9.8m deficit plan. • Year-to-date costs relating to the YDH maternity closure totalled £246,000 but this was expected to be fully reimbursed. • Key drivers of performance included operational pressures, particularly in urgent and emergency care, temporary staffing and patients with no criteria to reside. • Agency spend was performing well due to the level of controls in place. However, bank spend was significantly above planned levels and was a key focus for the Financial Recovery Board. The vast majority of instances of bank spend were to ensure quality and safety. • Non-pay costs across the trust were lower than planned and this was offsetting the overspend on bank. • Efficiency savings to date totalled £4.5m and was roughly in line with plan. £24.5m of the total £29.1m savings had been identified, with the remaining £4.5m savings unidentified. There was a £1.5m risk relating to system schemes and efficiencies. There was a shortfall to the plan of £11.6m due to ceasing the development of the subsidiary company and teams across the trust, system and NHS England were working at pace to understand how the full year plan could be met. This was the same position for DHC and UHD. • Cash position in month was £24.2m ahead of plan, largely due to timing of income received and capital spend. Cash continued to be monitored on a daily basis. • Capital spend was ahead of plan following the successful bidding of £2.7m critical infrastructure funding SPe noted that agency and bank spend seemed to be in common areas and asked whether this was related to activity or vacancies and what was being done to address this. CH confirmed that this was a key area of focus for Financial Recovery Board and that there had been increased controls which had suppressed recruitment unless there was a quality or safety impact. The result was that bank agency, which was the more cost-effective temporary staffing option, was above planned levels. The Financial Recovery Board continued to check and challenge recruitment and temporary staffing requirements with further controls being implemented to strengthen this further. Further discussion around temporary staffing would take place in the confidential part of the meeting. MBr highlighted four areas of key risk, which Finance and Performance Committee in Common continued to scrutinise: • The level of bank spend • A target to reduce workforce by 232 whole-time equivalent (WTE), with 160 achieved to date. This needed to be progressed at pace.	

	• The risk to the cost improvement plan (CIP) due to not being able to proceed with the subsidiary company • The balance between recurrent and non-recurrent savings Finance and Performance Committee in Common and Board would continue to focus on and scrutinise the financial position. <u>DHC</u> CH noted the planned surplus for the year of £9.8m, with an efficiency target of £38.5m (8.7% of operating expenses) which was phased across the year with activity increasing in the second half of the year. Updating on the DHC financial position CH highlighted a year-to-date deficit of £1.1m, in line with the phased plan. Drivers of the current position included: • Temporary staffing, particularly bank spend, which was overspent by £776,000 year-to-date • Out of area placements, although month five had ended with only one such placement above the block bed usage • Efficiency savings ahead of plan but a significant amount of work to reach the required savings by year end. Financial Recovery Board continued to focus on delivery of the plan. • Month five ended with a cash position of £35m largely due to timing and cash was not a significant risk for DHC. • Capital was behind plan primarily due to timing of externally funded schemes. The trust was working with NHS England to move any slippage in to the 2026/27 financial year. No questions were asked.	
	Resolved by the DCH Board: that the Finance Report be received for assurance. Resolved by the DHC Board: that the Finance Report be received for assurance.	
BoDiC25/032	Emergency Preparedness Resilience and Response (EPRR) Statement – DCH and DHC	
	The report was on the agenda for approval but was presented to provide the boards with assurance, as they were now with the ICB in the next stage of the process. No questions were asked. The boards received the reports for assurance.	
Setchell, Ryan 04/12/2025 09:14:16	Resolved by the DCH Board that: the Emergency Preparedness Resilience and Response (EPRR) Statement be received for assurance. Resolved by the DHC Board that: the Emergency Preparedness Resilience and Response (EPRR) Statement be received for assurance.	

BoDiC25/033	People and Culture Committee Assurance Report – DCH and DHC	
	Most of the escalation items were already on the agenda and FW noted that the committee had heard an update on the development of the subsidiary company. This had been brought to life for FW when she spoke to a housekeeping supervisor about how their team was feeling in relation to turnover and retention. Unprompted the supervisor shared the impact the subsidiary company was having on morale amongst cleaning and maintenance staff. This had been a stark reminder of the impact on staff and FW welcomed the increasing co-production with unions. FW highlighted the following key points from the report: • Discussion around mandatory training with a focus on increasing compliance rates; this would continue to be an area of focus for the people directorate and the committee. • Receipt of the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES), with a focus on the impact on staff in the current sociopolitical climate. The NHS in Dorset was far more diverse in its staff than in the community it served. Whilst the metrics of the WRES and WDES should be noted, the stories and lived experiences of the people should be borne in mind. • An update on the WTE reduction and financial implications; this would be further discussed with up-to-date data in part two of the meeting • Recommendation for the board to approve the Mutually Agreed Resignation Scheme.	
	Resolved by the DCH Board: that the People and Culture Committee Assurance Report be received for assurance. Resolved by the DHC Board: that the People and Culture Committee Assurance Report be received for assurance.	
BoDiC25/034	Guardian of Safe Working Report – DCH and DHC	
	<u>DCH</u> RW outlined that a new Guardian of Safe Working for DCH had been appointed in the last quarter, and that the process for raising exception reports had moved to HealthRota which was proving tricky initially but would provide better data in the long run. There were no particular concerns about the nature or number of reports raised, and it was felt that the level of reporting indicated that resident doctors felt empowered to raise concerns. EJ noted the cross-references between the work of the Guardian and the ten-point plan for improving resident doctors working lives. This would be monitored through People and Culture Committee in Common. <u>DHC</u>	

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	AD highlighted that the DHC Guardian of Safe Work was off sick at present and so the report was produced by the Director of Medical Education who was covering the role in the interim. 28 exception reports had been raised in the reporting period, with the breakdown of reasons detailed in the report. 16 of the reports related to one resident doctors work during normal office hours and their job plan had been reassessed to address the concerns. There were no reports requiring an escalation. The Guardian and the Chief Medical Officer were assured that resident doctors working hours were safe and there were no safety concerns raised by the Guardian.	
	Resolved by the DCH Board: that the Guardian of Safe Working Report be received for assurance. Resolved by the DHC Board: that the Guardian of Safe Working Report be received for assurance.	
BoDiC25/035	Workforce Equality Reports (WRES & WDES) - DCH and DHC	
Setchell, Ryan 04/12/2025 09:14:16	NP noted the reports were lengthy and whilst there was little time to discuss in detail today, the reports had been discussed in more detail at Senior Leadership Group and People and Culture Committee in Common which had allowed for a more experiential reflection on what the data told us. NP took each report for each trust in turn, and the four reports were then discussed by the Boards in the round. <u>DHC WDES</u> The report outlined a varied picture with improvements in some metrics. NP drew the Boards' attention to two metrics which indicated that non-disabled staff were twice as likely compared to disabled staff to be appointed from shortlisting, and that disabled staff were twice as likely to enter formal capability process. This was not fair, and work was underway to address these disparities. <u>DCH WDES</u> The report outlined an overall improving picture, but a continued gap across the indicators between those who were disabled and those were not. <u>DHC WRES</u> Whilst some metrics had improved, there were still disparities between staff from black and minority ethnic (BME) backgrounds which was a cause for concern. The report showed that staff from BME backgrounds continued to be more likely to experience harassment from staff and patients, which reflected experiences in the current sociopolitical climate. <u>DCH WRES</u> There was an improvement in the likelihood of BME staff being appointed, but the likelihood of BME staff entering formal disciplinary processes had deteriorated. There was also almost a 10% gap between white and BME staff experiencing abuse from the public.	

Setchell, Ryan 04/12/2025 09:14:16	<u>General discussion</u> NP reflected on the need for further progress to improve the position; there was an ongoing programme of work to address this, which was particularly necessary within the wider sociopolitical discourse. Whilst there were improvements in some scores within the trusts, some staff had voiced that they were scared to leave the house due to incidents of racism. The multicultural staff networks had raised that the trusts needed to take a clear antiracist stance, and to support managers to tackle inappropriate conversations which were being legitimised in society. NP did not see this as a political position, but as a straightforward decision about equity and that a zero-tolerance approach was needed. NEDs raised a number of questions and points of challenge, including what actions were taken against individuals who harassed or bullied staff members, evidence from other sectors of describing the benefits of a diverse and multicultural workforce, and that WRES and WDES data was an area that had not improved as much as hoped despite continued discussion around it. The need for the trusts to take a strong leadership approach in this regard was also highlighted, not just as local healthcare providers but as anchor institutions. MBI offered a strong challenge to the meeting, describing that during her tenure at the trust (DCH) the data had broadly remained static, particularly regarding bullying and harassment, despite various measures, campaigns and policies being put in place to address this. A different approach was now needed given the sociopolitical climate. The response needed to be robust to address that wider environment and the trusts needed to be decisive in implementing a true zero-tolerance approach, to be clear to staff, partners, and the communities we serve that racist behaviours would not be tolerated. Given the time constraints of the day and to give the topic the time it needed, the meeting broke for lunch and comments would be responded to upon returning. DCS recalled the earlier conversation and that the boards may resolve to do more in relation to equality today but the detail of this would be taken outside of the meeting. MBr reflected on the importance of the discussion and welcomed the strength of feeling from colleagues. He suggested that the views were reviewed outside the meeting by NP and executive colleagues, with input from colleagues such as MAG and JW, and that a response was returned to a Board Development Session for further discussion. DCS thanked NP for giving the matter visibility at Board. The WRES and WDES reports were approved notwithstanding the need to develop a clear statement about the trusts' position of antiracism. This statement should not be rushed but should be coproduced with those most affected by what the data showed. DCS thanked board members for their contributions, stating how seriously the boards take the matter. It was agreed that a Board	

	Development session to progress our work in this area would be arranged.	
	Resolved by the DCH Board: that the Workforce Equality Reports (WRES & WDES) be approved.	
	Resolved by the DHC Board: that the Workforce Equality Reports (WRES & WDES) be approved.	
BoDiC25/036	Reintroduction of Mutually Agreed Resignation Scheme – DCH and DHC	
	NP summarised the paper explaining the mutually agreed resignation scheme is the same as the one introduced at the beginning of the calendar year with no amendments and will run for a 3-month duration. Following Board approval the NHS England approval will likely be a quick process. Indicative take-up numbers are outlined in the workforce plan and the People and Culture Committee in Common has also reviewed and recommended it to the Board for approval.	
	Resolved by the DCH Board: that the Reintroduction of Mutually Agreed Resignation Scheme be approved.	
	Resolved by the DHC Board: that the Reintroduction of Mutually Agreed Resignation Scheme be approved.	
BoDiC25/037	Strategy, Transformation and Partnership Committee Assurance Report – DCH and DHC	
	DCS summarised the report with the following highlights: • Challenges remain in the development and production of a Strategy Delivery Dashboard to demonstrate tangible differences and benefits rather than the number of activities. • A recent multi-organisational Integrated Neighbourhood Team event was well attended in September led by the GP Alliance and positive feedback has been received. • Dorset place area has been successful in the first round of applications for the National Neighbourhood Health Implementation Programme which is recognition of all the positive work that is underway. • A presentation was received on the pilot of a Children and Young People Mental Health and Neurodiversity Training Programme which has informed helpful learning towards the implementation of a substantive training course. • The improving together programme team as part of the Joint Improvement Framework have used multiple opportunities to listen to colleagues through celebration events and QI Week including poster competitions and information stands This approach and culture supports working across departmental boundaries and there remains continued focus on making 'improvement' business as usual. • Dorset HealthCare has been able to increase support within community mental health services by 27% as part of the total Access Wellbeing model with over 9,500 contacts this year versus 7,500 last year.	

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	The Dorset Innovation Hub is undertaking positive work to support the organisation. There is now a welcome shift to greater alignment of that support to what the organisations need through co-creation of the work. NP reflected on the ongoing review of work and priorities for the second half of this year, assuring the Board that the strategy work remains relevant, focussed and aligned with the NHS 10-year plan; and looks forward to launching the enabling plans for the strategy. RS reflected that whilst the Integrated Corporate Dashboard (ICD) is being re-shaped with some metrics being removed, outcome measures that are already in place should not be lost. This allows a link to remain between 'strategy' measures and how these impacts on patients through ICD metrics.	
	Resolved by the DCH Board: that the Strategy, Transformation and Partnership Committee Assurance Report be received for assurance. Resolved by the DHC Board: that the Strategy, Transformation and Partnership Committee Assurance Report be received for assurance.	
BoDiC25/038	Green Plan Guidance Refresh – DCH and DHC	
	CH provided an update on the production of the Green Sustainability Plan to align with the new refreshed NHS England Guidance. Work has progressed against updating the 12-month action list for DCH and DHC to produce the plan for submission by the end of October 2025. The plan will be developed further across all three Dorset Providers and in collaboration with the ICB as it is in everyone's interest to be involved with the process. The costs to deliver the plan have not yet been full determined and checked for approval and therefore it is only the plan for approval by Board (not the £28k cost as outlined in the supporting paper). AHT queried if the plan related only to the estate. CH explained that there is also a Green Travel Plan and Social Value component. JoH also explained that many staff and teams are working on local projects which all contribute to the green sustainability agenda. There may also be cost improvement opportunities which could be incorporated into the plan.	
	Resolved by the DCH Board: that the Green Plan Guidance Refresh be approved. The indicative costs outlined in the paper were not approved and are subject to further review. Resolved by the DHC Board: that the Green Plan Guidance Refresh be approved. The indicative costs outlined in the paper were not approved and are subject to further review.	
BoDiC25/039	Charitable Funds Committee Assurance Report - DCH	

	DU summarised the report highlighting that total income at the end of August 2025 was £180k. In relation to the Lillian Martin Legacy, there is potential future commercial development of land. The committee agreed Knight Frank to submit plan on behalf of beneficiaries. The conversation continues in relation to engaging in extreme sports for fundraising. The sentiment was to not rule out these activities on the condition they are delivered by an accredited company.	
	Resolved by the DCH Board: that the Charitable Funds Committee Assurance Report be received for assurance.	
	CONSENT SECTION	
	The following items were taken without discussion. No questions had been previously raised by Board members prior to the meeting.	
BoDiC25/040	DCH SubCo Ltd Performance Report - DCH	
	Resolved by the DCH Board: that the DCH SubCo Ltd Performance Report be received for assurance.	
BoDiC25/041	Medical Appraisal and Revalidation – Statement of Compliance - DHC	
	Resolved by the DHC Board: that the Medical Appraisal and Revalidation – Statement of Compliance be approved.	
BoDiC25/042	Mental Health Scheme of Delegation - DHC	
	Resolved by the DHC Board: that the Mental Health Scheme of Delegation be approved.	
BoDiC25/043	Questions from the Public	
	Jean-Pierre Lambert: “To maximize the impact of our patient stories at the joint Board, may I suggest we use them to highlight the benefits of integrated working. For example, we heard this morning about dementia care at DHC, yet at DCH a number of dementia patients occupy beds for extended periods, often due to difficulties in follow-up care. Also, some of our veteran patients struggling with both alcohol and mental health issues sometimes find themselves “ping-ponged” between DHC for mental health and DCH for addiction. Similar patient stories by conditions would allow the Board to understand both the achievements and opportunities from operating jointly.” MBr was thankful for the suggestion and explained the importance of maximising learning from patient stories recognising the need to get the balance correct between joint versus single organisation patient stories.	
BoDiC25/044	Any Other Business	
	DCS explained that the Board meetings may move venues in the future to different parts of the county/region and within partner organisation buildings with opportunities to network; therefore, some flexibility may be required for future Board meeting timings.	

BoDiC25/045	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 9th December 2025 venue TBC.	
BoDiC25/046	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.	

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BoDiC Action Tracker, Part 1 - 2025/26

Topic	Minute Reference & Name	Date of Meeting	Action	Lead	Deadline	Response	Status
Review of score for SR7: Collaboration (DCH)	BoD25/114 / Board Assurance Framework	12/08/2025	Risk score for SR7: Collaboration to be reviewed, noting the introduction of clustering arrangements in the ICB and the trust's ability to influence in this space as a small district general hospital	MBr / JeH	09/12/2025	Complete and BAF the agenda. Recommend close	Complete
Safeguarding Board Development Session (DCH)	BoD25/119 / Safeguarding Adults and Children Annual Report	12/08/2025	A Board Development Session on the safeguarding responsibilities of Board members to be considered	JeH / DD	07/10/2025	October 2025: Board Briefing sessions have previously been held during 2025 including a sessions on 03/02/2025. We will schedule additional 'drop in' sessions during the remainder of 2025 for individuals who request further training December update: Closed – no further requests for training received	Complete
Technology Roadmap (DHC)		Aug-24	The Board requested the technology roadmap is presented at the board in October Update action June 2025 Board - Interim workplan outlining 'technology debt' with an inventory of outdated technology or anything that is due to expire in the next 18 months - a snapshot review would be undertaken to enable the assessment of any short-term risk to go to the next STP committee meeting (July 25) and the subsequent board meeting (August 25).	CH	October-2024 March-25 June-2025 09/12/2025	October 2024 - In progress. Digital strategy work commenced. Board agreed to change the due date to March 25 in line with the Digital Strategy March 2025 - Technology Roadmap to be brought through STP CIC (Date to be determined) April 2025: Planned to be brought to June Board meeting following an update to the STP Committee in Common. Beverly Bryant (chief digital officer) to be invited to June Board to support the conversation. Due date revised to June 2025. June 2025: NJ in discussion with BB regarding the technology roadmap and to discuss the requirement further with AH-T August 2025: The Digital Strategy will be prepared for November 2025, with a fully costed and deliverable plan to be completed by March 2026. We are also creating a Dorset-wide target operating model for digital. Regular updates have been presented to the STP Committee, including a detailed report on the development of the strategy in May 2025. This identified that a key chapter of the strategy will focus on infrastructure. Our work on technology debt has not yet commenced and will be a significant piece of work and will form part of the plans identified in the strategy. It is proposed that this action is reviewed in November for closure when the strategy is received. October 2025: Report on Digital Strategy development reported to STP May 25 shared with all Board Members (see below). As agreed - on agenda for Nov 25 STP Committee and Dec 25 Board. December 2025: Presented to STPCIC in Nov and on part 2 Board agenda. Recommend close	Complete
Re-presentation of information (DHC)	BoD24/023 / Freedom to speak up report	Dec-24	NP to review the content of table 5 and re-present in a different way.	NP	August-2025 December 2025	August 2025: Marked forward to December, when FTSU review is next scheduled to be presented at Board December 2025: Tables in the report have been updated since last report. Recommend close	Complete
Request for the Chair's Assistance (DHC)	BoD25/068 / Audit Committee Assurance Report	11/06/2025	SPe to brief DCS and Matthew Bryant to assist with closing the action regarding the system governance report.	SPe/DCS/MB	13/08/2025 07/10/2025 09/12/2025	August 2025: Meeting set for Thursday 18th September at 14:30 October 2025: Meeting has taken plan, approach agreed to write to ICB chair, letter drafted and will be sent in next 2 weeks October 2025: Action left open, pending confirmation that the letter had been sent December 2025: Verbal update to be provided in the meeting	Open - Update provided
Dermatology waiting list (DHC)	BoD25/088 / Patient Story	13/08/2025	RS to provide an update on waiting lists and the development of correspondence at the next Board.	RS	07/10/2025 09/12/2025	4 collated actions identified: 1. Comments from Mr L incorporated, 2. webpage info changed, 3. Skin Analytics being led by ICB, 4. Work underway around WL communication. Waiting List reporting is separate action referred to FPC - BoD25/103 / Integrated Corporate Dashboard (below) Recommend close	Complete
Resident doctor representatives (DHC)	BoD25/022 / CEO Update	07/10/2025	LK to decide who would be the senior doctor representative and peer resident doctor representative and to relay this to the Board.	LK	09/12/2025	Senior Doctor Representative is Ian Rodin, who is appointing the Resident Doctor Representative. Recommend close	Complete
Learning from Development of Shared Services	BoD25/022 / CEO Update	07/10/2025	MBr undertook to consider how to learn from the approach and assumptions made in the development of shared services.	MBr	09/12/2025	A learning session was held 26 November 2025. Action completed	Complete

Maternity services in Dorset and Yeovil	BoDIC25/024 / Maternity Safety Report	07/10/2025	MBr to arrange a three-way meeting with the ICB and Somerset Foundation Trust to take an overview of maternity services across Yeovil and Dorset to ensure they were sustainable and compliant.	MBr	09/12/2025	Meeting being arranged. Recommend close	Complete

Actions to other Committees								
Topic	Minute Reference & Name	Date of Meeting	Action	Lead	Deadline	Response	Status	Committee referred to
Ridgeway Ward Redesign (DCH)	BoD24/100 / CEO Update	09/10/2024	An investment review of the ridgeway ward redesign to be returned to Board.	CH	12/08/2025 07/10/2025 25/11/2025	The review of ridgeway ward would be returned to Board once it has been reported to Finance and Performance Committee. August update Deferred to the September Finance and Performance Committee in Common meeting. October update Deferred to November Finance and Performance Committee in Common December update: A review of the Ridgeway Ward will be included in the post-investment appraisal review through business planning for 2026/27. Recommend close.	Complete	FPC
Capital program for end of life / out of date equipment (DCH)	BoD25/115 / Corporate Risk Register	12/08/2025	CH to provide the board with further detail about the extent of the capital funds shortfall for replacing end of life equipment over the next 18 months and the next two to three years, and to identify areas where newer equipment would offer an enhanced service that was now expected. To be reviewed by FPCCIC, with cross referrals as needed to QCIC	CH	26/11/2025	A paper detailing expenditure on critical infrastructure and medical devices to be funded through successful external bids was discussed at FPC and included in Board papers. The corresponding action has been updated through FPC to include the external investment into mitigating significant risks through this route and an updated lifecycle risk report will be brought back to Board once further analysis has been completed. Recommend close	Complete	FPC
Appraisals (DHC)	BoD25/103 / Integrated Corporate Dashboard	13/08/2025	PCC to look at appraisal thresholds	NP	October/December 2025	Further work is required in the context of the national framework - there was a discussion at PCC in Sept 25 and a formal proposal will be presented to PCC in November December Update: Appraisal threshold of 90% is proposed and to be considered at upcoming JEMT meeting for approval. Recommend close	Complete	PC
Service Wait Metrics (DHC)	BoD25/103 / Integrated Corporate Dashboard	13/08/2025	Discussion at FPC regarding information to be provided to Board around community Service waits.	RS	09/12/2025	October Update: Actions are in train for information to be regularly reported to F&PCIC December update: information circulated and ongoing assurance via FPC Assurance Report. Recommend close	Complete	FPC
Correlation between productivity and deficit scores in PAF	BoDIC25/029 / Integrated Board Performance Report (DCH)	07/10/2025	Further analysis to be provided around the correlation between productivity (where DCH scored well) and deficit (where DCH scored poorly) within the PAF	AT/CH	09/12/2025	Verbal update to be provided by CH/AT	Open - Due	FPC
Clinical Coding	BoDIC25/023 / Quality Committee Assurance Report	07/10/2025	CH to provide update to FPC on work underway to address coding concerns	CH	09/12/2025	November Update: Cross-referred to FPC Action Tracker	Complete	FPC

Setchell, Ryan
04/12/2025 09:14:16

Report to	DCH and DHC Board of Directors in Common	
Date of Meeting	09 December 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	Y
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? <i>Delete as required</i>	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	Implications for all strategic risks with specific implications detailed in individual reports	
Financial	No specific implications arising from the report	
Statutory & Regulatory	Update on regulatory requirements and segmentation and ICB clustering	
Equality, Diversity & Inclusion	Update on community events and new changing space at DCH	
Co-production & Partnership	Update on system working	

Executive Summary
This report is presented to provide a strategic update on local, national and trust specific matters as of December 2025. It is aligned to our Joint Strategy and our four objectives of Care, Colleagues, Community and Sustainability. This report provides and overview of key national and local developments: • Resident Doctor strikes • Ten Point Resident Doctors Plan • Anti-Racism • Provider Capability Assessment • Advanced Foundation Trust • ICB CEO appointment • Planning guidance • Strategic commissioning framework • Clinical Services Strategy Review • EPRR Core Standards Assurance • Vaccination rates • Staff Survey update

Recommendation
Members are requested to receive the report for information.

Chief Executive Officer's Report – December 2025

This report is presented to provide a strategic update on local, national and trust specific matters as of December 2025. It is aligned to our Joint Strategy and our four objectives of Care, Colleagues, Community and Sustainability.

1 National updates

1.1 Resident Doctor Strikes

Resident Doctors undertook strike action from 14 November 2025 – 19 November. Whilst we felt the impact of this at both Dorset County Hospital (DCH) and Dorset healthcare (DHC) we had robust plans in place to minimise the impact on patient care.

The British Medical Association (BMA) have announced further strike action on 17-22 December 2025 and we continue to plan for this.

1.2 Ten Point Resident Doctors Plan

As previously reported, on 29 August 2025 NHS England issued a letter to all Trusts with a 'Ten Point Plan to improve resident doctors' working lives'. The ten actions are required to be completed by all Trusts over a twelve-week period from 29 August 2025 (so by 21 November 2025).

Trusts are also expected to develop a Board Assurance Framework to provide oversight of this work and the outcomes should be included in trust annual reports to demonstrate accountability and progress. Trust boards are expected to take clear ownership of local improvements to resident doctors' working lives by developing and implementing action plans informed by staff feedback and national survey results.

An update was provided to the People and Culture Committee in September 2025 and a summary of our progress and plans is provided below:

For Dorset County Hospital:

- We are making good progress overall, with 5 out of 10 domains rated Green on the latest RAG assessment.
- The outstanding amber items are primarily due to dependencies on external agencies for example the Wessex Deanery for training rotations and other external approvals.
- We continue to engage with partners to resolve these outstanding areas as quickly as possible.
- We are confident that the remaining actions will move to Green once the external inputs are confirmed.
- A recruitment process for maternity cover for the Peer Resident Doctor is in progress

For Dorset Healthcare:

- We are making good progress overall, with 4 out of 10 domains rated Green on the latest RAG assessment.
- The outstanding amber items are primarily due to dependencies on external agencies for example the Wessex Deanery for training rotations and other external approvals.
- We continue to engage with partners to resolve these outstanding areas as quickly as possible.
- We are confident that the remaining actions will move to Green once the external inputs are confirmed.
- We are in process for identifying a lead resident doctor representative

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1.3 Anti-Racism

On 17 October 2025 the NHS England CEO, Jim Mackey, sent a letter to all trusts requesting action on racism including antisemitism.

In response to this we want to reiterate our zero-tolerance stance to all forms of hatred, antisemitism, Islamophobia, racism and to any form of discriminatory behaviour. We reiterate our commitment to creating workplaces and services where everyone feels safe, valued and supported, regardless of their background, faith or identity.

To progress of work in this area our Joint Board Development Session on 4 November 2025 included a session on anti-racism and our approach to implementing an anti-racism framework. Members of our staff networks attended to share their experiences and the challenges that are still present with in both organisations.

In response to this session the Board committed to a number of actions, including establishing a Joint Anti-Racism and Inclusion Framework. This has subsequently been discussed out the Joint Inclusion and Belonging Reference Group and Senior Leadership Groups and a report setting out our commitments and approach was presented to the People and Culture Committee and will be discussed in board today. The introduction of this framework will strengthen our shared commitment to anti-racism and inclusion, aligned with the Workforce Race Equality Standard (WRES) and the Patient and Carer Race Equality Framework (PCREF).

1.4 Provider Capability Assessment

As previously reported, The NHS Oversight Framework (NOF) [NHS England » NHS Oversight Framework](#) sets out how NHS England (NHSE) will use Provider Capability Assessments to determine their improvement response, enabling them to understand how capable an organisation is of improving without additional support. On 26 August NHSE published the guidance for 'Assessing provider capability: guidance for NHS trust boards' [NHS England » Assessing provider capability: guidance for NHS trust boards](#).

The focus is on provider boards' awareness of the challenges facing their organisations, and what is needed to address them. It is intended to promote board self-awareness as well as transparency with oversight teams, providing a framework for NHSE engagement with providers. We were required to make our submission on 22 October 2025. Due to timing, this was approved considered at an Extra-Ordinary Board meeting on 22 October 2025 and is included with our Board papers today.

We were required to consider a series of Board statements against six domains and respond 'confirmed', 'partially confirmed' or 'not confirmed'.

A robust process was followed to build our overall conclusions:

- Each domain has been aligned to a Committee of the Board
- Sign off of domain response by executive leads
- Review at Joint Executive Management Team to confirm conclusions on 14 October 2025
- Sharing of detailed narrative against each domain and statement with Committee Chairs and 'Confirm and Challenge' meetings held with Leads and Committee Chairs during w/c 13 October 2025. This enabled assurance to be provided by Committee Chairs to the Board to support approval.

An overview of the submission for Dorset County Hospital is set out in the table below:

Domain	Response
Strategy, Leadership and Planning	Confirmed
Quality of care	Confirmed
People and Culture	Confirmed
Access and Delivery of Services	Confirmed
Productivity and Value for Money	Partially Confirmed
Financial performance and oversight	Partially Confirmed

An overview of the submission for Dorset HealthCare is set out in the table below:

Domain	Response
Strategy, Leadership and Planning	Confirmed
Quality of care	Confirmed
People and Culture	Confirmed
Access and Delivery of Services	Confirmed
Productivity and Value for Money	Confirmed
Financial performance and oversight	Confirmed

1.5 Advanced Foundation Trusts

On 12 November 2025, the Secretary of State for Health and Social Care announced that 8 trusts will be among those assessed as part of the first wave of the Advanced Foundation Trust Programme (AFT). Dorset Healthcare has been named as one of the eight trusts eligible to apply for wave one.

This first wave of applications will be assessed against the three priority areas of leadership, quality and financial sustainability. NHS England are currently consulting on the guidance. [NHS England » Advanced Foundation Trust Programme – guide for applicants](#). Wave one trusts to submit application by the end of December. Successful AFTs due to be announced from April 2026. Our application will build upon the Provider Capability Assessment detailed in the section above.

The AFT model is designed to incentivise good performance, giving well-governed and capable boards more freedom to respond to the needs of their communities and deliver improved care.

DHC will be part of a rigorous assessment process, working closely with NHS England & partners to demonstrate how we meet the assessment criteria.

Being selected to enter this process is a hugely positive reflection on all the hard work being done across the Federation alongside our partners across the health and care system.

2 Dorset Updates

2.1 ICB CEO Appointment

Jonathan Higman has joined Dorset ICB as the CEO for NHS Bath and Northeast Somerset, Swindon and Wiltshire ICB, NHS Dorset ICB and NHS Somerset ICB cluster. We welcome Jonathan to the role and look forward to working with him.

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2.2 Planning guidance

On 24 October 2025 NHS England published the 'Medium Term Planning Framework – delivering change together 2026/27 to 2028/29'. This includes some challenging delivery commitments between now and the end of 2028/29.

Following this, on 18 November 2025, NHS England published revenue/capital guidance and allocations. This included two years of revenue allocations, alongside four years of capital allocations. 2028/29 revenue allocations are expected to be published at a later date.

We have been asked to initially focus on the first two years of operational plans (finance, workforce and activity/performance). This will be included in the first planning submission due to be submitted on 17 March 2025. There is a later date of 12 February 2026 for the full submission, which we anticipate will cover the three-year period and a final plan submission in March 2026. The first planning submission is on the agenda for approval today.

2.3 Strategic Commissioning Framework and Commissioning Intentions

In early November NHS England published the Strategic Commissioning Framework to support ICBs to meet the ambition for the future of strategic commissioning. It is expected that all ICBs start to adopt the strategic commissioning approach outlined in the framework as part of the NHS planning process for the financial year 2026/27.

In October both trusts received the draft Strategic Commissioning Intentions from Dorset ICB. We were invited to provide feedback by beginning of November on the draft document ahead of finalising and receipt of the final document. We will share further details when available.

2.4 Clinical Services Strategy Review

Vista Health, led by Tom Hampshire, have been commissioned to undertake a Clinical Services Strategy review across Dorset. Tom attended our Board Development session on 4 November to provide an overview of the approach. The review has commenced and will take place over a twelve-week period. We will provide updates on progress.

2.5 EPRR Core Assurance

On 27 October 2025 both trusts received the outcome letter from Dorset ICB following the 2025 EPRR Core Standards Review. Both trusts were fully compliant with Dorset Healthcare meeting 58/58 of the core standards and Dorset County Hospital meeting 62/62 of the core standards (with a different number of standards due to the nature of each Trust).

A report was provided to the October meeting of the Board and the outcome letters are included in the consent section of the agenda today.

2.5 Vaccination

Our vaccination programme for staff launched in October 2025. Vaccination is incredibly important for us as we know we are likely to be facing a very difficult winter for flu this year. The indications from countries in the Southern Hemisphere are that they have had one of their most difficult winters of recent times. We know this will translate to our own experience and it's really important for all of us working in healthcare to protect ourselves and others.

As of 30 November 2025, the uptake rates for each Trust are:

- DCH – 54.85%
- DHC – 41.2%

We know that nationally there has been a significant increase in flu and it is expected to increase. The evidence is that the flu vaccination is effective against this strain of the flu, and we are actively encouraging our staff to be vaccinated. In addition, we are undertaking local risk assessments to determine prevalence and working alongside our wider clinical and operational teams to ensure all other infection prevention and control measures are in place.

2.6 Staff Survey

On Friday 28 November the staff survey closed. The survey was open for a period of 8 weeks, and we had a total of 43.5% responses at DCH (compared to 46% in the previous year) and at total of 50.5% responses at DHC (compared to 47% in the previous year).

Responses have a huge impact on what we do locally, and they also influence and shape what happens in the NHS nationally. I know how much colleagues care about our local services and how important the NHS is to everyone. Staff Survey completion rates are also an indicator in the National Oversight Framework (NOF).

We are already talking out how we will use the survey results when published and developing our plans for 2026.

2.7 Dorset Healthcare honoured nationally for outstanding end of life care

Staff across three hospitals run by Dorset HealthCare have been nationally recognised for delivering exceptional care for patients with a terminal illness. Five wards have received the Gold Standards Framework (GSF) Quality Hallmark Award, which sets the national benchmark for compassionate, high-quality and evidence-based end-of-life care.

The award-winning wards are:

- Guernsey Ward, Herm Ward, and St Brelades Ward – Alderney Hospital, Poole
- Ashmore and Shaston Wards – Westminster Memorial Hospital, Shaftesbury
- Willows Unit – The Yeatman Hospital, Sherborne

And in a further accolade, the Willows Unit at The Yeatman Hospital was named GSF Ward of the Year for 2025.

The GSF Quality Hallmark Award is granted to healthcare providers that proactively identify patients in their last year of life, assess both clinical and personal needs, and deliver care that avoids unnecessary hospital admissions. It also recognises organisations that support families and ensure dignity, respect, and peace for patients during their final days.

2.8 Minister visits Dorset County Hospital

It was great to welcome Health Minister Karin Smyth and South Dorset MP Lloyd Hatton to DCH on 13 November to see the progress on the construction of our new Emergency Department and Critical Care Unit. Our visitors were able to see the building beginning to take shape now that the ground and first floor concrete slabs have been poured.

The £100M scheme is being funded by the New Hospital Programme and is due to be completed in 2027. You can [read more about this on the DCH website](#).

It was also an opportunity to update Karin Smyth about a whole range of positive work happening locally, including our mental health NHP developments, the neighbourhood team pilot and some of the progress we're seeing in stroke care at DCH. We also discussed some of the challenges and I

raised the rate of change within the NHS; the demands on our services; the immediate financial challenges; the issues of rurality and how they affect the costs of care, and how colleagues are feeling and experiencing pressures in the NHS.

We also discussed examples of absolutely unacceptable racism and discrimination that some colleagues are experiencing in the workplace and in our communities, and what can be done to take a stand against this.

2.9 Dorset County Hospital Veteran Aware Trust

Dorset County Hospital have recently received there One Year Review as a Veteran Aware Trust. The trust's one year review was officially approved on 11 November 2025.

Following the trust's Reaccreditation awarded in October 2024, it is evident there has been significant work undertaken by those responsible for this agenda and the submission shows commitment to the military community with significant evidence in terms of continuous improvement and raising awareness of the healthcare needs of the Armed Forces Community across wider teams and departments.

Setchell, Ryan
04/12/2025 09:14:16

Report to	Board of Directors - DHC	
Date of Meeting	9 November 2025	
Report Title	Board Assurance Framework – Quarter 2 25/26	
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 24 November 2025 Full Board Assurance Framework considered by Audit Committee 28 November 2025	
Action Required	Approval	No
	Assurance	Yes
	Information	No

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? <i>Delete as required</i>	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	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 2 2025/26. 2. Board Assurance Framework: 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: a. Priority Strategies and Plans

- b. Risk controls and Plans
- c. Oversight Governance and Engagement

Each assurance has been assessed as Positive / Neutral / Negative. Where there is a gap in control or assurance this has been categorised as 'neutral'.

Each of the three categories above have an overall assessment based on the controls and assurances in place as Red / Amber / Green. Where there is an assessment of Amber or Red there will be a corresponding action to improve the level of control and/or assurance.

Each action is marked as:

- d. On Plan (Green)
- e. Behind Schedule' (Amber)
- f. Significantly behind schedule (Red)
- g. Complete (Grey)

Each risk has been assigned to an Executive Lead who has signed off the BAF for their assigned risk.

The BAF as reviewed and agreed by the Joint Executive Management Team

Each risk has also been assigned to a committee and was reviewed in w/c 24 November 2025 and by the Audit Committee on November 2025.

The following updates were made following the Audit Committee:

- Update to control in respect of the review of the estates operating model (SR5) and the timing of the technology roadmap (SR9) with the re-opening of the action

The Audit Committee had a rich discussion on the BAF and noted the clear triangulation of the information. It was agreed that the unmitigated scores would be reviewed in Quarter 3 through the individual Committee reviews.

3. Developments since the last review

The developments below were planned for this reporting cycle. A status update is provided below.

4. **Key metrics will be assigned to each risk** – key metrics were planned to be assigned to each risk. Work to identified key metrics has been reviewed in the light of the Performance Assessment Framework and the Ten-Year Plan. The strategic metrics were reported to the Strategy Transformation and Partnership Committee in September 2025 and as reporting is established, we will consider how they can be incorporated into the BAF.
5. **Risk appetite** – The Board held a workshop on 02 September 2025 to review the Risk Appetite statements of each organisation to see if they could be aligned, recognising that each organisation's tolerance may be different. There was a requirement to agree the approach around the qualitative approach across 8 risk types broadly based on the guidance provided by the Good Governance Institute (GGI). The qualitative approach was agreed. The results of the discussions resulted in a consensus of the Risk Appetite. This is a separate agenda item on the Audit Committee agenda. Once approved the risk appetite statements will be incorporated into the BAF.

6. Quarter Two 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; SR6: Finance and SR9: Digital Infrastructure (each with a score of 15 or more).

There has been two changes in score since the Q1 review:

SR2 Culture: Increase in score from 8 to 12. This reflects the need to embed the work undertaken to today and measure the impact and also recognises the impact that the level of change in the NHS both locally and nationally is having on our staff.

SR7 Collaboration: Increase in score from 9-12. Again, this reflects uncertainty created by the scale and pace of change in the NHS. The clinical services strategy review is underway and will report in Q4.

Actions

Gaps in controls and assurance are identified across all strategic risks and clear actions to address these have been identified. Where an action has not been achieved by the due date this is marked on the actions plan as 'Behind Schedule' and a revised date has been added.

Five out of ten risks have at least one action that is behind schedule (compared with four in the previous quarter), with revised dates agreed. In total there are 7 overdue actions, 11 on plan actions and 14 completed actions. There are no concerns regarding the overdue actions and there is confidence in the revised completion dates.

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 and provide any further commentary on the controls, assurance and actions.

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**Dorset HealthCare University NHS Foundation Trust
Board Assurance Framework
Quarter 2 October 2025**

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04/12/2025 09:14:16

Dorset HealthCare University NHS Foundation Trust													
Board Assurance Framework Overview -Q2 Nov 25		Strategic Objectives			Responsibility		Score						
Strategic Risks	Care	Communities	Colleagues	Sustainability	Committee	Executive	Unmitigated	Mitigated Q2 24-25	Mitigated Q3 24-25	Mitigated Q4 24-25	Mitigated Q1 25-26	Mitigated Q2 25-26	Target
							Score	Score	Score	Score	Score	Score	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	9
SR2: Culture If we do not achieve a culture of compassion and empowerment and engagement, we will not have a motivated workforce with the required capacity and skills to improve patient outcomes and deliver safe care.	X		X		People and Culture	Chief People Officer	10	8	8	8	8	12	6
SR3: Workforce Capacity If we are not able to recruit and retain the required number of staff with the right skills we will not be able to deliver high quality and safe sustainable services within our resources	X		X		People and Culture	Chief People Officer	20	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	12	12	12	12	12	4
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	12	9	9	9	9
SR6: Finance If we do not deliver on our financial plans, including the required level of savings, then and this will adversely impact our ability to provide safe sustainable services, and will impact upon the overall ICS position				X	Finance and Performance	Chief Finance Officer	16	16	12	16	16	16	12
SR7: Collaboration If we do not have effective and positive partnerships within the ICS then we will not be able to shape decisions and deliver the transformation required.		X		X	Strategy, Transformation & Partnerships	Chief Executive Officer	12	9	6	9	9	12	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 Nursing Officer	16	12	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 Digital Information Officer	20	9	16	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 Digital Information Officer	16	9	9	9	9	9	9

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Dorset HealthCare University 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	
Executive Lead		Risk Score	Consequence	Likelihood	Score
Chief Nursing Officer		Unmitigated	4	4	16
		Mitigated	4	3	12
		Target	3	3	9
		Rationale for Score No change in score. Good progress made in respect of PSIRP and reporting arrangements in place. Quality oversight arrangements to be strengthened.			

Controls	Assurance	Assessment
What we have in place to support delivery of the objective	Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)	Outcome of assurance
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
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 agreed. PSIRP plan progressing with organisational PSII's agreed and in progress.	Positive
Patient flow workstream and delivery of new inpatient environment through New Hospitals Programme and bed reconfiguration plan in place	Monthly reporting and Integrated Corporate Dashboard to Board, Patient Flow Report to Board Dec 24 showing impact of flow team. Improvements in numbers of people awaiting admission. OOA continues to be an area of focus with monitoring and oversight, including audit of patients who are being cared for by other providers. Melstock now up to full capacity to support improved patient flow across the service.	Neutral
Risk Controls and Plans		
Quality Priority Improvement Plan (inc agreed standards and measurement)	Quarterly Quality Priorities continue to report to QG Group (progress against KPIs) and upwards to Quality Committee via the Quality Report.	Positive
Patient Experience Metrics and Improvement Plans	Patient Experience Annual and Quarterly Report (inc local surveys and metrics), Friends and Family Test National Surveys, Patient Story to Board. Positive	Neutral
Complaints Protocol and Information	Proactive review and management aligned with the new policy and improved quality and learning recording and oversight to improve outcomes and experience of complainants.	Neutral
Quality oversight arrangements and assurance reporting	CQC Reports on Waterston and St Brelades received and no matters for escalation. PC Collaborative escalated concerns re Twynham. Review internal quality oversight arrangements to identify areas of concern. EQIA SOP approved and in line with national template with bi-monthly reporting to Quality Committee - June July Sept 25. CQC ratings remain unchanged (good) for Waterston and St Brelades. Improvement plan on Twynham continues with oversight.	Neutral
PSIRF implemented to improve patient safety	PSIRF Oversight Panel, External Niche Review (reported to QGC) and Board Development Session July 25. Positive progress continues	Positive
Health Inequalities Plan	Joint Health Inequalities Steering Group scoped and to commence, with a Joint health Inequalities Improvement Plan to be developed. PCREF reported to Board Oct 25	Neutral
Oversight Arrangements for Governance & Engagement		
Quality Governance Group reporting to Quality Governance Committee	Escalations are through Quality Governance Group and Quality Committee in Common from Q1 25/26. Six month review of progress at informal Quality CiC Oct 25. Quality Governance Framework to Quality Committee Sept 25.	Positive
PSIRF Oversight Group	Patient Safety Incidents Investigations to QGC (via PSIRF Oversight Group)	Positive
Complaints Review Group with partner membership	Complaints reporting to QGC. Now being progressed with consideration of key stakeholders with first meeting planned in December 2025.	Neutral

Actions to Improve Controls and Assurance	Lead	Target Date	Progress Summary
Development of approach to reporting and learning from complaints (including benchmarking), including Complaints Review Group purpose - Postponed to allow new Complaints Policy to be embedded. July 2025 - Policy aligned to DCH - approved QGG May 2025 - engagement team linked to complaints and considering our approach with involvement of stakeholders in review of complaints and consider implications arising from 10 year plan. November 2025: Plans in progress to now reintroduce this meeting from December 2025 after period of embedding the new complaints policy.	CS	Mar-25 Aug 25	Complete
Review internal quality oversight monitoring and reporting to identify areas of concern. Updated proceses are now in piloting phase with expected rollout Trust wide in April 2026, this focuses on the fundamentals of care and service compliance with CQC regulations. Continued oversight continues via QGG reporting.	CS	Sep-25	Complete
Review metrics and reporting against National Quality Board Recommendations - expected Dec 25	CS	Dec-25	On Plan
Review EQIA template against new national guidance - now in place	CS	Sep-25	Complete

Dorset HealthCare University 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	Likelihood	Rationale for Score
Chief People Officer		Unmitigated	5	2	Increased likelihood score. Much work has been done inc Joint Inclusion and Belonging Group, anti-racism framework, managers guidance on unacceptable behaviours and the inspire awards - now need to continue to launch and embed measure impact. Increased demand for services impacts on workload coupled with a high degree of uncertainty due to local and national changes
		Mitigated	4	3	
		Target	3	2	
				Score	
				10	
				12	
				6	

Controls	Assurance	Assessment
<i>What we have in place to support delivery of the objective</i>	<i>Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)</i>	<i>Outcome of assurance</i>
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. Joint Inclusion and Belonging Group met from September 25	Positive
Leadership and Management Development Strategy and Respect & Resolution Policy	Staff survey - 47% response rate 2024 (lower quartile) /Pulse Survey / FTSU Quarterly Report / Employment Relations Report in Workforce Dashboard 2025 Staff Survey underway and week monitoring of completion rates in place	Positive
Joint Workforce Wellbeing Plan	Plan approved Dec 24, Delivery Action Plan to report to PCC	Positive
People Plan DCH/DHC in place	WRES & WDES - to Board Oct 25 /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. Board Development Session on Anti-Racism and Inclusion Nov 25 and anti-racism framework to PCC and Board Nov / dec & launch of Guidance on Unacceptable Behaviours (and supporting tools)	Neutral
EDS 2	EDS 2 Self Assessment Annually - to PCC and STP CiC Jan 25	Positive
Staff Engagement Strategy	Staff Survey / Pulse Survey - Report to SLG and PC CiC in March 2025	Neutral
Risk Controls and Plans		
Workforce Delivery Framework 2024/25	Workforce report to Board (and PCC from Sept 2024) on progress against key metrics/Review of Directorate KPIs at Directorate Mgt Group (DMG)/Integrated Corporate Dashboard (ICD)	Positive
Staff Survey Action Plan	Workforce metrics as above - 2024 initial survey results received and reported to Board and Committees. Improving position on key workforce indicators.	Positive
Policies and training - Freedom to Speak Up; Respect and Resolution; Conscious Inclusion	Freedom to Speak Up Quarterly and Annual Reports to Board and Committees - moving to bi-annual reporting. Additional capacity in place; respect and resolution and conscious inclusion training launched. New joint FTSU policy ratified at TUPF May 2025. Self-assessment tool actions significantly complete.	Positive
Joint Inclusion and Belonging Action Plan	Reprioritisation of priorities and timeframes reported to PCC; Conscious inclusion and respect and resolution training launched	Positive
Oversight Arrangements for Governance & Engagement		
People & Culture Committee in Common (DCH & DHC) from Sept 24 (to Aug 24 Exec Workforce Committee)	Assurance / Escalation Report to Board	Positive
Directorate DMG - any areas escalation via governance routes	Minutes of Directorate DMG and KPI's in ICD	Positive
Staff Networks and Culture & Inclusion Group and Workforce Wellbeing Steering Group	Annual EDI Report and Minutes reported to PCC from Sept 24 and exec leads for all networks. Health and Wellbeing champions in place. Joint Inclusion and Belonging Group in place from Sept 25 with reporting to PCC from Nov 25	Positive

Actions to Improve Controls and Assurance	Lead	Target Date	Progress Summary
Establishing the Culture and inclusion Reference Group - Not yet established to commence 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 agreed to bring back to July Committee for approval - first meeting scheduled Sept 25 - first meeting took place in September 25 and scheduled quarterly with reporting to People and Culture Committee in Nov v25 - Complete	NP	Nov-24 Mar-25 May-25 Sept 25	Complete
Launch of Mangers Guidance on Unacceptable Behaviour - review impact in line with EDI review and reporting cycle	NP	Jul-26	On Plan
Implementation of Anti-racism framework and charter	NP	Jan-26	On Plan

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Strategic Objective		Strategic Risk			Overseeing Committee
Care Colleagues		SR3: Workforce Capacity If we are not able to recruit and retain the required number of staff with the right skills we will not be able to deliver high quality and safe sustainable services within our resources			People and Culture
Executive Lead	Risk Score	Consequence	x	Likelihood	= Score
Chief People Officer	Unmitigated	5	x	4	= 20
	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. over reliance on temp staffing. Ongoing high use of tempn staff is mitigating risk but present challenge to achieving overall required WTE reductions					

Controls	Assurance	Assessment
What we have in place to support delivery of the objective		
Priority Programmes and Strategies	Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)	Outcome of assurance
DHC Workforce and OD Strategy to 2025 aligned to Dorset ICS People Plan and NHS Long Term Workforce Plan	Workforce Metrics in Integrated Corporate Dashboard / 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
Workforce Planning Strategy and workforce reduction plan	Workforce Metrics in ICD. Workforce reduction plan in place - reported to Board Oct 25 and Board Development session Nov 25	Neutral
Grow your Own Strategy (apprenticeships)	Reported to People Committee in bi-annual progress review for the new Joint People Plan. Apprentice framework being developed to improve retention	Positive
People Promise Retention Exemplar Programme	Progress to NHSE and Board - Closure Report May 25	Positive
Retention Strategy	Staff Turnover metrics	Positive
Recruitment Strategy	Internal Audit Report - Recruitment / Vacancy rate metrics in ICD	Positive
Risk Controls and Plans		
Workforce Delivery framework 2024/25 - New Joint People Plan developed together with a new joint delivery framework 25/26	Workforce report to Board (and People and Culture Committee from Sept 2024) on progress against key metrics / Safer Staffing Report to Board / Annual Workforce Safeguards Declaration (approved Dec 24). Workforce reduction tracking and reporting in place	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. MARS scheme launched. Reported to PCC and Board	Neutral
Learning Needs Analysis	Annual Education Quality Self-Assessment / Learning Needs Analysis & affordability	Positive
Oversight Arrangements for Governance & Engagement		
People & Culture Committee in Common (DCH & DHC) (to Aug 24 Exec Workforce Committee)	Assurance / Escalation Report to Board when in place and governance structure established	Positive
Directorate DMG - any areas escalation via governance routes	Minutes of Directorate DMG and KPI's in ICD	Positive
Workforce Programme System Groups (Widening Participation and Apprenticeship) with recruitment considered at Provider Collaborative	Escalation Report to ICB People Committee (reports to ICB)	Positive
Safer Staffing Group	Staff Staffing Report to Board. Developing Workforce Safegards Report March 25	Positive
Vacancy Control Panel	Weekly Reporting to Executives and System	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	Lead	Target Date	Progress Summary
Ten year Plan publshsd July 25 - Implication for workforce to be considered and detailed NHS Workforce plans awaited and will respond as published - propose to close action as expect form and date unknown and we will respond when available	EH	Dec-25	Complete
Financial Recovery Board to be established to main oversight of workforce reductions - In place with reporting to Committee in place and update to Board Oct 25 and Board Development session Nov 25 - complete	NP	Jul-25	Complete
Additional workfrce controls - Increasing centralised control of temporary staffing at DCH, enhanced overtime controls, further reduction of FTC and exec review of additional workforce actions to achieve year end position	NP	Dec-25	On Plan
Mars scheme launched - impact on WTE to reviewed when process complete	NP	Jan-26	On Plan

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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	Rationale for Score No change in score. Whilst performing well against some national standards, we are below thresholds in some areas. Where below thresholds clear understanding of underlying issues and improvement plans and/or agreed recovery trajectories in place or in development-working closely with the ICB to agree these.
Chief Operating Officer		Unmitigated	4	x	4	=	16	
		Mitigated	4	x	3	=	12	
		Target	4	x	1	=	4	

Controls <i>What we have in place to support delivery of the objective</i>	Assurance <i>Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)</i>	Outcome of assurance	Assessment <i>(See assessment guidance)</i>
Priority Programmes and Strategies			
Access Wellbeing Programme Mobilisation (community mental health transformation)	Development milestones for the Wider Access Wellbeing initiative - included in the Highlight reports to Committee from March 25. MH DMG performance report showing year end performance for access wellbeing hit required target (March 25). / Internal Audit review of OOA bed process. On track from 25/26 trajectory	Positive	Amber
Children, Young Person and Adolescent Mental Health (CYP MH) Transformation Programme	System programme approach and governance structure in place with clear outcomes and milestones / OBC in development with demand/capacity modelling - expected completion by ICB end of March 25; limited assurance on available investment for programme. ICB have approved business case - approved with partial funding envelope agreed with remainder to be confirmed via medium term financial planning	Neutral	
Integrated Neighbourhood Teams (INT) Transformation Programme (aligned to UEC transformation)	System governance and reporting for INT's established and first draft business case on catalyst funding drafted awaiting confirmation of catalyst funding currently. Ongoing programme board oversees progress with workstreams - those that are not funding dependent remain on track. Catalyst funding agreed - further work to mobilise. Programme governance reset to take place Sept 25 (complete) to aid mobilisation.	Neutral	
Risk Controls and Plans			
Access Wellbeing - performance monitoring on access times and due reviews in community teams / Performance monitored and demand/capacity issues responded and escalated as BAU whilst transformation programmes are implemented / Monitoring via daily sitrep of bed occupancy, OOA bed utilisation and NRTR	Monthly Performance Report to Directorate Management Group (DMG) / System OPEL levels for MH capacity escalation & resilience structure in place (ICB Tactical Resilience Group) to manage demand/surges. Out of area bed recovery group established and trajectory set and on track	Neutral	Amber
CYP MH Programme - Performance monitoring on access times and due reviews in community teams.	Monthly Performance Report to DMG / Performance monitoring System CYP Delivery Group / One Transformation Approach Portfolio reporting for Joint Transformation and Innovation Board (JTIB) in development however will capture risks/ issues for awareness and escalation - access wait time is under performing and a formal recovery plan has been put in place to recover by end march	Neutral	
Productivity Plans for Community Services	Plans reported on and monitored via Directorate Management Group / ICB Performance and Contracts Review Meeting	Neutral	
Oversight Arrangements for Governance & Engagement			
Directorate Management Groups	Monthly Performance Reports, and Integrated Corporate Dashboard	Positive	Amber
Finance and Performance Committee	DHC Performance Report to F&P - from Sept 2024 and escalation report to Board	Positive	
JTIB reporting to Strategy, Transformation and Partnerships Committee from Sept 24	Transformation Highlight Reports	Positive	
Access Wellbeing Steering Group (membership include DHC, ICB, VCSE, LA, DMHF)	Internal programme assurance with links to contract reporting, DMG, VCSE assembly - review of JTIB to be undertaken (under transformation risk SR8)	Neutral	

Actions to Improve Controls and Assurance <i>(Required for any areas assessed Amber or Red)</i>		Lead	Target Date	Progress Summary
Review metrics and performance plans in response to Performance Assessment Framework and segmentation - new reporting framework presented to Finance and Performance Committee Sept 25 - however we have not yet made the changes to our reporting		RS	Aug-25	Behind Schedule
Undertake part mobilisation in 25/26 to address access and waiting times challenges - to recover access standard by 31.3.26.		RS	Mar-26	On Plan

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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		Rationale for Score	
Chief Finance Officer		Unmitigated		4		x	4		=	16		No change in score - work completed to identify gaps in compliance & ensure mitigating plans are in place and evidenced. Six facets survey commenced and due to complete Quarter 4 and strategy to be developed following this. Uncertainty regarding future operating model in light of latest NHSE guidance regarding wholly owned subsidiaries	
		Mitigated		3		x	3		=	9			
		Target		3		x	3		=	9			

Controls <i>What we have in place to support delivery of the objective</i>	Assurance <i>Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)</i>	Outcome of assurance	Assessment <i>(See assessment guidance)</i>
Priority Programmes and Strategies New Hospital Programme Joint Estates Strategy to be developed - not yet in place Review of operating model estates and facilities Capital Programme	NHP Business Case, programme approved and build progressing Not yet in place - Six facets survey commissioned which will inform strategy - due for completion Q4 OBC approved by Board Apr 25 and FBC May 25 Programme Board in place. Due diligence to be undertaken . NHS guidance received that cannot progress without Union support. Currently reviewing options. Monitoring to Finance and Performance Committee - Five year plan submitted to Dorset ICB	Positive Neutral Negative Positive	Amber
Risk Controls and Plans Estates compliance functions Backlog maintenance plan	Compliance reports in estates Function and reported to compliance groups - working to identify gaps and mitigations - Reporting in place on progress and PAM complete and provides positive assurance to be reported to November FPC. On track and reported to Capital Investment Meeting - six facets due to complete Quarter 4	Positive Neutral	Amber
Oversight Arrangements for Governance & Engagement Finance and Performance for estates planning and compliance and Strategy Transformation and Partnerships Committee for transformation (from Sept 24) Capital Investment Meeting Estates related compliance groups in place (water, fire, health and safety) Shared Services Programme Board New Hospital Programme Board	Escalation reports to Board - reported Dec 24 onwards QIA of capital schemes Reporting into F&P from Sept 24 Reports to Our Dorset Provider Collaborative and Board approvals re OBC & FBC - future arrangement to be confirmed Programme approved, NHP Programme Board report to STP Committee & NHSE	Positive Positive Positive Neutral Positive	Green

Actions to Improve Controls and Assurance <i>(Required for any areas assessed Amber or Red)</i>	Lead	Target Date	Progress Summary
Develop Joint Estates Strategy - Agreed date change to Nov 25 as the enabler for Estates Strategy is a Six Facet Survey to be completed across DCH and DHC - Now postponed to Jan 26 as awaiting six facets results for DHC and uncertainty re future operating model in light of subsidiary company plans	CH	Jul-25 Nov-25 Jan 26	Behind Schedule
Completion of all required governance and due diligence in respect of wholly owned subsidiary - revised date to Nov 25 due to pause - NHS guidance received that cannot progress without Union support. Currently reviewing options.	DM	Aug-25 Nov 25	Behind Schedule

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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		Risk Score	Consequence	Likelihood	Score
Chief Finance Officer		Unmitigated	4	4	16
		Mitigated	4	4	16
		Target	4	3	12
		Rationale for Score No change in score - on trajectory for delivery FOT. Surplus position against plan and breakeven to H2 trajectory, with a year to date surplus of £1.3m. The Trust's full year efficiency target is £38.5m, which is fully identified but retains some risk in relation to anticipated income.			

Controls	Assurance	Assessment
What we have in place to support delivery of the objective	Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)	Outcome of assurance
Priority Programmes and Strategies		(See assessment guidance)
25/26 operational plan to deliver a surplus position of £9.8m, within the Dorset system breakeven position (£38.2m efficiency target required to deliver the planned surplus - 40% agency reduction, 20% bank reduction, 10% reduction in corporate services costs. Nominal target of 411 WTE reduction to support delivery of efficiency target)	Finance and Operational Plan approved by Board April 2025. Board Assurance Template agreed Board April 25. Oversight via Efficiency Delivery Group and Finance and Performance Committee and Financial Recovery Board established Oct 25. Outputs from independent review to FPC July 25 and recommendations to be implemented - Financial Delivery Director in post from Oct 25	Neutral
H2 agreed trajectory plan with effect from month 7, to achieve FOT. 2025/26 CIP target of £38.5m required in full to meet £9.8m surplus plan. H2 recovery plan developed to bridge original unidentified CIP gap of £9.6m and deliver to plan. CIP achievement to date has led to a revised WT reduction requirement to support the financial position, moving the required 411 WTE reduction to 229 WTE.	Financial Recovery Board and Financial Delivery Director operating / in post. Triple Lock governance - £25k limit - all trust exp to go thorough tripe lock meet. Regular updates provided - NED briefings; Board and Committee reports and Board Development	Neutral
Medium Term Financial Plan - underlying position recovery and improve future sustainability	Medium Term Financial Plan - pending release of technical guidance templates and allocations. Draft organisation submission due 17 Dec 25 and final submission end Jan 26 - 3 year revenue plans and 4 year capital plans. Developing plans in accordance with timetables based on information and guidance available. Active disccsions taking place at CEO CFO level at system level re future financial envelopes. Regular updates provided - NED briefings; Board and Committee reports and Board Development	Neutral
Risk Controls and Plans		
Regular budget meetings, regular attendance at DMGs, budget manager training	Finance Reporting to Finance and Performance Committee and Trust Board; IA review of budgetary control provided positive assurance	Positive
System wide working and scrutiny	System groups - triple lock meeting and Medium term Plan Meeting (ICB chair + providers + NHSE - weekly)	Neutral
Increased focus on delivery of efficiencies and establishment of stakeholder groups to support delivery of plans	Efficiency delivery group oversight, with reporting to Finance and Performance Committee. Increased reporting requirements and scrutiny from NHSE	Neutral
Oversight Arrangements for Governance & Engagement		
Finance and Performance Committee	Escalation Reports to Board, Finance Report to Committee and Board; new grip and control template to be reviewed	Positive
Efficiency Delivery Group	Internal audit of process and recommendations implemented Efficiency Delivery Group reports to FPC and Financial Recovery Board to be established	Neutral
System wide working - Medium Term Plan Group, CEO Escalation meeting	Financial oversight reports internally and System ICB	Positive

Actions to Improve Controls and Assurance	Lead	Target Date	Progress Summary
New Financial Delivery Team arrangements to be established across DCH and DHC to give pace and focus on financial recovery - In progress - Financial Recovery Director in post from October 25 and team to be established now in post	CH	Sep-25	Behind Schedule
Financial Recovery Board DCH and DHC to be established July 25 and governance to be refined in line with independent review recommendations - Complete FRB in place with reporting to FPC	CH	Aug-25	Complete

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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		Risk Score	Consequence	x	Likelihood	=	Score	Rationale for Score Increased consequence score to 4. 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, locally clinical services strategy review commissioned and to report in Q4
Chief Executive Officer		Unmitigated	4	x	3	=	12	
		Mitigated	4	x	3	=	12	
		Target	3	x	2	=	6	

Controls	Assurance	Assessment
What we have in place to support delivery of the objective	Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)	Outcome of assurance (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. Review of clinical strategy work underway.	Neutral
Our Dorset Provider Collaborative	Our Dorset Provider Collaborative(PC) Board - Programme Director in post / ODPC minutes to Board / NED PC Oversight Group in place from Nov 24/ B2B2B March 25 and Sept 25/ Joint CDIO appointed April 25	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 - there is not a single transformation approach across the system but the strategy review may achieve this	Neutral
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
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 consistently meeting and to recommence Nov 25 - STP CiC Informal session Oct 25 to inform improvement framework	Neutral
Oversight Arrangements for Governance & Engagement		
ICB and ICP Membership	Changes in progress re ICB clustering arrangements and ten year plan re ICB membership and ICP	Neutral
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	Lead	Target Date	Progress Summary
Review of Joint Transformation and Improvement Board - Meeting re-commenced from November 25 and monthly thereafter	PL	Sep-25	Complete
Board development session of strategy transformation and improvement approach - STP CiC Informal session Oct 25 to inform improvement framework	PL	Sep-25	Complete
Review of function and membership of STP with a question about strengthening the involvement of other partners	JH	Jan-26	On Plan
ODPC oversight to be reviewed, with agreement with partners	JH	Feb-26	On Plan

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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		Risk Score		Rationale for Score	
Chief Nursing Officer		Unmitigated	Consequence x Likelihood = 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.	
		Mitigated	4 x 4 = 16		
		Target	4 x 3 = 12 3 x 2 = 6		

Controls	Assurance	Assessment
What we have in place to support delivery of the objective		
Priority Programmes and Strategies	Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)	Outcome of assurance
Joint Strategy	Approved Strategy - Metrics approved at STP CIC Sept 25 and will report on from Q3	Neutral
One Transformation Approach (including Integrated Neighbourhood Teams and Flagships Programmes)	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 consistently meeting and to recommence Nov 25. STP CIC Informal session Oct 25 to inform improvement framework	Neutral
New Hospital Programme	Programme approved, NHP Programme Board report to STP Committee & NHSE	Positive
Electronic Health Record (EHR) Programme (Outline Business Case - OBC)	EHR OBC approved for DCH and procurement stage commenced. DHC in approval process - progressing to preferred supplier stage Board approval Nov 25	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 and published Sept 25 (Digital delayed to enable new joint CDIO to review and input - Digital Strategy to STP CIC Nov 25 and Board Dec 25	Positive
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 - awaiting publication of further national implementation plans	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
Implementation of Patient Care Race Equality Framework (PCREF)	Self-assessment against national organisational competencies - reporting to STP Committee March 25 and Board Oct 25 which identified progress made and actions required, followed by Board Dev session Nov 25 on anti-racism and inclusion	Neutral
Oversight Arrangements for Governance & Engagement		
Portfolio Boards - Flagships, Integrated Neighbourhood Teams and Working Together Portfolio Boards	Transformation Reports	Positive
Joint Transformation Improvement Board	One Transformation Highlight Reports - not consistently met -and to recommence Nov 25. STP CIC Informal session Oct 25 to inform improvement framework	Neutral
STP Committee from Sept 24	Escalation Reports to Board	Positive

Actions to Improve Controls and Assurance	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 concept' and implementation to follow - Metrics approved at STP CIC Sept 25 and will report on from Q3	PL	Nov-24 Mar-25 Sept 25	Complete
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' - on plan for agreed revised timetable stage - Review of Joint Transformation and Improvement Board required - new executive leadership and JTIB to recommence from Nov 25 to establish as 'Business as Usual'	PL	Oct-24 June-25 Sept-25 Jan 26	Behind Schedule

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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	Rationale for Score
Chief Finance Officer		Unmitigated	5	x	4	=	20	Score unchanged - Strategy & roadmap will determine future state & seek to mitigate risks with legacy infrastructure. Now included in EHR. Joint CDIO appointed and enabling plan being developed.Senior leadership now appointed to and appointments made to senior team across mental health, communityand acute
		Mitigated	4	x	4	=	16	
		Target	3	x	2	=	6	

Controls	Assurance	Assessment
What we have in place to support delivery of the objective	Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)	Outcome of assurance
Priority Programmes and Strategies		(See assessment guidance)
Joint digital strategy for DCH/DHC	NHSE Digital Maturity Assessment (DMA), NHSE What Good Looks Like (WGLL)BDO Audit of digital maturity Dorset Wide Digital Strategy (DCH/DHC/UHD) presented to Committee Nov STP Committee and Dec Board	Positive Green
EHR Programme (HealthSet)	Board approved EHR (Healthset) OBC. Dorset and Somerset OBC approved and procurement now concluded - at preferred supplier stage Dec 25	Positive
Risk Controls and Plans		
Digital risks monitored and reported - non clinical risk register	Monthly to DHC SLG and Audit Committee - Non Clinical Risk Register. New Director of IT and Infrastrcure in post from Oct 25 and undertaking a review of all digital risks	Neutral Amber
Data Security & Protection Toolkit	Submission is via Audit Committee, and audited by BDO, reviewed by SIRO	Positive
Oversight Arrangements for Governance & Engagement		
Joint Digital Services Leadership Group DCH & DHC - in process of being replaced by Dorset wide forum	Governance and reporting to be developed - New Director of IT and Infrastrcure in post from Oct 25 and undertaking a review - to be reviewed across all 3 Dorset providers within the context of the development of a Dorset wide Target Operating Model	Neutral Amber
Strategy, Transformation and Partnership Committee from September2024	TOR approved - Reporting to Board commenced October 2024	Positive
EHR Programme Board and EHR Advisory Group	EHR Report into Board	Positive

Actions to Improve Controls and Assurance	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 - Complete STP CiC Nov 25 and Board Dec 25	BB	Mar-25 Sept-25 Dec-25	Complete
Implementation of Federated Data Platform (NHSE Mandate)	BB	Mar-26	On Plan
Development of Infrastructure roadmap to support joint digital strategy - postponed to Dec 25 as new joint CDIO in post from April 25 - To be prepared following Digital Strategy - March 26	BB	Mar-25 Dec-25 Mar-26	Behind Schedule
Establish Dorset wide digital leadership group - In progress - Review of DTAG and reporting arrangements to be undertaken by new Digital Senior Leadership Team (3rd person starts Jan 26)	BB	Dec-25 Mar-26	Behind Schedule
Full infrastrcuture audit or revenue and capital requirements moving forward	RK	Mar-26	On Plan

Dorset HealthCare University NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care Sustainability	SR10 Cyber security If we do not take sufficient steps to ensure our cyber security arrangements are maintained and up to date then we are at increased risk of a cyber security incidents	Strategy, Transformation & Partnerships
Executive Lead	Risk Score	Consequence x Likelihood = Score
Chief Finance Officer	Unmitigated	4 x 4 = 16
	Mitigated	3 x 3 = 9
	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. New Director of IT and Infrastrcure in post from Oct 25 and undertaking a review	

Controls	Assurance	Assessment
What we have in place to support delivery of the objective	Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)	Outcome of assurance
Priority Programmes and Strategies		
Joint DCH/DHC Digital Strategy (inc cybersecurity)	NHSE Digital Maturity Assessment & NHSE What Good Looks Like (WGLL) Dorset Wide Digital Strategy (DCH/DHC/UHD) presented to Committee Nov STP Committee and Dec Board	Positive Green
Risk Controls and Plans		
Data Security & Protection Toolkit	Submission is via Audit Committee, and audited by BDO, reviewed by SIRO	Positive
Monitoring of alerts, patching & maintenance, password controls, multifactor authentication	Cyber security audit conducted July 23, updated report to A.C March 24	Neutral
Use of Microsoft Defender for Endpoints and other NHSE central services for cyber security	Cyber security audit conducted July 23, updated report to A.C March 24	Neutral
Oversight Arrangements for Governance & Engagement		
Digital Services Leadership Group	Cyber exposure score reported monthly Digital Services Leadership Group - New Director of IT and Infrastrcure in post from Oct 25 and undertaking a review - to be reviewed across all 3 Dorset providers within the context of the development of a Dorset wide Target Operating Model	Neutral
IG Group (covers cyber)reporting to STP Committee from September2024	Reports to STP Committee	Positive
Strategy Transformation and Partnerships Committee from Sept 24	Escalation Report to Board (from Sept 24) Cyber Report to Board Dec 24 and Dec 25	Positive

Actions to Improve Controls and Assurance	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 - Complete now incorporated into Dorset Wide Digital Strategy - to STP CiC Nov 25 and Board Dec 25	AH	Nov-24 Jan-25 Dec 25	Complete
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 - Complete STP CiC Nov 25 and Board Dec 25	PK	Mar-25 Dec 25	Complete
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 - Complete STP CiC Nov 25 and Board Dec 25	SD	Mar-25 Dec 25	Complete
Full audit to be undertaken of cyber security arrangements (inc governance and technology) to be undertaken	RK	Mar-26	On Plan

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 - DCH	
Date of Meeting	9 December 2025	
Report Title	Board Assurance Framework – Quarter 2 25/26	
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 24 November 2025 Board Assurance Framework – Audit Committee 21 December 2025	
Action Required	Approval	No
	Assurance	Yes
	Information	No

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? <i>Delete as required</i>	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	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 DCH BAF for Quarter 2 2025/26. 2. Board Assurance Framework: 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.

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 as reviewed and agreed by the Joint Executive Management Team

Each risk has also been assigned to a committee and was reviewed during week commencing 24 November 2025. The full BAF was reviewed by the Audit Committee on 1 December 2025.

The following updates were made following the Audit Committee:

- The unmitigated score related to SR5 Estates was 16 which was lower than the mitigated score at 20. This has been reviewed and updated to 20.
- Update to control in respect of the review of the estates operating model (SR5) and the timing of the technology roadmap (SR9).

The Committee had a discussion on the overdue actions and were assured on the reasons for this and the robustness of the review process.

3. Developments since the last review

The developments below were planned for this reporting cycle. A status update is provided below.

- **Key metrics will be assigned to each risk** – key metrics were planned to be assigned to each risk. Work to identified key metrics has been reviewed in the light of the Performance Assessment Framework and the Ten-Year Plan. The strategic metrics were reported to the Strategy Transformation and Partnership Committee in September 2025 and as reporting is established, we will consider how they can be incorporated into the BAF.
- **Risk appetite** – The Board held a workshop on 02 September 2025 to review the Risk Appetite statements of each organisation to see if they could be aligned, recognising that each organisation's tolerance may be different. There was a requirement to agree the approach around the qualitative approach across 8 risk types broadly based on the guidance provided by the Good Governance Institute (GGI). The qualitative approach was agreed. The results of the discussions resulted in a consensus of the Risk Appetite. This is a separate agenda item on the Audit Committee agenda. Once approved the risk appetite statements will be incorporated into the BAF.

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4. Quarter Two 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 has been two changes in score since the Q1 review:

SR2 Culture: Increase in score from 9 to 12. This reflects the need to embed the work undertaken to today and measure the impact, and also recognises the impact that the level of change in the NHS both locally and nationally is having on our staff.

SR7 Collaboration: Increase in score from 9-12. Again, this reflects uncertainty created by the scale and pace of change in the NHS. The clinical services strategy review is underway and will report in Q4.

Actions

Gaps in controls and assurance are identified across all strategic risks and clear actions to address these have been identified. Where an action has not been achieved by the due date this is marked on the actions plan as 'Behind Schedule' and a revised date has been added.

Seven out of ten risks have at least one action that is behind schedule, with revised dates agreed. In total there are nine overdue actions, 12 on plan actions and 17 completed actions. There are no concerns regarding the overdue actions and there is confidence in the revised completion dates.

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 and provide any further commentary on the controls, assurance and actions.

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Dorset County Hospital
NHS Foundation Trust

Dorset County Hospital NHS Foundation Trust
Board Assurance Framework
Quarter 2 October 2025

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04/12/2025 09:14:16

Dorset County Hospital NHS Foundation Trust													
Board Assurance Framework Overview - Quarter 2 November 2025		Strategic Objectives				Responsibility		Score					
Strategic Risks	Care	Communities	Colleagues	Sustainability	Committee	Executive	Unmitigated	Mitigated Q2 24-25	Mitigated Q3 24-25	Mitigated Q4 24-25	Mitigated Q1 25-26	Mitigated Q2 25-26	Target
							Score	Score	Score	Score	Score	Score	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	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	12	6
SR3: Workforce Capacity If we are not able to recruit and retain the required number of staff with the right skills we will not be able to deliver high quality and safe sustainable services within our resources	X		X		People and Culture	Chief People Officer	15	15	15	15	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	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	20	12	16	16	20	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	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 Executive Officer	12	9	6	9	9	12	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 Nursing Officer	16	12	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 Digital Information Officer	20	12	16	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 Digital Information Officer	15	12	12	12	12	12	9

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Dorset County Hospital NHS Foundation Trust

Strategic Objective		Strategic Risk					Overseeing Committee		
Care		SR1: Safety and Quality If we are not able to deliver the fundamental standards of care in all of our services we will not be providing consistently safe, effective and compassionate care					Quality Committee		
Executive Lead		Risk Score	Consequence	x	Likelihood	=	Score	Rationale for Score	
Chief Nursing Officer		Unmitigated	4	x	4	=	16	Score remains the same. Trust is rated Good following recent CQC maternity inspection. EQJA panel is now established and reviewing all appropriate organisational changes. Ongoing checks and balances in place to manage safe levels of staffing according to operational pressures, acuity and dependency.	
		Mitigated	4	x	3	=	12		
		Target	3	x	4	=	12		

Controls	Assurance	Outcome of assurance	Assessment
<i>What we have in place to support delivery of the objective</i>	<i>Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)</i>		<i>(See assessment guidance)</i>
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 priorities	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. Maternity CQC Inspection Report 2025 'Good'	Positive	
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. Process of oversight of CQC self-assessments to CQC Compliance Group commenced (with reporting through to Quality Committee via QGC)	Positive	
Quality Committee Framework	Quality Reports and Dashboards; EQIA SOP approved and in line with national template with bi-monthly reporting to Quality Committee (June July Sept 25)	Neutral	
Health Inequalities Plan	Joint Health Inequalities Steering Group scoped and to commence, with a Joint health Inequalities Improvement Plan to be developed	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. Six month review of progress at informal Quality CIC Oct 25	Positive	Green
Patient Safety Committee	Patient Safety Incidents Report and Assurance Reporting to Quality Committee	Positive	
Patient Safety Committee and Clinical Effectiveness Committee and Experience of Care Committee and Infection Control Committee and Safeguarding Committee	Quality Governance Framework to Quality Committee Sept 25. Cadence of escalation and assurance report to Quality Governance Group and through to Quality Committee	Positive	

Actions to Improve Controls and Assurance	Lead	Target Date	Progress Summary
Completion of CQC self assessments and actions plans - Under review following recent CQC changes. Process of reporting self-assessments through to Quality Governance Group has commenced	Jhow	Mar-25 Sept 25	Complete
Review metrics and reporting against National Quality Board Recommendations - expected Dec 25	Jhow	Dec-25	On Plan
Review EQIA template against new national guidance - now in place	Jhow	Sep-25	Complete
Joint Health Inequalities Steering Group scoped and to commence, with a Joint Health Inequalities Improvement Plan to be developed	Jhow	Feb-26	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 Chief People Officer	Risk Score	Consequence	x	Likelihood	=	Rationale for Score Increased likelihood score. Much work has been done inc Joint Inclusion and Belonging Group, anti-racism framework, managers guidance on unacceptable behaviours and the inspire awards - now need to continue to launch and embed measure impact. Increased demand for services impacts on workload coupled with a high degree of uncertainty due to local and national changes
	Unmitigated	5	x	3	=	
	Mitigated	3	x	4	=	
	Target	3	x	2	=	

Controls <i>What we have in place to support delivery of the objective</i>	Assurance <i>Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)</i>	Outcome of assurance	Assessment <i>(See assessment guidance)</i>
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 2025 <i>Staff Survey underway and week monitoring of completion rates in place</i>	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. <i>Board Development Session on Anti-Racism and Inclusion Nov 25 and anti-racism framework to PCC and Board Nov / dec & launch of Guidance on Unacceptable Behaviours (and supporting tools)</i>	Neutral	Amber
Risk Controls and Plans			
Freedom to Speak Up Policy	Freedom to Speak Up bi-annual and annual reports; Sexual Safety Action Plan	Neutral	
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	Green
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	
Equality and Inclusion Group Health and Wellbeing Steering Group	Assurance Reports to People and Culture Committee. <i>Joint Inclusion and Belonging Group in place from Sept 25 with reporting to PCC from Nov 25</i>	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 <i>(Required for any areas assessed Amber or Red)</i>	Lead	Target Date	Progress Summary
Establishing the Culture and Inclusion Reference Group - Not yet established to commence 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 agreed to bring back to July Committee for approval - first meeting scheduled Sept 25 - <i>first meeting took place in September 25 and scheduled quarterly with reporting to People and Culture Committee in Nov 25 - Complete</i>	NP	Nov-24 Apr-25 Jun-25 Sept-25	Complete
Staff engagement capacity and plan to be considered as part of People Team Collaboration (DCH/DHC) - <i>in progress - moved to March 26 when process expected to be complete</i>	NP	Sept-25 Mar-26	Behind Schedule
Staff reporting anonymised system - policy and system to be lauched May 25 - Embed and review and report back to PCC Oct 25 - <i>in People Dashboard to PCC Nov 25 - Complete</i>	NP	Oct-25	Complete
<i>Launch of Managers Guidance on Unacceptable Behaviour - review impact in line with EDI review and reporting cycle</i>	NP	Jul-26	On Plan
<i>Implementation of Anti-racism framework and charter</i>	NP	Jan-26	On Plan

Dorset County Hospital NHS Foundation Trust									
Strategic Objective		Strategic Risk					Overseeing Committee		
Care Colleagues		SR3: Workforce Capacity If we are not able to recruit and retain the required number of staff with the right skills we will not be able to deliver high quality and safe sustainable services within our resources					People and Culture		
Executive Lead		Risk Score	Consequence	x	Likelihood	=	Score	Rationale for Score	
Chief People Officer		Unmitigated	5	x	3	=	15	Score unchanged. WTE reductions- WTE controls & QIA mitigate impact on delivery of safe services. Improving reporting and timely monitoring of progress. over reliance on temp staffing. Ongoing high use of tempn staff is mitigating risk but present challenge to achieving overall required WTE reductions	
		Mitigated	5	x	3	=	15		
		Target	3	x	3	=	9		

Controls	Assurance	Assessment
What we have in place to support delivery of the objective	Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)	(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
Workforce Planning approach 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 delivery 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
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. MARS scheme launched. DCH WTE continues to be away from plan - predom due to temp staff usgae in response to increased demand at the hospital - reported to PCC	Negative
Oversight Arrangements for Governance & Engagement		
People & Culture Committee	Assurance / Escalation Report to Board; underlying governance established and reporting in place	Positive
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	Lead	Target Date	Progress Summary
Ten year Plan published July 25 - implication for workforce to be considered and detailed NHS Workforce plans awaited and will respond as published - awaiting further detail - date amended to Feb 26	EH	Dec-25 Feb 26	Behind Schedule
Financial Recovery Board to be established to main oversight of workforc reductions - In place with reporting to Committee in place and update to Board Oct 25 and Board Development session Nov 25 - complete	NP	Jul-25	Complete
Additional workfrc controls - Increasing centralised control of temporary staffing at DCH, enhanced overtime controls, further reduction of FTC and exec review of additional workforce actions to achieve year end position	NP	Dec-25	On Plan
Mars scheme launched - impact on WTE to reviewed when process complete	NP	Jan-26	On Plan

Dorset County Hospital NHS Foundation Trust

Strategic Objective

Care
Communities
Sustainability

Strategic Risk

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

Overseeing Committee

Finance and Performance

Executive Lead

Chief Operating Officer

Risk Score

Unmitigated
Mitigated

Target

Consequence

4

3

3

x

x

x

Likelihood

4

3

2

=

=

=

Score

16

9

6

Rationale for Score

No change in score. In NOF 3 - driven by financial override and not operational performance. In latest NOF DCH ranked 48th / 134 providers& in 'Access to services' domain segment DCH in segment 2 (above average)& 5th highest performing small trust nationally with NOF. As at Sept 25 (Q2 data) strong performance across all operating plan metrics.

Controls

What we have in place to support delivery of the objective

Priority Programmes and Strategies

Patient Flow Program (Internal to DCH with partners)

UEC Review (Newton - Future Care) with System partners

Operational Plan 25/26 (in accordance with national planning guidance and inc Elective Recovery Fund - ERF)

Risk Controls and Plans

Elective Recovery activities and monitoring against Performance Assessment Framework

UEC Improvement Plan

Performance Management Framework (and resulting deep dive reviews)

Seasonal surge plan

Oversight Arrangements for Governance & Engagement

Finance and Performance Committee

System Planned Care Delivery Group /Elective Performance Management Group (EPMG) /Productivity weekly meetings / weekly regional meetings for oversight of the operational plan performance delivery

UEC System meetings - weekly/monthly/Qtrly and Seasonal Surge Planning

Divisional Performance Meetings

UEC (Newton) Governance framework agreed and in place

Assurance

Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)

Regular updates against key plans and outcomes via F&P reporting

Board Development Session Nov 24 and Approved Partnership Agreement Dec 24; Board Development session May 25 and report to board Aug 25

Reported to F&P and Board (including risks to achievement of plan). Underpinning governance shared with FPCIC and agreed

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 - averaging above 2% consistently

Work underpinning is within Divisional Performance and F&P reports - and underpinned by both Divisional Improvement Plans and Patient Flow Program achieving key targets for ambulance handovers and 4 hours ED performance - achieving key targets for ambulance handovers and 4 hours ED performance (End of Oct plan for meeting- 12hrs)

Performance Report to F&P and Board and Deep Dives / Internal Audit Reports

Surge plan reported to F&P with monitoring via Performance Report, Winter Plan approved

Performance Report to F&P and Assurance Report to Board

Performance Report to F&P and Board

Surge plan reported to F&P with monitoring via Performance Report

Performance Report to F&P and Board and Deep Dives

Performance Report to F&P and Board and Deep Dives

Outcome of assurance

Positive

Positive

Positive

Positive

Positive

Neutral

Positive

Positive

Positive

Positive

Positive

Positive

Assessment

(See assessment guidance)

Green

Amber

Green

Actions to Improve Controls and Assurance

(Required for any areas assessed Amber or Red)

Review performance plans in response to Performance Assessment Framework and segmentation - outline plan to FPC Sept 25 - complete

Lead

AT

Target Date

Aug-25

Progress Summary

Complete

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	Rationale for Score
Chief Finance Officer		Unmitigated	4	x	5	=	20	Mitigated score unchanged, unmitigated amended - increased assurance critical infrastructure and backlog and future funding however, uncertainty regarding future operating model in light of latest NHSE guidance regarding wholly owned subsidiaries
		Mitigated	4	x	5	=	20	
		Target	3	x	3	=	9	

Controls	Assurance	Assessment
<i>What we have in place to support delivery of the objective</i>	<i>Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)</i>	<i>Outcome of assurance</i>
Priority Programmes and Strategies		
New Hospital Programme	NHP Business Case, programme approved and build progressing	Positive
Joint Estates Strategy to be developed - not yet in place	Six facets survey complete and will inform strategy - six facets survey to FPC July 25 and Board Aug 25	Neutral
Review of the operating model for estates and facilities	OBC approved by Board Apr 25 and FBC May 25. Programme Board in place. NHS guidance received that cannot progress without Union support. Currently reviewing options.	Negative
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. We have submitted bids for funding for six facet priorities and favourable responses for high risk schemes. Five year plan submitted to Dorset ICB	Neutral
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 - Compliance and reporting in place - As at Oct 25 90% compliant. PAM complete and provides positive assurance to be reported to November FPC.	Positive
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. Good progress made - new Fire Safety Manager in post and local area Fire Service providing positive feedback on progress with update provided to November FPC.	Neutral
Backlog maintenance plan	Rported to Capital Investment Meeting - increased funding due to successful bid. However, six facets survey identified increased level of unfunded backlog maintenance - need new 5 year plan and funding to be identified - We have submitted bids for funding for six facet priorities and favourable responses for high risk schemes	Neutral
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
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 - future arrangement to be confirmed	Neutral

Actions to Improve Controls and Assurance	Lead	Target Date	Progress Summary
Develop Joint Estates Strategy - Agreed date change to Nov 25 as the enabler for Estates Strategy is a Six Facet Survey to be completed across DCH and DHC - Now postponed to Jan 26 as awaiting six facets results for DHC and uncertainty re future operating model in light of subsidiary company plans	CH	Jul-25 Nov 25 Jan 26	Behind Schedule
Completion of all required governance and due diligence in respect of wholly owned subsidiary - revised date to Nov 25 due to pause - NHS guidance received that cannot progress without Union support. Currently reviewing options.	DM	Aug-25 Nov 25	Behind Schedule
Re-prioritise critical infrastructure and total backlog maintenance based on funding available - Complete - all reprioritised and submitted to NHS Dorset	DM	Sep-25	Complete

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		Risk Score		Rationale for Score	
Chief Finance Officer		Unmitigated Mitigated Target		No change in score - we have closed over unidentified gap modelled through H2 trajectory, but there remains high risk in plans and outcome of shared services non delivery outcomes will impact on our ability to achieve our plan and sustain cash levels	
		Consequence	x	Likelihood	= Score
		4	x	5	= 20
		5	x	4	= 20
		4	x	3	= 12

Controls	Assurance		Assessment
What we have in place to support delivery of the objective	Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)		(See assessment guidance)
Priority Programmes and Strategies			
Operational Plan 2025/26 deficit plan of £9.8m for DCH within overall Dorset system plan requirement	Oversight via Finance Reporting to Finance & Performance Committee and Senior Leadership Group and Trust Board, plus bi-weekly Financial Recovery Board established to support Trust delivery. Outputs from independent review to FPC July 25 and recommendations to be implemented - Financial Delivery Director in post from Oct 25		Neutral
H2 agreed trajectory plan with effect from month 7 - 2025/26 8.6% CIP target of £29m required in full to meet £9.8m deficit plan. As part of £29m CIP £4.5 million classed as unidentified with further £1.5m system high risk schemes. Following mid year (H2) rview revised trajectory developed to bridge gap of £6m and deliver to plan.	Financial Recovery Board and Financial Delivery Director operating / in post. Triple Lock governance - £25k limit - all trust exp to go thorough tripe lock meet. Within efficiency programme assumption to deliver £11.6m through shared services (sub co) - ongoing discussions with NHSE regarding treatment of deliverability. Regular updates provided - NED briefings; Board and Committee reports and Board Development		Neutral
Medium Term Financial Plan - underlying position recovery and improve future sustainability inc cash focus	Medium Term Financial Plan - pending release of technical guidance templates and allocations. Draft organisation submission due 17 Dec 25 and final submission end Jan 26 - 3 year revenue plans and 4 year capital plans. Developing plans in accordance with timetables based on information and guidance available. Active discssions taking place at CEO CFO level at system level re future financial envelopes. Regular updates provided - NED briefings; Board and Committee areports and Board Development		Neutral
Mitigating risk of cash shortfall - without delivery of efficiency programme and effective cost contrrrols and treatment of shared service non-delivery the Trust is at risk of cash shortfall in current and next financial year	Daily cash monitoring; KPI review and action; efficiency delivery and cost controls and ongoing discussions with NHSE regarding treatment of deliverability - see above.		Negative
Risk Controls and Plans			
Operational workbook completion supported by Transformation & Finance with EQIA process updates - Trust CIP Tracker master for recording, CFO led support review meetings with all areas	Value Delivery Board Executive SRO oversight and reporting to Finance & Performance Committee, bi-weekly Financial Recovery Board re-established with reporting to FPC		Neutral
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
Updated Delivery/Recovery Group established to prevent deterioration in financial position and workforce controls and support delivery of plans	bi-weekly Financial Recovery Board to be re-established and Financial Delivery Director in post		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 reviewed and submitted to NHSE		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	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 established July 25 and governance to be refined in line with independent review recommendations -	NJ/CH	Apr 25 Aug 25	Complete
New Financial Delivery Team arrangements to be established across DCH and DHC to give pace and focus on financial recovery - In progress - Financial Recovery Director in post from October 25 and team to be established now in post	AS	Sept-25 Dec 25	Behind Schedule
Focus on reducing temporary staffing spend - work focussing on bank and agency spend in progress - agency is ahead of plan (ytd by £0.5m) and bank is behind plan (ytd £2.6m) which is linked to operational pressures - ytd 2.5k ED attendances above plan and no significant reduction in NCTR levels seen	NP	Sep-25	Behind Schedule
Active monitoring of cash position and trajectory and outcome of live discussions at CEO / CFO level	CA	Jan-26	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		Risk Score	Consequence	x	Likelihood	=	Score	Rationale for Score
Chief Executive Officer		Unmitigated	4	x	3	=	12	Increased consequence score to 4. 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, locally clinical services strategy review commissioned and to report in Q4
		Mitigated	4	x	3	=	12	
		Target	3	x	2	=	6	

Controls	Assurance	Assessment
<i>What we have in place to support delivery of the objective</i>	<i>Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)</i>	<i>Outcome of assurance</i> <i>(See assessment guidance)</i>
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. Review of clinical strategy work underway.	Neutral
Our Dorset Provider Collaborative	Our Dorset Provider Collaborative(PC) Board - Programme Director in post / ODPC minutes to Board / NED PC Oversight Group in place from Nov 24/ B2B2B March 25 and Sept 25 / Joint CDIO appointed April 25	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 - there is not a single transformation approach across the system but the strategy review may achieve this	Neutral
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
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	Neutral
Oversight Arrangements for Governance & Engagement		
ICB and ICP Membership	Changes in progress re ICB clustering arrangements and ten year plan re ICB membership and ICP	Neutral
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	Lead	Target Date	Progress Summary
Review of Joint Transformation and Improvement Board - Meeting re-commenced from November 25 and monthly thereafter	PL	Sep-25	Complete
Board development session of strategy transformation and improvement approach - STP CiC Informal session Oct 25 to inform improvement framework	PL	Sep-25	Complete
Review of function and membership of STP with a question about strengthening the involvement of other partners	JH	Feb-26	On Plan
ODPC oversight to be reviewed, with agreement with partners	JH	Mar-26	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		Risk Score	Consequence	Likelihood	Rationale for Score
Chief Nursing Officer		Unmitigated	4	4	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.
		Mitigated	4	3	
		Targeted	3	2	
				Score	
				16	
				12	
				6	

Controls	Assurance	Assessment
What we have in place to support delivery of the objective	Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)	Outcome of assurance (See assessment guidance)
Priority Programmes and Strategies		
Joint Strategy	Approved Strategy - Metrics approved at STP CiC Sept 25 and will report on from Q3	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 consistently meeting and to recommence Nov 25. STP CiC Informal session Oct 25 to inform improvement framework	Neutral
New Hospital Programme	Programme approved, NHP Programme Board report to STP Committee & NHSE	Positive
Electronic Health Record (EHR) Programme (Outline Business Case - OBC)	EHR OBC approved for DCH and procurement stage commenced. DHC in approval process - progressing to preferred supplier stage Board approval Nov 25	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 and published Sept 25 (Digital delayed to enable new joint CDIO to review and input - Digital Strategy to STP CiC Nov 25 and Board Dec 25	Positive
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 - awaiting publication of further national implementation plans	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
Joint Transformation Improvement Board	One Transformation Highlight Reports - not consistently met -and to recommence Nov 25. STP CiC Informal session Oct 25 to inform improvement framework	Neutral
STP Committee from Sept 24	Escalation Reports to Board	Positive

Actions to Improve Controls and Assurance	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 concept' and implementation to follow - Metrics approved at STP CiC Sept 25 and will report on from Q3	PL	Nov-24 Mar-25 Sept 25	Complete
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 - new executive leadership and JTIB to recommence from Nov 25 to establish as 'Business as Usual'	PL	Oct-24 June-25 Sept-25 Jan 26	Behind Schedule

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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	Likelihood	Rationale for Score
Chief Digital Information Officer		Unmitigated	5	4	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 and underlying senior leadership now appointed to across mental health, community and acute
		Mitigated	4	4	
		Target	3	2	
					Score
					20
					16
					6

Controls	Assurance	Assessment
What we have in place to support delivery of the objective	Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)	Outcome of assurance (See assessment guidance)
Priority Programmes and Strategies		
Joint digital strategy DCH/DHC	NHSE Digital Maturity Assessment (DMA), NHSE What Good Looks Like (WGLL) Dorset Wide Digital Strategy (DCH/DHC/UHD) presented to Committee Nov STP Committee and Dec Board	Positive Green
EHR Programme (HealthSet)	Board approved EHR (Healthset) OBC. Dorset and Somerset OBC approved and procurement now concluded - at preferred supplier stage Dec 25	Positive
Risk Controls and Plans		
Digital risks monitored and reported	Monthly Report to Digital Transformation and Assurance Group (DTAG). New Director of IT and Infrastructure in post from Oct 25 and undertaking a review of all digital risks. New IT demand at DCH paused to allow focus on triaging backlog and review of how digital decisions made.	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
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 governance and clarity on decision making role - new membership and TOR strengthened. New Director of IT and Infrastructure in post from Oct 25 and undertaking a review	Neutral Amber
Joint Digital Services Leadership Group DCH & DHC - in process of being replaced by Dorset wide forum	Governance and reporting reviewed and strengthened - to be reviewed across all 3 Dorset providers within the context of the development of a Dorset wide Target Operating Model	Neutral
Information Governance Group (also covers cyber)	Bi-monthly report to STP	Positive

Actions to Improve Controls and Assurance	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 - on plan for previously agreed revised date - Complete STP CIC Nov 25 and Board Dec 25	BB	Mar-25 Sept-25 Dec-25	Complete
Implementation of Federated Data Platform (NHSE Mandate)	BB	Mar-26	On Plan
Development of Infrastructure roadmap to support joint digital strategy - postponed to Dec 25 as new joint CDIO in post from April 25 and will form part of Dorset wide strategy and integrated approach across Dorset - on plan for previously agreed revised date- To follow Digital Strategy - revised to March 26	BB	Mar-25 Dec-25 Mar-26	Behind Schedule
Establish Dorset wide digital leadership group - In progress - Review of DTAG and reporting arrangements to be undertaken by new Digital Senior Leadership Team (3rd person starts Jan 26)	BB	Dec-25 Mar-26	Behind Schedule
Full infrastructure audit of revenue and capital requirements moving forward	RK	Mar-26	On Plan

Dorset County Hospital NHS Foundation Trust

Strategic Objective		Strategic Risk				Overseeing Committee
Care Sustainability		SR10 Cyber security If we do not take sufficient steps to ensure our cyber security arrangements are maintained and up to date then we are at increased risk of a cyber security incidents				Strategy, Transformation & Partnerships
Executive Lead		Risk Score	Consequence	x	Likelihood = Score	Rationale for Score
Chief Digital Information Officer		Unmitigated	3	x	5 = 15	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. New Director of IT and Infrastrcure in post from Oct 25 and undertaking a review
		Mitigated	3	x	4 = 12	
		Target	3	x	3 = 9	

Controls <i>What we have in place to support delivery of the objective</i>	Assurance <i>Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)</i>	Outcome of assurance	Assessment <i>(See assessment guidance)</i>
Priority Programmes and Strategies			
Joint DCH/DHC Digital Strategy (inc cybersecurity)	NHSE Digital Maturity Assessment & NHSE What Good Looks Like (WGLL) Dorset Wide Digital Strategy (DCH/DHC/UHD) presented to Committee Nov STP Committee and Dec Board	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. Dir of IT Infra to undertake review	Neutral	
Cyber Security monitoring arrangements and system controls	Quarterly cyber security report to FPC Dir of IT Infra to undertake review	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 - New Director of IT and Infrastrcure in post from Oct 25 and undertaking a review	Neutral	
Digital Services Leadership Group (recently implemented - with only digital team representation)	Governance and reporting to be developed - to be reviewed across all 3 Dorset providers within the context of the development of a Dorset wide Target Operating Model	Neutral	
Strategy Transformation and Partnerships Committee	Escalation Report to Board (from Sept 24) Cyber Report to Board Dec 24 and Dec 25	Positive	

Actions to Improve Controls and Assurance	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 - Complete now incorporated into Dorset Wide Digital Strategy - to STP CiC Nov 25 and Board Dec 25	SB	Nov-24 Jan 25	Complete
Implement multifactor authentication (MFA) for all staff (in progress) - postponed to July 25 as new joint CDIO in post from April 25 - in place - complete	SB	Nov-24 Feb 25	Complete
Development of Infrastructure roadmap to support joint digital strategy - postponed to July 25 as new joint CDIO in post from April 25 - Complete STP CiC Nov 25 and Board Dec 25	SB	Mar-25 Jul 25	Complete
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 - Complete STP CiC Nov 25 and Board Dec 25	SD	Mar-25 Jul 25	Complete
Full audit to be undertaken of cyber security arrangemnents (inc governance and technology) to be undertaken	RK	Mar-26	On Plan

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 in Common, DCH & DHC	
Date of Meeting	9 December 2025	
Report Title	Board Risk Appetite Statement	
Prepared By	Mandy Ford, Joint Deputy Director of Corporate Affairs	
Approved by Accountable Executive	Jenny Horrabin, Joint Executive Director of Corporate Affairs	
Previously Considered By	Board Workshop 2 September 2025	
	JEMT 5 November 2025	
	DHC Audit Committee 28 November 2025	
	DCH Audit Committee 1 December 2025	
Action Required	Approval	Y
	Assurance	N
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? <i>Delete as required</i>	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	Relates to all Strategic Objectives.	
Financial	Incorporated in risk appetite	
Statutory & Regulatory	Incorporated in risk appetite	
Equality, Diversity & Inclusion	Incorporated in risk appetite	
Co-production & Partnership	Incorporated in risk appetite	

Executive Summary
The risk management framework and the risk appetite form part of the organisation's internal control and corporate governance arrangements. Risk management must be embedded into the Trust's culture and all of its activities. Effective risk management is not about avoiding all risk; with an effective risk management culture and strengthened understanding of risk management we may decide to take more risks in some areas of the organisation. This will always be on an informed basis, ensuring that the benefits of the risk-taking enable us to achieve our ambitions and help us to innovate as effectively and cost efficiently as possible. The risk appetite statement sets out how the organisation balances threats and opportunities in pursuit of achieving its objectives. Understanding and setting a clear risk appetite is essential to achieving an effective risk management framework. It also assists the organisation to have a consistent approach in responding to risks. Following agreement of the risk appetite statements at Board, the risk appetite component will be added to the risk management frameworks and communicated across the organisation. The Board held a workshop on 02 September 2025 to review the Risk Appetite statements of each organisation to see if they could be aligned, recognising that each organisation's tolerance may be different. The results of the discussions resulted in a consensus of the Risk Appetite, and amendment to some of the supporting statements, which are detailed in Appendix 1. Following the workshop, the document was amended and circulated for comments. Any comments received have been included within the revised document. The document was discussed and agreed at JEMT on 05 November 2025 and reviewed by the DHC Audit Committee on 28 November 2025 and DCH Audit Committee on 1 December 2025 and recommended to the DHC and DCH Boards for approval.

The Risk Appetite Statement will be incorporated into the Joint Risk Management Strategy Policy which is currently being developed with the Nursing and Quality Team. This is planned to be presented to the relevant Committees in January 2026.

Recommendation

Members are requested to:

- **Approve the risk appetite statements for DCH and DHC.**

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Board Risk Appetite Statement

1. Introduction

- 1.1 The NHS Code of Conduct emphasises the importance of risk management and the need for a clear risk appetite statement. The statement balances the potential benefits of innovation with the threats that change inevitably brings. It is essential for the Board to continually assess the nature and extent of the risks that the organisation is exposed to and is willing to take to achieve its objectives. The Board sets specific limits (risk ratings) for the levels of risk that the organisation can tolerate, ensuring that planning and governance mechanisms are in place to manage risks effectively.
- 1.2 The risk appetite statement also informs all those responsible for identifying and managing risk at DCH and DHC of the context to use when assessing how a risk should be evaluated. It will form an appendix to the Risk Management Policy when it is updated. A Joint Risk Management Policy is currently being drafted within the Nursing and Quality Directorate. This is due to be presented to the relevant Committees in January 2026.
- 1.3 Having a shared understanding of our collective appetite and tolerance for the different risks and opportunities across the work of each organisation is integral to being an efficient, productive and well led organisation. We continue to develop a risk ethos that focuses on assessing, managing, mitigating and monitoring risks. As we continue to mature our risk culture and approach to risk management, this risk appetite statement ensures that risk management is at the centre of what we do.
- 1.4 DCH and DHC define risk appetite as 'the amount of risk that we are willing to seek or accept in the pursuit of long-term objectives.' It is key to achieving effective risk management and should be considered before risks are addressed. It is not possible to eliminate all risks which are inherent in achieving our corporate objectives and fulfilling our statutory duties. We will need to consider and/or accept a certain level of risk where it is in our, and ultimately patients, best interests.
- 1.6 By defining a risk appetite statement, the Board is able to set the optimal position in pursuit of its strategy and vision and the upper tolerances for reporting/escalation. It is best practice for the Board to review its risk appetite annually.

2. Defining our shared risk appetite

- 2.1 The risk appetite within both organisations aims to prevent failure caused as a consequence of reckless risk-taking and ensure that management and the Board are taking the right risks for success (e.g., to deliver improved impact and value for money). It should facilitate a forward-looking view of risk and be adaptable to local circumstances to help drive management action and facilitate informed decisions, and is:
 - set by the Boards
 - aligned with the federated organisations' strategy and corporate objectives and embedded into key business processes
 - linked to the underlying risks we face and integrated with our control culture, balancing our propensity to take risk with the propensity to exercise control
 - not a single, fixed concept. There will be a range of appetites for different risks across each service and organisation, and these appetites may vary over time; in particular the Board will have freedom to vary the amount of risk which it is prepared to take as circumstances change, for example, during periods of increased uncertainty or adverse changes in the operating environment

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- reviewed once a year, or sooner if circumstances dictate.
- 2.2 The purpose of stating risk appetite within the federated organisations are to:
- Provide awareness and an overall view of our risk profile, giving context to our risk position and exposure.
 - Help steer decision making across the organisations by providing a position against which potential decisions can be tested and challenged.
 - Provide guidance and an objective view on our ability to achieve longer term objectives; guides and monitors whether we are trending towards longer term objectives that the organisations are striving for – in particular the Long-Term Plan.
- 2.3 In the previous April 2025 paper, we proposed that the Boards adopted a **qualitative** approach to risk appetite. The approach was agreed at both Audit Committees and Boards, and agreement gained to undertake a survey of all Board members to review and agree a new risk appetite for each organisation.
- 2.4 The risk appetite is an intrinsic part of our risk management and business processes and should not be seen as something separate or extra. Agreeing a risk appetite will assist with our culture to empower and trust decision makers, to drive consistency and enable staff to take well calculated risks and make accurate risk trade-off decisions to improve delivery when opportunities arise (and identify when a more cautious approach should be taken to mitigate a threat),
- 2.5 From an operational perspective, we need to ensure that the risk appetite reflects the constraints that are already placed upon staff in the organisation. In terms of risk processes, a high-level qualitative risk statement was proposed, structured around the principal risk types.
- 2.6 We have been clear that any risk management process or strategy needs to link in with the Equality, Equity and Quality Impact Assessment processes to ensure that we are not disadvantaging any of the population with the decision making when looking at reviews, changes or cessation of services, and that quality and safety of services are not impacted.
- 2.7 The original proposal was to develop a shared risk appetite across DCH and DHC based around a qualitative approach across 8 risk types broadly based on the guidance provided by the Good Governance Institute (GGI). We proposed that included 8 'risk types' and to have different levels of appetite for each type, ranging from 'none' to 'significant'.
- 2.8 However, following the September 2025 Board Development session, it was decided that the 'Reputational' risk type was as an impact of the other risk types and should be removed as a risk type. The table below details the 7 risk types that were agreed at the Board workshop.

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2.9

Risk Type	Description
Workforce	The risk of unsafe or ineffective patient care resulting from inadequate systems and processes associated with the Trust's workforce supply, skills & capacity, performance and retention, within an appropriate culture.
Operational Performance	The risk of failing to meet national and locally agreed metrics and leading to poorer patient experience and outcomes.
Patient Safety and Quality of Care (Clinical)	The risk of poor patient experience and outcomes resulting from inadequate systems and processes associated with the Trust's capacity planning, infection prevention and management, patient experience, patient safety and outcomes and research and development.
Financial	The risk of direct or indirect loss resulting from inadequate systems and processes to the Trust's management of its finances, financial reporting, funding and cash management.
Compliance and Regulatory	The risk of direct or indirect loss, reputational impact or regulatory action as a result of a failure to comply with regulations, operate within the Law or deliver on our partnership obligations.
Innovation, Partnerships and Commercial	The risk of direct or indirect loss as a result of undertaking, or failing to maximise or deliver innovation, transformation or opportunistic and / or commercial developments or joint working. Risk management can help organisations not only manage the risk inherent in innovation, partnership and commercial arrangements, but also identify entirely new opportunities to improve performance.
Digital	The risk of direct or indirect loss resulting from inadequate systems and processes to the Trust's management of its digital systems, due to infrastructure or age of equipment, and adequate security measures to prevent cyber-attacks. New technologies, and ways of joint working across Dorset, are viewed as a key enablers of operational delivery, productivity and efficiency.

Risk Level	
NONE	Avoidance of risk is a key organisational objective.
MINIMAL	Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.
CAUTIOUS	Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential.
OPEN	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.
SEEK	Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).
SIGNIFICANT	Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust.

2.10 Following agreement at the relevant Committees and at Board, the risk appetite component will be added to the risk management frameworks and communicated across the organisation. The consensus reached at the Board workshop is presented as Appendix 1 (consensus in bold frame and darker shading).

2.11 Appendix 2 details the draft Risk Appetite statement for both organisations.

3 Recommendations

To **approve** the risk appetite for the organisations

Name and Title of Author:

Mandy Ford, Joint Deputy Director of Corporate Affairs

Date: 06.11.2025

4 Appendices

4.1 Appendix 1 Suggested risks type and levels of risk accepted

4.2 Appendix 2: Draft Risk Appetite statement

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Appendix 1: Suggested risks type and levels of risk accepted

	None	Minimal	Cautious	Open	Seek	Significant
Workforce risk	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability and safety are our primary interest.	We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere. Safety will remain our priority.	We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision. Safety will remain our priority.	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is potential for improved recruitment and retention, and developmental opportunities for staff. Safety will remain our priority.	We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognise innovation is likely to be disruptive in the short term but with the possibility of long-term gains. Safety will remain our priority.	We seek to lead the way in terms of workforce innovation. We can accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive change. Safety will remain our priority.
Digital risk	We have no appetite for decisions or actions that may result in digital loss or loss of security of our digital systems.	We are only willing to accept the possibility of very limited digital risk and security of our digital systems. This will include Cyber Security.	We are prepared to accept the possibility of limited digital risk. However, cyber security is our primary concern.	We are prepared to accept some digital risk as long as appropriate controls are in place. This will not include Cyber Security (which will sit with Minimal/Cautious)	We will invest for the best possible return and accept the possibility of digital risk including security elements, which do not include Cyber Security risks (which will sit within Minimal /Cautious).	We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial digital gain outweighs inherent risks. We will not compromise our Cyber Security.
Patient Safety and Quality risk	We have no appetite for decisions with a high chance of an adverse or uncertain impact on patient safety, quality of care and outcomes for the patient.	Appetite for taking very limited clinical risks if essential to patient care and outcomes. Such risks are properly assessed with mitigating controls in place. Avoid innovation unless established and proven to be effective in a variety of settings.	Our preference is for risk avoidance. However, if necessary, we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place. We will not compromise on safety.	We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation where there is potential for significant longer-term rewards and improvement on quality and safety outcomes. We will not compromise on safety.	We will pursue innovation wherever appropriate. We are willing to make decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains. We consistently challenge current working practices in order to drive improvement in quality and safety outcomes. We will not compromise on safety.	We seek to lead the way and will prioritise new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement. We will not compromise on safety
Compliance and Regulatory risk	No appetite for any decisions that present risks to the Trust maintaining its CQC registration, complying with the law, statutory requirements, and policy.	We will avoid any decisions that may result in heightened regulatory challenge unless related actions are essential to the safe and effective care of patients and outcomes.	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident, we would be able to challenge this successfully.	We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.	We are comfortable challenging regulatory proactive. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders.

	None	Minimal	Cautious	Open	Seek	Significant
Innovation, Partnerships and Commercial	We have no appetite for decisions that may have an uncertain impact on quality, outcomes or finance. We aim to maintain or protect, rather than create or innovate. Priority for tight management controls and oversight with limited devolved decision making. General avoidance of systems/technology developments.	We will avoid anything that may impact on quality, outcomes or finances, unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Our preference is for risk avoidance. However, if necessary, we will take decisions on innovation and opportunities where there is a low degree of inherent risk and the possibility of improved quality and outcomes, and appropriate controls are in place. Decision making authority generally held by senior management. Systems/technology developments limited to improvement or protection of current operations.	We support innovation with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery. Responsibility for non-critical decisions may be devolved.	We will pursue innovation wherever appropriate. We have a desire to 'break the mould' and challenge current working practices. New technologies viewed as key enabler of operational delivery. We are willing to take decisions on innovation and opportunities where there may be inherent risks but the potential for significant longer-term gains. Staff are able to act with their levels of devolved authority, within the Delegated Scheme of Authority process and monetary limits and are required to act within a framework of clinical safety. Where stated within the Delegated Scheme of Authority, appropriate sub-committee / Board approval will need to be sought.	We will seek to lead the way and will prioritise new innovations and opportunities, consistently breaking the mould and challenging current working practices. Investment in new technologies as a catalyst for operational delivery in order to drive improvement. Staff are able to act with their levels of devolved authority, within the Delegated Scheme of Authority process and monetary limits and are required to act within a framework of clinical safety. Where stated within the Delegated Scheme of Authority, appropriate sub-committee / Board approval will need to be sought.
Operational Risk	No appetite for action which may impact on operational service delivery. Focus on capability to protect services and maintain tight control.	Limited action may be taken which may impact on operational service delivery only where it is essential to deliver safe and effective, high quality patient care and outcomes. Decision making authority held by senior management.	Appetite for taking moderate risks relating to service delivery where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place. Robust performance oversight processes in place	We are willing to take decisions that will impact on the business-as-usual delivery of services to deliver transformation and secure longer term quality improvement.	Appetite to take investment and transformation decisions in areas which are likely to impact on the delivery and accessibility of services in the short term in order to deliver significant improvement for the long term.	We are willing to accept operational risks where this relates to manageable or tolerable operational issues with no long-term impact on the patient(s) or staff and where the time, money and effort to resolve the issues would not be proportionate to the benefit of doing so. We are willing to consider all potential delivery options and may well consider factors such as reward or reputational benefit when weighing up the benefit of taking a risk

	None	Minimal	Cautious	Open	Seek	Significant
Finance and VFM Risk	We have no appetite for decisions or actions that may result in financial loss. We are only willing to accept the low-cost option as VFM is the primary concern.	We are only willing to accept the possibility of very limited financial risk. VFM is the primary concern.	We are prepared to accept the possibility of limited financial risk. However, VFM is still our primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor. Resources allocated in order to capitalise on opportunities.	We will invest for the best possible return and accept the possibility of financial risk. Resources allocated without firm guarantee of return. (investment capital type approach)	We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks. Resources allocated in 'social capital' with confidence that process is a return in itself.

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Appendix 2: Draft Risk Appetite statement

Dorset County Hospital and Dorset Health Care Risk Appetite (Qualitative Statement)

The risk appetite of Dorset County Hospital (DCH) and Dorset HealthCare (DHC) is grounded in the NHS Constitution. The NHS Constitution sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities which the public, patients and staff owe to one another to ensure the NHS operates fairly and effectively. It is also aligned with the Good Governance Institute: Board guidance on risk appetite.

DCH and DHC believe that no risk exists in isolation from others and that risk management is about **finding the right balance** between risks and opportunities to act in the best interests of patients and taxpayers. Our approach to risk appetite inevitably involves risk trade-off conversations and a consideration of the counterfactual - giving us a flexible framework within which we can try new things, make agile decisions and find a balance between boldness and caution, risk and reward, cost and benefit. It also aims to provide a balance between an approach which is excessively bureaucratic and burdensome and one which lacks rigour.

When balancing risks, DCH and DHC will tolerate some risk types more than others.

Ranges to guide these trade-off discussions are provided in the table below.

	Risk Category	Risk Appetite	Statement
1	Workforce	Seek	We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognise innovation is likely to be disruptive in the short term but with the possibility of long-term gains. Safety will remain our priority.
2	Operational Performance	Open	We are willing to take decisions that will impact on the business-as-usual delivery of services to deliver transformation and secure longer term quality improvement.
3	Patient Safety and Quality of Care (Clinical)	Cautious	Our preference is for risk avoidance. However, if necessary, we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place. We will not compromise on safety.
4	Financial	Open	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor. Resources allocated in order to capitalise on opportunities.
5	Compliance and regulatory	Cautious	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.
6	Innovation, Partnerships and Commercial	Seek	We will pursue innovation wherever appropriate. We have a desire to 'break the mould' and challenge current working practices. New technologies viewed as key enabler of operational delivery. We are willing to take decisions on innovation and opportunities where there may be inherent risks but the potential for significant longer-term gains. Staff are able to act with their levels of devolved authority, within the Delegated Scheme of Authority process and monetary limits and are required to act within a framework of clinical safety. Where stated within the Delegated Scheme of Authority, appropriate sub-committee / Board approval will need to be sought.
7	Digital	Seek	We will invest for the best possible return and accept the possibility of digital risk including security elements, which do not include Cyber Security risks (which will sit within Minimal /Cautious).

Risk Level	
NONE	Avoidance of risk is a key organisational objective.
MINIMAL	Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.
CAUTIOUS	Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential.
OPEN	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.
SEEK	Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).
SIGNIFICANT	Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust.

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Report to	Board of Directors, DHC	
Date of Meeting	9th December 2025	
Report Title	Risk Report	
Prepared By	Karen Fulford, Joint Head of Risk and Clinical Legal Services	
Approved by Accountable Executive	Dawn Dawson, Joint Chief Nursing Officer	
Previously Considered By	Quality Committee on 25 November 2025 DHC Audit Committee on 28 November 2025	
Action Required	Approval	No
	Assurance	Yes
	Information	No

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? <i>Delete as required</i>	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	This report details several risks which are linked to the organisation's strategic risks, as well as emerging risks which may be reported within the Board Assurance Framework • SR1 Quality and Safety • SR3: Workforce Capacity • SR4 Capacity and Demand • SR5: Estates • SR6: Finance • SR9: Digital Infrastructure	
Financial	The report includes clinical risks where financial spends are cited as expected/needed to treat the risk, or the risk may impact on funding provided for service delivery.	
Statutory & Regulatory	The report includes risks which have been: • identified through statutory and regulatory requirements • may affect the organisation's ability to meet such requirements • Failure to treat the risk may lead to regulatory actions (improvement notices etc).	
Equality, Diversity & Inclusion	The report includes risks which may adversely impact on certain groups of patients and/or create health inequalities until the risk is treated.	
Co-production & Partnership	Risks scoring 15+ contained in this report are shared with Dorset Integrated Care Board (ICB) to support the triangulation of system risks.	

Executive Summary
This report has been produced to assure the Board of management of all risks across Dorset HealthCare. Relevant risks scoring 15+ have been considered. This report is a snapshot of relevant risks on the risk register on 19 November 2025. Subsequent updates may have been made to some of these risks before the Board convenes.



The purpose of this report is to provide assurance that risks are identified, mitigated, being treated and reviewed. In summary:

- 11 risks currently score 15+.
- There have been three new risks scoring 15 or above added to the register since the last Board report
- There has been one increase in risk score since the last report.
- There have been three reductions in risk score since the last report, all of these now fall below the Board's review threshold.
- One risk has been closed since the last report.
- Four risks overdue for review
- Full details of all risks are contained in Appendix 5.

Recommendation

Members are requested to:

- To note the report and current position regarding risk and the management of risk
- To receive this update for assurance of the management of risk's scoring 15+ across the Trust.

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Risk Report

1. Executive Summary

1.1 Risks scoring 15+ have been previously considered by the relevant committees:

- Joint Quality Committee on (25 November 2025)
- Strategy, Transformation Partnerships Committee (26 November 2025)
- People & Culture Committee (24 November 2025)
- Finance & Performance Committee (24 November 2025)
- Audit Committee on (28 November 2025)

1.2 This report was compiled 19 November 2025 and is a snapshot of the risk register on that date; therefore, subsequent updates may be made before the Board convenes.

1.3 The purpose of this report is to provide the Board with assurance that risks are identified, mitigated, being treated, and reviewed.

2 Introduction

2.1 This report has been produced for the Trust Board and provides a summary of strategic risks scoring at a risk score of 15 or above.

2.2 The data is based on manual reviews of the risk register due to system limitations with Ulysses to successfully extract all of the relevant data required by the Board

2.3 Risks included within this report have been reviewed by groups and committees named in section 1.1 within the month before this meeting.

2.4 This report and appendices are accurate at the time of data extraction on 19 November 2025

3. Summary of current risks

3.1 New Risks

There are three new risks scoring 15+ identified since the last report to the Board. Table 1 below sets out basic details of the new risks.

Risk Reference	Risk Title	Risk score
2019	Reconnect low staffing levels	15
2029	Staffing levels for dysphagia	15
2034	There is a risk to patient safety from an IPC perspective due to the lack of space and distance between beds in the bays on Jersey and Guernsey Wards.	15

3.2 Changes in Risk Score – Appendix 1

There has been one increase in risk score - risk 1567 relating to medical staffing deficits within Child and Adolescent Mental Health Services. The risk has been increased from 12 to 15. Continued vacancies due to a combination of poor quality applications and suitable applicants declining offers of employment.

- 3.3 Three risks have had their risk scores reduced since the last report and this takes the scores of the risks below the Board's threshold for review. These will be removed from future reports.

3.4 Risk Reviews – Appendix 2

Four risks are currently overdue for a review. All overdue actions and risk reviews have been raised with the action/risk owners and those overdue by more than one month have also been escalated to the relevant service lead or director and highlighted for further discussion action at all relevant groups including Senior Leadership Group. The Chief Operating Officer has supported the Risk Management Team with discussions around compliance with review expectations. Awareness regarding the timescales for reviewing risks continues to be raised across services.

Table 2 below identifies which Directorate the overdue risks are in.

Table 2

Directorate /	Total number of overdue risks	Risk Reference
MH/LD/CYP	3	1960, 1754, 2019
Estates and Facilities	1	1925
Total	4	

It has been identified that in some areas there is a training need related to the use of the Risk Management system (Ulysses). Training materials have been shared to remind staff how to use the system correctly (including a step-by-step guide).

3.5 Closed Risks

One risk has been closed since the last report. This related to the lease on accommodation in Southampton for the Steps to Wellbeing service. The service will now form part of Hampshire and Isle of Wight HealthCare NHS Foundation Trust. Notice has been given on the lease and the risk management of finding suitable accommodation has been transferred to Hampshire and Isle of Wight.

3.6 Risk Register – Appendix 3 (Excel Sheet)

There are 11 risks currently scoring 15 or above and they are detailed in full, within Appendix 3.

Conclusion

- 4.1 The number of risks currently scoring 15+ is within the usual range.



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- 4.2 The number of risks currently overdue for review is higher than normal. This continues to be escalated and discussed at meetings.
- 4.3 Work continues to raise awareness with risk owners and senior colleagues regarding the importance of reviewing and updating risks as per Trust policy.
- 4.4 Training materials have been reviewed and updated to support colleagues to manage risk effectively following feedback.
- 4.5 Staff are being actively encouraged to complete risk management training available on e-Hub.
- 4.6 Risk and risk management training continues to be included on Trust induction for discussion, on Managers induction in addition to bespoke events (such as Ward Managers Workshop).

5 Recommendations

Members are requested to:

- To note the report and current position regarding risk and the management of risk
- To receive this update for assurance of the management of risk's scoring 15+ across the Trust

Karen Fulford
Joint Head of Risk and Clinical Legal Services

6 Appendices

- 6.1 Appendix 1 – New Risks
- 6.2 Appendix 2 - Risk score changes
- 6.3 Appendix 3 – Risks overdue for review
- 6.4 Appendix 4 – Closed risks
- 6.5 Appendix 5 – Copy of Trust Risk Register (15+)

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Appendix 1

NEW RISKS					
Risk Reference	Directorate & Service	Risk title	Risk Description	Initial Risk Score	Mitigated Risk Score
2019	CYP/MH/LD Custody Liaison Service	Reconnect Low staffing levels	Reconnect are not fully recruited for both qualified practitioners and support workers. They are at risk of not being able to carry out assessments/interventions in the time frames specified in our contract leading to contacts not receiving the necessary support normally provided by Reconnect, on leaving prison.	15	15
2029	CYPF - Paediatric Speech and Language CYPF - Speech Therapy (Paediatrics)	Staffing levels for dysphagia	The service is the provider of children's oropharyngeal dysphagia assessment and follow up across the county, and we are commissioned to work in community settings, education and to provide inpatient care in the acute hospital trusts. Assessment of demand and capacity has indicated that the service is currently 0.99wte understaffed in this area. The service is not currently able to meet RCSLT levels of staffing in NICU and SCBU because of this. The service does not have capacity in the budget to increase hours of the appropriately skilled workforce. This creates a risk that Children and young people may be harmed as there may be a delay to their assessment and/or follow up. A delay in treatment puts children at risk of aspiration, pneumonia, choking and potentially death. Staff may be harmed due to the pressure of meeting the needs of the caseload, as this may impact on their health and wellbeing.	15	15

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2034	ICS Poole Guernsey and Jersey Wards	There is a risk to patient safety from an IPC perspective due to the lack of space and distance between beds in the bays on Jersey and Guernsey Wards.	There is insufficient space within the bays on Jersey and Guernsey wards to comply with the health building note (00-09 and 04-01). This means that Aseptic procedures may be compromised, staff and patients are unable to avoid knocking each other, patients are sitting within the 2-metre splash zone from sinks and also may be at an increased risk form airborne viruses being in such close proximity to each other. This creates a risk of harm to patients on the ward as they will be within closer proximity to other patients who may be infectious.	15	15

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Appendix 2

RISK SCORE CHANGES						
Risk Ref:	Directorate & Service	Risk title	Previous risk score	New risk score	Risk score change	Rationale for risk score change
1567	CYP/MH/LD CAMHS	Lack of medic staff across CAMHS services	12	15		Community CAMHS - 3 Consultant vacancies - long term locums in 2 posts; Bournemouth Christchurch CAMHS - largest medical caseload, high risk CYP, no substantive consultants - service running with locum doctors, trainees had to be moved as trainer/substantive is on long term leave. Weymouth Portland - under 16 no cover. NMP leaving in 2 services with no replacement due to lack of applications. Current workforce is spread thin to cover gaps due to NWDs, sickness. Posts have been advertised as Consultants/Specialist doctors - no quality applications. Current round of recruitment - 8 candidates invited - 6 attended - 3 appointable but offer still not accepted and may not start until September 26. Stand-alone Consultant posts cannot be offered to SAS or ACP/ANP. Alongside recruitment problems, we are facing retention crises, everybody is doing above and beyond, working in their own time, not enough opportunities to take SPA time within working hours. Pan Dorset ID CAMHS - sole Consultant for the county - higher trainees are helping out with service needs. CAMHS HIU opening is delayed - unit set to open in June 2026 and we do not have medical workforce recruited - this will have a knock on effect on the current inpatient team at Pebble lodge as Consultant and MPAC will need to work towards working across both units but this will not be possible if we cannot recruit at least 2 SAS to inpatient. Supervision - peer/senior supervision not always in place.

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						Complaints are on the rise due to gaps, vacancies and creating system wide pressure. The existing workforce is burning out if not already exhausted.
1818	ICS – DIUCS 111 Call Handlers/CAS	Delay in patient response from CATS (Clinical Assessment & Treatment Service), risk increased when service is experiencing high demand	16	12		Agreed at ICS Quality DMG to reduce risk to 12. Recruitment is ongoing.
1970	MH – AMH/ OPMH Inpatient	Nursing staff shortages – Waterston Ward	16	9		RNDs awaiting pins to commence substantive posts. Risk score reduced to 9 .
1456	MH – AMH/ OPMH Community	Poor staffing levels in Connection - below 50% of Qualified roles within the team currently filled.	16	8		Successful recruitment to 2.6WTE Band 6 RMN posts. Leaving remaining vacancy 3WTE B6. Currently continue to require 2x agency RMN to maintain safe staffing levels, but the number of shifts they work should reduce once new B6 through induction. Risk reduced on this basis.

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Appendix 3

RISKS OVERDUE FOR REVIEW				
Risk ID	Service	Risk Title	Current Risk Score	Date due for review
1925	Risks Trustwide – Estates	Lack of an asset management plan for DHC	16	09/11/2025
1960	BCP CLDT	Hydrotherapy provision withdrawal for Continuing Health Care (NHS Dorset) eligible adults	16	15/10/2025
1754	Trustwide MH Community	Significant staff issues in Bournemouth West CMHT	15	08/10/2025
2019	Custody Liaison	Reconnect low staffing levels	15	20/09/2025

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Appendix 4

CLOSED RISKS			
Risk ID	Service	Risk Title	Risk closure rationale.
1924	Steps to Wellbeing - Southampton	Lease expiry at Grenville House, Southampton 31 March 2027	Risk closed as risk transferred to another provider. DHC have given notice on Grenville house. Risk will now sit with Hampshire and Isle of Wight NHS Trust as the successor provider of the service in Southampton

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Risk Movement Since Last Report	Date added to register	Risk Ref	Directorate	Service	Risk Lead	Description of risk Cause, effect, impact	Initial risk score	Current score	Key Controls	Progress	Target risk score	Date of next review	Assurance Structure Groups, Primary and Secondary Committees	Strategic Objective	Strategic Risks
➡	11/06/2021	1273	Risk Trustwide	Risk Trustwide Medicines Management	Natasha King	Prescribing and review of valproate to persons of childbearing potential and men younger than 55-years without following the national standards Failure to comply with the current regulatory measures for prescribing of valproate including oversight of new patients and existing female patients may lead to pregnancies with a high risk of birth defects and neurodevelopmental disorders. Men exposed to valproate carry a risk of impaired fertility. Per NaPSA/2023/013/MHRA (28-Nov-2023) the relevant standards are: A. Valproate must not be started in new patients (male or female) younger than 55 years, unless two specialists independently consider and document that there is no other effective or tolerated treatment, or there are compelling reasons that the reproductive risks do not apply B. At their next annual specialist review, women of childbearing potential and girls should be reviewed using a revised valproate Risk Acknowledgement Form, which will include the need for a second specialist signature if the patient is to continue with valproate and subsequent annual reviews with one specialist unless the patient's situation changes C. Prior safety measures for valproate continue to apply, including the valproate PPP for anyone of child-bearing potential. Impact: Babies born to mothers who take valproate during pregnancy have a 30-40% risk of neurodevelopmental disorders and a 10% risk of birth defects. Men exposed to valproate carry a risk of impaired fertility, possibly long-term.	12	16	1) Baseline and follow-up audits looking at standards relating to prescribing of valproate to women of childbearing potential and men <55yrs. 2) Audit reports and action plans highlighted within Trust to Mental Health Medicines Management Group, Medicines Safety Group, Medicines Management Group, Medical Advisory Committee, and Clinical Audit Group. Actions also coordinated via Dorset Medicines Quality & Safety Group, NHS Dorset Medicines Optimisation and Patient Safety teams. 3) Presentation on Valproate Prescribing in Women of Child bearing Potential delivered at recent NMP conference in October 2019 4) Clinical protocol for valproate in women of child bearing potential developed and presented to the MHMMG in October 2019	07/11/2025 Risk score remains. Plan to reduce risk once CMHTs have been provided with a list of relevant patients who need to have annual risk assessment completed	4	07/12/2025	Nursing Therapies and Quality DMG Quality Governance Group Quality Governance Committee Senior Leadership Group Audit Committee	Care	SR1: Safety and Quality SR5: Estates SR6: Finance
➡	05/07/2023	1782	CYPF/MH/LD	MH AMH/OPMH Inpatients	James Smith	Physical Health Care provision in Inpatient Mental Health Services There has been a significant increase in complex physical health comorbidities that Mental Health Inpatient Services are being expected to manage and treat. The capacity of the Physical Health Team that supports inpatient services has limited capacity to support this increased level of acuity being faced by the inpatient services. This is along side fluctuating junior medical support on the wards with the required level of skill to manage these increasingly complicated comorbidities. Impact: This may lead to delays in patients having their physical health care needs met along leading to increased risk of patient becoming physically compromised and deterioration.	16	16	1) Escalated to Service Manager and Lead Consultant who are escalating further 2) Incident reports relating to patients for whom there was a missed deterioration in their condition and requiring transfer to acute care have been raised. 3) Physical health staff team had Safe staffing report undertaken. This identified an increase in staffing levels required.	11/11/2025 Risk has been discussed with Ellie Lindop who is going to discuss the risk at EXEC Level in regards to how this risk can be supported to be reduced	3	11/12/2025	MH/LD/CYPF DMG Quality Governance Group Quality Governance Committee Senior Leadership Group Audit Committee People and Culture CIC	Care	SR1: Safety and Quality SR3: Workforce Capacity SR4: Capacity and Demand
➡	17/05/2024	1898	CYP/MH/LD	Risks Trustwide - MH Inpatients	James Smith	Lack of SLT provision / input for mental health wards. Risk of reduced support and education for ward staff in managing dysphagia without SLT provision which will impact on clinical care of some patients. Previous pilot on mental health (MH) wards has ended due to capacity/lack of funding and staff changes - this was one dedicated day of band 7 SLT for all MH inpatient wards and community MH patients. Currently provision for wards is only via community SLT service with waiting list of approx. 400 patients Dorset wide and waiting time of approx. 8 weeks. Lack of dedicated provision means clinical risks to patient management of dysphagia. Patients may not be seen in timely fashion meaning they are at more risk of chest infections, aspiration, malnutrition, dehydration and potentially death. Also reduction in identification of appropriate patients meaning patients are being missed or not referred for dysphagia assessment Impact: Patients on the mental health wards will be placed on SLT community waiting lists due to lack of SLT provision thus resulting in these patients waiting 8 weeks or beyond for an SLT assessment however all referrals are triaged and prioritised in line with clinical need. If we were to recruit to the SLT post for St Brelades and Herm, then the remaining gaps would be all other mental health wards across the Trust including other OPMH wards (Alumhurst and Melstock) which would lead to an inevitable service and risks associated with SLT needs such as chokoin / Lack of an Asset Management Plan for DHC The Trust does not currently have an Asset Management Plan (AMP) in place. An AMP sets out how the Trust will manage its assets to support the delivery of strategic objectives and services. This should set out 3 distinct areas: 1) a Handbook for how we do asset management in DHC (policies, processes, systems); 2) a Performance Review - provides an understanding of how our assets are performing now, how we want to improve this, and what assets we need in the future (key areas for change); and 3) a Strategy for the future with an Action Plan setting out all the key asset related activity DHC will undertake over the next 3 - 5 years. This should be developed in support of the Trust's strategic aims and any other strategies such as the clinical and digital strategies. Without a clear strategy how does the Trust know it has the right buildings in the right places. An AMP is essential to support BQBV, capital planning investment, and the carbon zero journey. Impact: Unable to respond to new requests as teams unwilling to let go of surplus space or share space - therefore affecting services / patients/ staff - culture of My Space not Our Space. This may affect service delivery across the Trust. Some staff have their own office(s) and work from home, others may have no permanent base and are typing up notes in their car in a layby. This delivers inconsistent work space to staff and use of cars has potential health and safety and confidentiality No performance reporting data means the Trust is unable to understand the condition of the estate & lease liabilities, how suitable it is for service delivery, running costs, how sustainable it is to carbon zero targets etc. All are area which the Trust needs to be able to demonstrate understanding of With no clear understanding of what assets the Trust has and needs in the future there is a potential impact on delivery of services.	16	16	1) Escalated to service manager 2) Physical health business case being written 3) Current plan for a 0.6WTE SLT for St Brelades and Herm which is currently out for advert.	11/11/2025 The Therapies staff review is in process looking at AHP provisions across the trust and how we can support current lack of SLT provision	4	11/12/2025	MH/LD/CYPF DMG Quality Governance Group Quality Governance Committee Senior Leadership Group Audit Committee	Care	SR1: Safety and Quality SR3: Workforce Capacity SR4: Capacity and Demand
➡	05/08/2024	1925	Risks Trustwide	Risk Trustwide	Martin Wilkins	Lack of an Asset Management Plan for DHC The Trust does not currently have an Asset Management Plan (AMP) in place. An AMP sets out how the Trust will manage its assets to support the delivery of strategic objectives and services. This should set out 3 distinct areas: 1) a Handbook for how we do asset management in DHC (policies, processes, systems); 2) a Performance Review - provides an understanding of how our assets are performing now, how we want to improve this, and what assets we need in the future (key areas for change); and 3) a Strategy for the future with an Action Plan setting out all the key asset related activity DHC will undertake over the next 3 - 5 years. This should be developed in support of the Trust's strategic aims and any other strategies such as the clinical and digital strategies. Without a clear strategy how does the Trust know it has the right buildings in the right places. An AMP is essential to support BQBV, capital planning investment, and the carbon zero journey. Impact: Unable to respond to new requests as teams unwilling to let go of surplus space or share space - therefore affecting services / patients/ staff - culture of My Space not Our Space. This may affect service delivery across the Trust. Some staff have their own office(s) and work from home, others may have no permanent base and are typing up notes in their car in a layby. This delivers inconsistent work space to staff and use of cars has potential health and safety and confidentiality No performance reporting data means the Trust is unable to understand the condition of the estate & lease liabilities, how suitable it is for service delivery, running costs, how sustainable it is to carbon zero targets etc. All are area which the Trust needs to be able to demonstrate understanding of With no clear understanding of what assets the Trust has and needs in the future there is a potential impact on delivery of services.	16	16	1) Accommodation Principles were approved by the Executive at the beginning of 2024 - these principles set out how we can make better use of our estate and move from a 'my' space to 'our' space culture. 2) There is a Property Asset Management Policy but this only one small part of having a comprehensive Asset Management Plan. 3) MW has raised the lack of support and adherence to the Accommodation Principles with Nicola Plumb, Chris Hearn and Nick Johnson. Issue to be raised at Joint Exec on 20 August. MW highlighted the need for an Asset Management Plan. Advised that this would be considered as part of the Joint Estates & Infrastructure Strategy NJ was leading on.	10/10/2025 Slow progress due to other competing priorities. Until we have a clear strategy we cannot allocate our resources properly. We also need good engagement from clinical strategy and full line of sight re strategic thinking, to avoid any missed opportunities or abortive investment.	4	09/11/2025	Information Governance Group Senior Leadership Group Audit Committee Finance and Performance Committee	Care Colleagues Sustainability	SR1: Safety and Quality

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Risk Movement Since Last Report	Date added to register	Risk Ref	Directorate	Service	Risk Lead	Description of risk Cause, effect, impact	Initial risk score	Current score	Key Controls	Progress	Target risk score	Date of next review	Assurance Structure Groups, Primary and Secondary Committees	Strategic Objective	Strategic Risks
	04/12/2024	1960	MH - LD/Wheelchair/Vocational Serv	BCP CLDT	Gary Billen	Hydrotherapy provision withdrawal for Continuing Health Care (NHS Dorset) eligible adults Cause: NHS Dorset's new Choice & Equity Policy has inadvertently created inequity which disproportionately negatively impacts adults with Learning Disabilities who hold ordinary residence in Dorset (both those who are social care funded and AACC funded). Impact: 40% of NHS Dorset's CHC eligible clients having a Learning Disability, and Dorset HealthCare hold outsourced responsibility for monitoring the needs of these clients. The impact of the withdrawal of hydrotherapy funding, brought in through the new Choice & Equity Policy, has resulted in adults with Learning Disabilities who hold ordinary residence in Dorset (both those who are social care funded and AACC funded), no longer being in receipt of funding to continue to access hydrotherapy in order to meet their specific, complex and ongoing health needs. Effect: As literature and pandemic experience suggests, this loss in hydrotherapy access will result in an avoidable increase in medications for issues such as constipation, pain, and tone, alongside an increase in avoidable hospital admissions; all factors known contribute towards avoidable deaths for people with learning disabilities. From an inequity perspective, we are witnessing an uptake in hydrotherapy for service users in our area who are out of county funded as there are more hydrotherapy sessions becoming available to them through the loss of access to these services for ordinary resident individuals. BCP and Dorset social care colleagues are no longer attempting to request joint funding through the previously agreed and implemented joint funding pathway, as their hydrotherapy requests are being met with a blanket "no".	9	16	1) Learning Disability Physios continue to advocate for the needs of individual service users on their caseloads. Where appropriate we continue to implement land-based physiotherapy programmes in order to meet these clients complex postural and tonal management needs. 2) Carrie Tbally and Heather Felton (LD Physio leads) have escalated to Sara McCarthy (NHS Dorset) who is the writer of their Choice & Equity policy, to request that an exceptionality clause and process is added to their policy. 3) Carrie Tbally continues to escalate concerns to Sara McCarthy and via the CHC complaints team.	15/09/2025 Letter received from NHS Dorset informing DHC of decision to stop accepting all new referrals for funding of access to hydro pools and to review this. Letter sent from DHC OOD expressing concerns about this approach and its compatability with the CHC framework and equity for people with LD.	1	15/10/2025	MHILD/CYPF DMG Quality Governance Group Quality Committee Senior Leadership Group Audit Committee People and Culture CIC	Care Communities	SR1: Safety and Quality SR3: Workforce Capacity SR9: Digital infrastructure
	02/06/2014	72	CYPF/MHILD	CYPF/MHILD St Ann's Hospital MH Inp	Anna Chaney	Bed availability High demand and acuity, alongside a lack of capacity of inpatient beds both locally and out of area mean that there is a risk to service delivery across the system. High number of delayed transfers of care and clinically ready for discharge patients unable to be discharged due to lack of housing and supported accommodation provision means that patients are waiting longer for inpatient beds, resulting in patients remaining in inappropriate places such as the acute hospitals or within the community placing higher risk on both themselves and the teams supporting them. This could result in compromising the quality of care for the patient. The level of increased risk in the community and acute trusts could create high costs to the Trust. Impact: Patients held on TCI list for extended periods of time Delay in care resulting in the potential for inappropriate treatment or treatment that is less effective Large number of patients being held in acute trusts High risk being held by community teams due to the time required to access an inpatient bed Large numbers of patients being transferred to out of area beds due to lack of local bed availability	6	15	1) Reports to and monitoring by the Quality Governance Group 2) All out of area placements require senior management authorisation prior to the individual being placed out of area 3) Lenth of stay task and finish group 4) Out of area SOP developed for process to support flow and manage oversight of the quality of OOA placements. 5) OOA co-ordinator now in post to work alongside care co-ordinators to have oversight of risk assessments, care plans, incidents and discharge/repatriation plans of OOA placed service users.	20/10/25 challenges remain with flow - score left unchanged	4	19/11/2025	MHILD/CYPF DMG Quality Governance Group Quality Governance Committee Senior Leadership Group Finance and Performance Committee Audit Committee	Care Communities Sustainability	SR1: Safety and Quality SR3: Workforce Capacity SR4: Capacity and Demand
 Risk score increased from 12 to 15	05/05/2022	1567	CYP/MHILD	CAMHS	Dudley Marns	Lack of Medic Staff across CAMHS services Numerous and longstanding medic vacancies for consultant psychiatry including community, psych liaison and inpatient CAMHS. Existing medics capacity is stretched as is the Out of Hours rota Impact of clinical safety on a patient level in that there is no medic within some CAMHS teams, therefore limiting access to timely medic input (prescribing, medication reviews etc). Impact on existing staff as additional pressure to cover on call rotas and cross cover for services with no medic. Impact to service delivery as medics are key to the senior clinical leadership to CAMHS services.	12	15	1) Some cross cover provision from services that do have medics aligned to them. Some cross cover on the On Call rota.	07/11/2025 Community CAMHS - 3 Consultant vacancies - long term locums in 2 posts; Bournemouth Christchurch CAMHS - largest medical caseload, high risk CYP, no substantive consultants - service running with locum doctors, trainees had to be moved as trainer/substantive is on long term leave. Weymouth Portland - under 16 no cover. NMP leaving in 2 services with no replacement due to lack of applications. Current workforce is spread thin to cover gaps due to NWDs, sickness. Posts have been advertised as Consultants/Specialist doctors - no quality applications. Current round of recruitment - 8 candidates invited -	4	07/12/2025	MHILD/CYPF DMG Quality Governance Group Quality Governance Committee Senior Leadership Group Audit Committee	Care Colleagues	SR1: Safety and Quality SR3: Workforce Capacity SR4: Capacity and Demand SR6: Finance SR7: Collaboration SR8: Transformation and
	03/04/2023	1754	Trustwide	Trustwide MH Community	Marianne Gillingham	Significant staff issues in Bournemouth West CMHT. Due to long term sickness and staff vacancies, several teams are experiencing severe staff shortages. Teams most impacted are Bournemouth West and Poole. Some medic vacancies are impacting on availability for new assessments and waiting list performance. Impact: Unless staffing issues can be resolved, this will impact on the morale and wellbeing of staff. Patients may experience long delays in being offered an appointment, which will have a detrimental affect on their condition and risk of deterioration of their mental health possibly resulting in hospital admission. Capacity of Care Co-ordinators is also limited for allocation to new patients, completion of care planning and statutory paperwork, ie social circumstance reports for and risk management.	20	15	1) BCPs are enacted 2) Ongoing recruitment is in place 3) Ongoing discussions with HR and resourcing team within the Trust including recruitment campaigns 4) Escalated to Chief Nursing Officer and Service Director and discussed at Safe Staffing Forum 5) Bank and agency options explored 6) 2 services have been referred to Star Chamber. (Christchurch and ICSD) for reduction in service delivery to be approved	08/09/2025 Risk now only relates to Bournemouth West CMHT - risk title therefore rearticulated. Bournemouth West remains in a Business Continuity Plan and therefore risk remains. Ongoing recruitment to clinical roles continues and there is a high level action plan in place to address the longstanding issues in place.	4	08/10/2025	MHILD/CYPF DMG Quality Governance Group Quality Governance Committee Senior Leadership Group Audit Committee People and Culture CIC	Care Communities Colleagues	SR1: Safety and Quality SR3: Workforce Capacity
 Satchell, Ryan 04/12/2025 09:14:16	21/08/2025	2019	MH - AMH/OPMH Community	Custody Liaison Service	Anna Fitzsimmons	Reconnect Low staffing levels Reconnect are not fully recruited for both qualified practitioners and support workers. They are at risk of not being able to carry out assessments/interventions in the time frames specified in our contract. Not receiving the necessary support normally provided by Reconnect, on leaving prison.	15	15	1) Recruitment to posts is ongoing. Bank staff specific to our service (Prison and Police vetted) are being sought to cover vacancies. Permanent staff will be requested to cover gaps in assessments if no other solution can be found	First risk review due 20/09/2025	6	20/09/2025	MHILD/CYPF DMG Quality Governance Group Quality Governance Committee Senior Leadership Group Audit Committee	Care Colleagues Sustainability	SR1: Safety and Quality SR4: Capacity and Demand SR7: Collaboration

Risk Movement Since Last Report	Date added to register	Risk Ref	Directorate	Service	Risk Lead	Description of risk Cause, effect, impact	Initial risk score	Current score	Key Controls	Progress	Target risk score	Date of next review	Assurance Structure Groups, Primary and Secondary Committees	Strategic Objective	Strategic Risks
	26/09/2025	2029	CYPF - Paediatric Speech and Language	CYPF - Speech Therapy (Paediatrics)	Erica Davies	Staffing levels for dysphagia The service is the provider of children's oropharyngeal dysphagia assessment and follow up across the county, and we are commissioned to work in community settings, education and to provide inpatient care in the acute hospital trusts. Assessment of demand and capacity has indicated that the service is currently 0.99wte understaffed in this area. The service is not currently able to meet RCSLT levels of staffing in NICU and SCBU because of this. The service does not have capacity in the budget to increase hours of the appropriately skilled workforce. Impact:Children and young people may be harmed as there may a delay to their assessment and/or follow up. A delay in treatment puts children at risk of aspiration, pneumonia, choking and potentially death. Staff may be harmed due to the pressure of meeting the needs of the caseload, as this may impact on their health and wellbeing.	15	15	1) The service have moved staff to cover the gap where possible but we do not have enough staff with the post graduate skills to cover this area	03/11/2025 As current budget stands there is no slippage to allow for the service to offer extra hours for the dysphagia skilled workforce. Risk score remains the same	4	03/12/2025	MH/LD/CYPF DMG Quality Governance Group Quality Committee Senior Leadership Group Audit Committee People and Culture CIC	Care Colleagues Sustainability	SR1: Safety and Quality SR3: Workforce Capacity
	23/11/2025	2034	ICS - Poole	Jersey Ward	Cara Southgate	There is a risk to patient safety from an IPC perspective due to the lack of space and distance between beds in the bays on Jersey and Guernsey Wards. There is insufficient space within the bays on Jersey and Guernsey wards to comply with the health building note (00-09 and 04-01). This means that Aseptic procedures may be compromised, staff and patients are unable to avoid knocking each other, patients are sitting within the 2 meter splash zone from sinks and also may be at an increased risk form airborne viruses being in such close proximity to each other. This creates a risk of harm to patients on the ward as they will be within closer proximity to other patients who may be infectious. Impact: Patients are at risk of harm through increased proximity to other patients who may be or become infectious, increased risk of infection from aseptic procedures not being able to be maintained as aseptic, increased risk of infection form proximity to the sink in the bays which may harbour infectious organisms.	15	15	Details to be provided - Risk Management Team supporting ward managers and IPC to detail current controls.	First risk review due 22/11/2025	6	22/11/2025	ICS DMG Quality Governance Group Quality Governance Committee Senior Leadership Group Audit Committee	Care	SR1: Safety and Quality SR5: Estates
	24/10/2023	1818	ICS - DIUCS	111 Call Handlers / CAS	Maria Doherty	Delay in patient response from CATS (Clinical Assessment & Treatment Service), risk increased when service is experiencing high demand Risk of potential patient harm due to delays in clinical response from CATS. This is due to a number of contributory factors: _Digital functionality & development of current S1 module, including no access to real time live data dashboard for live oversight of clinical risk _Clinical vacancies _Alignment of workforce to meet demand _Inconsistent application of allocation of cases SOP, process introduced as a workaround to current system functionality Impact: Potential clinical delays could potentially result in a patient safety incident. The risk may also impact on other factors outside of patient harm. The risk could have a wider impact on clinical flow, system pressure and organisational reputation. Potential impact on staff wellbeing and retention	16	12	1) Clinical Shift Lead with responsibility for allocating clinical cases to Clinicians/ACPs/GPs. Allocation to individual triage queues using the Nationally defined priorities for dispositions. . 2) SOP for allocation of cases from CAS queue. SOP IUC-64 reviewed and approved June 2023. Allocation SOP ensures CSL is allocating cases to all Clinicians/ACPs/GPs on duty. Clinicians/ACPs/GPs allocated a designated triage case queue (case type queue) at start of shift. 3) Colour priorities set to National disposition specifications. Colour priorities provide the urgency and acuity of call backs.	27/08/2025 Agreed at ICS Quality DMG to reduce risk to 12. Recruitment is ongoing.	3	27/11/2025	ICS DMG Quality Governance Group Quality Governance Committee Senior Leadership Group Audit Committee	Care	SR1: Safety and Quality SR3: Workforce Capacity SR4: Capacity and Demand SR9: Digital In
	05/08/2024	1924	MH - Steps2WB	Steps2WB/Psych Southampton	Martin Wilkins Aisla Greenleas	Lease expiry at Grenville House, Southampton on 31 March 2027 There is a risk are that the service could become homeless and need to find alternative accommodation at short notice which could be less suitable and more expensive, or have to pay more to remain in Grenville House.The current lease on Grenville House expires on 31 March 2027. The lease is outside the 1954 Landlord and Tenant Act which means DHC, as the tenant, has no automatic right to renew the lease. The landlord, whilst suggesting they would be "open to a discussion" regards a renewal, have been open in saying they want to mothball Grenville House and encourage DHC to move next door to their more modern building Frobisher House. DHC cannot currently afford this option having explored it in 2023. Therefore, the risk is that if DHC is successful in bidding for the next contract which commences 1 April 2026 there is a clear risk that the service may not be able to operate from Grenville House the following year. The landlord may choose to renew but then there is the risk that they will increase rent and particularly the service charge as DHC maybe the only tenant left in Grenville House by this point. This needs to be considered in any bid for the contract DHC makes. Also, DHC should be raising this with the local ICB.	12	16	1) Martin Wilkins highlighted his concerns and this risk in an e mail to Morad Margoum and Melissa Mitchell on 17 June 2024.MW agreed at the beginning of August to raise this as a risk on Ulysses with Melissa and Aisla Greenleas. Risk actioned on 5 August 2024. 2) Continuing dialogue with Landlord's agent, and watching brief on other tenants in Grenville House. 3) Flagged with Dave Hambidge, Interim Director of Estates and Facilities	Risk cloed as Risk transferred to another provider. DHC have given notice on Grenville house. Risk will now sit with Hampshire and Isle of Wight NHS Trust as the successor provider of the service in Southampton	6		Senior Leadership Group Finance and Performance (Primary) Strategy, Transformation and Partnership Committee (Secondary) Audit Committee	Care Sustainability	SR1: Safety and Quality SR5: Estates SR6: Finance
	31/12/2024	1970	MH - AMH/OPMH Inpatient	Waterston AAU	Tom Conroy	Nursing Staff Shortages - Waterston Ward Risk of being unable to provide safe staffing with substantive staff on the ward due to extensive vacancies leading to a high reliance on bank and agency workers including the use of block booked agency. Currently we have 7.9 BS WTE vacancies Impact: The inability to provide safe staffing levels for the ward may lead to an increase in patient safety incidents, increase in patient complaints, reduction in patient flow (admission and discharges). This may have an impact on staff morale and staff sickness absence, cause increased stress to remaining staff and may result in further staff leaving their post, compounding the issues we are experiencing.	16	9	1) We have recruited our RNDAs (3 x WTE) who will graduate in May / June 2025. These are 4 of our 7 RMNs. We are currently using 3 block booked agency nurses. 2) Incident reports are completed when staffing drops below BCP 3) Information has been shared with line management	05/09/2025 RNDs awaiting pins to commence substantive posts. Risk score reduced to 9 .	6	04/12/2025	MH/LD/CYPF DMG Quality Governance Group Quality Governance Committee Senior Leadership Group Audit Committee People and Culture CIC	Care	SR1: Safety and Quality SR3: Workforce Capacity
	09/12/2022	1456	MH - AMH/OPMH Community	The Connection	Laura Ekelund	Poor staffing levels in Connection - below 50% of Qualified roles within the team currently filled. Unsafe staffing levels within Connections leads to a risk of service being unable to complete essential functions, leading to patient safety risks in relation to the care of patients, risk to health and wellbeing of remaining staff and risk of increased use of other services such as Police, paramedics and emergency departments. Impact: Due to lack of qualified staffing within the team, junior staff are at times unsupported on shift. This may mean that critical decision making is left to unqualified staff which may result in patients coming to harm, or in extreme cases death. Where there is only one, or no, qualified staff on shift Connection is unable to accept referrals or complete assessments which is a critical function of the service. This will result in undue delay to accessing services which again may result in patients coming to harm, or in extreme cases death. If Connection are unable to receive referrals or complete assessments then it is likely there will be an increase in inappropriate use of emergency services and increased attendances to emergency departments	12	8	1) All shifts out to Trust Bank to provide best change for shifts to be filled 2) Job adverts are out for vacancies 3) Block booking of agency staff 4) Escalated to service lead 5) Band 6 job advert out to external, paid channels 6) Meeting with HR to review advert including incentivising post and advertising on other platforms 7) Support offered from Home Treatment Team 8) Business Continuity Plan in place to use as required.	27/08/2025 Successful recruitment to 2.6WTE Band 6 RMN posts. Leaving remaining vacancy 3WTE B6. Currently continue to require 2x agency RMN to maintain safe staffing levels, but the number of shifts they work should reduce once new B6 through induction. Risk reduced on this basis.	2	26/11/2025	MH/LD/CYPF DMG Quality Governance Group Quality Governance Committee Senior Leadership Group Audit Committee People and Culture CIC	Care Colleagues	SR1: Safety and Quality SR3: Workforce Capacity SR4: Capacity and Demand

Audit	Board in Common (DCH Board)	
Date of Meeting	9 th December 2025	
Report Title	Corporate Risk Register – Quarter 2 25/26	
Prepared By	Laura Sellick, Risk Systems manager	
Approved by Accountable Executive	Dawn Dawson, Joint Chief Nursing Officer	
Previously Considered By	Risk and Audit Committee, 1 st December 2025	
Action Required	Approval	No
	Assurance	Yes
	Information	Yes

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? <i>Delete as required</i>	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	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 have formally reviewed and scrutinised the risks within their remit.

Committees have noted movement of risks in the intervening period and beyond the end of Quarter 2. Of note are the following movements superseding the reporting period and in relation to those risks scored at the highest level:

2197 Electrical Risk for RTS Units - mitigated by immediate and ongoing actions by Estates and Facilities
Subsequent Risk score - 9

2204 Electrical Safety Workforce capacity – mitigated by mutual aid from Dorset Healthcare.
Subsequent Risk score - 10

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:

- Receive the report for assurance.
- Note the current Risk Register and high-risk areas.
- Consider overall risks to strategic objectives and BAF.

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DCH Trust Board

1 Executive Summary- Overview of Risks

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

1.1 Electrical Risk for RTS Units (hot locks)

Risk 2197 added on 15/7/25, review date 26/11/25

1.2 Electrical Safety Workforce Capacity

Risk 2204 added on 15/7/25, review date 28/11/25

1.3 Maintaining levels of scanning legacy notes

Risk 2222 added on 24/9/25, review date 20/11/25

1.4 PACS Image Management Servers Memory Almost Full

Risk 2200, opened on 18/7/25 and review date 11/25

2 new opened risks scoring 15-19 added last quarter

1.5 Cardiac Physiology Shortfall in Staffing to perform ECG analysis

Risk 2221 added on 17/9/25, review date 5/12/25

1.6 ICE Performance Issues

Risk 2216 added on 4/9/25, review date 8th December

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:

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- 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 Corporate Risk Register detail 20+ (appendix 2)

2.6 Corporate 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 risks 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:

- Receive the report for assurance.
- Note the current Risk Register and high-risk areas.
- Consider overall risks to strategic objectives and BAF.

Name and Title of Author: Laura Sellick

Date 19/11/25

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

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Approval status	ID	Title	Review date	Opened	Care Groups	Service of responsibility	Risk level (initial)	Previous current risk level	Risk level (current)	Risk level (Target)	Type of Risk	Mitigations/Controls
Active	2200	PACS Image Management Servers Memory Almost Full	08/12/2025	18/07/2025	Radiology & Neurophysiology (B3b)	Digital Technology and Infrastructure (DTI)	25	↔	25	2	Strategy Transformation and Partnerships Committee in Common	Mitigation is the purchase of additional storage disks as advised by Intelrad and DCH DTI. Transition to new hardware is planned for November 2025. Risk review is due 8th December. It is anticipated this will reduce the current risk score towards target.
Active	1152	Current Digital Staffing levels present risk to both operational and strategic activities	07/11/2025	14/09/2021	Chief Information Officer	Clinical IT Systems	16	↑	20	9	People and Culture Committee, Digital Systems Risk	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 have progressed at a 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 usual and project 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 cannot be supported 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. Slough, Jane - Business Manager Digital Services 11/09/2025 12:55:12 Chief Digital Office, Beverley Bryant is undertaking a new Target Operating Model. Until this has been finalised along with the Digital Strategy, this risk is on hold.
Active	2222	Maintaining levels of scanning legacy notes	20/11/2025	24/09/2025	Chief Information Officer	Medical Records	9	↑	20	4	Strategy Transformation and Partnerships Committee in Common	Health Records manager have put an options paper together. This will be sent to the CIO.
Active	2153	Out of support Core Network Infrastructure	08/12/2025	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. Risk for review 8th December. Funding approved for a two-year implementation plan. This will expedite risk reduction towards target score.
Active	472	Patient Safety Concerns and Increased Risk of Adverse Outcomes Due to Prolonged Wait Times in Community Paediatrics	17/12/2025	10/09/2018	Family Services (B4)	Paediatrics Service	15	↑	20	10	Finance and Performance Committee	Nov 25 Internal Governance at DCH completed - RCP approved in principle pending discussions regarding funding. AE to meet with SC (Divisional Director of Operations). Grading back log cleared. New temporary process in place, new referrals graded within 5 working days of receipt into Paeds admin. Permanent process still required to be finalised. Review of locally held data underway. PLT meetings instigated by LC (Assistant Service Manager FS), first meeting Nov 6th, then monthly.

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Active	2164	Significant delay in receiving results of 24 hour tape, increasing the risk of unidentified AF causing further stroke or TIA	24/11/2025	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	1752	2003 Servers Out of Support Since 2010	08/12/2025	01/11/2023	Chief Information Officer	Digital Technology and Infrastructure (DTI)	16	↔	16	4	Strategy Transformation and Partnerships Committee in Common	Systems will be migrated to supported platforms when commitment from projects and other digital staff become available. Systems have been updated where possible. ICE upgrade in progress, no solution for Booked Admissions and Endo Form. Recommendation to invest in off the shelf solutions and to be included in business planning.
Active	1735	2008 Servers Out of Support Since January 2020	08/12/2025	01/01/2020	Chief Information Officer	Digital Technology and Infrastructure (DTI)	16	↔	16	4	Strategy Transformation and Partnerships Committee in Common	Plans are ongoing to reduce the no of legacy systems within the Trust, these are evidences in the Trusts quarterly cyber report, which is discussed at both DTAG and IGG (summary is as below) Reducing the presence of systems that no longer receive vendor patches or support considerably improves the Trusts cyber posture. Legacy systems contain known vulnerabilities and backdoors which are frequently abused by online crooks in large scale malicious campaigns. In retaining these known susceptible systems inevitably opens the Trust to unacceptable levels of risk. Through the snapshots below it is clear to see the departments commitment to reducing legacy systems wherever possible. 07/01/22 EoL Endpoint estate – 30.30% 27/03/23 EoL Endpoint estate – 10.62% 21/06/23 EoL Endpoint estate – 7.5% Note: A portion of the remaining 7.5% requires additional hardware to replace the EoL kit that does not support software upgrades to the latest iterations of Windows OS. The department continued to make progress with the server estate following a similar trend as the endpoints above. This typically takes longer due to the associated resources required (financial, operational & staffing) to successfully plan and implement system level upgrades. This process is also frequently held up due to contractual reasons – with suppliers not being liable for replacing/upgrading systems. As of the close of Q1, DCH has reduced the percentage of legacy servers down from 18.2% to 6.8% at the start of January. In addition, the department has been proactively upgrading the Server 2012 estate which is due go EoL in October, halving the number of these devices from 86 to 50. Risk review due 8th December.
Active	1745 Setchell, Ryan 04/12/2025 09:14:16	2012 Servers Out of Support Since October 2023	07/11/2025	16/10/2023	Chief Information Officer	Digital Technology and Infrastructure (DTI)	16	↔	16	3	Strategy Transformation and Partnerships Committee in Common	list of servers is regularly reviewed with Technical support teams and cyber, risks are shared at IGG and through quarterly cyber reporting. Mitigations as for relevant IT infrastructure risks.

Active	1903	Age of Washers in EDU	04/12/2025	06/06/2024	Theatres, Anaesthetics, Critical Care & Decontamination (B3a)	Decontamination Service	16	↔	16	2	Finance and Performance Committee	EDU Washer 1H100255 EDU Washer 2H100256 EDU Washer 3H100257 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	1550	ambulance delays and hospital flow	01/01/2026	17/11/2022	Unscheduled Care (A3)	Emergency (ED) Services	20	↓	16	6	Finance and Performance Committee	the splitting of the blue light and walk in entrances has allowed the department to manage ambulance offloads better SWAST is currently implementing work to reduce conveyances THP has been implemented and this risk remains open while policy is embedded with plans to close once your next patient is embedded
Active	2209	Blood Sciences Service Provision is Unsustainable	30/11/2025	12/08/2025	Pharmacy, Pathology and Medical Physics (A4)	Pathology Service	12	↑	16	4	Quality Committee	Current staff are dedicated and volunteering to fill shifts, but this is putting significant physical and psychological pressure on them, further contributing to issues. Training meetings in place to address skill mix. Training meetings have failed due to sickness. Gaps in controls: Vacancy factor (currently approx. 1.5 WTE at band 6, 2 WTE band 5.) One individual on maternity leave. No locum backfill. Blood Sciences manager filling in gaps in hours and out of hours. Requirement to review service, skill mix, resource and capacity as part of One Dorset Pathology but this is not an immediate fix.
Active	2137	Careflow Printing & Re-Scanning	16/10/2025	04/04/2025	Chief Information Officer	Clinical IT Systems	16	↔	16	6	Strategy Transformation and Partnerships Committee in Common	CSST are liaising with Training team to see if there is any enhancement to training that could help mitigate this issue.
Active	1877	Clinical digital Safety - DCB0160 assurance debt	24/10/2025	29/04/2024	Chief Information Officer	Clinical IT Systems	12	↑	16	8	Strategy Transformation and Partnerships Committee in Common	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.

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Active	2188	Clinical Engineering Staffing	10/12/2025	08/07/2025	Pharmacy, Pathology and Medical Physics (A4)	Clinical Engineering	16	↔	16	4	Quality Committee	Support officer post going through vacancy control. No JD found for Band 6 engineer so new one has been drafted and sent to HR for matching. Will advertise as soon as possible. Update end Sept 2025: Band 4 post appointed to and starting by mid November. Band 6 post advertised but all shortlisted candidates turned down interviews. Need to re-advertise. This will be done by end of September. However, now the Head of Department is leaving the Trust at end of September, and the Band 5 post has become vacant, so will need to advertise for those posts as well. Update 5/11/25: Band 6 post interviewed for and post offered. Band 5 shortlisted for interview. Second (new) Band 5 post to be advertised with money coming from an unused Band 4 post to be scrapped. New Head of Department to go to advert by end of this week. When these posts appointed to then risk score can be reduced to $3 \times 3 = 9$ (Moderate). Additional new 4 x Band 3 posts for Clinical Engineering added to business planning for 26/27, and will bring risk score down to $2 \times 2 = 4$ (Low Risk).
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	30/12/2025	18/05/2023	Chief Information Officer	Clinical IT Systems	12	↑	16	12	Strategy Transformation and Partnerships Committee in Common	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	1782	Diabetic Follow Up Long Waiters	12/12/2025	04/01/2024	Head & Neck, Specialist Medicine and Outpatients (B2)	Ophthalmology Service	20	↑	16	6	Finance and Performance Committee, Patient Safety Group	Returning Consultant on an as & when basis undertaking virtual FOWL review and undertaking additional clinics. In house Diabetic Consultant undertaking additional clinics as and when capacity allows. All patients overdue that were clinically appropriate were called back in July 2024 to DESP for community review.
Active	1914	ED crowding	01/12/2025	08/07/2024	Unscheduled Care (A3)	Emergency (ED) Services	16	↔	16	9	Finance and Performance Committee	UEC recovery plan/ ICS recovery plan/ Joint SOP with SWAST/ alternative pathways with ICS system partners/ Patient flow and transformation board/ future NHP and Emzone project/ UTC implementation. bed reconfiguration introduction of sdec
Active	1919	Electronic Health Record - Insufficient Digital Resource to support EHR readiness and implementation	26/09/2025	12/07/2024	Chief Information Officer	Digital Technology and Infrastructure (DTI)	16	↔	16	12	Strategy Transformation and Partnerships Committee in Common	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

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Active	1815	Electronic Health Record, risk of not receiving FD Funding	07/12/2025	02/02/2024	Chief Information Officer	Digital Technology and Infrastructure (DTI)	16	↔	16	12	Strategy Transformation and Partnerships Committee in Common	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	2152	End of Support wireless access points in use within the corporate wireless network	08/12/2025	01/05/2025	Chief Information Officer	Digital Technology and Infrastructure (DTI)	20	↓	16	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 on. This would mean that expensive cisco licensing would no longer be required. Newer access points have a newer generation of wireless technology in them and would provide a better wireless service. Linked to Risk 2153 and financial investment/2 year plan.
Active	1965	Endoscopy - Replacement of AER's	30/01/2026	06/09/2024	Chief Finance Officer	Estates Department	16	↔	16	9		06.09.24 Reviewed taking account of current financial position and adjusted risk accordingly
Active	486	ESTATES - General Estates Back Log Maintenance	27/02/2026	15/01/2017	Chief Finance Officer	Estates Department	16	↔	16	6	Finance and Performance Committee	August 2018 - Agree 10 year programme to be included within annual estates capital projects to reduce backlog. Obtain support from Capital Planning Group to ensure funding is guaranteed for the duration of the programme. 6 Facet survey Updated as of May 2025, significant increase in backlog value, NHSE Critical infrastructure CIR bids awarded to trust £2.1m funding to commence with works to reduce backlog based on highest risk as priority, further Bidding expected in December for 26/27 delivery.
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	1781	Glaucoma FOWL Long Waiters	12/12/2025	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	2161	HICCS Endoscopy system nearing end of life	19/12/2025	13/05/2025	Surgery & Gastroenterology (B1b)	Endoscopy Service	16	↔	16	4	Strategy Transformation and Partnerships Committee in Common	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	2144	Home Enteral Nutrition (HEN) Service Risk - Growing demand, insufficient staff & supply chain for enteral and SIP feed supplies	08/12/2025	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	2216	ICE Performance Issues	07/12/2025	04/09/2025	Chief Information Officer	Clinical IT Systems	16	↔	16	4	Strategy Transformation and Partnerships Committee in Common	Various checks/suggestions have been put forward by the supplier and DTI. A document of the background and investigations to-date have been attached to this risk. The issue is particularly difficult to troubleshoot due to it's inconsistent nature, can be present on a particular user's session, and seemingly resolve itself and not occur again for some time. Restarting the computer, or sometimes even the browser window can resolve the issue. The problem can be witnessed on ICE Test and via different connection methods. The problem cannot seem to be replicated, and for some users, the problem never occurs.
Active	2157	Inability to fund the replacement of medical devices from capital	11/11/2025	02/05/2025	Pharmacy, Pathology and Medical Physics (A4)	Clinical Engineering	16	↔	16	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 order to score those 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. UPDATE - 09/09/2025: MDG Meeting received update from James Claypole on equipment replacement priorities for rest of 2025/26 based on the risk scoring carried out in the past two months. The combination of better information and more funds available warrants a reducing in the current risk score back to the starting point of 16 (i.e. from 20 back down to 16), with the prediction that from the start of the next financial year this risk will be below 12 and can be considered to be Controlled. Score has to remain at 16 for now until the purchases currently identified for this year have been made and delivered.
Active	1207	Insufficient HD capacity across all sites - increase in demand does not meet our capacity	28/11/2025	07/02/2022	Vascular and Metabolic (A1)	Renal Service	16	↔	16	1	Finance and Performance Committee	Almost daily meeting currently due to need to sign off work plan. Summary for meeting held on 29th Oct 2025: - Agreement was reached that 5 dialysis spaces would deliver as per the latest plans from Strategic Estates. This will be to provide two side rooms and a three station dialysis bay. This was supported by the clinical representatives at the meeting and has support from Infection Prevention Management (IPM). This gives 2 isolation side rooms and a 3 chair bay this compares favourably with the Isolation Pod which had 1 side room and 5 chair bay. We gain one side room, at the meeting on Friday last week it was agreed, that it was better to develop a plan for 5 spaces as this would better meet the needs of the service, for bed access and IPM issues. - It was acknowledged that more work needs to be done to provide office accommodation for the wider Renal team impacted by the changes. The planning aims to maintain MDT working of the service, which has been taken to mean that, consultants, nursing and secretarial support are co-located. Offices may be shared, and consultants are happy to share up to three consultants together, noting that currently 3 consultants share an office and 4 consultants share 2 offices and one is in an office on their own. Such an arrangement would enable the consultant body to carry out the clinical and clinical support activities highlighted in your email below. Sign off complicated by contention within the MDT. This risk links to risk 1635 as resolution of business continuity will remove dialysis from home therapies suite & POW side room. Yeovil ground floor works completion due November 7th 2025 with patients ready to transfer. Unit will then have 16 as opposed to original 11.

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Open - Waiting for review	2186	Insufficient substantive staffing in Catering	04/08/2025	04/07/2025	Chief Finance Officer	Catering Services	16	↔	16	4	Finance and Performance Committee	We have explored the following options as short term solutions which we utilise frequently in some cases, there is a long term solution of a paper that is going through governance at present to transfer some of the regular overspend in bank staff in catering to substantive which would be financially positive as a whole as it would allow us to deliver consistent retail services and push forward several improvement projects such a making more food in house and reducing our costs / increasing our GP%. Business case subsequently approved at SLG for substantive staffing.
Active	2234	IR Consultants Vacancies	11/12/2025	08/10/2025	Radiology & Neurophysiology (B3b)	Radiology Service (DCH)	16	↔	16	1	People and Culture Committee	Budget meetings, monitored at FPC
Active	2007	Lack of Adequate Support for Digital Systems in a 24/7 Acute Trust	06/12/2025	19/11/2024	Chief Information Officer	Clinical IT Systems	12	↑	16	8	Strategy Transformation and Partnerships Committee in Common	Clinical systems support provided for out of hours. Greater number of on-call analysts to cover all areas of DTI.
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	30th October 2025 This risk links with risk 1207 Plans for dialysis unit expansion to enable exit from business continuity underway almost daily currently in order to sign off by end of Oct 2025. POW currently has 3 inpatient side room in use which will increase to 5 once works have been completed & outpatient dialysis removed from the ward & annex. Home therapies will also be able to return to the Home therapies suite freeing up the old discharge lounge. Almost daily meeting currently due to need to sign of work plan. Summary for meeting held on 29th Oct 2025: • Agreement was reached that 5 dialysis spaces would deliver as per the latest plans from Strategic Estates. This will be to provide two side rooms and a three station dialysis bay. This was supported by the clinical representatives at the meeting and has support from Infection Prevention Management (IPM). This gives 2 isolation side rooms and a 3 chair bay this compares favourably with the Isolation Pod which had 1 side room and 5 chair bay. We gain one side room, at the meeting on Friday last week it was agreed, that it was better to develop a plan for 5 spaces as this would better meet the needs of the service, for bed access and IPM issues. [2] Sign off complicated by contention within the MDT.
Active	1780	Macular FOWL Long Waiters	24/12/2025	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. Insourcing at weekends with Medinet, using the agreement funds from the LTFU and ERF work Utilising nurse led clinics for Risk 2 patients following macular meeting 19/11/25.

Active	659	Medicines Supply Challenges	18/11/2025	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	2253	Mental Health bed delays	18/12/2025	18/11/2025	Unscheduled Care (A3)	Emergency (ED) Services	16	↔	16	1		Process between DCH and DHC ongoing meetings and development of pathways with a focus on the patient receiving the correct treatment plan and having everything commenced in ED or where the patient is within DCH.
Active	1629	Move of Hampshire Trust to a Sectra PACS	02/01/2026	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. Rowe, Ian - PACS / RIS / IT Manager 22/10/2025 14:10:09 The risk remains. The additional risk around how the Trust will fund the solution beyond 2026 remains. The functionality proposed for the mitigation of the loss of the full DCH<->HHFT patient imaging record will not be achieved. Final functionality is still being developed and live product deployment anticipated in 2026, date to be confirmed. Testing and development of product functionality continues. Recent advice from SWASH is that only the HHFT imaging that has been stored on the SWASH Sectra PACS, following the HHFT PACS changeover , will be available via the XCAi solution being developed. Previous imaging of DCH patients that is on their systems from the HHFT Intelerad PACS will be unavailable to DCH PACS via this solution. Risk to be revised by DTI with clinical colleagues to understand patient safety implications.
Active	1881	Neonatal Nursing & Medical Staffing	04/12/2025	01/05/2024	Family Services (B4)	Special Care Baby Unit (SCBU)	16	↔	16	6	People and Culture Committee	New business case approved by Trust Board, that improves part of the gap in the nursing establishment as per BAPM guidance. This has increased slightly the establishment and allowed to recruit more wte in the next few months (hopefully by September 2025). However, to achieve full BAPM compliance we require the establishment to increase by 4.0wte still. Bank staff working in SCBU increased recently, with at least 8 new members of staff joining our team and covering significant gaps in the rota.
Active	2132	NIHR Heidelberg award implementation	31/10/2025	25/03/2025	Medical Director	Research and Development	16	↔	16	4		Active project group now stood up with DTI and clinical service to work through requirements and prioritisation of the project in the context of the wider DTI challenges AGreenlight from DTAG to proceed. Funding expected to land from NIHR in July. Project group to be stood up with PM resource from DTI – likely start September
Active	2198	Patient care being impacted on Moreton Ward due to skill mix of staffing and insufficient budget allocation	08/12/2025	16/07/2025	Integrated and Holistic Care (A2)	Respiratory Service	16	↔	16	6	Quality Committee	Staff training programme in place. Internal Ward skill mix review across the care group to mitigate. Review of patient pathways from ITU step down with Ilchester ward supporting with non respiratory step down patients. Staffing skill under constant review of matron to try to mitigate.

Active	1502	Pharmacy Aseptic Unit - High risk to patient safety	15/12/2025	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 business case Monthly review of action plan progress NJ 14/11/2025 15:01:12 Have been stepped down from compliance management. Unit currently closed, with risks remaining due to availability of commercial compounders and lack of business continuity. Business case approved for additional staff and capital works. lead in time for capital improvemenst resulting in delay in reopening until Spring 2026.
Active	1865	Pharmacy Aseptic Unit - inability for commercial sector to provide resilience	15/12/2025	23/04/2024	Pharmacy, Pathology and Medical Physics (A4)	Pharmacy Service	12	↑	16	4	Finance and Performance Committee, Medicine Safety Committee	Regular discussions with regional leads Relationships being built with UHS and Portsmouth who are building larger units that could support some of our lines SW regional strategy being developed Task and Finish Group for Dorset set up Update Following approval of the business case, Lead times have become more challenging. Linked to 1502, business case supported but will be March/April 26 before unit reopens
Active	2012	Revalidation Officer	19/12/2025	25/11/2024	Workforce and Human Resources	Human Resorces	16	↔	16	9		Banding has been reviewed as we are an outlier in comparison to many other Trusts. It is now a B5, as of October 2024, although other comparable roles are a B6 and have administrative support. Approved 6hrs a week overtime; but added to end of existing working days. Post holder does not want permanent additional hours. Significant work re centralisation of the management of Drs At DHC before we can explore collaborative options. 30/07 update - Additional 0.4WTE now in place so 1 WTE in total. Improved resilience however significantly low total WTE in place for size of medical workforce and dedicated LED appraisal process.
Active	2145	Risk of eating disordered patients not receiving expert specialist care both in hospital and community.	08/12/2025	15/04/2025	Integrated and Holistic Care (A2)	Dietetics and Nutrition Service	12	↑	16	6		Inpatients: Protocols in place for management of these patients. Easting disorder MDT's in place. Ability to convene system MDT for patients with Psych Liaison support / Gastro. ACP support (BS). Adequate MDT support and policies in place. Community Patients: This is area of greatest risk. Ultimate mitigation of inpatient admission.
Active	2244	Risk of RO failure in the main DCH dialysis unit due to its age if not replaced in 2025/early 2026	28/11/2025	23/10/2025	Vascular and Metabolic (A1)	Renal Service	9	↑	16	4	Finance and Performance Committee	Works to remove business continuity to have completed by end of March 2026 which will include replacement of the RO system.

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Active	2139	Risk to the Maternity Advice Line Provided by UHD for all of Dorset	26/11/2025	07/04/2025	Family Services (B4)	Maternity Service	12		16	1		none required as currently the service is being provided by UHD
Active	2235	Spacelabs Sentinel, Pathfinder and LifeScreen Pro Analysis System NOT Windows 11 compatible	02/02/2026	09/10/2025	Vascular and Metabolic (A1)	Cardiology Service	4		16	4	Finance and Performance Committee, Quality Committee	Equipment already on the DTI radar for the Windows 11 upgrade project. Equipment also on the Trust capital bids register for equipment prioritisation. 11 month window covered by the Microsoft extension, this provides scope to build a case for a capital equipment bid.
Active	1168	System revenue affordability pressures	31/03/2026	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. 12/05/25 - Unchanged 12/11/25 - Unchanged. Continue to manage the workforce plans in the context of system affordability challenges. Starting business planning round shortly.
Active	1221	Tackling the backlog of elective care	20/10/2025	09/03/2022	Chief Operating Officer	Central Appointments	20		16	8	Finance and Performance Committee, Clinical Effectiveness Group	The trust has had a challenging August, especially in cancer performance however, witing times metrics for elective care have been strong year to date. Main area of concern is the size of the waiting list. Mitigating actions are: 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 is currently not in any performance management with NHS England however, this is likely to change for cancer.

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Active	1843	There is insufficient capacity for consultant led clinics in Haematology for current demand levels	08/12/2025	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	1272	Trust Integration Engine	06/12/2025	20/05/2022	Chief Information Officer	Clinical IT Systems	20	↓	16	9	Strategy Transformation and Partnerships Committee in Common	This is a known risk which has been escalated to the Digital Transformation and Assurance Group chaired by Nick Johnson and attended by Executive team. Digital Services are meeting suppliers to mitigate risk. Request to pass risk to new Deputy CDO (Acute) Risk review due 6th December
Active	2189	Capital Replacement of CRCU Mechanical Ventilators used for Adult/Paediatric	31/12/2026	08/07/2025	Theatres, Anaesthetics, Critical Care & Decontamination (B3a)	Critical Care Service (CRC)	6	↑	15	3	Quality Committee	The unit has additional access to 3 transfer ventilators and 3 Savina ventilators for short use only. The Draeger ventilators remain on a service contract to ensure safety. If we were unable to provide the service we would complete a non-clinical transfer as per Network policy. The risk management plan would be: - early reporting of equipment failure to Draeger - if delays in repairing equipment consider if it is possible to loan machine. -assess patients for NIV by Breas and use the Savinas for ventilation. -Source Hamilton transfer ventilators from CRCU and ED. -Surge to Theatres and use Anaesthetic machines for ventilation whilst awaiting and assessing for non-clinical transfers.

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Active	2221	Cardiac Physiology Shortfall in Staffing to perform ECG analysis	22/12/2025	17/09/2025	Vascular and Metabolic (A1)	Across all specialties	8		15	6	Finance and Performance Committee, Quality Committee	In October 2024, external outsourcing was used to successfully clear a backlog of 500 ambulatory ECG recordings. However, with over 100 new recordings received each week and a current capacity to analyse only 30–40 recordings weekly, the backlog has once again accumulated beyond in-house recovery. A staffing restructure is underway to address this issue in the long-term. However, due to the specialist training, expertise, and competence required—combined with a national shortage of qualified cardiac physiologists—the restoration of full service capacity will take time. This ongoing mismatch between demand and capacity continues to pose a risk to timely patient care and service delivery. 13/11/25 - Currently reviewing contract to utilise UHD's current analysis capacity to clear backlog. PIP in place at both DCH and UHD which has been put forward to both Digital demand groups. Once approved, license to be purchased and installed to transfer recordings for reporting which will address backlog. Admin team have been prepping recordings to send. Meeting booked Mon 17/11/25 with key stakeholders within Cardiology - Andy Miller, Jo Jones, Laura Starr, Dumiso Ncube and Dr Charlie Butcher to work through options. Current mitigation is to screen all recordings for serious abnormalities that may require urgent management. Please note that there is also a slight delay with this process and the Physiology team are currently screening monitors fitted in September 2025. Comms has been sent to primary care and DCH colleagues to inform teams of current backlog with the reassurance that if there is a clinical need for urgent reporting, then to contact the Cardiology team with a request and any supporting information.
Active	641	Clinical Coding Resource	28/11/2025	17/05/2019	Chief Information Officer	Clinical Coding	20		15	3	Strategy Transformation and Partnerships Committee in Common	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.

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Active	759	Failure to Replace X-Ray Room 1	12/12/2025	31/01/2018	Radiology & Neurophysiology (B3b)	Radiology Service (DCH)	12	↑	15	4	Finance and Performance Committee, Medical Devices Group	When a breakdown occurs patients are moved to other rooms, however this results in delays for these areas. Attempts to source part from other sites if their equipment has failed and the part we require is useable.
Active	2257	Head of Midwifery post remains vacant	01/12/2025	24/11/2025	Family Services (B4)	Maternity Service	15	↔	15	3	Quality Committee	The midwifery management team are already working over their contracted hours and continue to do so. Quality improvement projects have been delayed or stopped.
Active	1912	ICE - unsent EDS (Electronic Discharge Summary) issues	16/10/2025	03/07/2024	Chief Information Officer	Clinical IT Systems	20	↓	15	12	Strategy Transformation and Partnerships Committee in Common	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	2133	Inability to undertake necessary clinical systems upgrades	16/10/2025	27/03/2025	Chief Information Officer	Clinical IT Systems	20	↓	15	8	Strategy Transformation and Partnerships Committee in Common	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 capacity. 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 management controls in place. Similarly, opportunities to utilise departmental CSOs are being explored.
Active	2072	Lack of networking segmentation - risk of cyber attack on supplier Admin Accounts	11/12/2025	19/02/2025	Chief Information Officer	Digital Technology and Infrastructure (DTI)	20	↓	15	6	Strategy Transformation and Partnerships Committee in Common	Segmentation of contractors being tested by Networks Team which will mitigate this issue entirely. Discussed at CAB on 8th September 2025 and approved for progress.
Active	1852	Neurophysiology Workforce levels not meeting Demand	12/12/2025	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

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Active	1664	Skill Mix within - Paediatric Outpatient Department - No Registered or Lead Nurse	17/11/2025	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	29/12/2025	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	01/12/2025	08/02/2023	Family Services (B4)	Paediatrics Service	12	↑	15	3	People and Culture 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	1913	TPP SystmOne - EPR core unit	16/10/2025	03/07/2024	Chief Information Officer	Clinical IT Systems	15	↔	15	4	Strategy Transformation and Partnerships Committee in Common	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	2169	Video platform for Paediatric epilepsy service (V-create platform)	24/11/2025	04/06/2025	Family Services (B4)	Paediatrics Service	16	↑	15	1	Strategy Transformation and Partnerships Committee in Common	None. Funding request sat on Trust capital expenditure list

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Quality Committee in Common Assurance Report
for the informal meeting held on Tuesday 21 October 2025 and
for the formal meeting held on Tuesday 25 November 2025

Chair	Eiri Jones, NED
Executive Lead	Dawn Dawson, Joint Chief Nursing Officer Lucy Knight, Chief Medical Officer (DHC) Rachel Wharton, Chief Medical Officer (DCH)
Quoracy met?	Y
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	• Receipt of the Board Assurance Framework and Corporate Risk Register as detailed below. • DCH – non-compliance with some regulatory clinical audits. Clinical Effectiveness Committee is aware of this and making progress to address the issues. Quality Committee will continue to monitor this closely. Issues with the systems used to manage audits was noted for both trusts. • DCH – positive report following the recent reinspection of maternity services by CQC • Receipt of the safe staffing reports, with assurance that the correct processes and methodologies had been followed. Additional requirements will be processed through business planning round.

Key issues / matters discussed at the meeting	The informal meeting of the committee held 21st October 2025 received: • An update on the CMHT and Intensive and Assertive Community Mental Health Service Review – System Level Joint Action Plan (DHC), noting that all actions were on track with no concerns to highlight. CMHT was mid-transformation and the phenomenal service and extra mile staff went for patients in the assertive community team was highlighted. • An update on the quality impacts of the DCH six facets survey • An update on the closure and planned reopening of the Yeovil Maternity Unit, noting that plans were in development to transition care from DCH back to Yeovil. The formal meeting of the committee held 25th November 2025 received, discussed and noted the following reports: Chief Nursing and Chief Medical Officer Update (DCH/DHC) • DHC had been invited to apply for Advanced Foundation Trusts status.

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- At a national and regional level, work was ongoing about ambient voice technology and AI in nursing, and a focus on aligning processes in PSIRF.
- The World Health Organisation (WHO) had declared antimicrobial resistance a public health emergency with a system-wide group looking in to this.
- Updated CQC relationship teams for the trusts. DHC was currently undergoing an unannounced CQC visit to Twynham (forensic) ward.
- For DCH 27 appointments were cancelled or rearranged in the recent industrial action. The trust met the 95% activity target. There were no cancellations at DHC.
- For DHC the new medical leadership structure was almost complete.
- A successful joint appraisers meeting was held between DHC, DCH and UHD

Board Assurance Framework (Assigned Risks) (DCH/DHC) noting that for both trusts the score for SR1 Safety and Quality remained at 12 with good progress to address actions. Metrics for strategic risks were currently being reviewed and the proposed risk appetite statement for patient safety and quality was 'cautious'. This will be considered further in discussion at future QCIC meetings.

Corporate Risk Register (Assigned Risks) (DCH/DHC) noting the appointment of joint risk manager in early November; work starting to align reporting and procure a joint risk management system. Thorough discussion around the risks for each trust with assurances given around specific risks.

Quality Report (DCH/DHC)

Dorset County Hospital

- Positive infection prevention management (IPM) performance but low thresholds set for certain infections which the trust was likely to exceed. This was recognised by the regional team.
- Following targeted work there were no pressure ulcers reported in month on the elderly care ward
- Mixed sex accommodation was an area of focus for the southwest region, with the trust seeing an increase during in October due to a period of escalation. Work ongoing to reduce mixed sex accommodation.

Dorset HealthCare

- Three cases of seclusion in October (no under-18s secluded since November 2024)
- Work ongoing to improve complaint responses to ensure the crux of the complaint was fully addressed
- IUCS call backs was an area of focussed work to improve performance

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Clinical Audit Plan – progress report (DCH/DHC)

Dorset County Hospital: Non-compliance with some regulatory audits following a period of instability in the team; Clinical Effectiveness Committee was working to address this.

Dorset HealthCare: Met all mandatory and regulatory clinical audits except for one due to a late notification.

Annual Reports (DCH/DHC)

Dorset HealthCare:

- Research and Development Annual Report
- Patient Experience Annual Report
- Complaints Annual Report

Dorset County Hospital:

- Patient Experience Annual Report

Learning from Deaths Report (DCH/DHC)

Dorset County Hospital

- Positive SHMI position at 1.01, and improved completion rates of Structured Judgement Reviews (SJRs).
- Mortality data and SJRs were triangulated with other metrics such as patient safety incidents, coroners inquests, and complaints to ensure there were no areas of concern.

Dorset HealthCare

- Unexpected deaths for Q2 (total 29) were below the 24-months average.
- Themes emerging from inquests and unexpected deaths include identification of risk assessments, crisis response, and timing and quality of multiagency responses.
- The trust is moving to embedding PSIRF within the learning from deaths process.

Internal Assurance report (DHC) noted

Quality Impact Assessment Assurance Report (DCH/DHC)

Safe Staffing reports (DCH/DHC)

Dorset HealthCare:

- Mental Health
- Community

Dorset County Hospital:

- Acute

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	The reports detailed the methodology and process followed for each safe staffing review and detailed the recommendations to improve safe staffing levels. The reports would be presented to Board and the committee was assured that the correct processes were followed. The reports were approved. CQC Maternity Report (DCH) noting the positive outcome and achievement, with a rating of 'good' for the service and removal of the section 29a warning notice. Maternity Reports (DCH). The below reports were received: • Maternity and Neonatal Quality and Safety Report • Midwifery and Maternity Staffing Report • Perinatal Mortality Review Tool Report • SCORE Implementation Action Plan • NHSE Letter: Actions to improve care for women, babies and families The committee noted: • The ongoing work and focus on the planned reopening of Yeovil maternity unit and the subsequent impact on the trust. • Work to improve rates of third- and fourth-degree tears, improvements in staffing, and discussion around compliance with the Maternity Incentive Scheme. National Maternity Survey (DCH) noting broadly positive scores with a number of recommendations, including improving personalised care planning and continuity of care. Health Inequalities Workstream Update (Joint) Quality Governance Groups Assurance Reports (DCH/DHC)
Decisions made at the meeting	• Approval of the Learning from Deaths Report (DCH & DHC) • Approval of the Patient Experience Annual Report (DCH & DHC) and DHC Complaints Annual Report • Approval of the DCH Quality Governance Group Terms of Reference • Approval of the Safe Staffing Annual Reports (DCH & DHC)
Issues / actions referred to other committees / groups	• Nil

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Quoracy and Attendance						
	27 May 2025	29 Jul 2025	23 Sep 2025	25 Nov 2025	27 Jan 2026	24 Mar 2026
Quorate?	Y	Y	DCH – Y DHC – N	Y		
Claire Lehman	Y	Y	Y	Y		
Suresh Ariaratnam	Y	Y	A	A		
Dawn Dawson	Y	Y	A	Y		
Lucy Knight	Y	Y	Apols for most of meeting. Present for the last 45 minutes	A		
Eiri Jones	Y	Y	Y	Y		
Stuart Parsons	Y	Y	Y	Y		
Rachel Small	A	Y	A	Y		
Anita Thomas	Y	Y	Y until 1500 A for last hour of meeting	Y		
Rachel Wharton	A	A	Y	Y		

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Report to	Board in Common (DCH Board)	
Date of Meeting	9 th December 2025	
Report Title	Maternity and Neonatal Quality and Safety Report	
Prepared By	Jo Hartley Director of the Midwifery and Neonatal Service	
Approved by Accountable Executive	Dawn Dawson, Chief Nursing Officer	
Previously Considered By	Quality Governance Group 12/11/2025, Quality Committee in Common 25/11/2025	
Action Required	Approval	No
	Assurance	Yes
	Information	No

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

Executive Summary
This report sets out the quality and safety activity covering the months of September and October (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 showing an improvement in CO monitoring. Smoking at time of birth remains below the 6% maximum target - The Avoiding Term Admissions into Neonatal Units percentage fluctuates but in October was below the maximum 5% - The rate of 3rd degree tears has increased. This will continue to be reviewed through the MDT process. No themes identified thus far. - There has been a statistically significant improvement in babies born with Apgar's less than 7 at 5 minutes 170 incidents have been reported through Datix for the two months. There has been a significant improvement in the number of Datix submitted for poor staffing, escalation and delayed inductions of labour. The homebirth service continues to be suspended regularly due to not being able to roster a senior midwife to attend as second. 6 incidents of in utero transfer required. Three women delivered at the receiving hospital - A new report has been produced provided bringing together all PMRT, MNSI, Child Death Overview Panel (CDoP) and Coroner's cases - Maternity Advice Line provided by UHD - ongoing challenges around lost calls and shifts not covered. Currently mitigated by increased staffing but Healthier Together Triage App progressing as further mitigation - There were three incidents of opening a second theatre in an emergency – all successful with good outcomes

- Risk register
 - 2180**, moderate (12) – lack of psychological support in SCBU
 - 2159**, moderate (8) – lack of patient and governance confidentiality in SCBU
 - 2183**, moderate (12) – increase in obstetric workforce to two SHOs on labour ward
 - 2139**, high (16) – concerns about the sustainability of the maternity advice line and CQC interest in UHD and the possibility of mutual aid from DCH. (*Subsequently rescored due to UHD increase in staffing*).
 - 1980** moderate (8) – awaiting confirmation of costs for proposed EPAC business case.
 - 1881**, high (16) – neonatal nursing remains very challenging. Risk raised to high due to concerns about recruitment. Progression to recruitment for agreed BAPM uplift approved. Risk will be mitigated.
 - 2044**, low (6) – maternity digital team now has an interim lead appointed for 3 months
 - 1689**, moderate (9) – no change to risk associated with a second theatre
 - 876**, moderate (12) – maternity staffing significantly improved due to YDH midwives and MSWs as well as NQMs appointed
 - The Q2 Scorecard is included. The themes are
 - Consent
 - Birth plans
 - Communication
 - Acuity
- And the action plan focused on
- Consent
 - Birth outside of guidance
 - Antenatal classes addressing consent, birth plans and expectations
 - PMRT & MNSI learning to be shared when available
-
- There were three complaints reported
 - Insufficient pain relief after a caesarean
 - Lack of compassion when caring for a woman after a caesarean
 - Provision of a clear plan of care following a change in the risks associated with the pregnancy
-
- The SBL update for quarter two is very positive with 100% achieved in four of the safety standards Diabetes standard has improved to 83%. Element 1 compliance for 'Very Brief Advice' was just below minimum target for Q2 with assurance provided since Q2 review that compliance is now 92%.
 - One neonatal transfer of a term baby for treatment of a suspected metabolic disorder
 - The majority of training data is compliant as of the 9th November. For those that are non-compliant, there is a plan to ensure compliance by 30th November.
 - Safeguarding training has shown sustained improvement. Newly qualified midwives are unable to be compliant until they can attend the Trust's level 3 training – awaiting new dates.

Recommendation

Members are requested to receive the report for **assurance**

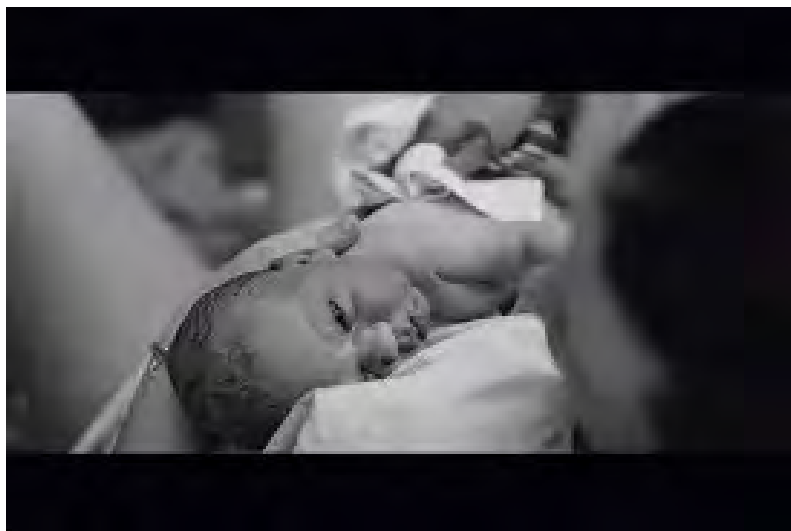
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Maternity & Neonatal Quality and Safety report

September and October 2025

Submitted by Jo Hartley, Director of Midwifery & Neonatal Services

Executive sponsor: Dawn Dawson CNO



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Executive Summary

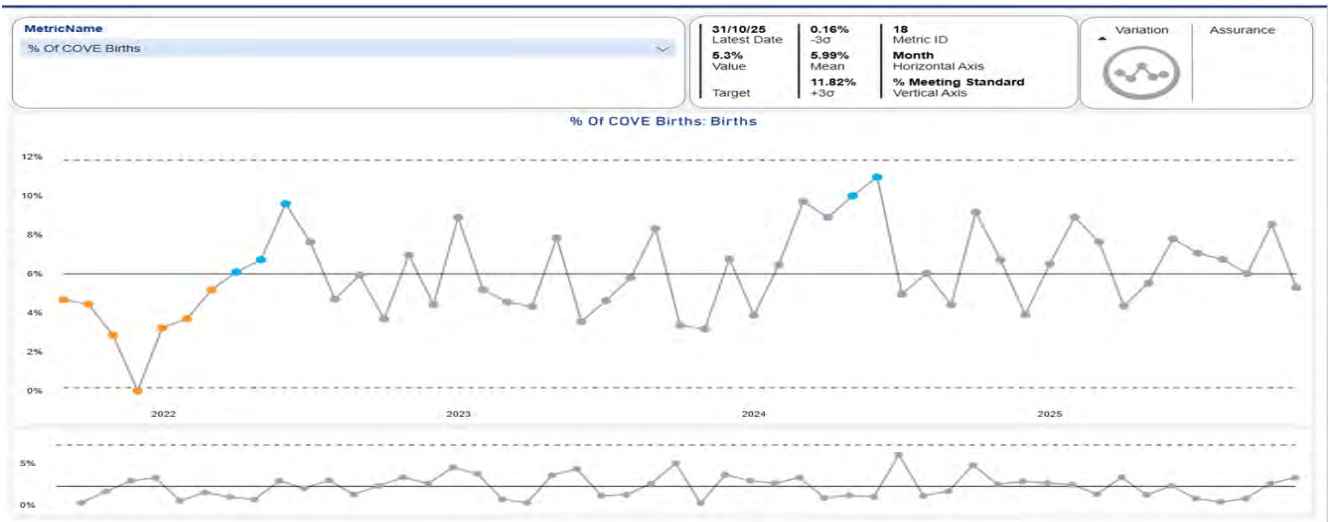
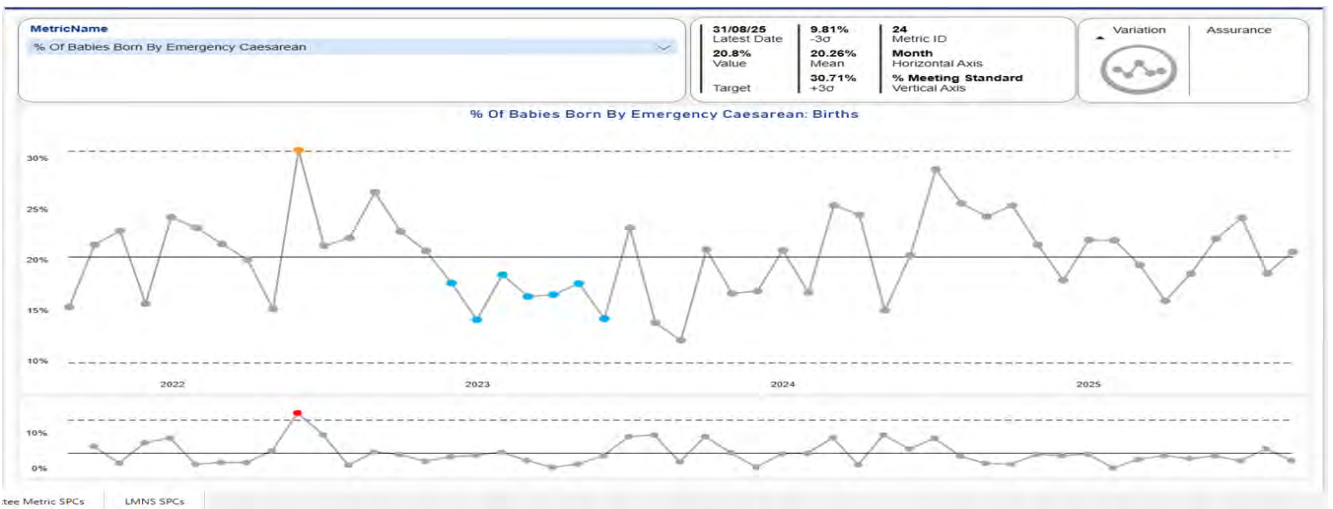
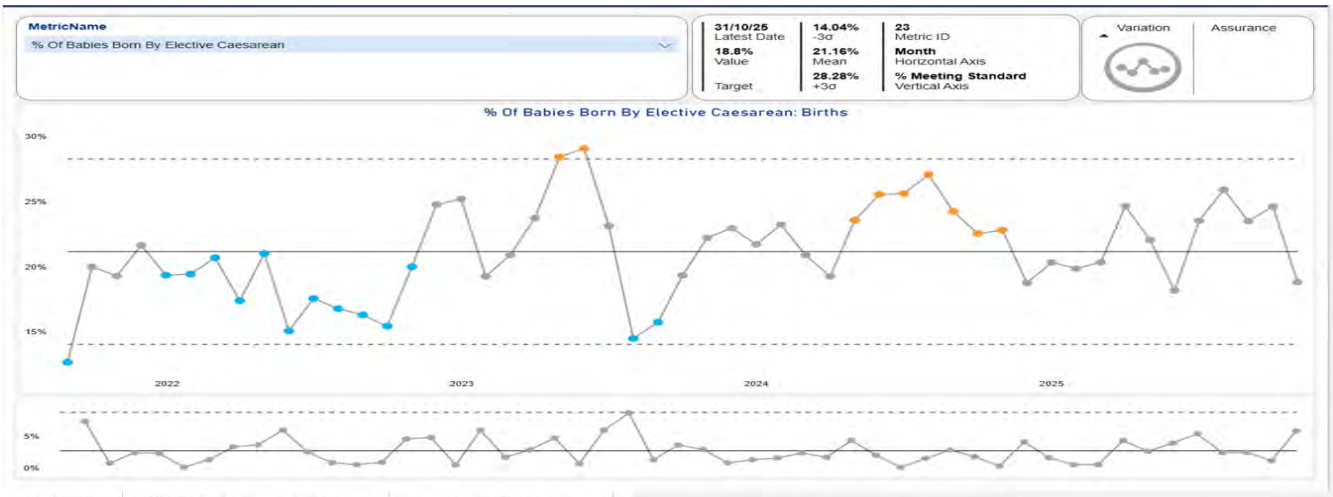
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- KPIs for smoking cessation are showing an improvement in CO monitoring. Smoking at time of birth remains below the 6% maximum target
- The Avoiding Term Admissions into Neonatal Units percentage fluctuates but in October was below the maximum 5%
- The rate of 3rd degree tears has increased. This will continue to be reviewed through the MDT process. No themes identified thus far.
- There has been a statistically significant improvement in babies born with Apgar's less than 7 at 5 minutes
- 170 incidents have been reported through Datix for the two months. There has been a significant improvement in the number of Datix submitted for poor staffing, escalation and delayed inductions of labour. The homebirth service continues to be suspended regularly due to not being able to roster a senior midwife to attend as second.
- 6 incidents of in utero transfer required. Three women delivered at the receiving hospital
- A new report has been produced provided bringing together all PMRT, MNSI, Child Death Overview Panel (CDoP) and Coroner's cases
- Maternity Advice Line reported. Highlighting the ongoing challenges around lost calls and shifts not covered
- There were three incidents of opening a second theatre in an emergency – all successful with good outcomes
- Risk register
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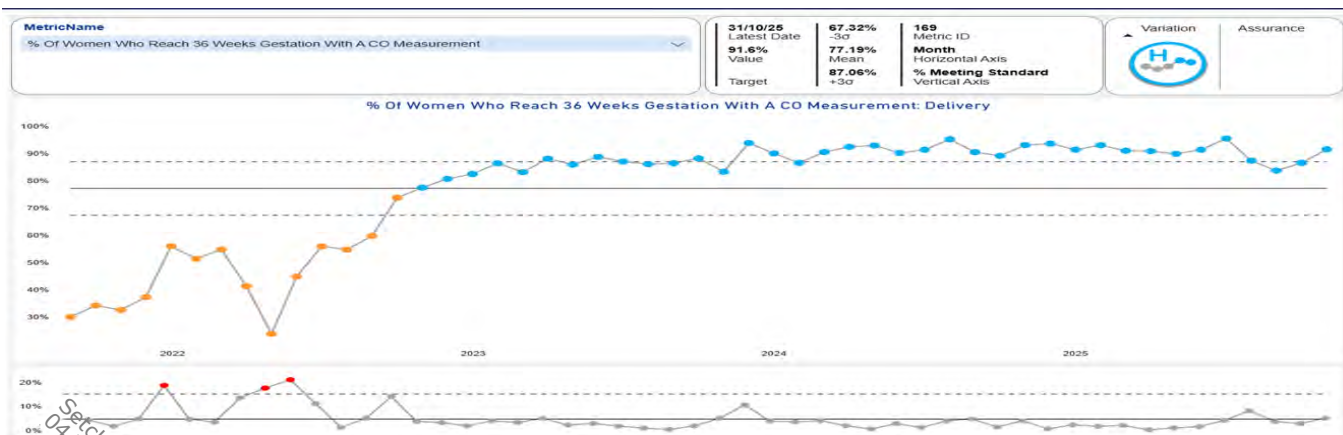
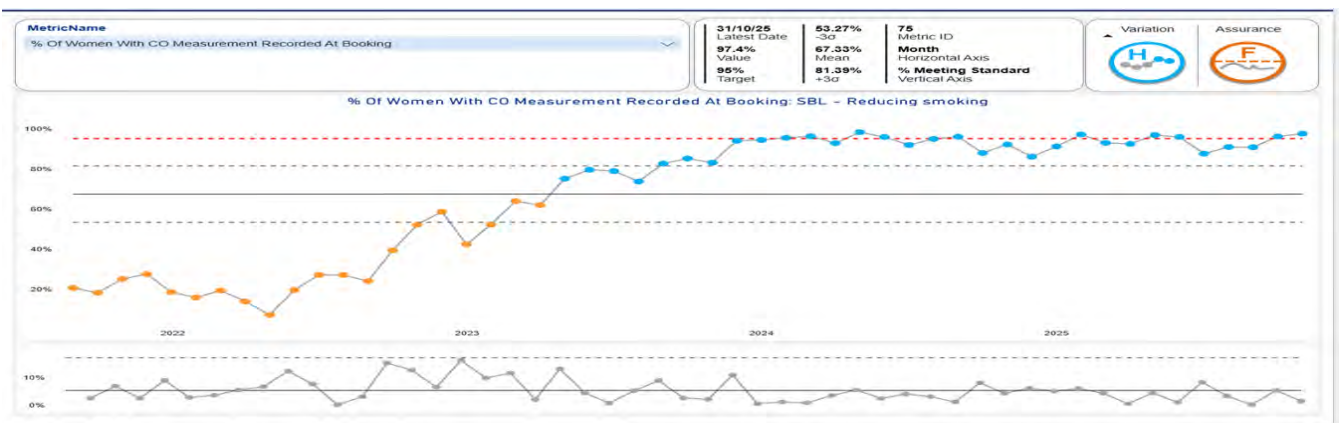
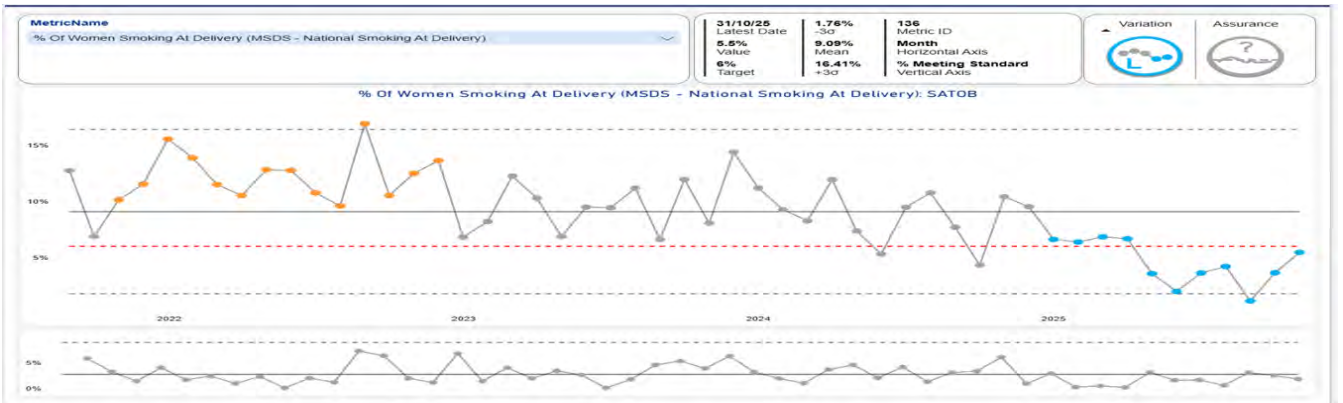
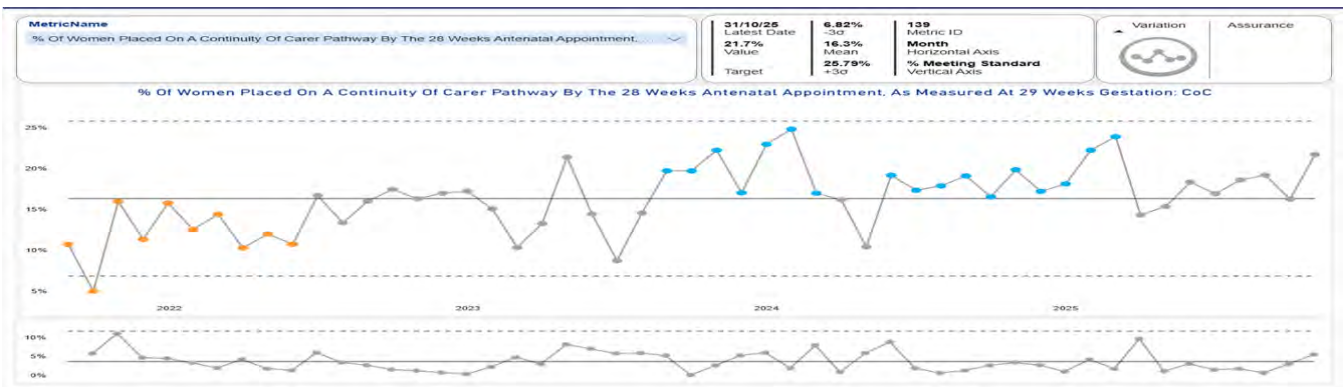
- The SBL update for quarter two is very positive with 100% achieved in four of the safety standards Diabetes standard has improved to 83%. Element 1 compliance for 'Very Brief Advice' was just below minimum target for Q2 with assurance provided since Q2 review that compliance is now 92%.
- One neonatal transfer of a term baby for treatment of a suspected metabolic disorder
- The majority of training data is compliant as of the 9/11. For those that are non-compliant, there is a plan to ensure compliance by 30/11.
- Safeguarding training has shown sustained improvement. Newly qualified midwives are unable to be compliant until they can attend the Trust's level 3 training – awaiting new dates.

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

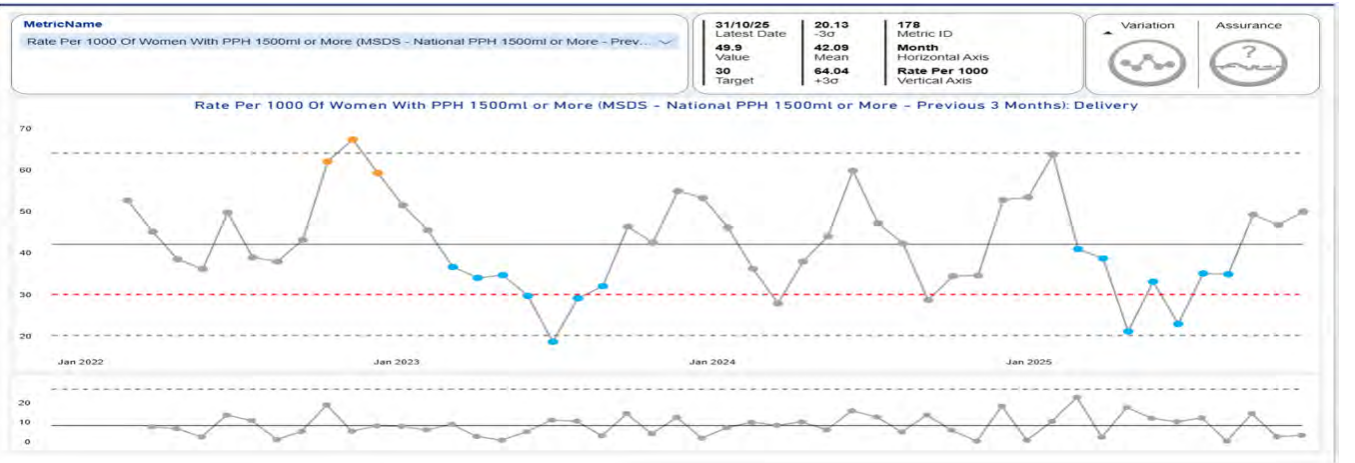
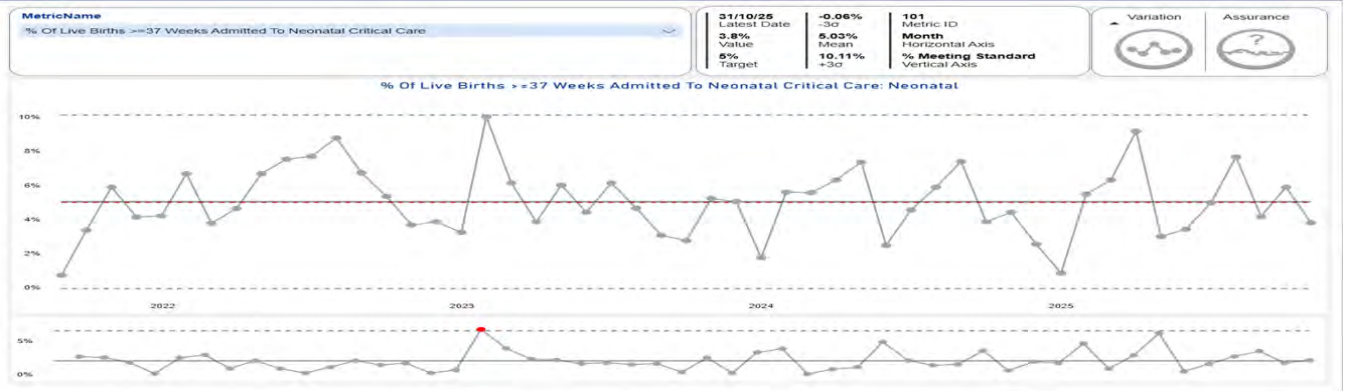
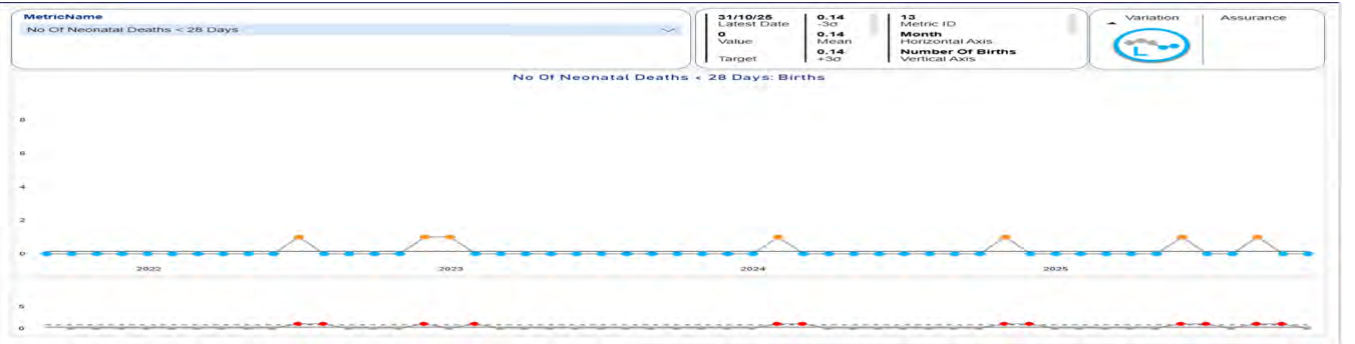
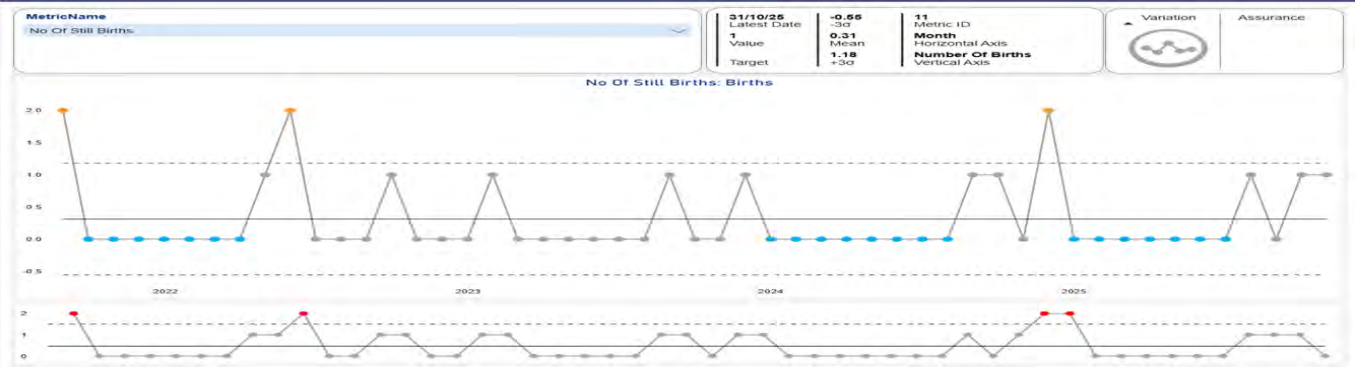
Metric	Target	Current position
Number of babies born		199 in Sept, 170 in Oct
% babies born by elective caesarean	NTI	18.8% ↓
% babies born by emergency caesarean	NTI	21.8% ↑
% of births in the midwife-led unit (The Cove)	NTI	8.5 - 5.3% minimal change
% of women on a continuity of care pathway by 28 weeks	NTI	21.7%↑
% women smoking at time of delivery (MSDS national data)	< 6%	5.5% ↑
% CO recorded at booking	> 95%	97.4% ↑
% CO record at 36 weeks	> 95%	91.6% ↑
Number of stillbirths		2 (across the two months)
Number of neonatal deaths		0
% babies >37 weeks admitted to SCBU	< 5%	5.9 – 3.8% ↓
Rates per 1000 of PPH >1500mls (current 3 months)	< 30	49.9 ↑ minimal change
Rates per 1000 of 3 rd /4 th degree tears (current 3 months)	< 25	40.1 ↑
% live births <37 weeks gestation	< 6%	4.2%↓
Hypoxic Ischemic Encephalopathy incidents		Nil
% of babies with 1 st feed breast milk	NTI	79.6%
% of babies with fetal growth restriction <3 rd centile, born after 37 weeks and 6 days	nil	nil
Rates per thousand of singleton babies born with an apgar score <7 at 5 minutes (rolling 3 months)	National average score 14	17.9 ↓ statistically significant improvement
Number of neonatal admissions		28 ↑



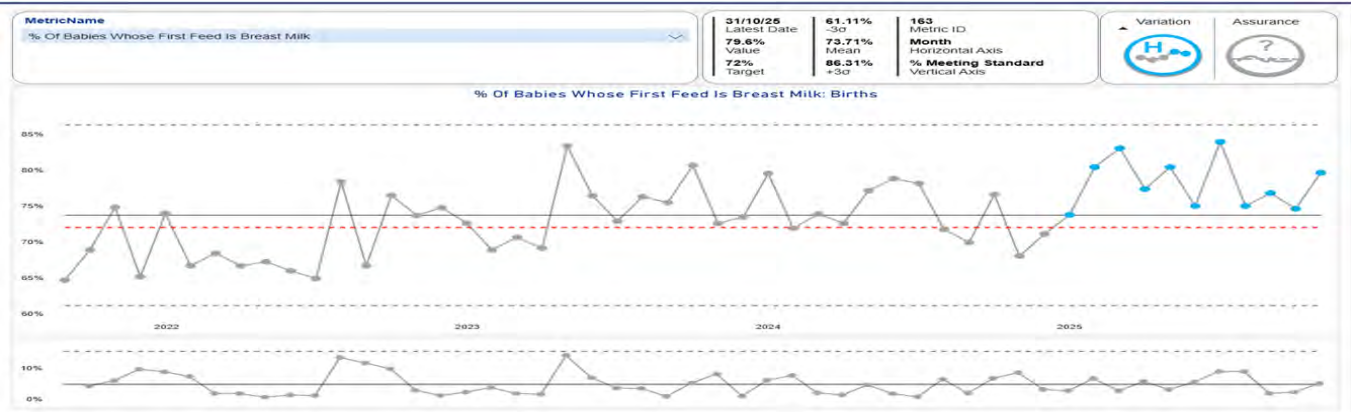
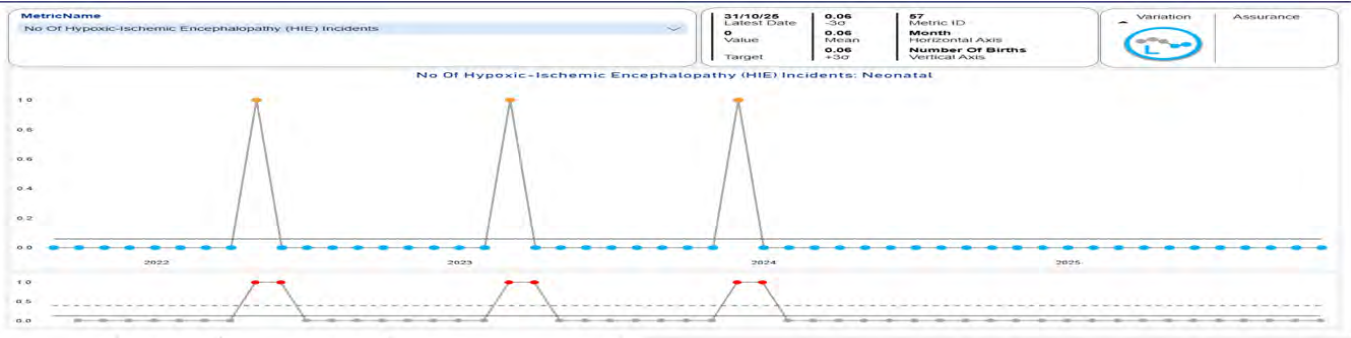
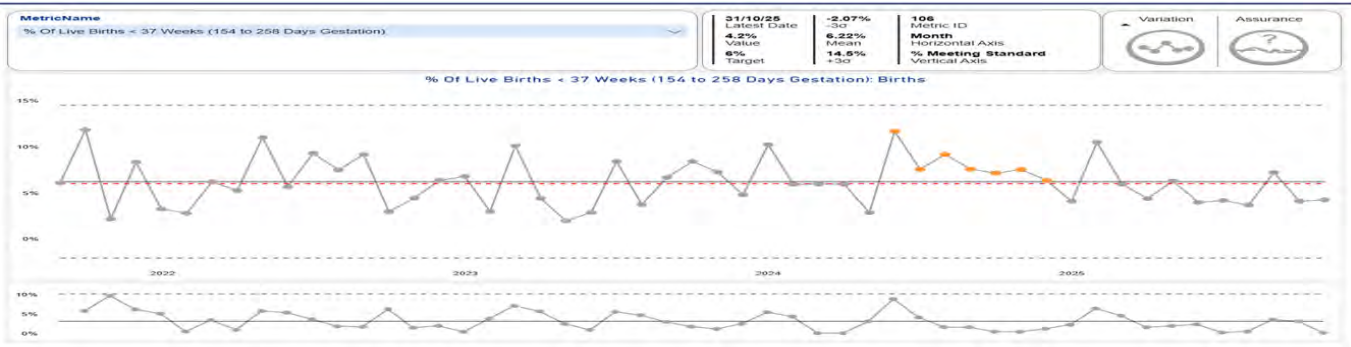
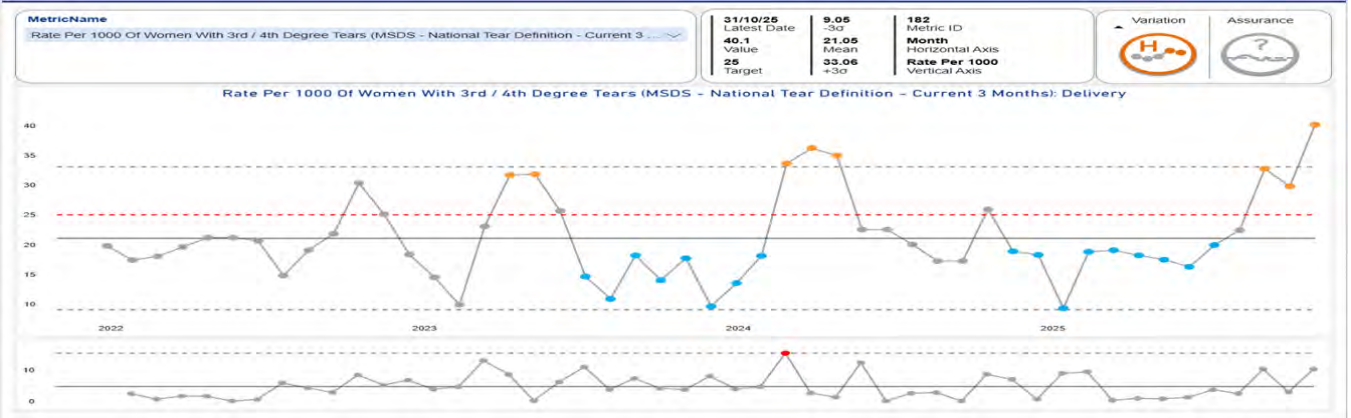
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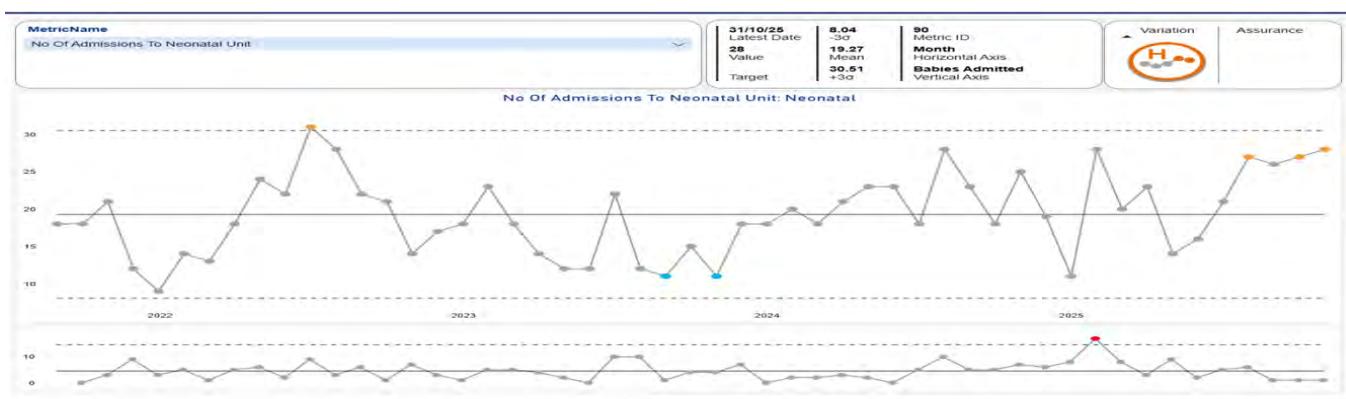
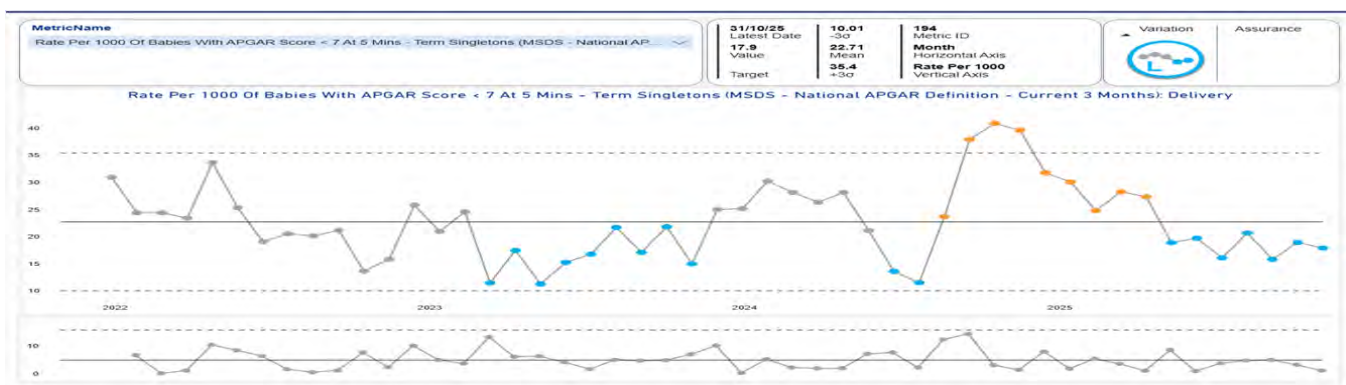
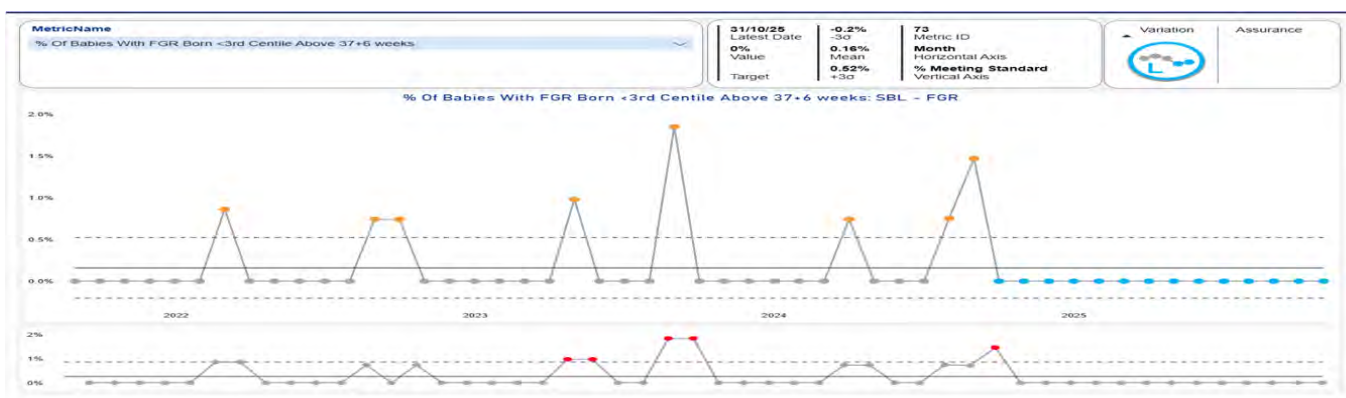
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Total Number of Incidents submitted for September and October 2025

maternity & neonatal
170

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

Red flag	Descriptor	Incidents for September and October
RF1	Escalation to divert of maternity services & poor staffing numbers, including medical staffing and SCBU	3 incidents – 1 OPEL 4 with 3 women diverted to other maternity units
RF2	Missed medication	0
RF3	Delay in providing or reviewing an epidural in labour	0
RF5	Full examination not carried out when presenting in labour	0

RF6	Delay of ≥ 2 hours between admission for induction of labour & starting process	7 delayed IOLs
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 several times in relation to sickness and vacant senior cover shifts
RF10	Delay of time critical activity	0

In-utero transfers – UHD is default level 2 NICU for DCH pregnancy <32 weeks	
24/40, threatened preterm labour, ruptured membranes at 18/40	Transfer to Southampton and discharged
24/40, threatened labour	Transfer to Portsmouth and baby born 24+5
32+1/40 no neonatal cot in DCH	Transfer to UHD then back to DCH and baby born 32+4
30+2 threatened labour, positive actum partis test	Transfer to UHD and discharged
30+5 DCDA twins threatened labour	Transfer to UHD and delivered
29+2 DCDA twins, abnormal CTG	Transfer to Salisbury as UHD no capacity – 2 further transfers to UHD, discharged

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PMRT, (perinatal mortality review tool) MNSI (maternity and neonatal safety investigations), CDoP (child death overview panel) and Coroner cases

IUD – intrauterine death/stillbirth

NND – neonatal death

Incident	Gestation	Date of Incident/death	Case IDs	Investigator	External Owner	Update	PMRT grading	Reasons for Grading	Open and Honest Conversation	Duty of Candour Letter	Open or Closed
IUD both twins	33+1	11/11/2024	96009	PMRT	No	PMRT review completed report being written	B, A	B relating to details within the USS reporting	Yes	Required	open
NND	41 weeks NND 2 days old	22/05/2025	98704/1, MI42426	PMRT/MNSI/CDoP	Yes/UHS	waiting for MNSI report	not for grading until all investigations completed.		Yes	Awaiting outcome	open
IUD	36+5	09/07/2025	99340	PMRT	No	22/9/25 report published- awaiting PM results	B, A	B for availability of emergency transfer trolley in the USS dept	Yes	Required	awaiting PM
NND	40+6 NND less than 6 hours of age	17/08/2025	99869/1, MI45424	PMRT/MNSI/CDRM	No	MNSI interviews undertaken. Providing evidence to MNSI.PMRT with UHD for oversight 12/11/25	not for grading until all investigations completed.		Yes	Awaiting outcome	open
IUD	35+2	28/09/2025	100493	PMRT	No	PMRT 10/12/25			Yes	Awaiting outcome	open
IUD	31+6	06/10/2025	100620	PMRT	No	PMRT 7/1/26			Yes	Awaiting outcome	open

Maternity Advice Line call and lost calls report

Month	Total (All calls)	Total Admin Calls	Total Clinical Calls	Answered by MW		Total transferred		Total abandoned		Calls Requeued		Answered within 30 seconds	Yeovil calls**		Unfilled shifts
				Number	%*	Number	%*	Number	%*	Number	%*		Number	%*	
March	3673	719	2329	1575	68	754	32	164	7.0	566	36	61%	n/a		20 (14 nights)
April	3774	877	2370	1790	76	411	17	169	7.1	575	29	59%	n/a		12 (10 nights)
May	3973	934	2654	1805	68	591	22	160	6.0	531	26	61%	54	2	18 (14 nights)
June	4132	889	2741	1682	61	871	32	188	6.9	621	33	58%	51	2	11 (3 nights)
July	4638	1003	2796	1819	65	977	35	188	6.7	643	35	57%	31	1	18 (7 nights)
August	4727	1206	2665	1740	65	1102	41	177	6.6	654	42	52%		0	
Sept	4765	920	3058	1765	58	1097	36	196	6.4	768	39	51%		0	
Oct	4759	969	2976	1564	53	1412	47	181	6.1	588	38	57%		0	
Average	3710	707	2327	1522	58	725	31	178	7.6	618	27	57%	19	1	

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Incidents of moderate harm and above not reported elsewhere		
harm	incident	Action
Moderate DCH109751	There was a delay in an SBR (serum bilirubin blood test) being taken on a baby. The baby was readmitted to DCH for triple phototherapy for 10 days.	Baby has follow up appointment December 2025, Level of harm reviewed following appointment.

Opening a second theatre in an emergency	
DCH111360	Second theatre required to repair a third degree tear
DCH110118	Second theatre required to deliver a woman following an allergic reaction to monofer and fetal distress
DCH111290	Second theatre required for category caesarean due to fetal distress

3rd & 4th degree tears (OASI - obstetric anal sphincter injury) Sept and Oct

In September there were 2 OASI and 6 OASI in October which is an increase over previous months. An MDT comprising safety lead midwife, governance lead midwife, inpatient matron, practice development midwife (PDM) and digital midwife carried out a thematic analysis. No themes were identified in care and this led to the group reviewing the data for the year (1/1/25-31/10/25). No themes were identified that were preventable.

Actions:

- The PDM has commenced a series of “tea-trolley” interactions with staff to raise the importance of perineal protection which will involve some practical displays (using a model).
- Email sent to all staff reminding them of the importance of ensuring all women are appropriately referred, including to physiotherapy service, following OASI
- The MDT will continue to review the OASI regularly.
- Lead physiotherapist for women’s health will be asked to provide data around long-term complications for women.

Risk Register

ID	Title	Risk Statement	Open	Risk	responsi bility
2180	Lack of psychological support service for neonatal service	Lack of funding for specialist psychological professionals, to support parents, in line with staffing recommendations for the Neonatal Units. Discrepancy in care across the region, as some units have psychological support in place (level 2 and 3 around us). When infants step down in care and move to DCH this support is nonexistent. Update No update this month	25/06/2025, Débora Pascoal-Horta, Neonatal Matron, quarterly review	Moderate 12	Service specific

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2159	Patient and governance confidentiality	Layout of neonatal unit results in daily breaches of confidentiality. Update Proposal made to Space Utilisation Group accepted. However , it was decided that this project should merge we existing project for offices across the Trust. Unsure at present when this can be actioned.	09/05/2025, Débora Pascoal-Horta, Neonatal Matron, quarterly review	Moderate 8	Division
2183	YDH closure impact on obstetric workforce	Update Obstetric cover is poised to improve with new doctors starting next month. This will provide an extra SHO for labour ward, alongside the established gynae middle-grade and obstetric middle-grade for daytime hours. The acuity is notably higher on labour ward and the attendance at DAU has increased.	30/06/2025, James Male, Service Manager. Quarterly review	moderate 12	division
2139	Risk to the maternity advice line provided by UHD for all of Dorset	the maternity advice line provides a dedicated maternity triage service for all pregnant women in Dorset. Update Update from UHD. CQC has requested information about the mutual aid from DCH to support MAL. Currently, in discussion about DCH bank staff having bank contracts at UHD. October: 4759 calls, 2976 clinical, 53% answered. Risk raised to possible major impact following the ongoing scrutiny of MAL by CQC. Progress with Triage app solution underway. Risk score will be reduced accordingly.	07/04/2025, Jo Hartley, DoMN Services, monthly review	high 16	Division
1980	EPAC restricted service	Update Currently EPAC remains open for most days Mondays- Fridays but establishment requires review. Business case has been submitted and awaiting amendments Update EPAC business case awaiting updated funding costs. Small but steady number of complaints from women unable to access a DCH appt for several days (sometimes over a week)	20/09/2024, Jo Hartley, DoMN Services, quarterly review	Moderate 9	Division

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1881	Neonatal Nursing	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. Recruitment ongoing. Consultation with some staff to change band 3 to band 6 nurse on nights - allowing for 3 RNs and therefore a supernumerary lead nurse. Update Recruitment is ongoing for band 5 posts but no progress made with recruitment to approved business case. This is now taking a priority to stabilise the workforce. Increased sickness now impacting on daily staffing levels and until new vacancies are appointed to.	01/05/2024 Débora Pascoal-Horta, Neonatal Matron, monthly review	High 16	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 Interim appointment of digital lead midwife for three months	14/01/2025, Jo Hartley, DOMN, quarterly	Low 6	division
1689	Opening a second theatre in an emergency & the elective pathway	Update A second theatre was required three times in Sept and Oct. There were also several incidents where elective activity was significantly delayed, sometimes for more than 24hrs, because the maternity theatre was being used for emergencies and elective work cannot continue past 1700	29/06/2023 managed by Jo Hartley DoM, quarterly review	moderate 9	division
876	Maternity Staffing	Update whilst incidents of escalation to OPEL 3 and 4 continue to occur regularly and IOLs and LSCSs are regularly delayed, there has been progress in relation to recruitment. 6.4wte NQM appointed for 12 months fixed term. 2 wte additional band 6 midwives recruited for fixed term 12 months. Agency now used regularly, and ward staffing increased to 8 plus the coordinator. Update Staffing significantly improved due to additional midwives and MSWs following YDH closure, access to agency and newly recruited NQM. However, they are only employed for 12 months.	21/09/2021 Managed by Jo Hartley, Director of Midwifery, monthly reviews	Moderate 12	Division

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Complaints and birth debrief feedback for maternity and SCBU

Total informal and formal

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

Themes

Insufficient pain relief after a caesarean

A lack of compassion when caring for a woman after a caesarean

Provision of a clear explanation about a plan of care following a change in the risks associated with the pregnancy

Claims Scorecard Q2

Scorecard July-Sept 2025	
Trust Claims(obstetric) 2013-2023	
Top injuries by volume: - Psychological damage (6) - Unnecessary pain (3) - Bowel damage/dysfunction (2) - Brain damage (2) - Hypoglycaemia (1)	Top injuries by value: - Brain damage (2) - Chromosomal abnormality (1) - Bowel damage/dysfunction (2) - Psychiatric/psychological damage (6) - Hypoxia (1)
Top causes by volume: - Fail to warn – informed consent (3) - Not specified (2) - Assault, Etc by hospital staff (2) - Perineal Tear 1st, 2nd, 3rd Deg (2) - Fail to recog. complication of (2) - Foreign body left in situ (1)	Top 5 causes by value: - Fail to warn – informed consent (3) - Fail AN screening (1) - Perineal tear 1st, 2nd, 3rd Deg (2) - Assault, Etc by Hospital staff (2) - Fail / Delay treatment (1)
Complaints Q2 25-26 (6x Early resolution complaints) Birth choices dismissed Understanding consent when in pain Birth plans not acknowledged Wound Infection -lack of communication for follow up Concern that Anti-D administered incorrectly Patient felt they had to chase appointments and book own follow ups	
Incidents Q2 25-26 3 cases of opening a second theatre 23 reported incidents of delay of Induction 6 in-utero transfers 6 delay or failure to monitor a patient 7 incidents of escalate to divert reported 3 Perinatal deaths reported to MBRRACE	

Maternity Incentive Scheme - SA9

Quarterly review of Trust's claims scorecard alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (Board or directorate) quality meeting



Themes Q2 25-26

- Consent
- Birth plans
- Communication
- Acuity

Learning Q2 25-26

Birth choices & plans should be discussed A/N and then reviewed and read on admission
 Follow up plans/appointments should be clearly communicated with families & documented

Action Plan Q2 25-26

Consent has been raised in complaints. To work with the trusts PSIRF priorities surrounding consent	
Antenatal classes to discuss birth plans & expectation	
Off guidance birth choices SOP/Guideline	
PMRT & MNSI learning to be shared when available	

Not started In progress Completed

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Saving Babies' Lives (Version 3.2) Board Report



Dorset Local Maternity
and Neonatal System



Trust	Dorset County Hospital
Date of review meeting	18/11/2025
Review period	Quarter 2, 2025/26
ICB accountable officer	Pam O'Shea (Interim ICB Chief Nursing Office)
Trust accountable officer	Dr Rachel Wharton (Chief Medical Officer)
LMNS peer assessor name(s)	Vicky Garner (LMNS Lead Midwife)

Executive summary:

- In accordance with the Maternity Incentive Scheme Year 7 requirements for Safety Action 6.3, sufficient progress has been made towards implementing SBLv3.2, in line with the improvement trajectory agreed with the ICB.
- Significant improvements in uterine artery Doppler assessment (intervention 2.7) and next working day ultrasound scan (Intervention 3.2) reflect the successful embedding of processes and the impact of quality improvement work.
- Q3 2025/26 priorities, alongside sustaining improvements, include:
 - Close monitoring of process indicator 1e (CO-verified quit at 4 weeks) advised. Q2 minimum target (50%) only just met and should be aiming for stretch target of 60% by Q3 2025/26.
 - Formalising multi-disciplinary training requirements for onboarding and management of women using pregnancy specific Hybrid Closed Loop systems (intervention 6.2).

	Q1	Q2	Q3	Q4
Element 1 Smoking in pregnancy:	100%	90%		
Element 2 Fetal growth restriction:	100%	100%		
Element 3 Reduced fetal movements:	100%	100%		
Element 4 Fetal monitoring in labour:	100%	100%		
Element 5 Preterm birth:	100%	100%		
Element 6 Diabetes:	67%	83%		
Total implementation (all elements):	97%	97%		

Agreed Improvement Activity and Shared Learning

Element 1	- Compliance for 'Very Brief Advice' training (intervention 1.9) just below minimum target for Q2, with assurance provided since the Q2 review that compliance is now at 92%. - Focus needed on process indicator 1e (CO verified quit at 4 weeks) to ensure minimum target maintained – aiming for stretch ambition of 60% by Q3 2025/26.
Element 2	- High levels of compliance (≥95%) to be commended with aspirin, vitamin D and FGR risk assessment (interventions 2.1, 2.2 and 2.4). 83% compliance with uterine artery doppler assessment (intervention 2.7) achieved for Q2 against target of 50%. New target set for Q3, aiming for ≥80% from Q4 2025/26 to align with LMNSs within the NHSE SW region now process embedded. - Exception reports for outcome indicator 2d (<3rd birthweight centile born after 38 weeks) and process indicator 2b (antenatal detection of small for gestational age babies) continue to provide assurance of processes and outcomes with no associated harm.
Element 3	Achieving 93% compliance with next working day ultrasound (Intervention 3.2, Process Indicator 3b) is a significant milestone. This demonstrates the tangible benefits of the quality improvement efforts to date and is something to celebrate.
Element 4	100% compliance with element 4 consistently sustained. - Perinatal mortality review tool reporting shows no associated risks of harm identified.
Element 5	100% compliance with element 5 sustained for a second quarter. - Assurance has been provided regarding the introduction of a new preterm birth audit to inform quality improvement. Plans are in place to include the NNAP dashboard in clinical governance to meet SBL v3.2 requirements for reviewing dashboard data at improvement meetings.
Element 6	100% audit compliance achieved for element 6 to be celebrated. - Focus for Q3 is formalising multi-disciplinary training requirements for onboarding and management of women using pregnancy specific Hybrid Closed Loop systems.

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- All eligible perinatal deaths were reviewed using the Perinatal mortality review tool (PMRT)
- Focus on learning, safety, and equity.
- Aligned with Saving Babies' Lives Care Bundle (SBLCB).

- 3 deaths reported by DCH in Q2
- 1 Early neonatal death
- 2 Antenatal stillbirths
- There was 1 PMRT review published in Q2. This was an antenatal stillbirth from this quarter. This has been through the PMRT review meeting and (as MIS guidance) the report will be re-opened once the postmortem is back and any learning identified.

- 1 case was benchmarked against SBLCB:
- 14 total cases (Jan 2024–Sept 2025) included in equity analysis.

- 64% of cases involved social/health behaviour factors.
- 21% involved smoking – top modifiable risk.
- 28% of cases were in quintile 3 or below

Smoking in pregnancy remains a key focus.

- All standards met or on track change

From 1st June 2025 – 31 August 2025 a total of 46 clinical situations were documented on BadgerNet where a consultant obstetrician was required or requested to attend.

Number of clinical situations	Consultant Attended	Percentage Attended
46	42	91.3%

One request to attend was reported as the Consultant was not present for evening ward round. This was escalated at the time to the Maternity Manager On Call and followed up appropriately. At the time of the reported non-attendance for evening ward round it is noted there had been a recent change to the time of ward rounds.

There were 13 cases of postpartum haemorrhage (PPH) over 2,000mls and ongoing, ten of which were attended by a consultant obstetrician. Of the three cases not attended, in two cases the consultant obstetrician was notified when the blood loss was 1500mls but not requested to attend as it was thought the blood loss was settling. In the one remaining PPH case, the consultant was not informed or requested to attend.

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

Neonatal Transfer Out Data for Sept

Gestation	Weight	Reason	Transferred to
40+1	3338kg	Postnatal collapse and, at the time, complex metabolic disorder strongly suspected	The Evalina Hospital

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

		None to report for Sept

Babyloss Data for Sept and Oct

Intrauterine death	Neonatal death	Late neonatal death
D294957 IUD 31+6/40. Admitted to labour ward by ambulance following an antenatal haemorrhage at home. Baby died in utero due to a placental abruption.	nil	nil
D445503 Late miscarriage 22+6/40.		
D832874 Low risk pregnancy and attended for a routine antenatal check at 34+6 weeks. Baby had died in the womb.		

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Perinatal Training Compliance

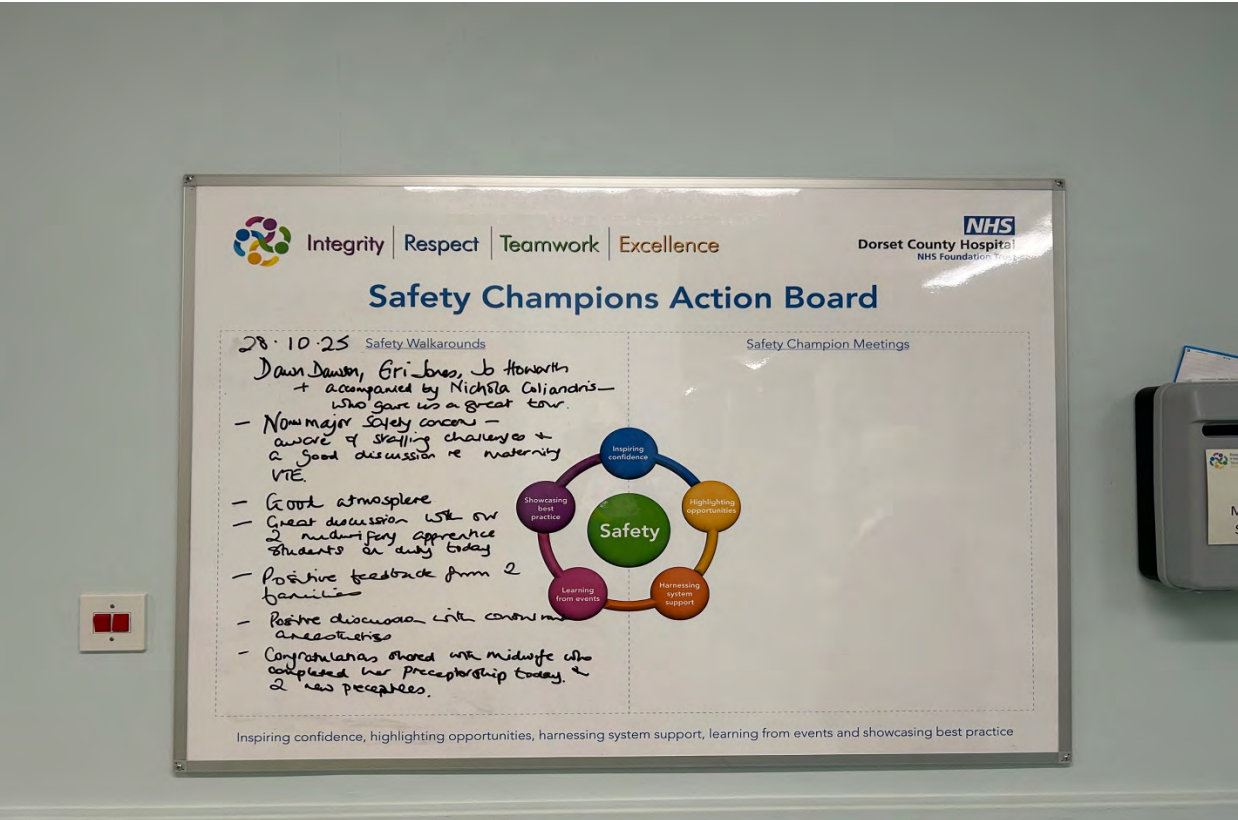
Key	
≥90% compliance	
<90% compliance	

MIS Year 7 Reportable Training	Staff Group	Compliance (%)	
SA6 SBLv3 Element 1.8	Carbon Monoxide Monitoring Midwives and MSWs giving Antenatal Care	85%	Will be compliant as of the end of November (prior to MIS deadline)
SA6 SBLv3 Element 1.9	Very Brief Advice all staff (midwives, obstetricians and MSWs)	84%	
SA6 SBLv3 Element 2.11	Practical SFH assessment (obstetricians and midwives)	80%	
Fetal Monitoring and Surveillance in the AN and Intrapartum period	Obstetric Consultants	100%	
	Obstetric doctors (Registrars)	100%	
	Midwives	90%	
PROMPT	Obstetric consultants	100%	
	Obstetric Registrars	100%	
	Doctors on obstetric SHO rota	100%	
	Midwives	97%	
	MSWs	100%	
	Obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors	100%	
	All other obstetric anaesthetic doctors contributing to the obstetric rota	100%	
	Rotational anaesthetic staff commencing after the 1 st July 2025 – lower compliance accepted providing Trust Board agreed action to attend within 6 months	87%	2 anaesthetists booked to attend January and February
Neonatal Basic Life support (NBLS) Yearly	Paediatric consultants	100%	
	Paediatric registrars	89%	Will be completed this week
	Paediatric SHOs	100%	
	Neonatal nurses	100%	
	MSWs and HCAs who require this training as per local policy	86%	Will be completed by 20/11
	ANNP	100%	
	Midwives	87%	Will be compliant after the 18/11
RCUK NLS Certification	Senior midwives and homebirth midwives	100%	

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	Paediatric Consultants	100%	
	Paediatric Registrars	100%	
	Neonatal Nurses	100%	
Safeguarding training Level 3	Midwives	86%	NQMs excluded from this as started with the Trust Oct 2025 and have completed the 4hrs training. Unable to book onto the Trust day due to unavailability of dates
	MSWs	61%	Significant improvement

Safety Walkabout with CNO and DoN



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Report to	Board in Common, DHC	
Date of Meeting	9 th December 2025	
Report Title	Mental Health Inpatient Establishment Setting Review	
Prepared By	Cara Southgate, Director of Nursing, Therapies and Quality; Alex Matutino, Safer Staffing Lead; Katie Powell, Data Support and Analyst	
Approved by Accountable Executive	Dawn Dawson Joint Chief Nursing Officer	
Previously Considered By	Directorate Management Group, 29 th August 2025; Quality Governance group, 2 nd September 2025, Quality Committee in Common 25 th November 2025	
Action Required	Approval	Y
	Assurance	-
	Information	-

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? <i>Delete as required</i>	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1: Quality and Safety SR2: Culture SR3: Workforce Capacity SR4: Capacity and Demand SR6: Finance	
Financial	Management Accounts have confirmed that the recommended establishment/staffing level changes cannot be accommodated within the current budget. The indicative costs are located in the recommendation section (pending full business case if the recommendation is approved)	
Statutory & Regulatory	The report meets the national requirements for safer staffing reporting as guided by the National Quality Board (2016) and Developing Workforce Safeguards (2018).	
Equality, Diversity & Inclusion	The narrative and data in this report have been drawn from a range of partners including professional judgement discussions with ward managers, service managers, management accounts, business and performance and eRoster.,	
Co-production & Partnership	As above	

Executive Summary
Purpose This report provides assurance that Dorset HealthCare is meeting national safer staffing requirements and outlines recommendations to ensure that budgeted establishments have the right number of staff, with the right skills, deployed in the right place at the right time to deliver safe, effective, and compassionate care across mental health inpatient wards. Methodology The annual Safer Staffing Review was undertaken in line with the National Quality Board's (2016) and Developing Workforce Safeguards (NHS England, 2018) guidance. A triangulated approach was applied, incorporating: - Mental Health Optimal Staffing Tool (MHOST) evidence-based data collections - Workforce and eRoster data review - Incident data

- Professional judgement from ward managers and service leads
- Benchmarking against similar wards in other trusts
- Findings and reporting in monthly reports to Quality Governance Group

The review was undertaken with governance from the Director of Nursing, Therapies and Quality

Key Findings:

Right Staff

To comply with CQC Regulation 18: Staffing, providers must ensure that they have enough qualified and competent staff to meet service users' needs at all times. While England does not set national staffing ratios, the CQC expects staffing decisions to reflect individual needs, acuity, and risk—supporting a responsive, person-centred approach rather than fixed ratios.

We understand that safe and high-quality inpatient mental health care relies on staff being alongside people in a lot of pain and distress. Witnessing human distress every day can take its toll on staff wellbeing, and therefore their ability to provide a compassionate response. We are committed to providing all our ward staff with the right practical support to protect their time to care, and with the right emotional support so that they can nurture the people they are working with as well as themselves (NHS England, Culture of Care standards for mental health inpatient services, 2024)

Research demonstrates that lower staffing levels in mental health services negatively affect both staff wellbeing and patient safety. Reduced staffing is linked to increased stress, diminished morale, lower job satisfaction, and heightened concerns about personal, physical, and psychological safety among staff. Incidents of violence and aggression are more likely when staffing levels are low, particularly where therapeutic relationships with patients are limited (Lawes et al., 2016).

Having fewer Registered Nurses on duty also restricts opportunities for quality supervision and peer support, especially for junior staff. This situation undermines the facilitation of meaningful debriefs following adverse incidents, reflection in and on practice, pastoral care, and support for safety-critical decision-making.

Each morning, the Clinical Site Manager facilitates an operational touchpoint meeting to discuss the day's staffing, assess safety, and discuss bank/agency needs. Staffing concerns and escalations for temporary staffing are discussed.

Average fill rates across the reporting period for Registered Nurses and Healthcare Support Workers remained above the minimum KPI of 90%. However, in some months Registered Nurse fill rates fell below this threshold, with the lowest recorded average at 88%.

Healthcare Support Worker fill rates consistently exceeded the higher-limit KPI of 120% throughout the year, with an overall average of 136%.

Ongoing vacancies have affected the balance of substantive and temporary staffing, with some wards consistently falling below the minimum KPI threshold of a 60% substantive to 40% temporary staffing split.

Care Hours Per Patient Day (CHPPD) is a workforce measure that reflects the total time nursing staff spend on direct patient care and related activities, including medication preparation, record updates, and care coordination. It includes both temporary and permanent registered and unregistered staff but excludes student nurses and staff working across multiple wards.

The planned average CHPPD across the service was 16.5, compared with an actual average of 15.9. Variations between wards are expected and reflect the diverse nature of mental health inpatient services across the Trust.

The Mental Health Optimal Staffing Tool (MHOST) is a nationally endorsed, evidence-based tool that supports ward-based clinicians in assessing patient acuity. It uses a staffing multiplier to align baseline

funded establishments with patient needs. Where possible, this review has incorporated MHOST outcomes into the decision-making process, triangulated with professional judgement and patient and staff outcomes.

Training in the practical application of the MHOST is ongoing. In wards with more than eight beds where significant variances have been identified, targeted training and quality assurance visits are scheduled. These sessions are designed to ensure that assessments of both acuity and dependency are applied accurately and consistently. It is recognised that dependency is often under-assessed, as greater emphasis may be placed on acuity. Addressing this imbalance will improve the accuracy of staffing data, strengthening its validity and reliability for future workforce planning.

Right Skills

At the time of reporting, the overall average mandatory training compliance was 93.5%, slightly below the Trust's KPI of 95%.

We recognise the national and local challenges in recruitment and the importance of developing our workforce. Significant investment has been committed to professional apprenticeships, including pathways for Registered Nursing Degrees, Nursing Associates, Allied Health Professions, and Advanced Clinical Practitioners. Currently, 143 apprentices are enrolled in clinical professional registration programmes across the organisation.

Headroom is applied across all inpatient wards to account for annual leave, sickness absence, temporary staffing, and training requirements. For 2025/26, the headroom rate is set at 23.2% for the majority of wards, with Florence House (26.6%) and Twynham (27.8%) allocated slightly higher levels to reflect additional training requirements. This allowance includes 4% for sickness absence, with actual sickness absence averaging between 4% and 5% each month.

Headroom is calculated using WTE figures rather than actual headcount, which can result in insufficient cover during periods of staff absence.

Right Place and Time

Rostering practices indicate that rotas are significantly influenced by formal and informal flexible working arrangements and staff preferences, leading to imbalances where some shifts are overstaffed and others understaffed.

Annual leave approvals exceeded the recommended upper limit of 17% during key calendar periods, such as school holidays and the end of the financial year. Throughout the year, work has been undertaken to support managers in improving rostering effectiveness. This includes a comprehensive review of rosters by the eRoster team to ensure that rules are updated, and best practices are applied. Trust guidance is available to support staff in addressing staffing shortfalls, as outlined in the document 'Guidance on the Management of Staff Shortfalls on Wards'. During the reporting period, 179 staffing incidents were recorded. However, anecdotal feedback and analysis of staffing fill rates suggest that incidents are not consistently reported across all wards. Underreporting limits the reliability of direct comparisons and may misrepresent the true extent of staffing pressures.

Summary

Funded staffing establishments are assessed as safe and appropriate overall. However, the review has highlighted specific gaps that require attention to ensure consistency and resilience in safer staffing provision.

Haven Male and Haven Female wards currently have one budgeted Registered Nurse on each ward overnight. Within the new facilities being developed at the St Ann's Hospital site, the Registered Nurse establishment for night duty will be increased to strengthen safe, effective, and compassionate care. This change is being progressed through the new hospital programme

However, this report highlights that a gap remains in night duty cover, with only one Registered Nurse currently in place until the move to the new build, pending approval of the revised staffing model. The review has identified areas that warrant further exploration, as detailed in the additional recommendations.

Waterston – It is recommended that consideration be given to funding the staffing establishment to align with the historical rostering of an additional Mental Health Support Worker on early, late, and night duty. This would help ensure safer staffing levels, address environmental needs, and meet the acuity and dependency requirements of individuals accessing the service.

This recommendation has been made in successive Annual Establishment Review Reports (2021–2024) but has not been reflected in ward budgets; therefore, it continues to present a cost pressure.

Glendinning - The review identified gaps in meeting patients’ needs during evenings and weekends, primarily due to insufficient staffing levels. It also highlighted the unit’s reliance on temporary staff and support required from other wards to maintain safe care. As only one Registered Nurse is currently funded per duty, the unit remains vulnerable as a lone service.

It is recommended that consideration be given to revising the staffing establishment to include a Registered Nurse on late or twilight duty during weekdays. Consideration should also be given to increasing weekend staffing from the current level of one Registered Nurse and one Mental Health Support Worker to two Registered Nurses and one Mental Health Support Worker.

The recommendations have been reviewed by:

- Cara Southgate, Director of Nursing, Therapies and Quality
- Darren Wickwar, Head of Nursing, Professional Practice and Workforce
- Anna Chainey, Joint Interim Deputy Service Director CYPF, MH and LD & Head of High Acuity Mental Health Services
- Gary Billen, Joint Interim Deputy Service Director CYPF, MH and LD & Head of High Acuity Mental Health Services

Additional recommendations:

- Review the Activity Coordinator role across the mental health inpatient service to ensure it is effective and funded equitably across all wards.
- Review the current headroom allocation and provide recommendations to ensure it adequately covers time-out requirements. This will support safer staffing levels and help reduce reliance on additional duties and temporary staffing.
- Review the allocation of non-clinical time for Band 6 Clinical Team Leaders to ensure equitable and consistent funding across all wards. Currently, some wards are rostering non-clinical time without having the corresponding budget, leading to discrepancies in capacity for supervision, auditing, monitoring ward progress, and leading development programmes such as Culture of Care and Reducing Restrictive Practice. A standardised approach will help ensure that non-clinical time is both appropriately funded and effectively utilised and may support a reduction in temporary staffing.
- Review the use of the Registered Nursing Associate role to ensure that clear roles and responsibilities are defined where it is currently implemented. Additionally, assess the efficacy of the role and explore opportunities to introduce it in wards where it is not yet in place, with the aim of enhancing nursing practice.

Recommendations

Members are requested to:

- Receive the report for assurance that Dorset HealthCare is adhering to national safer staffing guidance.
- Acknowledge the recommendations to ensure the provision of consistently safe, effective and compassionate care.

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Mental Health Inpatient Annual Establishment Review

April 2024 – April 2025

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Healthier lives



Empowered citizens



Thriving communities

Assurance statement Dawn Dawson, Chief Nursing Officer

The Trust continues to monitor safer staffing levels closely and is compliant with the recommendations outlined in the National Quality Board and Developing Workforce Safeguards guidance.

The data collection cycles from the Mental Health Optimal Staffing Tool have supported the nursing establishment review process through a recognised evidence-based approach.

I am satisfied with the assessment outcome, which confirms that daytime staffing levels are safe and effective. However, the report highlights wards that require particular attention to ensure safer overnight staffing levels for registered nurses.

We will continue strengthening our staffing and consider the recommendations in this report to further enhance safe, compassionate, and effective care.

The Director of Nursing and Medical Director's signatures are to be added when the final report is ratified following the Board of Directors

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1.0 Introduction

1.1 The purpose of this report is to provide the Trust Board with a comprehensive annual report on safer staffing within our mental health wards. It aims to provide assurance that the Trust has a clear and validated process for monitoring and ensuring safer inpatient staffing in accordance with the expectations of NHS England (NHSE), National Quality Board, Improvement Resource for Mental Health (2018) Care Quality Commission (CQC) and Developing Workforce Safeguards (NHSE, 2018).

1.2 The National Quality Board (2016) Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time – provides a framework within which organisations and staff should make decisions about staffing that puts patients first. These expectations are to support provider boards to make local decisions that will deliver high-quality care for patients within the available staffing resources.

1.3 NHS provider boards are accountable for ensuring their organisation has the right culture, leadership, and skills in place for safe, sustainable, and productive staffing (National Quality Board 2016). They are also responsible for ensuring proactive, robust, and consistent approaches to measurement and continuous improvement, including the use of a local quality framework for staffing that will support safe, effective, caring, responsive, and well-led care (Care Quality Commission).

1.4 This report is written in a format consistent with the requirements of the National Quality Board expectations of the right staff, with the right skills, in the right place and time to ensure safe, sustainable, and productive staffing.

1.5 The data referenced within the report is obtained through Power BI, Ulysses, Healthroster, Finance, Learning and Development, and Workforce Reporting Team. It is acknowledged that workforce data fluctuates and therefore illustrates a point in time.

2.0 Dorset Healthcare Governance

2.1 Dorset HealthCare is compliant with ensuring the principle of safer staffing (evidence-based tools, professional judgement, and outcomes) - as outlined in the Developing Workforce Standards (2018) is embedded in safer staffing processes.

2.2 The Quality Governance Group receives a monthly safer staffing report that reviews clinical staffing performance in mental health wards, escalating issues to the Quality Governance Committee (a subgroup of the Board).

2.3 A safer staffing forum meets monthly to discuss staffing levels and challenges. Risks and emerging areas of concern are discussed, included in the monthly Safer Staffing Report, and escalated to the Quality Governance Group. In the event that the forum identifies an area of risk or the safer staffing team raises concerns about a particular team, support meetings are facilitated to monitor emerging themes and progress.

2.4 Each morning, the Clinical Site Manager facilitates an operational touchpoint meeting to discuss the day's staffing, assess safety, and discuss bank/agency needs. Staffing concerns and escalations for temporary staffing are discussed.

3.0 Methodology for Annual Establishment Review Process April 2024 – April 2025

3.1 The annual establishment review, covering the period from April 2024 to April 2025, drew on workforce, eRoster, and financial data. Insights from the Mental Health Optimal Staffing Tool (MHOST), professional judgement (Saville et al. 2023), and peer benchmarking formed a key component of the methodology, ensuring a comprehensive and evidence-based approach.

3.2 All reviews were conducted under the oversight of the Director of Nursing, Therapies and Quality.

3.3 The report has been reviewed by:

- Cara Southgate, Director of Nursing, Therapies and Quality
- Darren Wickwar, Head of Nursing, Professional Practice and Workforce

- Anna Chainey, Joint Interim Deputy Service Director CYPF, MH and LD & Head of High Acuity Mental Health Services
- Gary Billen, Joint Interim Deputy Service Director CYPF, MH and LD & Head of High Acuity Mental Health Services

4.0 Expectation One: Right Staff *(evidence-based workforce planning, professional judgement, compare staffing with peers)*

4.1 Boards should ensure there is sufficient and sustainable staffing capacity and capability to provide safe and effective care to patients at all times, across all care setting in NHS provider organisations.

4.2 Boards should ensure there is an annual strategic staffing review, with evidence that this is developed using a triangulated approach (i.e., the use of evidence-based tools, professional judgement, and comparison with peers), which takes account of all healthcare professional groups and is in line with financial plans. This should be followed with a comprehensive staffing report to the Board after six months to ensure workforce plans are still appropriate. There should also be a review following any service change or where quality or workforce concerns are identified.

4.3 Safer staffing is a fundamental part of good quality care, and CQC will therefore always include a focus on staffing in the inspection frameworks for NHS provider organisations.

4.4 Commissioners should actively seek to assure themselves that providers have sufficient care staffing capacity and capability, and to monitor outcomes and quality standards, using information that providers supply under the NHS Standard Contract.

5.0 Registered Nurse to Patient Ratios:

5.1 To ensure compliance with Regulation 18: Staffing, the Care Quality Commission (CQC) requires providers to deploy sufficient numbers of suitably qualified, competent, skilled, and experienced staff to meet the needs of people using the service at all times. While England does not mandate national safer staffing ratios, the CQC emphasises that staffing decisions should be based on individuals' needs, acuity, and associated risks, rather than relying solely on numerical staff-to-patient ratios. This approach supports a more responsive and person-centred model of care.

5.2 Research indicates that lower staffing levels in mental health services can negatively impact staff wellbeing and patient safety. Reduced staffing is associated with increased stress, diminished morale, lower job satisfaction, and heightened concerns about personal, physical, and psychological safety among staff. Furthermore, incidents of violence and aggression are more likely to occur when staffing levels are low, particularly when staff lack a therapeutic relationship with the individuals in their care (Lawes et al., 2016)

5.3 While further research is needed to fully understand the impact of staffing levels and skill mix in mental health settings, existing evidence suggests that low numbers of Registered Nurses on duty can significantly limit the ability to provide high-quality supervision and support to peers and junior staff. It may also hinder the facilitation of meaningful debriefs following adverse incidents, reflective practice, pastoral care, and safety-critical decision-making. Additionally, suboptimal staffing levels can compromise the completion of documentation essential for safe and effective care. Ensuring staff are able to take breaks—either on or away from the ward—to support their wellbeing can also become challenging to manage safely.

5.4 Ward demand templates across the Mental Health wards indicate that Registered Nurse-to-patient ratios during the day range from 1:2.5 to 1:10, and from 1:2.5 to 1:14 at night. However, it is noted that Seaview, Harbour, Chine, and Alumhurst wards frequently roster only one Registered Nurse on night duty. This results in actual ratios—assuming full bed occupancy—of up to 1:14 at Seaview, 1:16 at Harbour, 1:11 at Chine, and 1:20 at Alumhurst.

5.5 Ward Managers have expressed a preference for prioritising the staffing of day shifts with Registered Nurses for several reasons: the higher level of activity during the day; the importance of promoting sleep hygiene, with patients being less active during the night; reluctance to roster more than one Registered Nurse on night duty as the second registrant is often redeployed to ensure safer staffing levels on other wards; and

a preference for rostering an experienced Mental Health Support Worker who is familiar with the ward and the patients over a temporary registrant who may lack prior experience on the ward.

5.6 The number of formal and informal flexible working patterns has been reported as a challenge in balancing the service's needs with those of individual staff members.

5.7 A review of flexible working arrangements for night duty found that 36% of Registered Nurses in mental health inpatient settings did not work night shifts. Of this group, 18% had formal agreements in place, while 29% had informal arrangements. The Service Manager has supported Ward Managers to review historical agreements to ensure maximum staff availability

5.8 When only one Registered Nurse is rostered on a lone site, they are unable to leave the unit during their shift. This means that duties consistently carry the potential to escalate to a critical level if the nurse becomes unwell or must leave the ward mid-shift. At the Glendinning Unit, this challenge is recognised through a historical arrangement whereby rest breaks are paid, acknowledging the staff's inability to leave the unit. This arrangement is currently under review by the Service Manager in consultation with HR colleagues.

5.9 This situation has wider implications across the service, as staff may need to be temporarily redeployed to support other units. For example, Melstock House is typically staffed with one Registered Nurse on night duty. If that nurse is off sick and cannot be replaced by a substantive or temporary colleague, support must be drawn from Waterston Ward. This leaves Waterston operating below optimal staffing levels, which may result in unsafe conditions and/or an inappropriate skill mix.

5.10 Waterston Ward faces additional pressure as it is the primary ward called upon to support Glendinning Unit during periods of sickness absence or duty cancellations, further compounding staffing challenges.

5.11 **Planned vs Unplanned Nursing Hours (Fill Rates)**

5.1 Fill rates are a useful metric for identifying wards that are not meeting their planned levels of nursing hours. However, they do not account for factors such as skill mix or the proportion of temporary staff, both of which can impact care quality and patient safety.

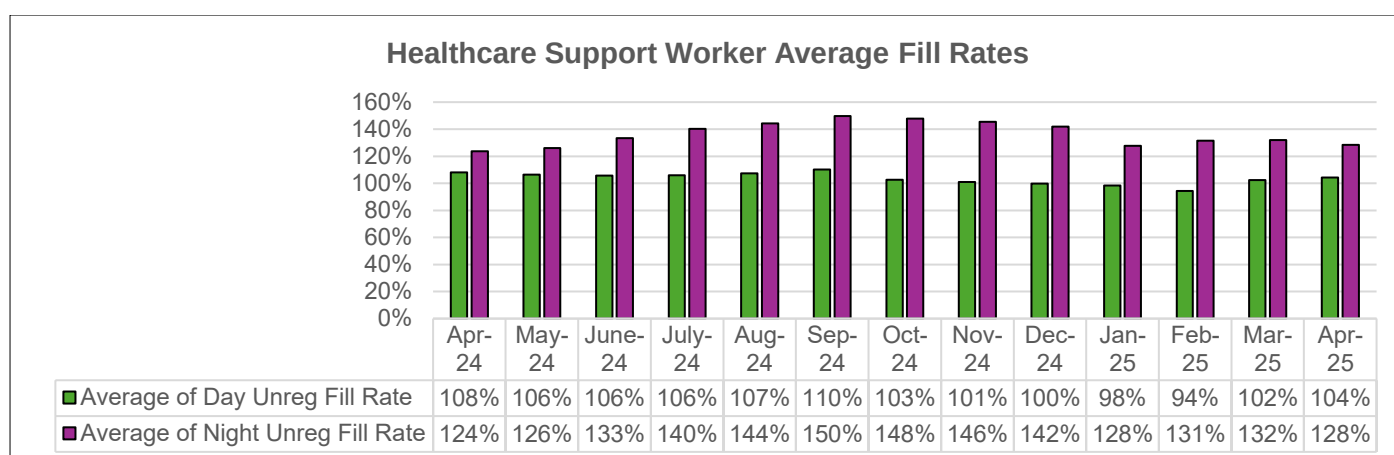
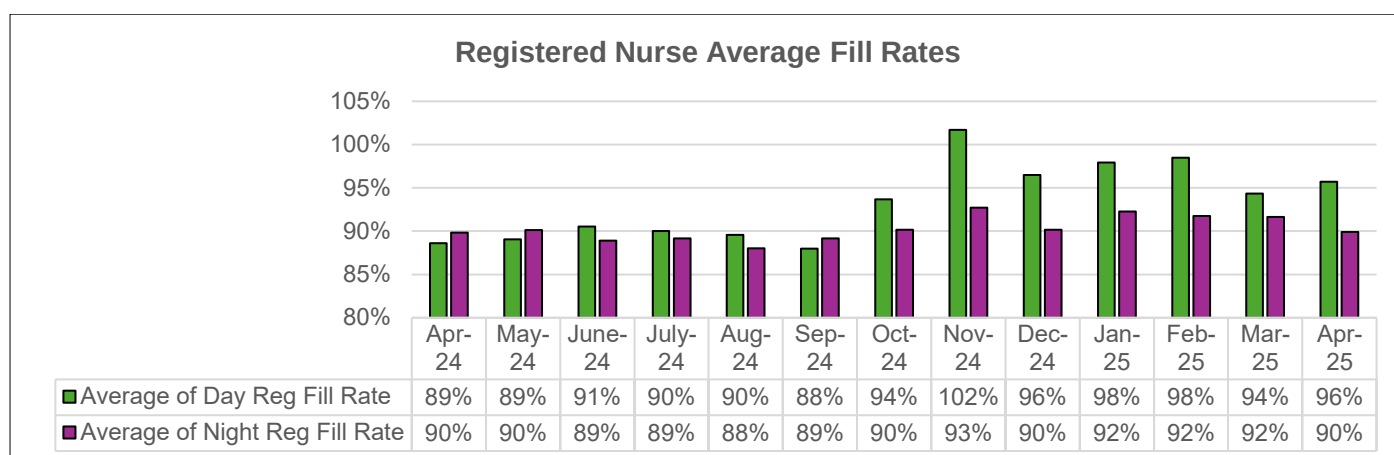
5.2 Professional judgement is applied when reviewing staffing levels, taking into consideration patient acuity, dependency, skill mix, and bed occupancy. As a result, planned hours may be adjusted—either reduced (e.g. during periods of low bed occupancy) or increased (e.g. to support enhanced care or patient escorts). These adjustments are reflected in the reported fill rate percentages.

5.3 Fill rates are reported monthly in the Safer Staffing Report and included in the Integrated Corporate Dashboard within the Trust Board report. When individual ward fill rates fall outside the Trust's agreed parameters of 90–120%, they are flagged as exceptions. The monthly report provides additional detail, including the ratio of substantive to temporary staff, workforce data, and nurse-sensitive indicators.

5.4 The following graph illustrates average fill rates across mental health inpatient wards. Therapy staff are not currently included in this dataset because they are not included in the ward budget, although their inclusion is an aspiration for future reporting.

Average Fill Rates

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5.5 Average fill rates for Registered Nurses were 93% on day shifts and 90% on night shifts.

5.6 Average fill rates for Mental Health Support Workers were 104% on day shifts and 136% on night shifts.

5.7 Fill rates exceeding 120% reflect a combination of factors: increased care needs requiring additional staff, backfilling of the second RN role with a MHSW, and agreed adjustments to the budgeted demand template to ensure safer staffing levels in specific environments (Waterston, Haven Female, and Chine).

5.8 Vacancies, extended periods of supernumerary status or induction (such as for Registered Nurses newly joining the NMC register), short-term and long-term sickness absences, and the need for additional staffing to provide enhanced care have continued to impact fill rates across all wards throughout the year. However, it is noted that sickness absence levels have decreased.

6.0 Temporary Staffing

6.1 Temporary staffing is utilised to maintain safer staffing levels when all internal options have been exhausted. The Trust operates a successful staff Bank, and wherever possible, staffing shortfalls are filled using bank workers. If this is not feasible, unfilled duties may be escalated to on-framework agencies in the first instance

6.2 If on-framework agencies are unable to fill the duty, clinical areas may request to use the 'break glass' process to ensure patient safety is maintained. Agency usage is reported weekly to the Executive Team and NHS England.

6.3 Temporary staffing continues to be relied upon to address workforce gaps and support the delivery of enhanced care.

6.4 Sourcing temporary staff is noted to be more challenging in West Dorset. Ward Managers report a reliance on the substantive workforce to work additional shifts to maintain safe staffing levels.

6.5 When demand templates are adjusted to accommodate enhanced care needs, the additional staffing is often met through temporary staff. Consequently, an increase in the proportion of temporary staffing is expected in the reported data.

6.6 Where the ratio of substantive to temporary staffing falls below 60:40, this triggers an exception in the monthly staffing report and may prompt a staffing review.

6.7 The table below illustrates the proportion of substantive hours worked compared to temporary hours. It is important to note that substantive staff who also hold a bank agreement are recorded under temporary hours when working additional shifts via the Trust Bank. Therefore, the data alone may not provide a complete picture when assessing quality and safer staffing.

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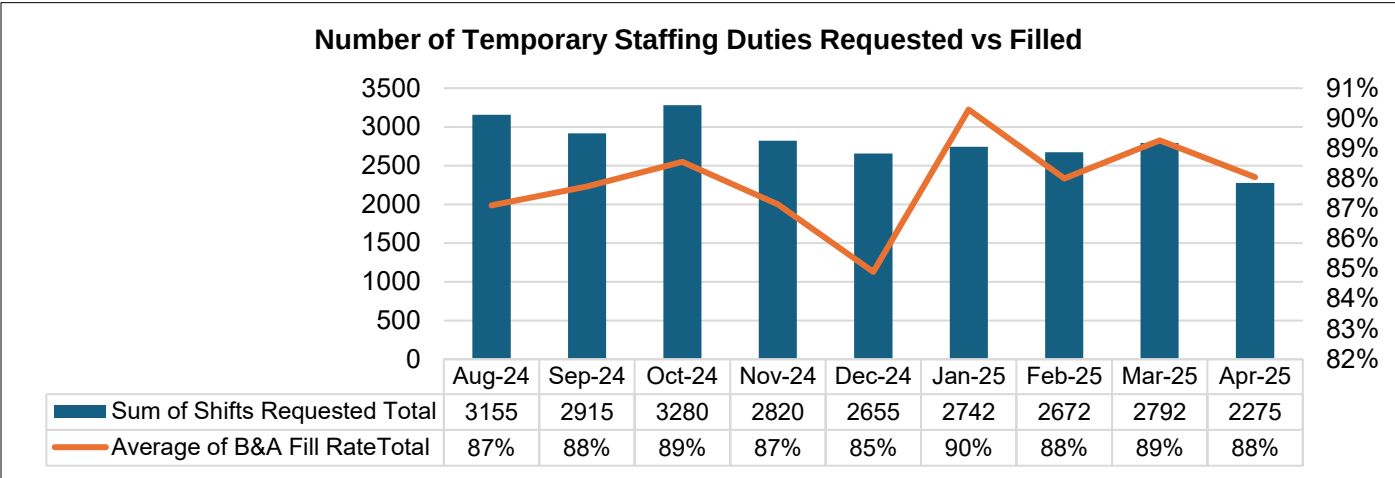
Substantive/Temporary Percentage

% Of Hours Worked (Substantive)	Apr -24	May- 24	June -24	July- 24	Aug- 24	Sep- 24	Oct- 24	Nov- 24	Dec- 24	Jan- 25	Feb- 25	Mar- 25	Apr- 25
AAU Seaview	73%	73%	69%	79%	63%	76%	79%	71%	63%	73%	70%	67%	70%
Alumhurst	77%	71%	71%	70%	63%	76%	74%	78%	78%	74%	73%	74%	80%
Chine	83%	80%	83%	83%	61%	72%	75%	77%	87%	80%	77%	87%	87%
Florence House	61%	56%	62%	62%	73%	65%	65%	63%	78%	81%	74%	61%	73%
Glendinning	81%	77%	77%	71%	56%	84%	80%	85%	86%	79%	71%	73%	76%
Harbour	63%	55%	60%	61%	55%	62%	60%	54%	53%	54%	48%	63%	56%
Haven Female	64%	52%	52%	66%	59%	57%	60%	59%	65%	72%	62%	67%	66%
Haven Male	64%	67%	62%	60%	62%	66%	77%	76%	77%	76%	74%	64%	73%
Herm	78%	76%	82%	66%	67%	80%	84%	81%	87%	89%	86%	86%	92%
Kimmeridge Court	66%	62%	67%	63%	82%	60%	61%	59%	52%	56%	49%	50%	54%
Melstock House	96%	85%	77%	77%	71%	77%	74%	73%	81%	77%	76%	75%	83%
Nightingale House	70%	57%	66%	62%	59%	71%	66%	71%	67%	61%	53%	58%	62%
Pebble Lodge	46%	53%	63%	67%	79%	66%	51%	50%	64%	66%	64%	60%	66%
St Brelades	64%	61%	52%	79%	66%	52%	42%	53%	54%	60%	54%	75%	79%
Twynham	68%	74%	68%	64%	75%	59%	73%	77%	72%	78%	67%	66%	78%
Waterston	59%	56%	59%	77%	61%	57%	57%	63%	58%	46%	46%	55%	68%

% Of Hours Worked (Temporary)	Apr -24	May- 24	June -24	July- 24	Aug- 24	Sep- 24	Oct- 24	Nov- 24	Dec- 24	Jan- 25	Feb- 25	Mar- 25	Apr- 25
AAU Seaview	27%	27%	31%	21%	37%	24%	21%	29%	37%	27%	30%	33%	30%
Alumhurst	23%	29%	29%	30%	37%	24%	26%	22%	22%	26%	27%	26%	20%
Chine	17%	20%	17%	17%	39%	28%	25%	23%	13%	20%	23%	13%	13%
Florence House	39%	44%	38%	38%	27%	35%	35%	37%	22%	19%	26%	39%	27%
Glendinning	19%	23%	23%	29%	44%	16%	20%	15%	14%	21%	29%	27%	24%
Harbour	37%	45%	40%	39%	45%	38%	40%	46%	47%	46%	52%	37%	44%
Haven Female	36%	48%	48%	34%	41%	43%	40%	41%	35%	28%	38%	33%	34%
Haven Male	36%	33%	38%	40%	38%	34%	23%	24%	23%	24%	26%	36%	27%
Herm	22%	24%	18%	34%	33%	20%	16%	19%	13%	11%	14%	14%	8%
Kimmeridge Court	34%	38%	33%	37%	18%	40%	39%	41%	48%	44%	51%	50%	46%
Melstock House	4%	15%	23%	23%	29%	23%	26%	27%	19%	23%	24%	25%	17%
Nightingale House	30%	43%	34%	38%	41%	29%	34%	29%	33%	39%	47%	42%	38%
Pebble Lodge	54%	47%	37%	33%	21%	34%	49%	50%	36%	34%	36%	40%	34%
St Brelades	36%	39%	48%	21%	34%	48%	58%	47%	46%	40%	46%	25%	21%
Twynham	32%	26%	32%	36%	25%	41%	27%	23%	28%	22%	33%	34%	22%
Waterston	41%	44%	41%	23%	39%	43%	43%	37%	42%	54%	54%	45%	32%
Outside of 60/40% KPI threshold													

- 6.8 On average, the percentage of substantive hours worked for the reporting period was 66%. This is a 2% decrease when compared the previous reporting period.
- 6.9 Seven out of sixteen wards saw an increase in substantive hours worked when compared to 2023/24.
- 6.10 Block booking arrangements have been in place throughout the review period to support staffing shortfalls with consistent staff. At the time of reporting the following wards had Registered Nurse block booking arrangements in place: Harbour, Kimmeridge Court, Seaview, and Waterston.
- 6.11 As a Trust, we have continued our work with the Southwest Collaborative, which has enabled us to maintain the use of capped-rate agencies and avoid engaging any off-framework providers since July 2024. This approach has contributed to a reduction in overall agency expenditure.
- 6.12 A number of agency workers have been successfully converted to bank workers.
- 6.13 There has been a reduction in the use of non-registered agency workers, with the intention of ceasing their use entirely by the end of the 2025/26 financial year.
- 6.14 No negative impact on patient safety has been reported.
- 6.15 There has also been a reduction in the use of non-registered agency workers with a view to ceasing their use completely by the end of the 25/26 financial year.
- 6.16 There has been no reported negative impact on patient safety.
- 6.17 The graph below illustrates the temporary staffing duties requested compared to the number filled for mental health inpatient services.

Number of Temporary Staffing Duties Requested vs Filled



6.18 Due to changes in the reporting of temporary staffing data, information from April to July 2024 is unavailable and cannot be compared with data from other periods.

6.19 The total number of temporary staffing duties requested for the reporting period was 22,916, a decrease of 8,244 compared to 2023/2024.

6.20 The average fill rate for the reporting period is 88%, which is a 3% increase from the previous reporting period.

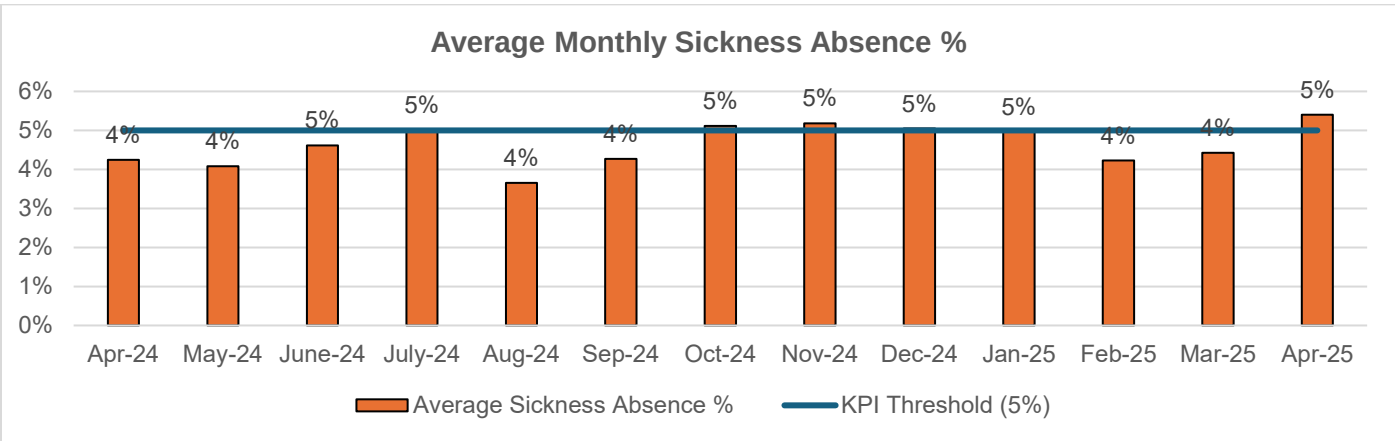
6.21 Vacancies have contributed to the increased reliance on temporary staffing across the service. Notably, Harbour, Kimmeridge Court, and Waterston wards have faced ongoing challenges in recruiting and retaining Registered Nurses and or Mental Health Support Workers throughout the year.

6.22 Monitoring of night duties where temporary staff are in charge has continued and shows improvement over the past year. This practice remains under review to ensure safety and consistency in care delivery.

7.0 Sickness Absence

7.1 The graph below shows the average monthly sickness absence percentages across mental health inpatient wards. This includes all staff associated with the ward cost code, both clinical and non-clinical. The red line indicates the trust's KPI of 5%.

Average Sickness Absence %



7.2 The average sickness absence for the reporting period is 5%, which is at the upper limit of the trust's KPI. However, the headroom allocation includes a 4% allowance for sickness absence. This discrepancy could contribute to staffing pressures and the need for additional duties to maintain safe staffing levels. The trust continues to work on reducing sickness absence across the organisation.

7.3 Anxiety, stress, depression, and other psychiatric reasons accounted for the majority of sickness absences, followed by other musculoskeletal and gastrointestinal problems.

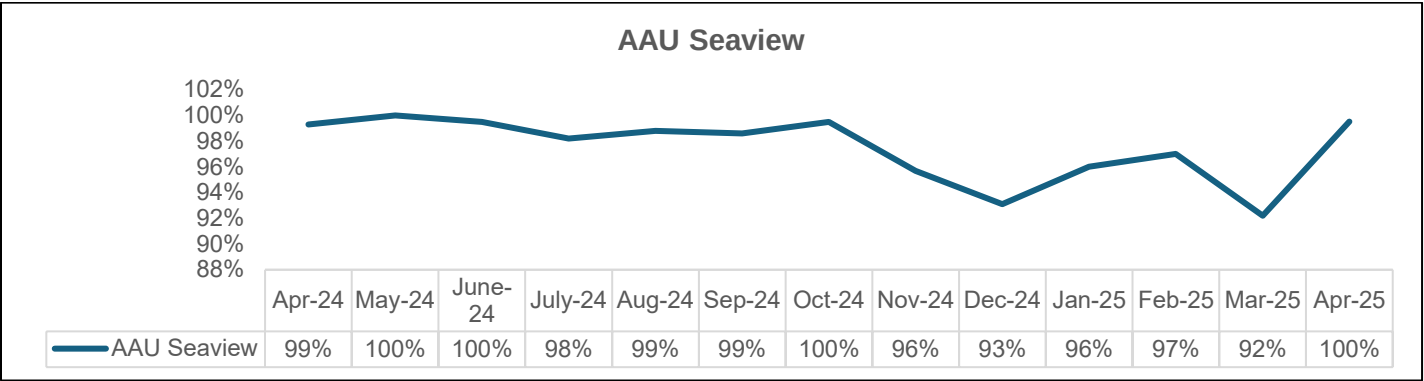
8.0 Bed Occupancy:

8.1 Mental health inpatient services encompass a range of specialities, each with a different number of available beds. For meaningful comparisons, individual wards should be evaluated against peer wards with similar service profiles and bed capacity.

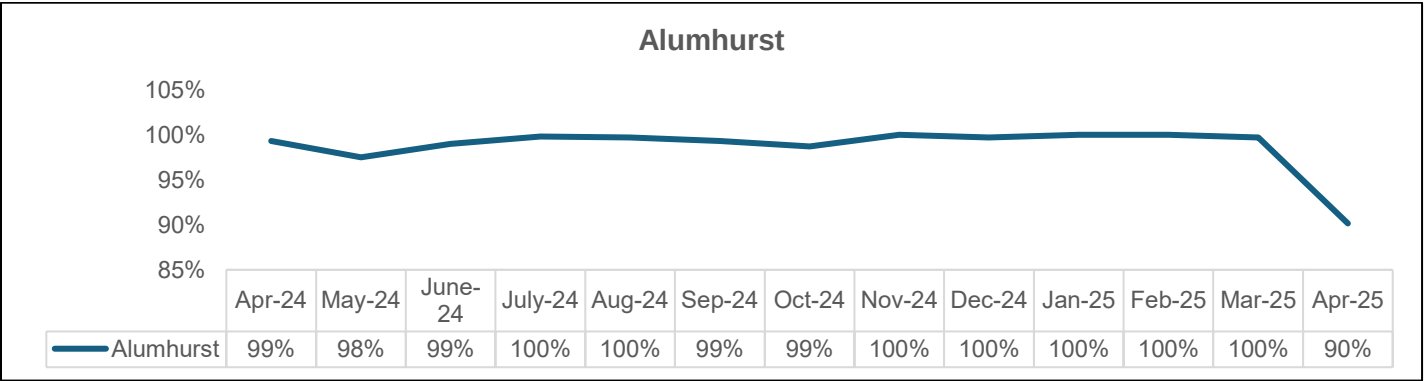
8.2 Professional judgement is applied to assess acuity, dependency, and bed occupancy in relation to the demand template. If bed occupancy is deemed lower than required for full staffing, adjustments may be made to staffing levels and skill mix accordingly.

8.3 Individual ward and average bed occupancy is reported monthly in the staffing report and to the Trust Board through the Integrated Corporate Dashboard.

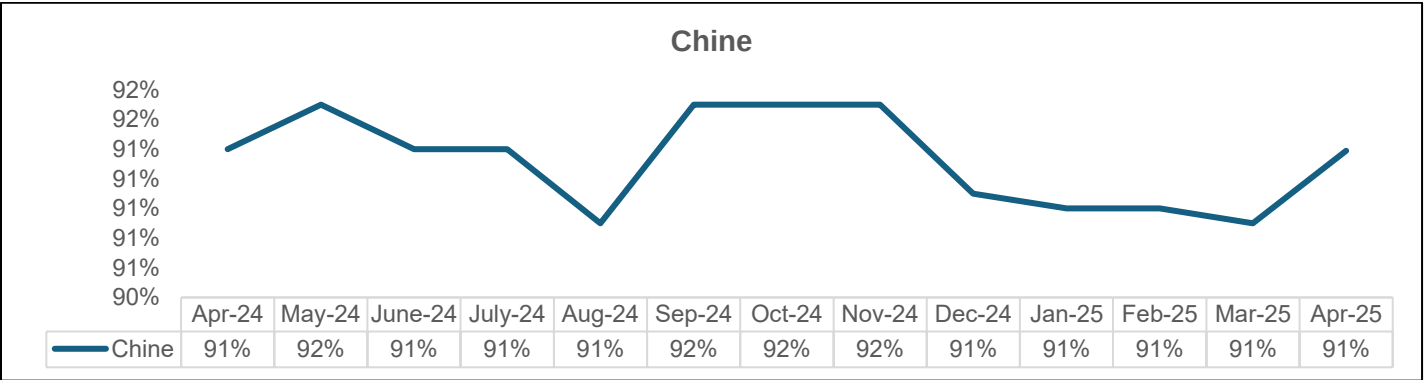
8.4 The graphs below illustrate bed occupancy across all MH inpatient wards.



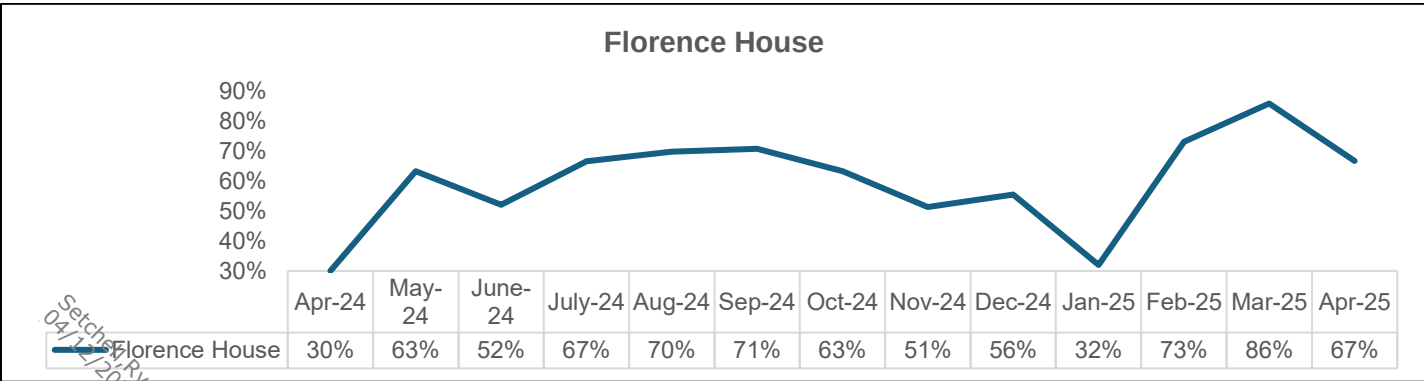
8.5 Average bed occupancy for the reporting period is comparable at 98% when compared to 2023/24.



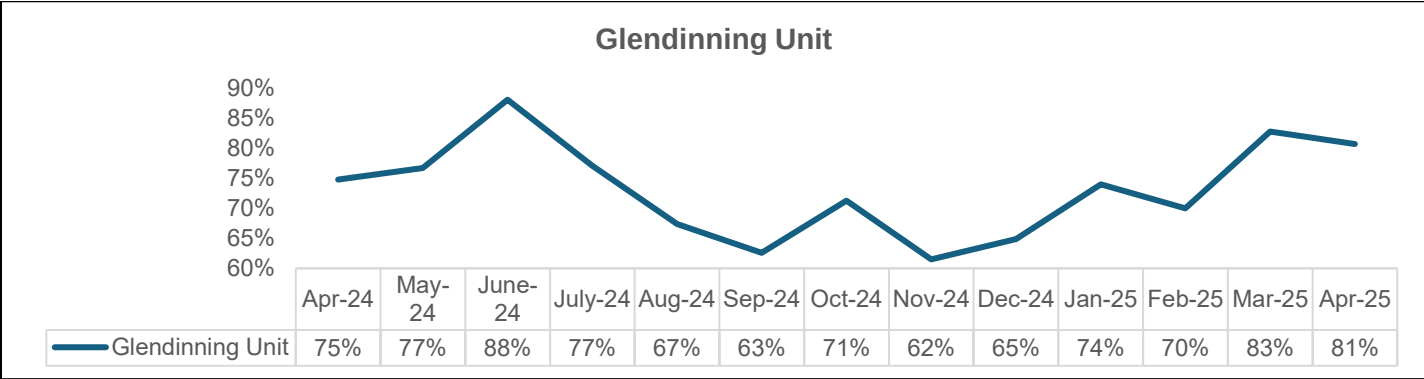
8.6 Average bed occupancy for the reporting period has increased by 3% when compared to 2023/24.



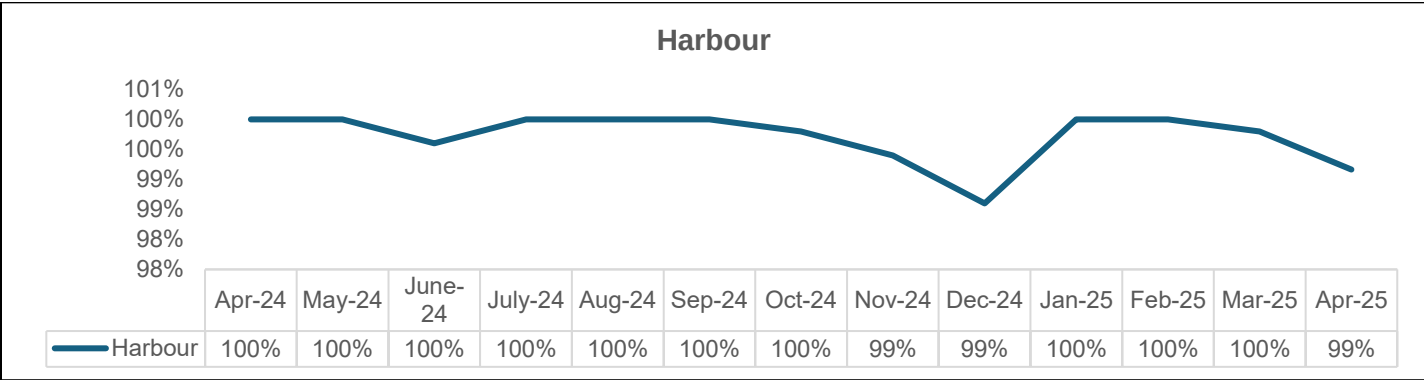
8.7 Average bed occupancy for the reporting period has decreased by 2% when compared to 2023/24.



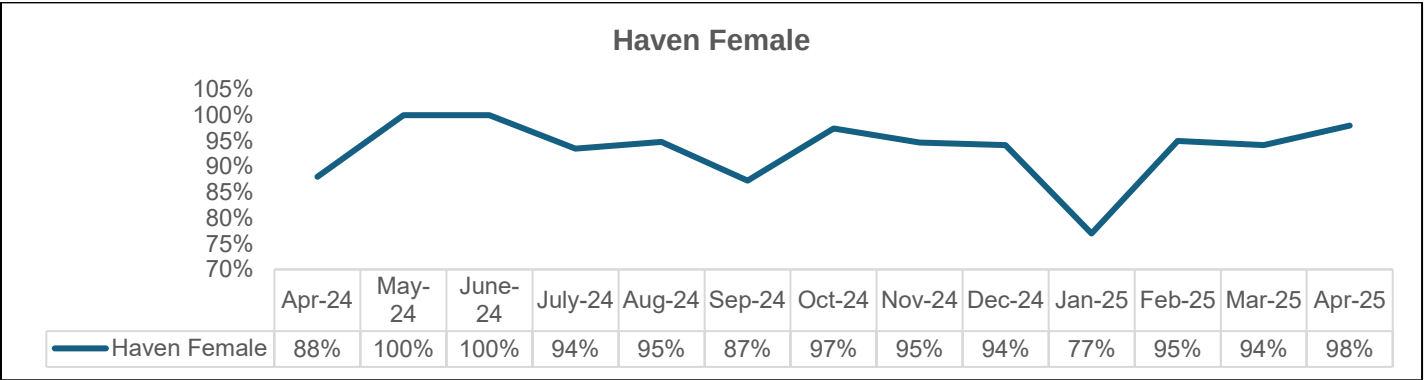
8.8 Average bed occupancy for the reporting period has increased by 3% when compared to 2023/24.



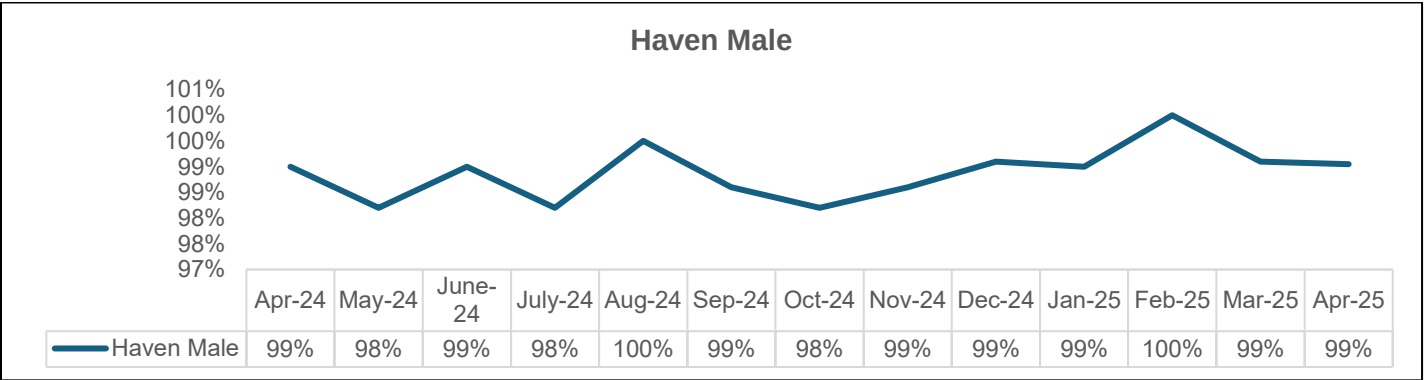
8.9 Average bed occupancy for the reporting period has decreased by 11% when compared to 2023/24.



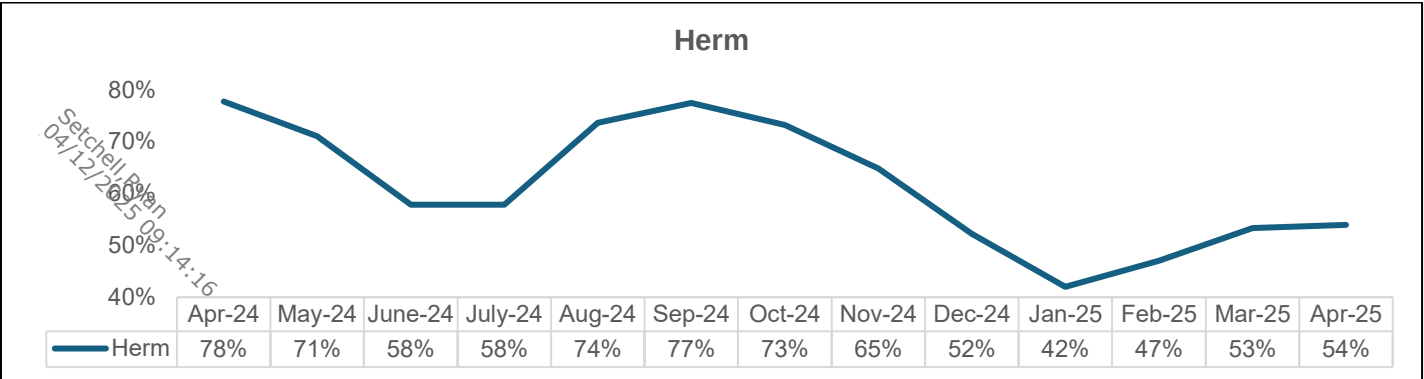
8.10 Average bed occupancy for the reporting period is comparable at 100% when compared to 2023/24.



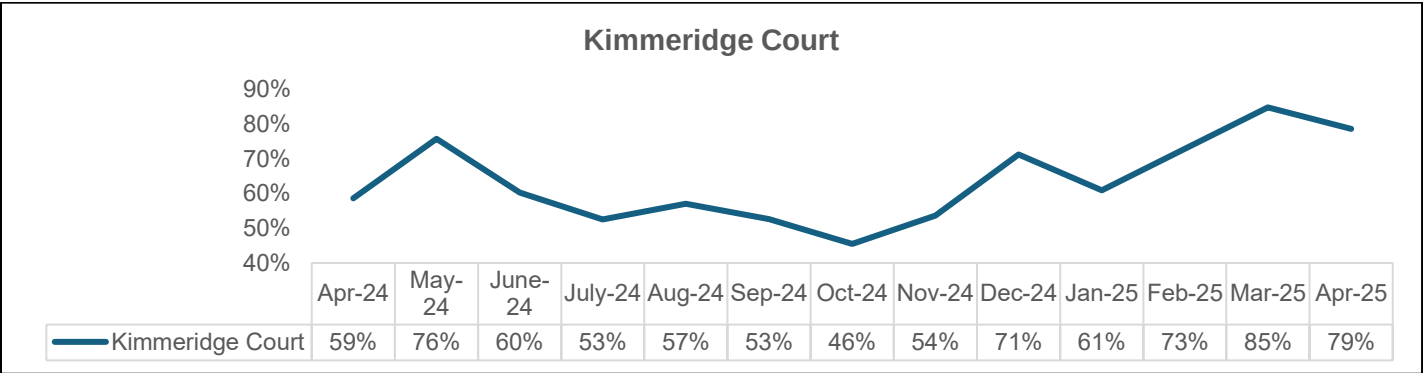
8.11 Average bed occupancy for the reporting period is comparable at 93% when compared to 2023/24.



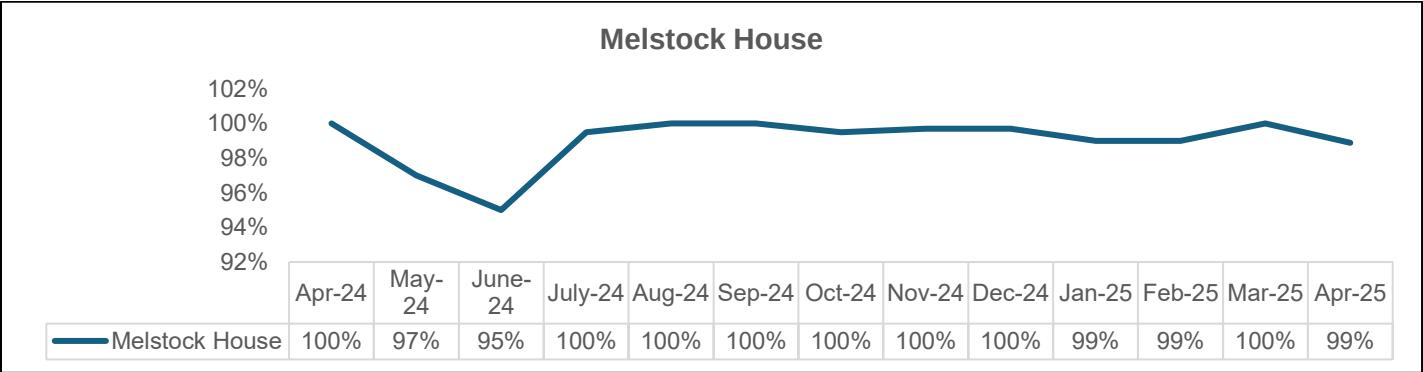
8.12 Average bed occupancy for the reporting period is comparable at 99% when compared to 2023/24.



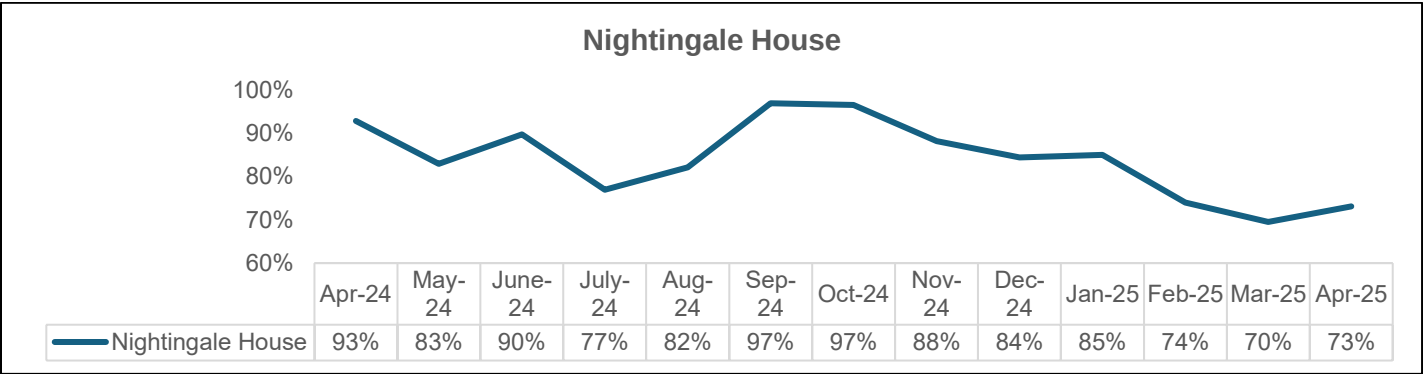
8.13 Average bed occupancy for the reporting period has decreased by 13% when compared to 2023/24.



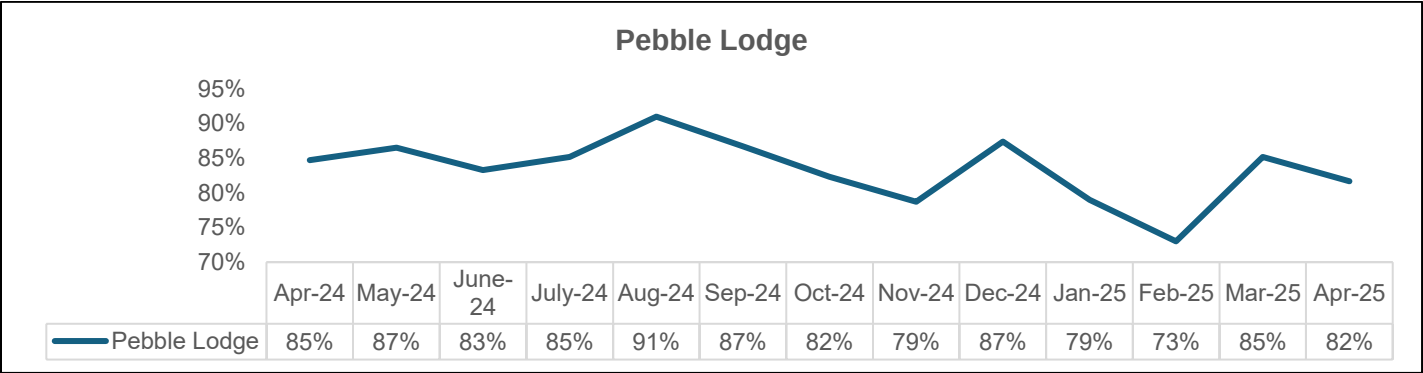
8.14 Average bed occupancy for the reporting period has decreased by 7% when compared to 2023/24.



8.15 Average bed occupancy for the reporting period has increased by 3% when compared to 2023/24.

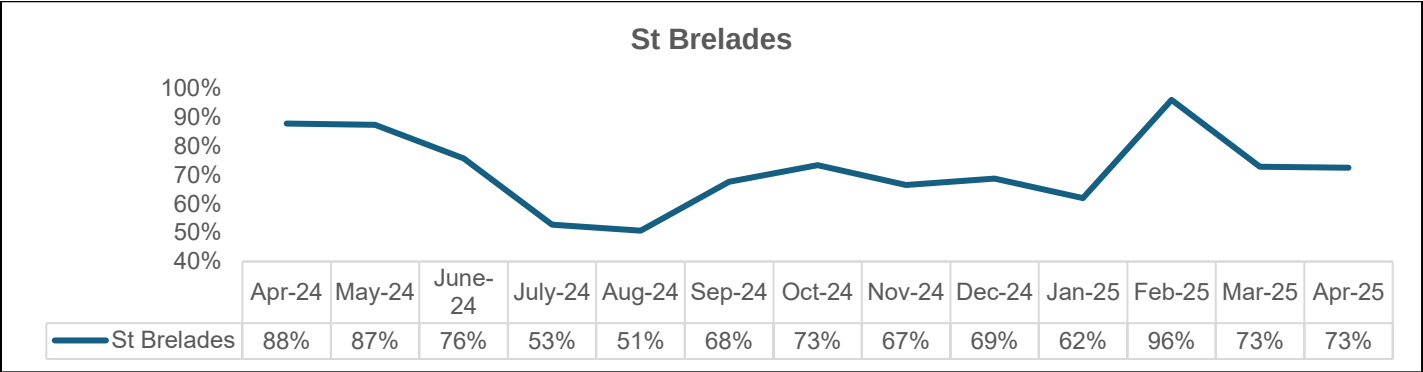


8.16 Average bed occupancy for the reporting period has decreased by 11% when compared to 2023/24.

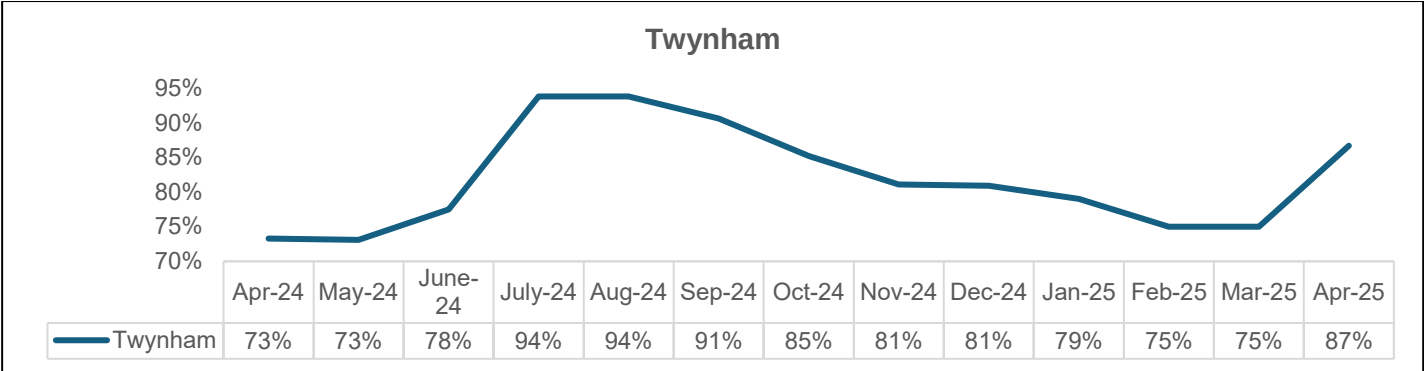


8.17 Average bed occupancy for the reporting period has increased by 23% when compared to 2023/24.

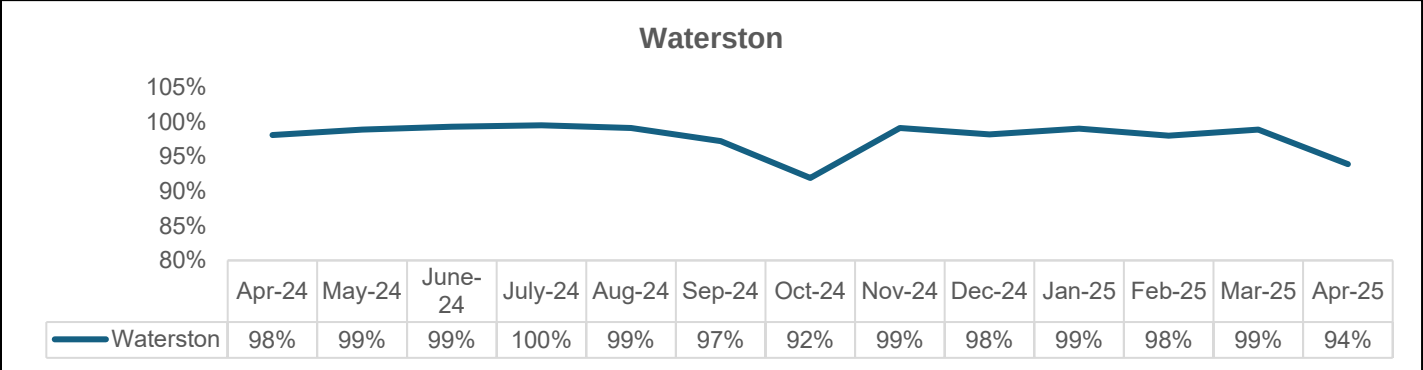
Setchell, Ryan
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8.18 Average bed occupancy cannot be compared with the previous year due to a reduction in bed numbers from 17 to 12, implemented to support a recovery programme.



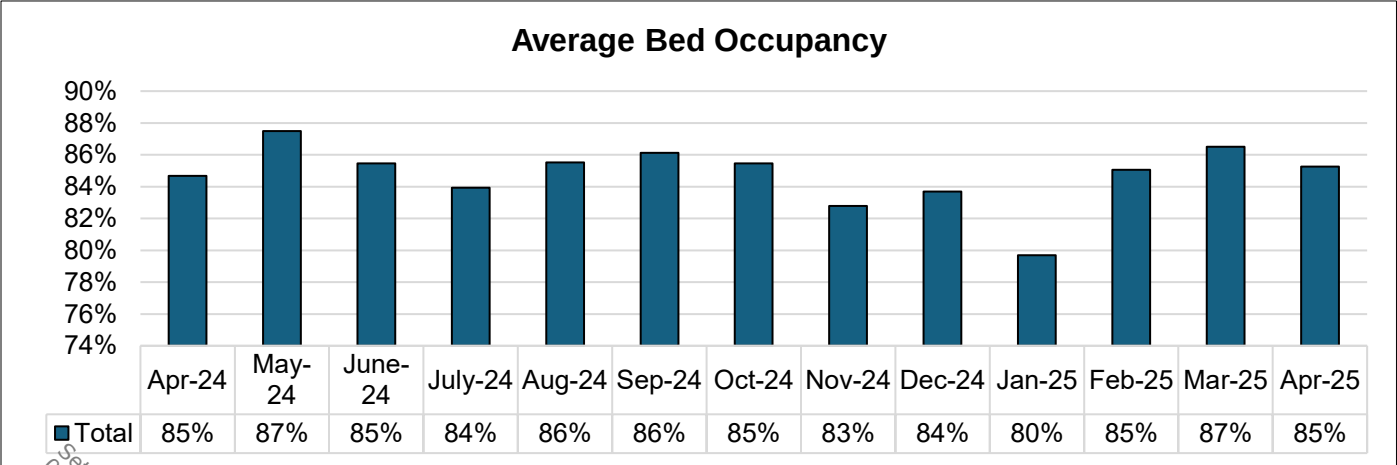
8.19 Average bed occupancy for the reporting period has increased by 1% when compared to 2023/24.



8.20 Average bed occupancy for the reporting period is comparable at 98% when compared to 2023/24.

The graph below illustrates average bed occupancy across all wards.

Average Bed Occupancy



8.21 Overall, average bed occupancy for the reporting period has decreased by 1% when compared to 2023/24.

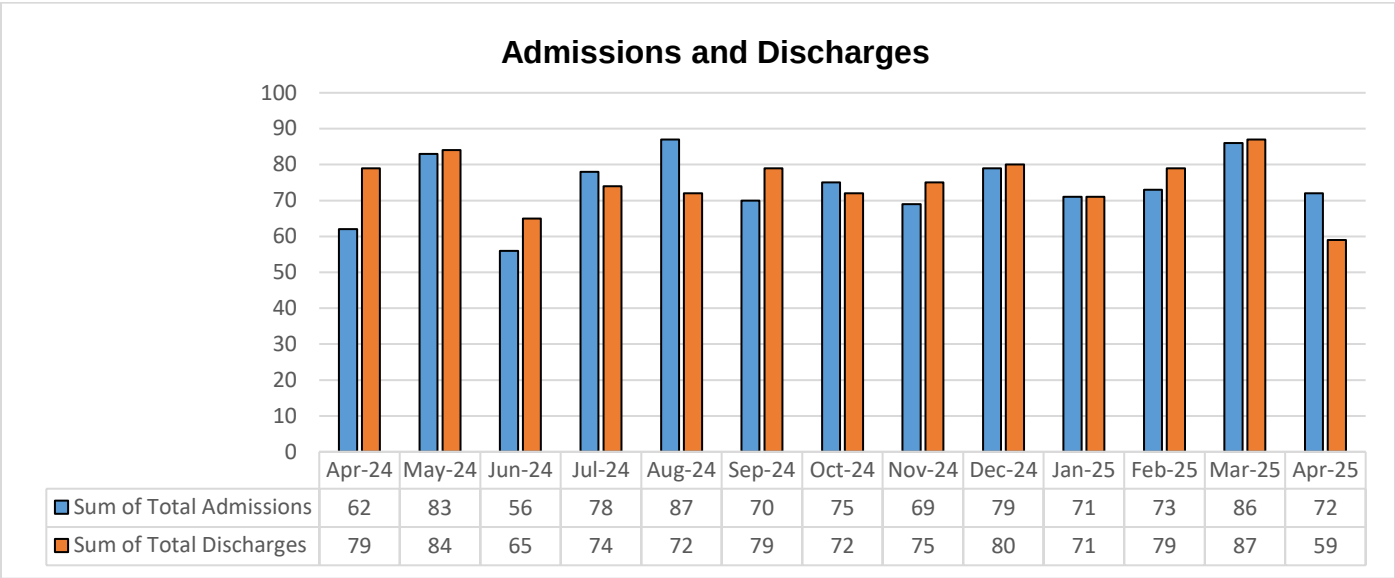
9.0 Admissions, Discharges and Length of Stay

9.1 Fluctuations in patient length of stay, alongside frequent admissions and discharges, have a direct impact on ward staffing requirements. Shorter stays and high turnover rates increase the demand for administrative and

clinical tasks such as assessments, care planning, and discharge coordination. This requires concentrated staff input and can reduce the time available for direct patient care. Conversely, longer stays may necessitate sustained staffing for patients with complex or ongoing needs.

9.2 The following graph illustrates the total of admissions and discharge figures across the Mental Health Inpatient Service.

9.3 The data was not reported on in 2023/24’s annual staffing reviews, so no comparison is available.

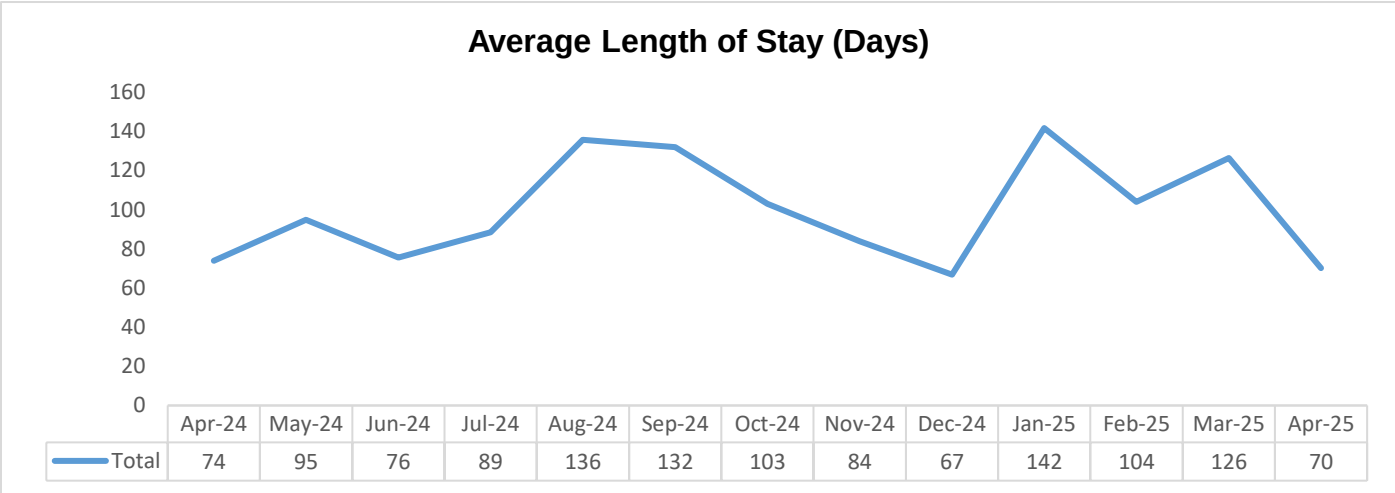


9.4 Admissions ranged from a low of 56 in June 2024 to a peak of 87 in August 2024. The summer months, particularly July and August, saw a noticeable rise in admissions, followed by a slight decline in the autumn. Admissions remained relatively stable through the winter and early spring, with a small increase in March 2025 before dropping slightly in April 2025.

9.5 Discharges followed a similar but slightly more stable pattern, peaking at 87 in March 2025 and reaching their lowest point of 59 in April 2025. Most months showed moderate fluctuations, with discharges generally keeping pace with admissions throughout the year.

9.6 The balance between admissions and discharges was close in most months, with January 2025 showing an exact match of 71 each.

9.7 The following graph illustrates the average length of stay. The data was not reported on in 2023/24’s annual staffing reviews, so no comparison is available.



9.8 The average length of stay ranged from a low of 67 days in December 2024 to a peak of 142 days in January 2025. The highest durations were observed in the late summer and winter months, particularly from August 2024 to January 2025.

9.9 The lowest durations were recorded in April 2024 (74 days), June 2024 (76 days), and April 2025 (70 days), indicating relatively shorter stays during the spring months. December 2024 also showed a notable drop to 67 days.

9.10 The overall average time on ward across the reporting period was approximately 100 days.

10.0 Care Hours Per Patient Day (CHPPD)

- 10.1 Care Hours Per Patient Day (CHPPD) is a workforce measure used in inpatient care.
- 10.2 It includes total nursing staff time spent on direct patient care and associated activities such as preparing medicines, updating patient records, and sharing care information with other services. It covers both temporary and permanent registered and unregistered staff but excludes student nurses and staff working across more than one ward.
- 10.3 CHPPD alone does not capture the full extent of care delivered on a ward, nor does it directly indicate whether care is safe, effective, or responsive. Therefore, as recommended by NHS England, it should be interpreted in conjunction with other measures of quality and safety.
- 10.4 It is calculated by adding the actual hours of Registered Nurses and the actual hours of Mental Health Support Workers and dividing by the total number of patients at midnight. It is reported as a total figure and split by Registered Nurses and Mental Health Support Workers to provide a complete picture of care and skills mix (NHS England 2021).
- 10.5 CHPPD is monitored and reported in the monthly Safer Staffing Report. Any unexpected or unwarranted variance between planned and actual CHPPD is explored further.
- 10.6 All trusts with inpatient wards are required to submit monthly CHPPD data to NHS England to support national benchmarking. This data is published on the Model Health System platform and is accessible to the public via a dedicated website. A link to this site is available on the Safer Staffing page of the Trust's intranet.
- 10.7 If a senior staff member undertakes a clinical shift but eRoster is not updated to reflect this at the time, those hours will not be captured in the actual nursing hours data. As a result, these hours are excluded from the Care Hours Per Patient Day (CHPPD) calculation. This means that, in some cases, the actual CHPPD may be higher than reported.
- 10.8 The planned average Care Hours Per Patient Day (CHPPD) was 16.5, while the actual CHPPD achieved was 15.9. For the same period in 2023/24, the planned average was 17.2, with an actual CHPPD of 15.8.

11.0 Benchmarking with Peers

- 11.1 Identifying directly comparable wards for benchmarking can be challenging, as factors such as ward layout, referral criteria, and geographical location vary significantly. These differences can limit the accuracy of direct comparison.
- 11.2 While it is recognised that care is delivered by the entire multidisciplinary team, this benchmarking exercise focuses specifically on comparing the core nursing safer staffing levels as defined in the demand templates.
- 11.3 The following tables show a benchmarking overview of RN and MHSW staffing levels across various service types and shift patterns.

Trust	Gender	Service	Bed Numbers	Early			Late			Twilight	Night			RN Ratio
				RN	SW	Total	RN	SW	Total	SW	RN	SW	Total	
Dorset	F	Acute	12	3	3	6	3	3	6	0	2	1	3	53%
Trust 1	F		12	3	3	6	3	3	6	0	2	3	5	47%
Trust 2	Unspecified		16	2	3	5	2	3	5	0	2	3	5	40%
Trust 3	F		15	3	4	7	3	4	7	1	2	3	5	42%

- 11.4 Dorset and Trust 1 share an almost identical staffing structure across early and late shifts for an acute ward with 12 beds. Trust 1 rosters an additional MHSW on night shift. Dorset Female ward is funded for one MHSW on night duty, but fire evacuation plans require them to roster two. This is a cost pressure.
- 11.5 Trust 2 and 3 also roster an additional two MHSW on night shift when compared to Dorset.

Trust	Gender	Service	Bed Numbers	Early			Late			Twilight	Night			RN Ratio
				RN	SW	Total	RN	SW	Total	SW	RN	SW	Total	
Dorset	M	Acute	16	4	2	6	3	3	6	0	2	2	4	56%
Trust 1	M		18	3	4	7	3	3	6	1	2	3	5	44%
Trust 2	Unspecified		16	2	3	5	2	3	5	0	2	3	5	40%
Trust 3	M		15	3	4	7	3	4	7	0	2	3	5	42%

- 11.6 Dorset has the highest RN ratio at 56%.
- 11.7 Trusts 1, 2, and 3 assign one additional MHSW compared to Dorset during night shifts.

Trust	Gender	Service	Bed Numbers	Early			Late			Night			RN Ratio
				RN	SW	Total	RN	SW	Total	RN	SW	Total	
Dorset	Mixed	Acute	18	3	4	7	3	4	7	2	3	5	42%
Trust 1	Mixed		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Trust 2	Unspecified		16	2	3	5	2	3	5	2	3	5	40%
Trust 3	Mixed		18	3	5	8	3	5	8	2	4	6	36%

11.8 Dorset has the highest RN ratio at 42%.

11.9 Dorset and Trust 2 both allocate 2 RNs and 3 SWs at night.

Trust	Gender	Service	Bed Numbers	Early			Late			Night			RN Ratio
				RN	SW	Total	RN	SW	Total	RN	SW	Total	
Dorset	Mixed	CYP	10	3	4	7	3	4	7	2	4	6	44%
Trust 1	Mixed		14	4	4	8	4	4	8	3	4	7	48%
Trust 2	Mixed		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Trust 3	Mixed		12	3	3	6	3	3	6	2	2	4	50%

11.10 Dorset has the lowest RN ratio at 44%. However, has lower bed numbers.

11.11 Dorset has the lowest bed numbers compared to Trust 1 and 3 yet maintains similar early and late shift staffing levels.

11.12 Trust 3 has a higher bed count however rosters two fewer MHSWs compared to Dorset HealthCare.

Trust	Gender	Service	Bed Numbers	Early			Late			Night			RN Ratio
				RN	SW	Total	RN	SW	Total	RN	SW	Total	
Dorset	Mixed	Eating Disorders	10	4	5	9	4	5	9	3	3	6	46%
Trust 1	Mixed		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Trust 2	Mixed		10	2	2	4	2	3	5	1	2	3	42%
Trust 3	Mixed		10	2	4	6	2	4	6	2	1	3	40%

11.13 All trusts with available data report 10 beds, allowing for direct comparison of staffing ratios. However, the peer trust has not indicated whether they provide high dependency beds comparable to our two beds.

11.14 Dorset has the highest RN ratio at 46%.

11.15 Dorset provides the highest night shift coverage with 6 staff (3 RNs and 3 MHSWs).

11.16 Dorset staff 4 RNs and 5 SWs for both early and late shifts, 9 staff per shift. This is higher compared to Trusts 2 and 3 (4–6 staff per shift total).

Trust	Gender	Service	Bed Numbers	Early			Late			Twilight	Night			RN Ratio
				RN	SW	Total	RN	SW	Total	SW	RN	SW	Total	
Dorset	Mixed	Functional Older Adults	20	2	4	6	2	4	6	0	2	2	4	38%
Trust 1	Mixed		18	3	4	7	3	3	6	1	2	3	5	44%
Trust 2	Mixed		16	2	4	6	2	3	5	0	1	3	4	33%
Trust 3	Mixed		20	3	5	8	3	5	8	0	2	4	6	36%

11.17 The average RN ratio across all trusts is 37.8%. Dorset sits slightly above average.

11.18 Dorset and Trust 3 both have 20 beds however Trust 3 allocates more staff across all shifts.

Trust	Gender	Service	Bed Numbers	Early			Late			Night			RN Ratio
				RN	SW	Total	RN	SW	Total	RN	SW	Total	
Dorset	M	Low Secure	12	3	4	7	3	4	7	2	2	4	44%
Trust 1	M		15	2	5	7	2	5	7	2	3	5	32%
Trust 2	M		15	2	2	4	2	2	4	1	2	3	45%
Trust 3	M		14	2	2	4	2	2	4	2	2	4	50%

11.19 Trust 1 provides one additional staff member on night shifts; Trust 2 operates with one fewer night staff and Trust 3 matches Dorset’s night staffing exactly when compared to Dorset.

11.20 Despite having more bed that Dorset, Trusts 2 and 3 operate with fewer staff during the day (4 total).

Trust	Gender	Service	Bed Numbers	Early			Late			Twilight	Night			RN Ratio
				RN	SW	Total	RN	SW	Total	SW	RN	SW	Total	
Dorset	F	Organic Older Adults	23	4	7	11	4	7	11	1	2	3	5	37%
Trust 1	Mixed		15	3	5	8	3	4	7	1	2	3	5	40%
Trust 2	Unspecified		16	2	6	8	2	6	8	0	2	4	6	27%
Trust 3	Mixed		20	3	5	8	3	5	8	0	2	4	6	36%

- 11.21 Dorset has the highest bed count (23) and maintains the highest day shift staffing levels.
- 11.22 Dorset maintains 4 RNs and 7 SWs for both early and late shifts (11 total per shift), the highest amongst all trusts.
- 11.23 Trusts 2 and 3 provide one more MHSW on night shifts compared to Dorset. However, we utilise a twilight duty.
- 11.24 RN coverage at night is consistent across all trusts (2 RNs).
- 11.25 Dorset and Trust 1 include 1 SW in the twilight shift, while Trusts 2 and 3 do not.

Trust	Gender	Service	Bed Numbers	Early			Late			Twilight	Night			RN Ratio
				RN	SW	Total	RN	SW	Total	SW	RN	SW	Total	
Dorset	M	Organic Older Adults	17	4	7	11	4	7	11	1	2	7	9	32%
Trust 1	Mixed		15	3	5	8	3	4	7	1	2	3	5	40%
Trust 2	Unspecified		16	2	6	8	2	6	8	0	2	4	6	27%
Trust 3	Mixed		20	3	5	8	3	5	8	0	2	4	6	36%

- 11.26 Dorset sits below the average RN ratio, despite having the highest overall staffing levels.
- 11.27 Dorset maintains 4 RNs and 7 SWs for both early and late shifts (11 total per shift), the highest amongst all trusts.
- 11.28 Dorset and Trust 1 include 1 SW in the twilight shift, while Trusts 2 and 3 do not.
- 11.29 Other trusts operate with less night staff, especially Trust 1, which has 4 less than Dorset.
- 11.30 Trust 3 has a larger bed count and a higher RN ratio (36%) than Dorset.

Trust	Gender	Service	Bed Numbers	Early			Late			Night			RN Ratio
				RN	NN	Total	RN	NN	Total	RN	NN	Total	
Dorset	F	Perinatal	5	2	1	3	2	1	3	1	1	2	63%
Trust 1	F		8	3	4	7	3	4	7	2	2	4	44%
Trust 2	F		8	3	3	6	3	3	6	2	2	4	50%
Trust 3	F		4	2	2	4	2	2	4	1	1	2	50%

- 11.31 Dorset has the highest RN ratio at 63%.
- 11.32 Dorset utilises 3 staff for early and late shifts. Other trusts operate with 4–7 staff per shift.

Trust	Gender	Service	Bed Numbers	Early			Late			Night			RN Ratio
				RN	SW	Total	RN	SW	Total	RN	SW	Total	
Dorset	F	PICU	5	2	3	5	2	3	5	1	3	4	36%
Trust 1	F		6	2	5	7	2	5	7	2	3	5	32%
Trust 2	Unspecified		10	2	3	5	2	3	5	2	3	5	40%
Trust 3	F		8	3	3	6	3	3	6	3	3	6	50%

- 11.33 The average RN ratio across all trusts is 39.5%, placing Dorset below average.
- 11.34 Dorset and Trust 2 both utilise 5 staff on early and late shifts.
- 11.35 Dorset has the lowest RN coverage at night (1 RN)

Trust	Gender	Service	Bed Numbers	Early			Late			Night			RN Ratio
				RN	SW	Total	RN	SW	Total	RN	SW	Total	
Dorset	M	PICU	7	3	3	6	3	3	6	1	3	4	44%
Trust 1	M		8	2	5	7	2	5	7	2	3	5	32%
Trust 2	Unspecified		10	2	3	5	2	3	5	2	3	5	40%
Trust 3	M		6	2	3	5	2	3	5	2	3	5	40%

- 11.36 Dorset has the highest RN ratio at 44%.

11.37 All other trusts provide one additional staff member on night shifts compared to Dorset.

11.38 Dorset has fewer beds (7) but maintains a higher RN ratio than Trust 1

Trust	Gender	Service	Bed Numbers	Early			Late			Night			RN Ratio
				RN	SW	Total	RN	SW	Total	RN	SW	Total	
Dorset	Mixed	Rehab	9	1	1	2	1	1	2	1	1	2	50%
Dorset	Mixed		13	2	3	5	2	3	5	1	2	3	38%
Trust 1	Mixed		24	3	4	7	3	4	7	2	3	5	42%
Trust 2	Mixed		10	2	3	5	2	3	5	1	2	3	38%
Trust 3	Mixed		10	1	2	3	2	1	3	1	1	2	50%

11.39 Dorset and Trust 3 share the highest RN ratio at 50%.

11.40 Dorset maintains 2 total per shift for both early and late shifts, other trusts utilise more staff overall.

11.41 RN ratios across Dorset’s services range from 32% to 63%.

11.42 Perinatal service stands out with the highest RN ratio (63%) despite having the fewest beds.

11.43 Most Dorset services maintain 2 RNs at night, with SW numbers varying from 1 to 7 depending on the service.

11.44 Dorset uses a minimal staffing (1 RN, 1 SW per shift) but maintains a high RN ratio due to small team size.

11.45 Support worker utilisation in low secure and acute services is occasionally lower than peer trusts.

12.0 Evidence-based Tool: Mental Health Optimal Staffing Tool (MHOST)

12.1 MHOST is a nationally endorsed, multidisciplinary, evidence-based tool that enables ward-based clinicians to assess patient acuity. It incorporates a staffing multiplier to help ensure that baseline funded ward establishments align with patient needs. However, it is acknowledged that MHOST does not account for factors such as ward environment, geographical location, or workforce competency, all of which may influence staffing requirements.

12.2 MHOST assessments are conducted twice a year—in spring and autumn—to help mitigate seasonal bias. If a data collection period coincides with a month that does not reflect typical ward activity (e.g. significantly higher or lower acuity or bed occupancy), it is recommended that the cycle be extended or repeated to ensure data accuracy.

12.3 To reflect the increased demand for mental health services during the summer months, a summer data collection has been added to the annual MHOST schedule. This change, commencing in 2026, will support more meaningful comparisons across seasonal variations.

12.4 The Shelford Group of Chief Nurses has commissioned a refreshed review of the Mental Health Optimal Staffing Tool (MHOST), with Dorset HealthCare acting as a key contributor to the study. As part of this contribution, the Trust has provided 150 hours of clinical practice data, collected through a time-in-motion study, to support the national data collection.

12.5 It is acknowledged that MHOST-recommended staffing levels should not be used in isolation to determine staffing establishments. Professional judgement and data triangulation are essential in informing decisions and outcomes. Once each data collection cycle is verified, the results are shared with the Ward Manager to incorporate their professional insights into the review process.

12.6 Caution is advised when interpreting MHOST recommendations for wards with eight beds or fewer, and for night duty, as the tool may not suggest sufficient staffing to ensure safe care. In these cases, professional judgement should be applied to ensure that safer staffing levels provide the appropriate number and skill mix of staff to deliver safe and effective care.

12.7 Significant and persistent variances between MHOST-recommended baseline establishments and Dorset HealthCare’s funded establishments—where such differences cannot be justified by professional judgement or patient and staff outcomes—are escalated to the Director of Nursing and the Service Director for review.

MHOST Outcomes October 2024 and April 2025

Ward	Beds	MHOST Recommendation		MHOST Average (Two Cycle)	Funded Establishment	WTE Variance +/-
		October 2024	April 2025			

AAU Seaview	14	26.51	27.10	26.81	39.87	-13.06
Alumhurst	20	28.42	19.71	24.07	32.72	-8.65
Chine	11	20.68	24.32	22.50	27.16	-4.66
Glendinning Unit	9	5.61	6.89	6.25	12.75	-6.50
Haven Female	5	6.70	18.37	12.54	25.55	-13.01
Haven Male	7	24.65	16.47	20.56	33.59	-13.03
Herm	23	33.08	22.77	27.92	55.88	-27.96
Melstock House	12	11.15	15.27	13.21	26.60	-13.39
Nightingale House	13	13.27	11.99	12.63	23.59	-10.96
Pebble Lodge	10	17.32	28.90	23.11	40.40	-17.29
St Brelades	17	36.54	32.23	34.39	51.11	-16.72
Twynham	12	9.66	9.75	9.70	33.59	-23.89
Waterston	18	26.42	41.19	33.81	32.30	+1.51

12.8 Harbour did not submit sufficient data for analysis during either the October 2024 or April 2025 data collections. This was primarily due to ongoing staffing challenges

12.9 Florence House was excluded from the data collection due to being a small ward in line with guidance.

12.10 Kimmeridge Court's data collection was suspended due to the *safest staffing* protocol being applied in April 2025. Data collection will resume in October 2025.

12.11 Care should be taken when interpreting the data without the accompanying narrative. In some areas, there are notable discrepancies between the MHOST-recommended WTE and the actual funded establishment.

12.12 MHOST calculates staffing based on average patient acuity, dependency, and numbers; however, it does not account for contextual factors such as ward environment or geographical location. The tool may generate staffing recommendations that do not adequately support safe and effective care for smaller wards (eight beds or fewer) Professional judgement, informed by patient outcomes and local knowledge, remains the most reliable guide for determining appropriate staffing levels.

12.13 Training in the practical application of the tool is ongoing. In wards with more than eight beds where significant variances have been identified, targeted training and quality assurance visits are scheduled for October 2025. These sessions are designed to ensure that assessments of both acuity and dependency are applied accurately and consistently. It is recognised that dependency is often under-assessed, as greater emphasis may be placed on acuity. Addressing this imbalance will improve the accuracy of staffing data, strengthening its validity and reliability for future workforce planning

12.14 Herm and St Brelades experienced periods of reduced bed occupancy during the data collection cycles, which will have influenced the staffing data outcomes. It is anticipated that the October 2025 data collection cycle will provide a more accurate and representative assessment of staffing requirements.

12.15 The MHOST licence does not permit organisations to capture the acuity, and dependency needs of individuals accessing assessment under Section 136 of the Mental Health Act in Health-Based Places of Safety (HBPoS). As a result, Seaview's funded establishment is significantly higher than the MHOST recommendation to ensure adequate staffing. This is necessary because the ward provides Mental Health Support Workers to deliver continuous 1:1 observation within the HBPoS suite.

12.16 Professional Judgement:

12.17 Professional judgement was applied using an adapted version of the Professional Judgement Framework (Saville et al., 2023). Due to their size, the templates are not embedded in this report.

12.18 The narrative in *italics* is directly taken from the Ward Manager's template in answer to the following questions:

- *Does the daily staffing template enable the team to provide safe, compassionate and consistent care? Are there any gaps*
- *Do you have a recommendation that is different to the agreed staffing levels? If your recommendation is for higher staffing levels, please provide your rationale*

12.19 **AAU Seaview:** *In an ideal world, we would have staff separate from the safe staffing numbers to ensure activities run on the ward, lengthy reports relating to housing, social services etc can be actioned. The ward acuity and demands of staff time can fluctuate day to day, requiring Seaview to be able to be dynamic and flexible to meet the needs of our patients and to maintain the ward's safety.*

12.20 The Ward Manager reported that, when fully staffed according to the demand template, the ward is able to provide safe and effective care. However, the current staffing model includes the Mental Health Support Worker WTE required to staff the two Health Based Place of Safety beds (HBPoS)

12.21 When patient acuity and dependency levels are high, staffing becomes particularly challenging, especially when HBPOS beds are occupied, as they require continuous 1:1 care. If Seaview simultaneously experiences enhanced care needs or staffing shortfalls, additional duties are often created to maintain safe staffing levels. In such scenarios, aspects of care—such as therapeutic activities—may be missed, delayed, or cancelled due to limited staff availability

12.22 Once the HBPOS relocates to its new purpose-built facility on the St Ann's site, the operational plan is for it to be staffed independently from Seaview. However, this transition is causing psychological unease among existing Mental Health Support Workers, some of whom may not wish to work substantively in an HBPOS environment. Recruitment has been temporarily paused while the operational plan is being finalised, to ensure that the recruitment process clearly outlines the expectations and work locations for new staff.

12.23 **Alumhurst:** *I believe the template is effective at meeting the ward's demands at this time.* However, they noted that Tuesday and Friday mornings often require increased staffing levels to accommodate patients receiving ECT.

12.24 Previously, the ward repurposed Band 3 Mental Health Support Worker funding to create a Band 4 Activities Coordinator post. The funding was locally agreed upon and not assessed through the Quality Impact Assessment process.

12.25 The role has been difficult to establish, as it is included in the safer staffing numbers, leading to conflicting responsibilities throughout the day. The Ward Manager advocates for a substantively funded Activities Coordinator working Monday to Friday, separate from core staffing numbers. At present, activity provision is facilitated by Mental Health Support Workers, and a timetable of activities is visible during ward visits.

12.26 The ward has introduced a Band 7 Enhanced Clinical Practitioner (ECP) post by repurposing Band 6 funding. Although this funding arrangement was locally agreed upon, it was not assessed through the Quality Impact Assessment process.

12.27 **Chine:** *We believe that the current template can enable the team to provide safe, compassionate and consistent care. There are however some gaps in the roster caused by career development opportunities which does leave some difficulties in consistently providing a safer staffing roster. For example, permanent staff who are undertaking apprenticeship training, across both nursing and occupational therapy, their study commitments away from the ward will leave gaps in the service.*

12.28 Chine has been challenged with rostering two Registered Nurses on night duty due to historical flexible working patterns. The interim Ward Manager has been working with the clinical team to address this.

12.29 Chine is due to relocate to a purpose-built unit on the St Anns site in March 2026. The number of beds will increase from eleven to fourteen. The staffing model required for the new unit is currently being reviewed.

12.30 **Florence:** *The daily staffing template works well, as evidenced by low sickness and low staff turnover.*

12.31 Additional staffing is required on Mondays due to the MDT, which cannot be held on the ward because of environmental constraints. This has been identified as contributing to a cost pressure, and the Management Accountant is working with the Provider Collaborative to review the ward's funding.

12.32 Florence operates with one Registered Nurse and one Nursery Nurse per duty. National guidance requires a Nursery Nurse to be present on all duties. Previous reviews assessing the potential benefits of increasing Registered Nurse presence have concluded that there is no clinical need for three staff members overnight. Replacing the Nursery Nurse with a Registered Nurse would not comply with national standards.

12.33 Florence maintains a pool of regular bank staff to cover staffing shortfalls. Additional support may also be drawn from Nightingale and Pebble wards, which are located on the same site. However, it is important to note that Nightingale also operates with only one Registered Nurse overnight; therefore, support from this ward is available during day duty only.

12.34 **Glendinning:** *Glendinning does require bank and agency support quite a lot. This can be due to the ward running on minimum safer staffing numbers of 1RMN and 1MHSW, therefore should we experience staff sickness, or we have vacant shifts that we can't allocate substantively, then we rely on either bank, agency or colleagues within the acute wards to support.*

12.35 *I feel more MHSWs would be a benefit to the ward. If there was capacity to have 2MHSWs on shift this would enable more activities, appointments and community engagement to take place.*

12.36 The review identified gaps in meeting patients' needs during evenings and weekends, primarily due to insufficient staffing levels. It also highlighted the unit's reliance on temporary staff and support from other wards (destabilising staffing levels) to maintain safe staffing, and the vulnerabilities of being a lone unit, as only one Registered Nurse is currently funded.

12.37 Whilst the Ward Manager's professional judgement supports increasing the ratio of Mental Health Support Workers, this would not resolve the safety concerns associated with having only one Registered Nurse on duty. Therefore, this review recommends revising the staffing establishment to include a Registered Nurse on late or twilight duty during weekdays and increasing weekend staffing from the current level of one Registered Nurse and one Mental Health Support Worker to two Registered Nurses and one Mental Health Support Worker.

12.38 Previous reviews assessing the potential benefits of increasing Registered Nurse presence have concluded that there is no clinical need for three staff members overnight. Substituting a Mental Health Support Worker for a Registered Nurse was considered an inadequate use of a registrant post.

12.39 A review of rehabilitation services is pending that may lead to changes in how the service operates, creating opportunities for teams to work in new and innovative ways. These changes may also affect existing staffing models and how teams are deployed across services. However, a gap will remain while the review is underway, and the organisation should acknowledge that maintaining current overnight staffing levels presents a risk. This is particularly due to reliance on agency staff or the redeployment of staff from other wards—practices that can destabilise staffing levels elsewhere and compromise continuity of care

12.40 **Harbour:** *The current template will enable the team to provide safe, compassionate, and consistent care once the number of staff vacancies diminishes and we can close the vacancy gap. The Ward Manager and Service Manager are happy with the agreed staffing levels currently set out for the Harbour ward.*

12.41 Throughout the review period, Harbour experienced ongoing challenges in filling Registered Nurse and Mental Health Support Worker positions. Despite the implementation of recruitment and retention premia, vacancies persist.

12.42 As staffing levels were affected, the Safest Staffing Protocol was applied from October to December 2024. This measure was lifted following successful recruitment efforts and the introduction of block-booked Registered Nurses, which helped ensure consistent care. At the time of writing, the ward remains on the Safest Staffing 'Watchful Waiting' list. T

12.43 The Resourcing Team is actively supporting the Ward Manager in delivering a targeted recruitment programme.

12.44 Work is underway to explore the barriers that may be discouraging potential applicants from applying to roles on the ward.

12.45 **Haven Female:** *We are currently creating additional duties for MHSW at night to allow for 3 MHSW on at night. This is currently not within Haven Female budget, but I recommend that it is. This extra MHSW at night allows the ward to have safe staffing at all times which supports patient care.*

12.46 The additional duty referenced by the interim ward manager reflects a longstanding practice. The 2024 annual establishment review process recommended a revised skill mix—changing from one Registered Nurse and three Mental Health Support Workers to two Registered Nurses and two Mental Health Workers. Although this differs from the interim ward manager's recommendation, it is considered to offer a safer and more balanced staffing model. At the time of writing, the recommendations continue to be discussed as part of the financial business planning cycle.

12.47 Both Haven Female and Male wards are relocating to a new purpose-built unit on the St Ann's site in March 2026. A programme of work has been completed to review the proposed staffing model, including recommendations for night staffing. If the proposal is approved as part of the new hospital programme, a staffing gap will remain between now and the wards' transition to the new environment.

12.48 **Haven Male:** *An additional RMN at night – this is required based on national guidance of best practice, and would support the required standard of skill overnight to contribute to safe and effective way of working.*

12.49 *Formalise the uplifting workforce for the new build – There will be an increased bed capacity within the new build and the workforce needs to take this into account as well as the environmental factors.*

12.50 *Formalise additional B6 funding – It is apparent that the workforce demand has now changed, and from completing scoping work into the demand of being a team leader within a PICU setting, it is apparent that without a good number of team leads, the quality of care as well as staff experience is reduced. This shouldn't be accepted and must be reviewed with some urgency.*

12.51 *Formalise the additional "activity" shift timings – Currently, the hours are extended and shifts are created across a 7 day period. It would not be possible to function without this. Objectively, from a financial perspective, we have dramatically reduced our agency spend, and it is therefore important to consider that this additional activity timing has directly contributed to this. This change allows resilience to sickness as well as supporting the team's provision of meaningful activity.*

12.52 All of the issues outlined above are being actively addressed through the ongoing new hospital programme.

12.53 **Herm:** A completed professional judgement template was not returned. However, the following questions were answered by the Matron.

- *Does the daily staffing template enable the team to provide safe, compassionate and consistent care? Are there any gaps?*
- *Do you have a recommendation that is different to the agreed staffing levels? If your recommendation is for higher staffing levels, please provide your rationale*

12.54 *Currently, Herm is capped at 22 patients and has variable bed occupancy. Typically Herm runs at around 50% capacity. The current staffing template is safe for this number of patients. However the number of patients and their individual acuity is variable. If the ward had 23 patients with high acuity, then the current staffing level would not necessarily be sufficient.*

12.55 *Currently no change recommended, this may change when patient number increase, dependant on individual patient acuity.*

12.56 Although outside the review period, it is important to note that Herm and St Brelades wards will transition from organic services to a mixed organic and functional model from July 2025. This change is intended to support Melstock House, which is changing from a functional older person's ward to a discharge ward for individuals aged 18 and over who are ready for discharge but awaiting social care packages.

12.57 Close monitoring of safer staffing levels and associated metrics will be necessary to ensure that staffing levels continue to provide safe, effective, and compassionate care.

12.58 **Kimmeridge Court:** A completed Professional Judgement Template was not submitted. However, the Safer Staffing Team has been working closely with the Ward and Service Manager to address ongoing vacancies for Registered Nurses and Mental Health Support Workers.

12.59 Due to concerns about increased reliance on temporary staffing and its potential impact on patient experience, the Safest Staffing Protocol was activated on 10 April, alongside Enhanced Surveillance from the Provider Collaborative.

12.60 Staffing is reviewed daily, with additional weekly reviews conducted in collaboration with the Ward and Service Manager.

12.61 Block-booked Registered Nurse arrangements are in place to ensure continuity of care. However, additional temporary staffing is still required to cover shortfalls. At the time of writing, all Registered Nurse vacancies have been successfully recruited. It is noted that the new post holders are either internationally educated nurses or newly qualified registrants graduating in September and will therefore require a period of preceptorship support.

12.62 The Provider Collaborative is exploring funding for a Practice Educator role to support preceptorship, coaching, pastoral care, and training needs. If approved, this role will operate across Dorset and Southampton to help alleviate pressure on the existing team.

12.63 **Melstock House:** A Professional Judgement Template was not completed due to the ward's change in purpose, as previously described. A revised staffing model has been agreed upon, informed by a professional judgement working group and benchmarking with one other trust. Benchmarking proved challenging due to the ward's unique and specialised nature.

12.64 Close monitoring of safer staffing levels and associated metrics will be necessary to ensure that staffing levels continue to provide safe, effective, and compassionate care.

12.65 **Nightingale Court:** The Ward Manager reported no concerns regarding the current demand template and did not recommend any changes at this time.

12.66 Nightingale currently operates with one Registered Nurse and two Mental Health Support Workers during the night shift. Previous reviews conducted with operational services concluded that there is no clinical need to increase Registered Nurse presence overnight, given the ward's rehabilitation focus and the self-sufficiency of service users during these hours. Should activity levels rise, staffing levels may be reviewed, with consideration given to adding an additional Registered Nurse if required.

12.67 Nightingale maintains a pool of regular bank staff to cover staffing shortfalls. Additional support may also be drawn from Florence and Pebble wards, which are located on the same site. However, it is important to note that Florence also operates with only one Registered Nurse overnight; therefore, support from this ward is available during day duty only.

12.68 See 12.39

12.69 **Pebble Lodge:** *When our acuity is at its 'normal', the current staffing is adequate, what we struggle with is a sudden influx of young people needing to be on increased observations and no flexibility to increase this.*

12.70 As part of a Provider Collaborative, the ward is required to request enhanced packages of care through the provider collaborative when it is assessed that a young person requires ongoing enhanced care.

12.71 **St Brelades:** A completed professional judgement template was not returned. However, the matron answered the following questions.

12.72 *Does the daily staffing template enable the team to provide safe, compassionate and consistent care? Are there any gaps?*

12.73 *Do you have a recommendation that is different to the agreed staffing levels? If your recommendation is for higher staffing levels, please provide your rationale*

12.74 *Currently St Brelades is capped at 12 patients. The current staffing template is safe for this number of patients. However, the number of patients and their individual acuity is variable. If the ward had 17 patients with high acuity, then the current staffing level would not necessarily be sufficient. Currently no change recommended, this may change when patient number increase, dependant on individual patient acuity.*

12.75 Please see 12.51 and 12.52

12.76 **Twynham:** A completed professional judgement template was not returned. However, the Ward Manager reported no concerns with the demand template in a discussion with the Safer Staffing Lead as part of the review process.

12.77 Last year's review recommended a skill mix on night duty from one Registered Nurse and three Mental Health Support Workers to two Registered Nurses and two Mental Health Support Workers. This was agreed upon by the Quality Impact Assessment Panel on November 28th, 2024. The proposal was submitted through the Quality Impact Assessment Panel and not through the Financial Business Planning Cycle because no investment was required.

12.78 **Waterston:** 7-7-5 as a basic staffing level for this ward is what the ward manager considers to be and is the recommendation for safe staffing levels. Given the ward's footprint, its spread, the isolation, and the fact that it is the only unit on the site, which has lower staffing levels and very limited capacity to support in the event of a major incident.

12.79 In the acute pathway, Waterston is described as an Acute Assessment Unit which by its very nature will mean accepting challenging patients at the point of crisis or urgent assessment. This also justifies taking account of geography, the size and layout of the ward and should support the 7-7-5 model as it would for any other AAU on any other site. In addition, all the data that has been gathered over the last few years by MHOST support the model of 7-7-5.

12.80 An additional Mental Health Support Worker is rostered onto early, late, and night duties to ensure safer staffing levels, addressing both environmental needs and supporting acuity and dependency. This practice originated several years ago when a former Director of Mental Health Services approved a change to the demand template, although this adjustment was not reflected in the budget. Notably, Waterston is the only ward showing a consistent deficit in whole-time equivalent positions when comparing MHOST recommendations with the funded establishment.

12.81 It is a recommendation of this review that the additional Mental Health Support Worker rostered be funded for early, late, and night duty. Although increased staffing was outlined in the annual establishment reviews since 2020, it has not been reflected in the ward budget and continues to represent a cost pressure.

12.82 A consistent message from ward managers consistently stressed the importance of being flexible and adjusting staffing levels in response to changing clinical needs. This adaptability is crucial for maintaining safe and effective care, especially in dynamic ward environments.

12.83 **Revalidation:** For 2024/25 all Registered Nurses working in mental health inpatient services successfully revalidated, with one exception on Twynham Ward.

12.84 **Staff Experience and Satisfaction:**

12.85 Staff are encouraged to share their experiences of working within the Trust through a variety of channels. These include direct discussions with line managers, participation in the national Staff Survey and internal PULSE survey, engagement with Freedom to Speak Up Guardians and Staff Side representatives, reporting via the Ulysses incident reporting system, and support from Professional Nurse Advocates (PNAs). These mechanisms provide valuable insight into staff wellbeing and organisational culture.

12.86 Service Managers are responsible for ensuring that concerns raised through the Staff Survey are thoroughly explored and addressed in collaboration with clinical teams. Progress is monitored through the Directorate Management Group.

13.0 Staff Survey Results 2024:

Staff Survey 2024	Responses	%	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale	All Themes
Florence House	13	76%	93%	86%	87%	74%	70%	88%	87%	77%	79%	93%
Herm	16	24%	61%	43%	53%	50%	50%	56%	51%	56%	44%	52%
Nightingale House	15	54%	80%	57%	61%	61%	54%	63%	64%	65%	65%	64%
vs 2023 Staff Survey			Better	+/- 1%	Worse							

13.1 Wards not appearing in the data above did not achieve enough respondents to ensure anonymity.

13.2 There has been a decline in staff engagement on Herm when compared to 2023's staff survey.

14.0 Freedom to Speak Up:

14.1 Colleagues working within mental health inpatient services made 17 contacts, a decrease of 6 contacts compared to 2023/24.

14.2 The primary concern across all services (not limited to mental health inpatients) was colleague behaviour, with the largest group of contacts being Registered Nurses followed by Admin and Clerical.

15.0 **Expectation Two: Right Skills** (mandatory training, development, and education; working as a multi-professional team; recruitment and retention)

15.1 Boards should ensure clinical leaders and managers are appropriately developed and supported to deliver high-quality, efficient services, and there is a staffing resource that reflects a multi-professional team approach. Decisions about staffing should be based on delivering safe, sustainable, and productive services.

15.2 Clinical leaders should use the competencies of the existing workforce to the full, further developing and introducing new roles as appropriate to their skills and expertise, where there is an identified need or skills gap.

15.3 Dorset HealthCare is committed to ensuring that staff have the appropriate training and competencies to support patient care, and the communities in which they work. The Learning & Development Service and Leadership Team offer a wide range of learning activities beyond mandatory training including, clinical skills training, the Care Certificate for all Healthcare support workers as well as a band 2-4 development program, apprenticeship opportunities, a multi-professional preceptorship programme for new registrants, accredited leadership programs and career development options linking in with local education providers.

16.0 Headroom

16.1 Headroom is applied to all inpatient establishments to account for cover requirements for time out, such as annual leave, sickness absence, temporary staffing, and training or educational requirements. For 2024/25, headroom was set at 23.2% for all inpatient areas with the exception of Florence House (26.6%) and Twynham (27.8%)

16.2 The average sickness absence for the reporting period is 5%. However, the headroom allocation includes only a 4% allowance for sickness absence, suggesting that this component may be insufficient for some wards. This discrepancy could contribute to staffing pressures and the need for additional duties to maintain safe staffing levels.

16.3 Headroom is currently calculated based on whole-time equivalent figures rather than actual headcount. This approach may result in insufficient staffing cover during periods of time out, across the ward's staffing complement.

17.0 Mandatory Training, Appraisal and Clinical Supervision

17.1 All staff must undertake mandatory training, clinical supervision, and annual appraisal to meet national and local requirements. Compliance is monitored and reported monthly to the Trust Board.

17.2 The table below highlights compliance for May 2024. The overall average for mandatory training for Mental Health wards is slightly lower than the Trust's KPI of 95%; at 93.55%.

Compliance figures (April 2025)

Ward	Mandatory Training	Appraisals
AAU Seaview	94%	97%
Alumhurst	89%	75%
Chine	98%	82%
Florence House	92%	81%
Glendinning	98%	94%
Harbour	97%	65%
Haven Female	97%	88%
Haven Male	99%	75%
Herm	92%	85%
Kimmeridge Court	96%	76%
Melstock House	88%	52%
Nightingale House	94%	88%
Pebble Lodge	96%	87%
St Brelades	93%	90%
Twynham	95%	90%
Waterston	97%	88%

17.3 As of April 2025, the Trust Supervision Policy has changed. Both qualified and non-qualified staff are now required to record a minimum of one Clinical Supervision session every two months. Therefore, reporting the compliance has also changed from quarterly to bi-monthly.

17.4 It is acknowledged that the data may not fully reflect the actual practice of clinical supervision. Anecdotal feedback indicates that there is often a delay between when supervision is received and when it is reported on Ulysses.

Ward	Qualified Staff Clinical Supervision Compliance	Non-Qualified Staff Clinical Supervision Compliance
AAU Seaview	0%	0%
Alumhurst	0%	0%
Chine	17%	6%
Florence House	30%	40%
Glendinning	10%	0%
Harbour	63%	57%
Haven Female	67%	17%
Haven Male	86%	0%
Herm	0%	0%
Kimmeridge Court	67%	94%
Melstock House	15%	9%
Nightingale House	29%	0%
Pebble Lodge	81%	11%
St Brelades	6%	0%
Twynham	100%	70%
Waterston	31%	6%

17.5 In addition to clinical supervision the Trust is now offering restorative supervision with trained Professional Nurse Advocates (PNA) to support the health and wellbeing of the workforce. The programme is the first clinical model of restorative supervision for nurses in England that equips PNA-trained staff to listen and understand the challenges colleagues and teams are facing and to provide and deliver quality improvement initiatives in response. DHC currently has twenty-eight qualified PNAs of which seven work within Mental Health inpatients.

17.6 Recruitment and Retention

17.7 Four internationally educated nurses were recruited to B5 roles in mental health inpatient settings during the review period. Although the organisation is not actively pursuing international recruitment, international colleagues are welcome to apply via the normal recruitment process.

17.8 Dorset Healthcare recognises the national and local challenges with recruitment and the need to develop our people. It has committed significant investment into professional apprenticeships, including the Registered Nursing Degree, Registered Nursing Associate, Allied Health Professions, and Advanced Clinical Practitioner pathways.

17.9 There are currently 143 apprentices on clinical professional registration programmes, broken down by programme as below. An additional 17 are due to start in September 2025.

17.10 Although the breakdown reflects apprenticeship placements across various services, not specifically mental health inpatients, it highlights the breadth and diversity of development currently underway.

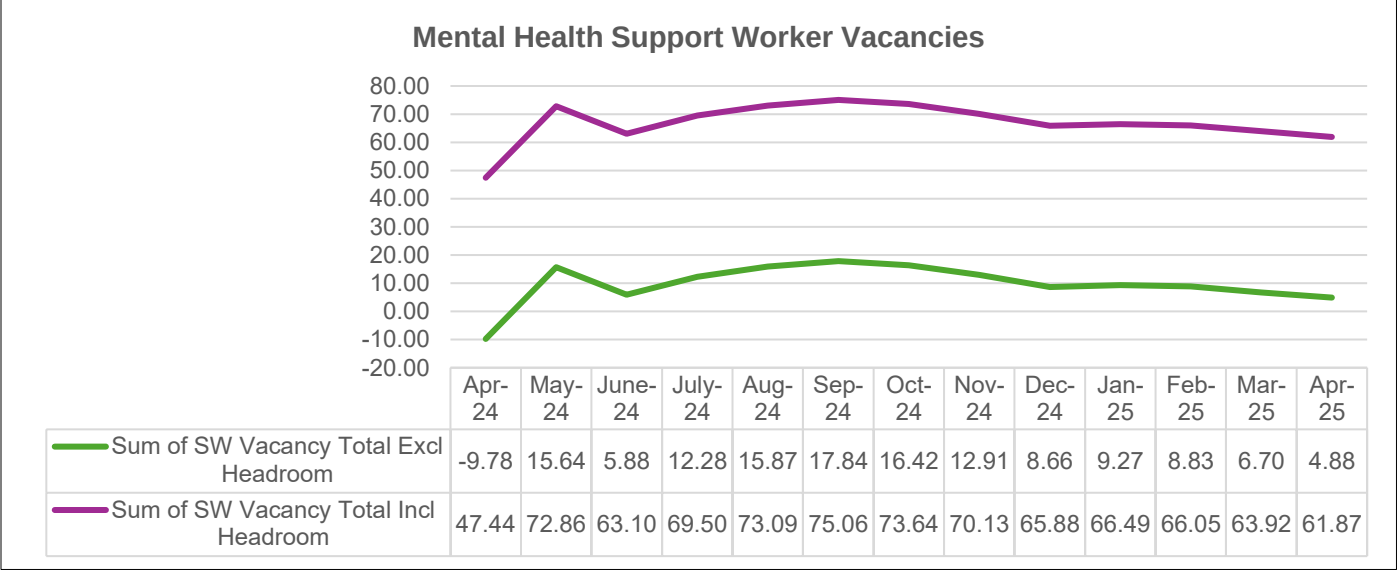
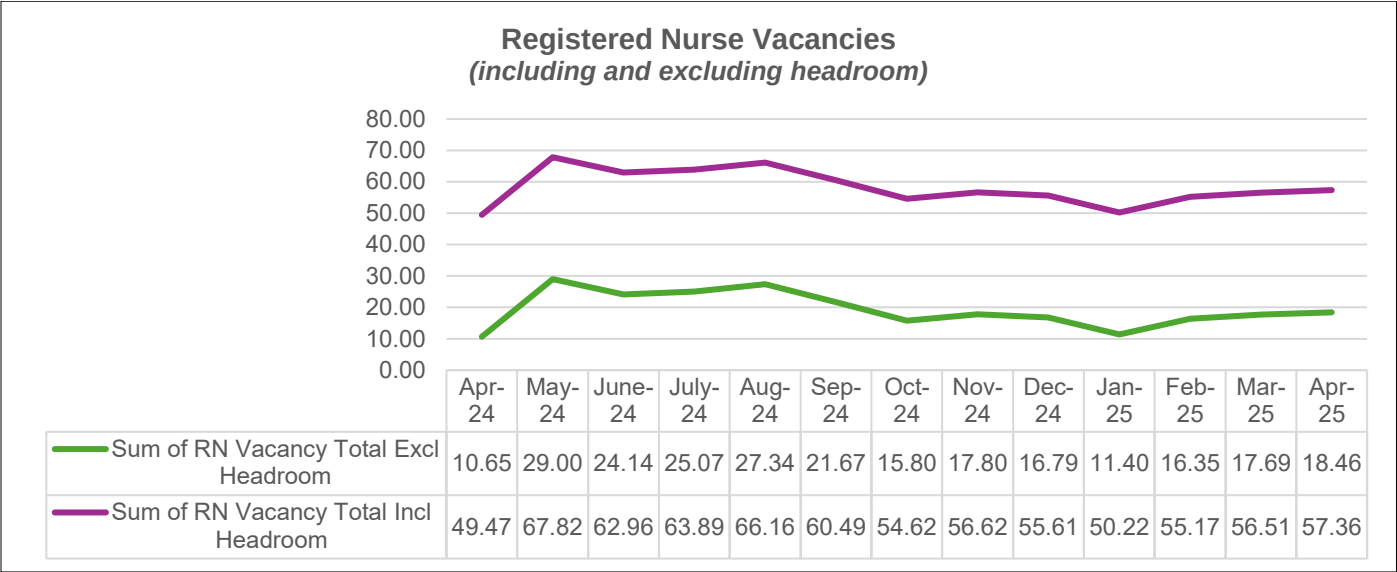
Number of Clinical professional apprentices currently on programme at Dorset HealthCare as at 7th August 2025	
Apprenticeship Programme	No.
Advanced Clinical Practitioner	16
Audiology	3
Audiology Top Up	1
Healthcare Assistant Practitioner	15
Healthcare Science Associate	1
Occupational Therapy	16
Physiotherapy	4
Podiatry	2
Podiatry Masters	2
Registered Nurse Degree – Adult	22
Registered Nurse Degree – Learning Disability	1
Registered Nurse Degree – Mental Health	32
RNA Top-up - Adult Nursing	8
RNA Top-up Mental Health	7
Speech and Language	3
Student Nurse Associate	10
Total	143

17.11 Vacancy data is provided by the Workforce Team using the ward cost centre-funded establishment.

17.12 The following graph illustrates registered nurse and non-registered nurse vacancies.

Registered Nurse and Mental Health Support Worker Vacancies

Setchell, Ryan
04/12/2025 09:14:16



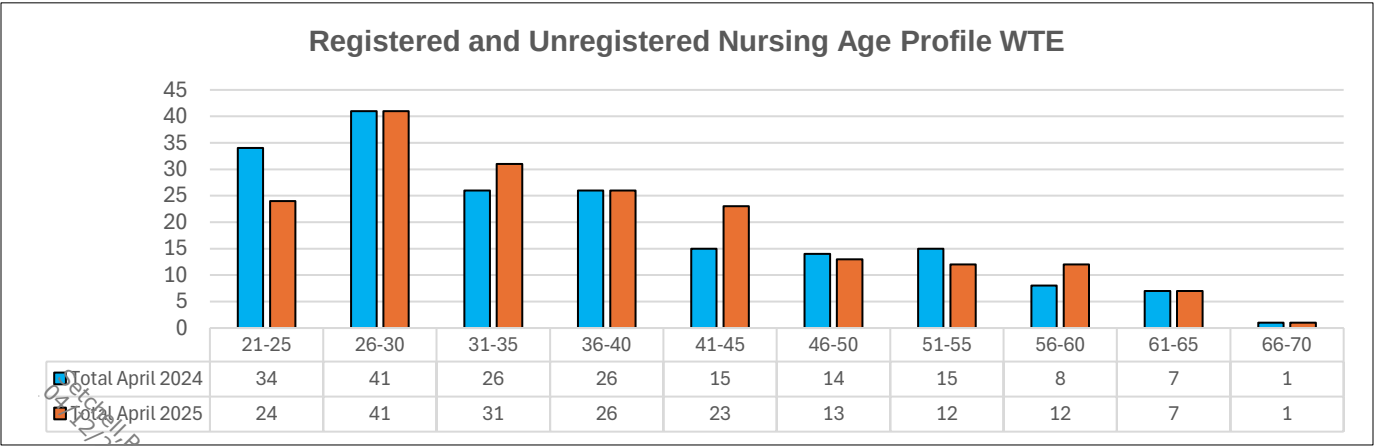
17.13 Harbour, Waterston and Kimmeridge have specifically experienced challenges in recruiting staff throughout the

17.14 While a comparison between 2023/24 and 2024/25 vacancy figures is possible, it should be approached with caution due to budgetary realignments still in progress at the start of the new financial year.

18.0 Registered Nurse Age Profile

18.1 At the end of April 2025, workforce data identified a total of 20 WTE Registered Nurses aged 56+ working in mental health wards. This is an increase of 4 WTE when compared to 2023/24.

Age Profile Position by WTE (as of April 2025)



18.2 The figures include all Registered Nurses whose roles are funded within the ward’s budgeted establishment, which may also encompass Advanced Clinical Practitioners. However, the data does not distinguish those with Special Class (SC) status under the 1995 NHS Pension Scheme, which permits retirement at age 55 without a reduction in benefits.

18.3 Mental Health Officer Status (MHOS) is held by mental health nurses who opted into the scheme before March 1995, allowing them to retire and take their pension at age 55. While holding MHOS does not necessarily mean these individuals will retire at 55, it is important not to assume that all will do so. However, the data provides a useful indication of the potential impact on the workforce.

18.4 In total, 63% of the Registered Nurses are 40 and under. This is a 7% decrease from the previous reporting period.

18.5 Kimmeridge Court continues to have the highest number of Registered Nurses 56 years and over at 4.00 WTE; all are Band 5. Herm continues to have the highest number of Registered Nurses 30 years and under at 7 WTE.

19.0 Multi-Professional Team Working:

19.1 **Allied Health Professionals:** AHPs are often referred to collectively; however, they are not a homogeneous group. Each profession has a unique perspective and skill set to bring to MDT working. There is evidence that supports MDTs are more effective when it is a true multi-professional team.

19.2 AHP staffing is based predominantly on historic information and funding. We currently don't map our AHP services against a formal framework or national effective staffing for the AHP workforce in MH inpatient settings, as this information is not widely available in these settings.

19.3 Across inpatient mental health teams, AHP professions are 1 WTE or less per team/service. This WTE provision does not provide full-time cover throughout the year. A 1.0 WTE will be 42.85 weeks cover when annual leave, sickness and mandatory training are removed, as there is no headroom allocation in budgets. This leads to significant restrictions on cross-coverage arrangements per profession, which are not possible due to the lack of resilience in small professions. i.e. one Dietitian for all adult inpatients' mental health, 0.8 SLT for all older adults with no backfill for maternity cover.

19.4 There is a risk of a single point of failure in the current provision of Dietetics, SLT or Physio in inpatient mental health. The need for funding for SLT in older adults has been recognised but remains a small provision when benchmarked against another similar organisation.

19.5 Due to the multiple complex transformations in the organisation, a new NHS 10-year plan, introduction of the peri-hospital, reconfiguring to improve patient flow and reduction in out-of-area, this led to pausing the AHP inpatient review, which is reconvening in September 2025. A revised membership has given new momentum to better represent the AHP workforce leadership from these workforce services. Different models of provision will be explored that meet the current needs of our inpatient population. Following a work plan, delivery is expected by the end of the financial year.

19.6 To further understand our workforce, job planning will be revisited for all AHPs in Q3-4. This will further aid understanding our capacity in this workforce.

19.7 When we have robust leadership, with professional skills and identity valued resilience can thrive in the AHP workforce.

19.8 **Advanced Clinical Practitioners (ACP):** As of April 2025, Haven Male and St Brelades have a Band 8a ACP as a part of their funded establishment. Although sitting on these budgets, the post holders work across St Brelades/Herm and Haven Female/Male.

19.9 ACPs working across other wards are funded by the medical establishment.

20.0 Medical Staffing

20.1 Medical support is provided in a variety of ways, with consultants and Deanery-appointed foundation year 1 or year 2 (FY1/FY2) resident doctors rotating every three months from the acute trusts. Core Medical Trainees (CMT) are in their third-year post-qualifying, rotating from the acute trusts every six months. Both FY1/FY2 and CMT doctors, although full-time, will be out of the clinical area regularly across the week for statutory training requirements. It should be noted that these posts are not always filled by the Deanery, which creates issues around reliance.

20.2 Consultants: Two wards - Herm and St Brelades - currently have Consultant cover provided on a locum basis.

20.3 **Multi-Professional Approved Clinician (MPAC):** Three MPACs—Harbour, Melstock, and Glendinning—are currently in post, supported by a Responsible Clinician, with a fourth trainee based on Chine. Plans are in place to make the trainee post substantive.

21.0 Workforce Strategy:

21.1 *Trusts must have an effective workforce plan updated annually and signed off by the Chief Executive and Executive Leaders. The Board should discuss the workforce plan in a public meeting.*

21.2 The annual operational workforce plan has been developed and agreed upon with the Executive Leadership team. It is signed off by the Trust Board and then subsequently approved by NHSE. The workforce operational plan is triangulated with financial data and developed in collaboration with operational leads to ensure it is achievable, sustainable, and provides the necessary level of qualified and non-qualified staff to deliver Trust services.

21.3 Weekly monitoring is in place, with more extensive monthly and quarterly regional reviews. The workforce planning strategy, toolkit, and training are being embedded across the Trust, and the first service-level 5-year workforce plans are in place.

21.4 The Trust also has a People Plan 2025-2028, which is approved by the Board and sets out the key workforce priorities for the next 18-36 months.

22.0 Expectation Three: Right Place and Time *(productive working and eliminating waste; efficient deployment and flexibility; efficient employment and minimising agency)*

22.1 *Boards should ensure staff are deployed in ways that ensure patients receive the right care, first time, in the right setting. This will include effective management and rostering of staff with clear escalation policies, from local service delivery to reporting at the Board, if concerns arise.*

22.2 *Directors of nursing, medical directors, directors of finance and directors of workforce should take a collective leadership role in ensuring clinical workforce planning forecasts reflect the organisation’s service vision and plan while supporting the development of a flexible workforce able to respond effectively to future patient care needs and expectations.*

22.3 **Rostering practices:** Rostering practices have shown that rotas are significantly influenced by the number of formal and informal flexible working arrangements and preferences. This has led to imbalances, with some shifts being overstaffed while others are understaffed. Additionally, higher levels of annual leave were approved in August and March, exceeding the recommended upper limit of 17%.

22.4 Work has been undertaken throughout the year to support managers in improving effective rostering. The ERoster team has reviewed all rosters with ward managers to ensure that rules are updated, and best practices are adhered to.

22.5 Despite ongoing efforts, gaps in effective rostering remain. Key themes contributing to these challenges include, but are not limited to:

- High A/L allocation in February, March and August
- Flexible working arrangements, particularly night duty
- Unfunded/part-funded posts (Activity Coordinators for example)
- Unfunded non-clinical time
- Headroom – sickness absence is higher than the allowance (4%). Clinical supervision, as well as national programmes such as Culture of Care and Reducing Restrictive Practices, which can increase workload, are not included in the training element.
- Unfunded or partially funded apprenticeship roles

22.6 A working group, led by operational services, is being established to address the identified issues.

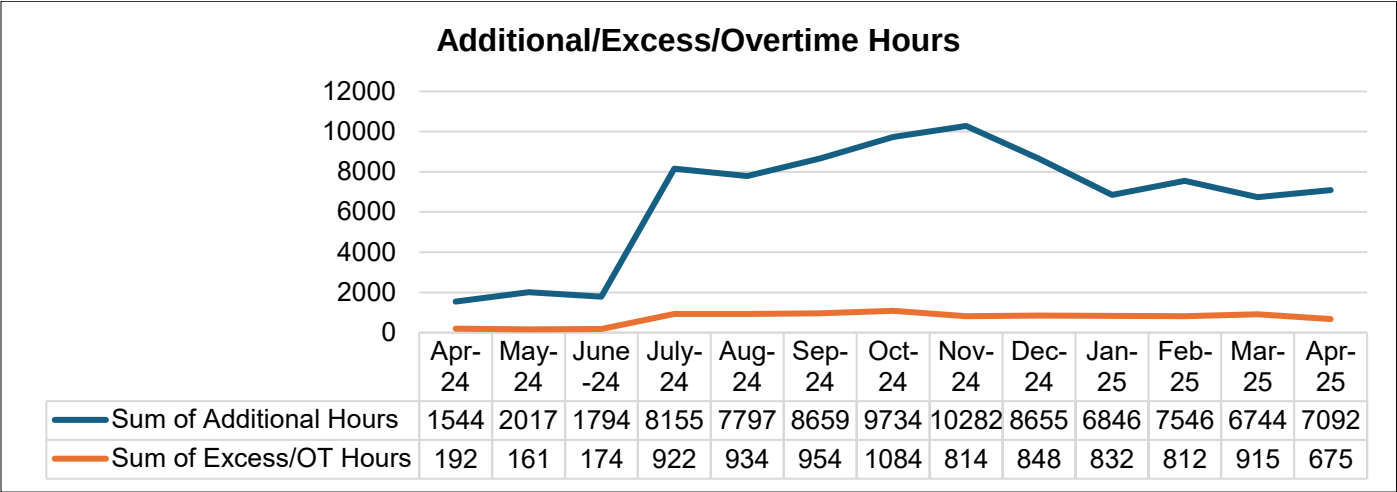
22.7 Additional/Excess/Overtime Hours

22.8 Additional duties/hours are created when professional judgment is applied to enhance staffing levels beyond the agreed ward demand template to ensure safer care. The most frequent reason for requesting these extra duties is the need for close therapeutic observations (levels 3 or 4) and/or high patient acuity, which requires additional staff to meet care needs. Other reasons may include increasing the expertise of the clinical team on duty or adjusting staffing levels in response to environmental changes, such as building works.

22.9 Unfunded hours may be recorded on eRoster as additional duties. As a result, wards such as Haven Female and Waterson, which operate with unfunded hours to maintain safer staffing levels, are expected to report higher levels of additional hours.

22.10 The following graph shows the total number of additional hours across mental health services.

Additional/Excess/Overtime Hours



- 22.11 The total number of additional hours increased from 67,249 in 2023/24 to 84,794 in 2024/25.
- 22.12 The top three reasons for additional hours usage are “*High Patient Acuity MH*”, “*Level 3 Obs*” and “*Level 1 General Obs*”.
- 22.13 The total number of excess/overtime hours has decreased from 10,010 in 2023/24 to 9,068 in 2024/25.

23.0 Escalating Staffing Concerns:

- 23.1 The organisation has written guidance on managing staffing shortages. The document, *Guidance on the Management of Staff Shortfalls on Wards*, is available on the Safer Staffing intranet page.
- 23.2 Wards must assess staffing levels on a shift-by-shift basis to ensure they are sufficient and appropriate for patient needs. If a shortfall is identified and cannot be resolved—such as operating below minimum staffing levels, having a non-Dorset HealthCare staff member in charge without ward knowledge, or no Registered Nurse on duty—escalation to a Senior Manager should take place and an incident must be reported in Ulysses (the incident reporting system) as soon as it becomes apparent.
- 23.3 While optimal staffing is the goal, teams may sometimes operate at “amber” staffing levels. Persistent amber levels will trigger a dynamic staffing review to assess risks and develop mitigation plans. However, the number of shifts with suboptimal staffing is not always reflected in Ulysses incident reports.
- 23.4 All incidents of suboptimal staffing should be reported via Ulysses, detailing missed, delayed or cancelled care. The Safer Staffing Team reviews these and includes them in the monthly staffing report. It is acknowledged that anecdotal feedback shared with the Safer Staffing Team may not always match the number of formal incident reports.
- 23.5 It is recognised that colleagues may feel reluctant to raise concerns via the Ulysses system or may not have time to complete it. To support anonymity, the Safer Staffing intranet page offers a brief online form that allows colleagues to raise concerns about staffing levels anonymously.
- 23.6 As noted earlier in the report, the Clinical Site Manager leads a daily operational touchpoint meeting each morning. This meeting reviews staffing levels and discusses temporary staffing needs. Where possible, substantive staff are redeployed to support other wards.
- 23.7 The monthly reviews of staffing incidents have not found any evidence that staffing levels have explicitly impacted patient safety. However, delays in attending to patients' needs, timely completion of documentation, and prioritisation of care have been reported, along with the impact on staff, such as leaving their duty consistently late and not being able to take rest breaks.

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Staffing Incidents



23.8 The number of reported staffing incidents has increased to 179, up from 91 in the previous reporting period. This rise is likely attributable to improved reporting practices rather than a genuine increase in staffing shortfalls

23.9 Harbour reported the highest number of staffing incidents during the reporting period, with a total of 85. While this increase is partly attributed to improved reporting practices, it also reflects ongoing challenges related to recruitment and retention within the service.

Patient Incidents

23.10 The following table illustrates the total number of incidents recorded and the timings logged per specialism. The data was not reported on in 2023/24’s annual staffing reviews, so no comparison is available.

23.11 The figures exclude staffing incidents as they are reported in point 26.8.

Acute	AAU Seaview	Chine	Harbour	Waterston	Total
Midnight - 3am	20	33	8	17	78
3am - 6am	9	13	6	17	45
6am - 9am	30	32	27	23	112
9am - 12pm	63	68	63	51	245
12pm - 3pm	50	88	57	49	244
3pm - 6pm	58	89	66	40	253
6pm - 9pm	87	130	80	49	346
9pm - Midnight	36	70	30	26	162
No Time Given	242	372	151	141	906
Total	595	895	488	413	2391

23.12 The highest volume of reported incidents occurred between 6:00pm and 9:00pm, with a total of 346 incidents recorded during this period. Notably, this timeframe typically coincides with lower staffing levels, including reduced presence from the wider multidisciplinary team.

23.13 Chine reported the most incidents, 895.

23.14 906 incidents have no time recorded against them.

OPMH	Alumhurst	Herm	Melstock House	St Brelades	Total
Midnight - 3am	16	6	6	32	60
3am - 6am	10	7	8	23	48
6am - 9am	26	25	13	55	119
9am - 12pm	47	76	24	86	233
12pm - 3pm	45	59	16	85	205
3pm - 6pm	49	61	22	64	196
6pm - 9pm	62	56	11	62	191
9pm - Midnight	19	15	14	48	96
No Time Given	56	191	46	239	532
Total	330	496	160	694	1680

23.15 The highest volume of reported incidents occurred between 9am – 12pm with 205 reports.

23.16 532 incidents have no time recorded against them.

23.17 St Brelades reported the highest number of incidents.

PICU	Haven Female	Haven Male	Total
Midnight - 3am	10	22	32
3am - 6am	19	27	46
6am - 9am	45	64	109
9am - 12pm	78	140	218
12pm - 3pm	74	107	181
3pm - 6pm	80	107	187
6pm - 9pm	90	101	191
9pm - Midnight	14	34	48
No Time Given	78	106	184
Total	488	708	1196

23.18 The highest volume of reported incidents occurred between 9am-12pm with 218 reports.

23.19 184 incidents have no time recorded against them.

Rehab	Glendinning	Nightingale House	Total
Midnight - 3am	1	3	4
3am - 6am	1	0	1
6am - 9am	10	5	15
9am - 12pm	11	17	28
12pm - 3pm	7	18	25
3pm - 6pm	11	19	30
6pm - 9pm	21	10	31
9pm - Midnight	9	11	20
No Time Given	20	32	52
Total	91	115	206

23.20 The highest volume of reported incidents occurred between 6pm - 9pm with 31 reports.

Specialist Services/Provider Collaborative	Florence House	Kimmeridge Court	Pebble Lodge	Twynham	Total
Midnight - 3am	1	4	17	5	27
3am - 6am	0	4	2	3	9
6am - 9am	5	55	24	10	94
9am - 12pm	7	46	93	23	169
12pm - 3pm	10	58	92	25	185
3pm - 6pm	7	81	91	25	204
6pm - 9pm	8	101	75	17	201
9pm - Midnight	3	25	75	11	114
No Time Given	13	165	160	90	428
Total	54	539	629	209	1431

23.21 Pebble Lodge reported the most incidents (629), followed by Kimmeridge Court (539).

24.19 428 incidents have no time recorded against them.

23.22 Overall, the 6pm–9pm timeframe recorded the highest number of incidents, with 960 entries accounting for 14% of all incidents with a known time.

23.23 The 3am–6am period had the lowest number of incidents, with 149 entries (3%), followed closely by the midnight–3am slot with 201 entries (3%).

23.24 High numbers of incidents were also recorded during the 9am–12pm (893 entries) and 3pm–6pm (870 entries) timeframes.

23.25 Of the 6,904 entries, 2,102 (30%) did not include a recorded time for the incident. This significant data gap may result in the underrepresentation of certain time periods. As such, any time-based analysis should be interpreted with caution

23.26 The locations with the highest number of incidents recorded without a time entry were:

- Chine: 372 incidents (42%)
- Herm: 191 incidents (39%)
- Kimmeridge Court: 165 incidents (31%)
- St Brelades: 239 incidents (34 %)

23.27 Florence House had the lowest percentage of incidents with no time entry; 13 out of 54 incidents (24%)

24.0 Nurse Sensitive Indicators/Red Flags:

24.1 The National Institute for Health and Care Excellence (NICE) guidance outlines key safety metrics that should be monitored. These include patient falls, pressure ulcers, and medicine administration errors.

24.2 In addition to these metrics, other indicators (as shown below) are monitored monthly. The data is presented in the integrated corporate dashboard and included in the monthly staffing reports, where it is reviewed and cross-referenced to identify trends and risks.

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Nurse Sensitive Indicators

Ward	Falls (based on date reported)			Risk assessments			Incident data (based on date reported)										Compl- aints
	All falls	Falls resulting in harm	Falls per 1000 occupied bed days	Average Venous Thromboembolism (within 24 hours)	Average Purpose T assessment (within 4hrs)	Average Falls risk assessment (within 24hrs)	Deaths	Pressure ulcers Total acquired in hospital	Pressure ulcers Category 3 and above	Medication Incidents	Abscending Incidents	Rapid tranq	Prone restraint	Patient-Patient (physical) violent incidents	Patient-Staff violent incidents (physical)	Staffing Incidents	Complaints
AAU Seaview	7	5	17.15122	96%	70%	80%	0	1	0	6	8	11	5	15	30	5	3
Alumhurst Ward	41	20	67.61981	96%	81%	94%	0	1	0	3	1	3	0	4	13	1	1
Chine Ward	5	1	15.48739	50%			0	0	0	12	1	2	0	20	23	1	3
Florence House	0	0	0	93%			0	0	0	2	1	0	0	0	0	0	1
Glendinning Unit	0	0	0	88%			0	0	0	0	10	0	0	3	0	1	0
Harbour Ward	2	2	4.116638	100%			0	0	0	6	3	1	0	2	14	60	0
Haven Ward Female	10	5	71.64316	90%			0	1	1	3	5	7	0	8	22	0	1
Haven Ward Male	10	4	46.99153	100%			0	1	0	6	2	5	2	17	38	0	2
Herm Ward	22	9	49.97927	100%	93%	90%	2	1	0	3	0	0	0	34	54	5	0
Kimmeridge Court	1	1	4.926108	85%			0	0	0	9	5	0	0	1	0	5	0
Melstock House	26	15	72.09209	100%	100%	86%	0	0	0	3	0	0	0	0	13	3	3
Nightingale House	0	0	0	33%			0	0	0	2	8	0	0	1	1	0	0
Pebble Lodge	0	0	0	79%			0	1	0	7	4	4	8	7	5	3	0
St Brelades Ward	72	38	218.6229	96%	96%	71%	3	3	0	9	1	3	0	64	107	8	0
Twynham Ward	1	0	3.067485				0	0	0	8	0	0	26	5	27	4	0
Waterston Ward	5	1	9.283892	86%	75%	88%	0	0	0	4	7	4	2	4	53	10	1

24.3 Compared to the previous reporting period, the number of incidents across several categories has increased: falls rose from 312 to 342, pressure ulcers from 16 to 22, medication incidents from 164 to 177, absconding from 132 to 161, patient-on-patient violence from 212 to 285, and patient-on-staff violence from 426 to 752.

24.4 It is important to note that a proportion of the increase in patient-on-staff violence relates to repeat incidents involving the same individual, which may have disproportionately impacted the overall figures.

24.5 The number of complaints decreased from 36 to 32 when compared to 2023/24.

24.6 St Brelades reported the highest number of patient-staff violence (168 incidents).

24.7 Incident forms do not consistently include details relating to red flags. Even when such information is submitted, the impact of suboptimal staffing levels may not be fully recognised by the person completing the form, or the concerns may not be clearly articulated. The Deputy Director of Nursing is currently progressing work to support teams in improving the quality and consistency of incident reporting.

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25.0 Risk Register

25.1 Seven risks were on the risk register, an increase of five when compared to the previous reporting period.

25.2 The Pebble Lodge risk, now closed, has been included in this review as it was active during the reporting period.

Ward	Risk Number	Date Entered	Description	Latest Update	Risk Rating Score
Pebble Lodge (Closed Risk)	1626 v5	04/03/2022	Staffing Levels Pebble Lodge	RMN fully recruited. MHSW just 1.7 WTE under staffed. OT joining in December. Psychology post unfilled	6
Waterston	1806 v5	14/09/2023	No OT Therapy input for ward	Risk reduced as Band 6 has started and Band 7 awaiting start date	8
Harbour	1816 v4	03/10//2023	Nursing staff shortages	1.12 WTE B6, 4.52 WTE B5, 4.17 WTE B3. Recruitment on going.	12
All Wards	1952 v3	07/11/2024	There is a desire to have 2 substantive registrants rostered on wards for all night shifts. Currently many wards do not have the demand template for 2 registrants, and those that do are often not able to fulfil that roster demand. There are also a significant number of wards who are reliant on block booked agency to support night registrant cover due to a number of factors including vacancies and acuity of wards during the day. This creates a risk to patients, staff and potentially the organisation.	Risk score remains unchanged. Work ongoing to review roster practice for those who have 2 staff on their demand at night but are unable to fulfil this consistently. Business cases submitted for key units who do not have 2 rostered at night to review funding of this to enable staffing to be increased.	12
Waterston	1970 v2	31/12/2024	Risk of being unable to provide safe staffing with substantive staff on the ward due to extensive vacancies leading to a high reliance on bank and agency workers including the use of block booked agency. Currently we have 7.9 B5 WTE vacancies	Risk of being unable to provide safe staffing with substantive staff on the ward due to extensive vacancies leading to a high reliance on bank and agency workers including the use of block booked agency. Currently we have 7.9 B5 WTE vacancies	16
All Wards	1983	24/01/2025	There is a risk that if we do not have robust identity checks with at least two points of photo ID confirmation in place then we may have temporary workers in the Trust who have not undertaken the required identity checks, training relevant to role and DBS checks	Review of current risk and all actions/ mitigations continue. Compliance checks are not 100% so must continue as described.	12
Kimmeridge Court	2000 v2	28/04/2025	High temporary workforce due to high vacant posts. The Inpatient Unit at Kimmeridge Court is seeing a link between staffing shortfalls, patient outcomes, patient safety, and staff experience	High temporary workforce due to high vacant posts. The Inpatient Unit at Kimmeridge Court is seeing a link between staffing shortfalls, patient outcomes, patient safety, and staff experience	12
	2001 v1	28/04/2025	Reduced Dietetic expertise on Adult Inpatient Unit and Day Service. Dietetic eating disorder knowledge and skill development for newly recruited Dietician replacing very experienced Dietician.	Dietetic eating disorder knowledge and skill development for newly recruited Dietician replacing very experienced Dietician.	8

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26.0 RECOMMENDATION: CHANGES TO THE FUNDED ESTABLISHMENT REQUIRING FINANCIAL INVESTMENT

Ward	Recommendation					
Waterston	It is a recommendation of this review that the additional Mental Health Support Worker rostered be funded for early, late, and night duty. This would help ensure safer staffing levels, address environmental needs, and meet the acuity and dependency requirements of individuals accessing the service. Although increased staffing was outlined in the annual establishment reviews since 2020, it has not been reflected in the ward budget and continues to represent a cost pressure.					
		Current WTE	Current WTE£	Proposed WTE	Proposed WTE£	Difference WTE
	B3 Substantive	15.17	£625,510	21.04	£861,177	5.87
	The figures above include the base amount plus headroom. This is 4.76 WTE (£191,245) plus 1.11 WTE (£44,422) for headroom for the additional requirements.					
Glendinning	It is a recommendation of this review that the staffing establishment be revised to include a Registered Nurse on twilight duty during weekdays. It is also recommended to increase weekend staffing from the current level of one Registered Nurse and one Mental Health Support Worker to two Registered Nurses and one Mental Health Support Worker. The review identified gaps in meeting patients' needs during evenings and weekends, primarily due to insufficient staffing levels. It also highlighted the unit's reliance on temporary staff and support from other wards (destabilising staffing levels) to maintain safe staffing and the vulnerabilities of being a lone unit, as only one Registered Nurse is currently funded.					
		Current WTE	Current WTE£	Proposed WTE	Proposed WTE£	Difference WTE
	B5 Substantive	3.81	208,623	5.61	300,774	1.80
	B5 Bank	1.17	58,619	1.58	80,440	0.41
	Total	4.98	267,242	7.19	381,214	2.21
Costings supplied by management accounts						

Members are requested to:

- Approve the recommendation to ensure the provision of consistently safe, effective and compassionate care.
- Receive the report for assurance that Dorset HealthCare is adhering to national guidance on the reporting of safer staffing.

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APPENDIX A:

Funded Establishment and Demand Templates

Mental Health Inpatients			Finance Funded Recurrent WTE (Finance Data Apr 2025) Includes substantive, agency, bank funding B2-B6 ONLY)			Staffing Numbers					
Ward	Shift	Total Beds	Funded Nursing (WTE)	Funded RN (WTE)	Funded MHSW Staff (WTE)	Demand RN (count)	Demand HCSW (count)	Total nurse per shift	Skill Mix (RN:HCSW)	RN: Patient Ratio	MHSW Patient Ratio
AAU Seaview	Early	14	39.87	13.23	26.64	3	4	7	42 : 58	1:5	1:4
	Late					3	5	8	38 : 62	1:5	1:3
	Night					2	4	6	33 : 66	1:7	1:4
Alumhurst	Early	20	11.56	21.16	32.72	2	4	6	33 : 66	1:10	1:5
	Late					2	4	6	33 : 66	1:10	1:5
	Night					2	2	4	50 : 50	1:10	1:10
Chine	Early	12	11.27	15.89	27.16	3	2	5	60 : 40	1:4	1:6
	Late					2	3	5	40 : 60	1:6	1:4
	Night					2	2	4	50 : 50	1:6	1:6
Florence House	Early	5	14.01	9.14	4.87	2	1	3	66 : 33	1:3	1:5
	Late					1	1	2	50 : 50	1:5	1:5
	Night					1	1	2	50 : 50	1:5	1:5
Glendining	Early	9	7.36	5.39	12.75	1	1	2	50 : 50	1:9	1:9
	Late					1	1	2	50 : 50	1:9	1:9
	Night					1	1	2	50 : 50	1:9	1:9
Harbour	Early	16	31.82	16.37	15.45	3	3	6	50 : 50	1:5	1:5
	Late					3	3	6	50 : 50	1:5	1:5
	Night					2	2	4	50 : 50	1:8	1:8
Haven Female	Early	5	7.50	18.05	25.55	2	3	5	40 : 60	1:3	1:3
	Late					2	3	5	40 : 60	1:3	1:2
	Night					1	2	3	33 : 66	1:5	1:3
Haven Male	Early	7	8.00	25.59	33.59	2	4	6	33 : 66	1:4	1:2
	Late					2	4	6	33 : 66	1:4	1:2
	Night					1	3	4	25 : 75	1:7	1:2
Herm	Early	23	16.05	39.83	55.88	3	8	11	27 : 73	1:8	1:3
	Late					3	8	11	27 : 73	1:8	1:3
	Night					2	5	7	29 : 71	1:12	1:5
Kimmeridge Court	Early	10	37.56	17.74	19.82	3	3	6	50 : 50	1:3	1:3
	Late					3	3	6	50 : 50	1:3	1:3
	Night					2	1	3	66 : 33	1:5	1:10
Melstock House	Early	12	11.32	15.28	26.60	2	2	4	50 : 50	1:6	1:6
	Late					2	2	4	50 : 50	1:6	1:6
	Night					1	2	3	33 : 66	1:12	1:6
Nightingale House	Early	13	9.53	14.06	23.59	2	3	5	40 : 60	1:7	1:4
	Late					2	3	5	40 : 60	1:7	1:4
	Night					1	2	3	33 : 66	1:13	1:7
Pebble Lodge	Early	10	14.69	25.71	40.40	3	4	7	43 : 57	1:3	1:3
	Late					3	4	7	43 : 57	1:3	1:3
	Night					2	4	6	33 : 66	1:5	1:3
St Brelades	Early	17	15.75	35.36	51.11	3	7	10	30 : 70	1:6	1:2
	Late					3	7	10	30 : 70	1:6	1:2
	Night					2	5	7	29 : 71	1:9	1:3
Twynham	Early	12	13.05	20.54	33.59	3	4	7	43 : 57	1:4	1:3
	Late					3	4	7	43 : 57	1:4	1:3
	Night					2	2	4	50 : 50	1:6	1:6
Waterston	Early	18	10.44	21.86	32.30	3	3	6	50 : 50	1:6	1:6
	Late					3	3	6	50 : 50	1:6	1:6
	Night					2	2	4	50 : 50	1:9	1:9

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Appendix B: Mandatory training requirements

Topic	Frequency	Time to Complete
Breakaway	3 yearly	2 hours – F2F
Conflict Resolution	3 yearly	50 minutes
Dementia Awareness Level 1 2022	One off	60 minutes
Dementia Awareness Level 2 2022	One off	60 minutes
EPMA Foundation e-learning	One off	60 minutes
EPMA Clinicians e-learning	One off	60 minutes
EPMA Nurses e-Learning	One off	60 minutes
EPMA Prescribers (if applicable)	One off	60 minutes
Equality, Diversity & Inclusion inc. Human Rights	3 yearly	45 minutes
Fire Safety Awareness (e-learning or workbook)	3 yearly	20 minutes
Fire Marshall Warden e-learning Not for all staff	Annually	40 slide presentation to read to 20 minutes
Fire Marshall Warden classroom Not for all staff	Annually	2-hour session – F2F
Health, Safety and Awareness (includes Moving & Assisting Level 1)	3 yearly	30 minutes/45 minutes
Infection Control Clinical	Annually	40 minutes
Information Governance	Annually	30 minutes
BLS 1-1 assessment	Annually	Max 30 minutes
BLS e-learning	Annually	15 minutes
Moving & Assisting Level 2/3 classroom	3 yearly	Max 3 hours – F2F
Prevent Level 3	3 yearly	55 minutes
Safer Caring Interventions of the Older Person	3 yearly	4 hours – F2F
Safeguarding Children & Adults Level 2	One off	1 hour
Safeguarding Children & Adults Level 2 Update	3 yearly	1 hour
Oliver McGowan Mandatory training	One off	1hr e-learning F2F 4hrs (tier 1) or 1 day (tier 2)
F2F = Face to Face		

Appendix C: Training commitment by staff group on a 3-year cycle

Year	Staff group	Induction	Mandatory/updates	Professional development	Totals
1	HCSW	21hrs		15hrs (care certificate)	36hrs (5 days)
	RGN	21hrs		35.5hrs (5 days) 84hrs (11 days) Clinical skills	56.5hrs (7.5 days)*
	NQ/IEN	21hrs		90hrs (preceptorship)	111hrs+ (15 days)
2	HCSW		1.5hrs (BLS, IG & IPC)		1.5hrs
	RGN			5hrs (clinical skills) + 9.5hrs (professional dev)	6.5hrs (1 day) to 16hrs (2.5 days)
3	HCSW		13.75hrs		13.75hrs (2 days)
	RGN			4hrs (professional dev)	17.75hrs+ (2.5 days)
*Completing all of the available extended clinical skills may not be relevant for all registered staff within year 1 either due to local skill mix or consolidation of their clinical practice					

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Appendix D: Competencies for Registered Nurses

Competency	Training method	Training time	Frequency of updates
Clinical skills			
Medication management	E-Hub and workplace competency assessment	2 hours online	
EPMA	E-learning	1 hour	
Venepuncture	F2F and workplace competency assessment	Pre course reading (2 hour) 2.5 hours F2F	No update required
Cannulation	F2F and workplace competency assessment	Pre course reading (2 hours) 4 hours F2F	Online update 1 hour
IV therapy PICC and Mid-line management	F2F and workplace competency assessment	Pre course reading (2 hour) 7.5 hours F2F	2 year- 1 hour
Pressure ulcer toolbox	E-hub and support from TV team		
Diabetes update	E-hub and support from Diabetes team		
Safe caring interventions of the older person	PMVA team, F2F	5 days initial training.	
Bladder scanning	Provider of the device	F2F	
Conducting an ECG	Face to face	F2F 90 minutes	
Syringe driver training	F2F and work-based competency	3 hours	2 years online update
Male and female catheterisation	F2F and competency assessment	7.5 hour (Morning Online theory then F2F practical). Workplace competency	e-learning update 2 yearly (1 hour)
Verification of death	Big Blue button/ F2F and workplace competency assessment	2 hours	As required
Near patient testing INR	Provided by device supplier		
Total		35.5hrs (5 days) – 84hrs (11 days) as indicated by clinical need	
Professional development			
Clinical Supervision	Big Blue Button	2 hours online	
Assessor	F2F	7.5hrs	4hr update annually
Total		9.5hrs	4hr
F2F = Face to Face			

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Report to	Board of Directors, DHC	
Date of Meeting	9 th December 2025	
Report Title	Community Hospital Inpatient Establishment Setting Review	
Prepared By	Cara Southgate, Director of Nursing Alex Matutino, Safer Staffing Lead Katie Powell, Data Support and Analyst	
Approved by Accountable Executive	Dawn Dawson Joint Chief Nursing Officer	
Previously Considered By	Directorate Management Group 27 th August 2025; Quality Governance Group 2 nd September 2025, Quality Committee in Common 25 th November 2025	
Action Required	Approval	Y
	Assurance	
	Information	

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? <i>Delete as required</i>	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1: Quality and Safety SR2: Culture SR3: Workforce Capacity SR4: Capacity and Demand SR6: Finance	
Financial	Management Accounts have confirmed that the recommended establishment/staffing level changes cannot be accommodated within the current budget. The indicative costs are located in the recommendation section (pending full business case if the recommendation is approved)	
Statutory & Regulatory	The report meets the national requirements for safer staffing reporting as guided by the National Quality Board (2016) and Developing Workforce Safeguards (2018).	
Equality, Diversity & Inclusion	The narrative and data in this report have been drawn from a range of partners including professional judgement discussions with ward managers, service managers, management accounts, business and performance and eRoster.,	
Co-production & Partnership	As above	

Executive Summary
Purpose This report provides assurance that Dorset HealthCare is meeting national safer staffing requirements and outlines recommendations to ensure that budgeted establishments have the right number of staff, with the right skills, deployed in the right place at the right time to deliver safe, effective, and compassionate care across community hospital inpatient wards. Methodology The annual Safer Staffing Review was undertaken in line with the National Quality Board's (2016) and Developing Workforce Safeguards (NHS England, 2018) guidance. A triangulated approach was applied, incorporating: • Safer Nursing Care Tool (SNCT) evidence-based data collections • Workforce and e-Roster data review

- Incident data
- Professional judgement from ward managers and service leads
- Benchmarking against similar wards in other trusts
- Findings and reporting in monthly reports to Quality Governance Group

The review was undertaken with governance from the Director of Nursing, Therapies and Quality

Key Findings:

Right Staff

To comply with CQC Regulation 18: Staffing, providers must ensure that they have enough qualified and competent staff to meet service users' needs at all times. While England does not set national staffing ratios, the CQC expects staffing decisions to reflect individual needs, acuity, and risk—supporting a responsive, person-centred approach rather than fixed ratios.

Acuity data and local evidence show that patients admitted to our community hospitals present with increasingly complex needs and higher levels of illness. This requires Registered Nurses to make more frequent safety-critical decisions.

National evidence consistently shows that higher numbers of Registered Nurses are linked to improved patient safety and lower mortality. Current staffing ratios in community hospitals range from approximately 1:5 to 1:8 during the day and 1:6 to 1:12 at night.

Each morning, safer staffing levels are reviewed in relation to skill mix, bed occupancy, and patients' acuity and dependency needs to ensure every ward has the right staff to deliver safe, effective, and compassionate care. Where gaps are identified, staff may be redeployed to other wards or the shortfall escalated for temporary cover.

Average fill rates for Registered Nurses and Healthcare Support Workers remained above the minimum KPI of 90% throughout the year, consistent with the previous annual establishment review. Occasional night shift fill rates for Health Care Support Workers exceeded the upper KPI of 120%, primarily due to additional staffing required for fire evacuation safety and to meet the enhanced care needs of patients receiving bariatric care.

Overall, wards remained within the 60/40 KPI threshold for substantive and temporary staffing. Care Hours Per Patient Day (CHPPD) is a workforce measure that reflects the total time nursing staff spend on direct patient care and related activities, including medication preparation, record updates, and care coordination. It includes both temporary and permanent registered and unregistered staff but excludes student nurses and staff working across multiple wards.

The planned and actual average CHPPD for the reporting period were consistent. Variations between similar-sized wards (Tarrant and Colmers) are expected due to differences in night staffing models, with previous establishment reviews recommending enhanced night cover for Tarrant Ward.

The Safer Nursing Care Tool (SNCT) is a nationally endorsed, evidence-based tool that supports ward-based clinicians in assessing patient acuity. It uses a staffing multiplier to align baseline funded establishments with patient needs. All wards except Guernsey, Jersey, Stanley Purser, and Tarrant have funded establishments that are comparable to or exceed SNCT recommendations.

This review has incorporated SNCT outcomes into the decision-making process, triangulated with professional judgement and patient and staff outcomes, and supports the recommendation to increase nursing establishments on Tarrant, Jersey, and Guernsey wards.

Right Skills

At the time of reporting, the overall average mandatory training compliance in community hospitals was 94%, slightly below the Trust's KPI of 95%.

We recognise the national and local challenges in recruitment and the importance of developing our workforce. Significant investment has been committed to professional apprenticeships, including pathways for Registered Nursing Degrees, Nursing Associates, Allied Health Professions, and Advanced Clinical Practitioners. Currently, 143 apprentices are enrolled in clinical professional registration programmes across the organisation.

Headroom is applied to all inpatient wards to cover time out for annual leave, sickness absence, temporary staffing, and training requirements. For 2024/25, headroom is set at 22%, including a 4% allowance for sickness absence. Average sickness absence exceeded this threshold in all months. Additionally, headroom is calculated using WTE figures rather than actual headcount, which can result in insufficient cover during periods of time out.

Right Place and Time

Rostering practices indicate that rotas are significantly influenced by formal and informal flexible working arrangements and staff preferences, leading to imbalances where some shifts are overstaffed and others understaffed. Annual leave approvals exceeded the recommended upper limit of 17% during key calendar periods, such as school holidays and the end of the financial year. Throughout the year, work has been undertaken to support managers in improving rostering effectiveness. This includes a comprehensive review of rosters by the eRoster team to ensure that rules are updated, and best practices are applied.

Trust guidance is available to support staff in escalating staffing shortfalls, outlined in the document Guidance on the Management of Staff Shortfalls on Wards. During the reporting period, 111 staffing incidents were recorded. However, anecdotal feedback and analysis of staffing fill rates suggest that incidents are not consistently reported across all wards. Underreporting limits the reliability of direct comparisons and may misrepresent the true extent of staffing pressures.

Summary

Funded staffing establishments are assessed as safe and appropriate overall; however, the SNCT, supported by professional judgement, consistently highlights a variance between the budgeted establishment and the staffing required to safely meet the recorded acuity and dependency of patients in Jersey, Guernsey, and Tarrant wards. Professional judgement has been critical in interpreting SNCT data within the context of patient complexity, operational realities, and clinical risk, ensuring that recommendations reflect both evidence and frontline expertise.

If these changes are not implemented, there is an increased risk of delayed care delivery, reduced patient experience, higher reliance on temporary staffing, and negative impacts on staff wellbeing, retention, and financial sustainability.

Safer Staffing Recommendations

Guernsey & Jersey Wards – Based on consistent recommendations arising from SNCT data collections, data review, and professional judgement, it is recommended that the number of Healthcare Support Workers on late duty shifts be increased by one on each ward to better meet patients' needs. Allied Health Professional support is available during the morning but ceases after late afternoon, which increases pressure on late shifts and impacts timely care delivery.

Tarrant Ward – Based on consistent recommendations arising from SNCT data collections, data review, and professional judgement, a similarly sized and standalone ward, it is recommended that the number of Registered Nurses on night duty be increased to enhance patient care and safety and ensure sufficient staffing to meet fire evacuation requirements. This was a recommendation in the previous Annual Establishment Review Reports for 2020, 2021, 2022, 2023, and 2024.

Additional recommendations for consideration

- Review the Activity Coordinator role across the community hospital inpatient service to ensure it is effective and funded equitably across all wards.
- Review the current headroom allocation and provide recommendations to ensure it adequately covers time-out requirements. This will support safe staffing levels and help reduce reliance on additional duties and temporary staffing
- Review the allocation of non-clinical time for Band 6 Clinical Team Leaders to ensure equitable and consistent funding across all wards. Currently, some wards are rostering non-clinical time without having the corresponding budget, leading to discrepancies in capacity for supervision, auditing, monitoring ward progress, and leading development programmes. A standardised approach will help ensure that non-clinical time is both appropriately funded and effectively utilised, and may support a reduction in temporary staffing

The report and recommendations have been reviewed by:

- Cara Southgate, Director of Nursing, Therapies and Quality
- Darren Wickwar, Head of Nursing, Professional Practice and Workforce
- Darren Cox, Service Manager, Community Hospitals

The ICS Directorate Management Group reviewed the report, but the recommendations were not accepted, given the potential impact of the Future Care programme on service design.

Recommendation

The Board is asked to:

- Receive the report for assurance that Dorset HealthCare is adhering to national safer staffing guidance.
- Acknowledge the recommendations to ensure the provision of consistently safe, effective and compassionate care.

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Community Hospital Inpatient Annual Establishment Review

April 2024 – April 2025



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Assurance statement from Dawn Dawson, Chief Nursing Officer

The Trust continues to monitor safer staffing levels closely and is compliant with the recommendations outlined in the National Quality Board and Developing Workforce Safeguards guidance.

Data collection cycles using the Safer Nursing Care Tool have supported the nursing establishment review process through a recognised, evidence-based approach.

I am satisfied with the assessment outcome, confirming that daytime staffing levels are safe and effective. However, Tarrant Ward has been identified as an area requiring particular attention to ensure safer staffing levels overnight.

We will continue strengthening our staffing and consider the recommendations in this report to further enhance safe and effective care.

Dawn's and medical director's signatures to be added when the final report is ratified following the Board of Directors

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1.0 Introduction

1.1 The purpose of this report is to provide the Trust Board with a comprehensive annual report on safer staffing within our community hospital inpatient wards. It aims to provide assurance that the Trust has a clear and validated process for monitoring and ensuring safer inpatient staffing, in accordance with the expectations of NHS England (NHSE), the National Quality Board (2016), the Care Quality Commission (CQC), and the Developing Workforce Safeguards (NHSE, 2018).

1.2 The National Quality Board (2016), *Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time*, provides a framework within which organisations and staff should make decisions about staffing that put patients first. These expectations are designed to support provider boards in making informed local decisions that deliver high-quality care to patients within the available staffing resources.

1.3 NHS provider boards are accountable for ensuring their organisation has the right culture, leadership, and skills in place for safe, sustainable, and productive staffing (National Quality Board, 2016). They are also responsible for ensuring proactive, robust, and consistent approaches to measurement and continuous improvement, including the use of a local quality framework for staffing that will support safe, effective, caring, responsive, and well-led care (Care Quality Commission).

1.4 This report is written in a format consistent with the requirements of the National Quality Board expectations of the right staff, with the right skills, in the right place and time to ensure safe, sustainable, and productive staffing.

1.5 The data referenced within the report is obtained through Power BI, Ulysees, HealthRoster, Finance, Learning and Development, and the Workforce Reporting Team.

1.6 Dorset HealthCare Governance

1.7 Dorset HealthCare is compliant with ensuring the principles of safer staffing (evidence-based tools, professional judgement, and outcomes), as outlined in the Developing Workforce Standards (2018), are embedded in safer staffing processes.

1.8 The Quality Governance Group receives a monthly safer staffing report that reviews clinical staffing performance in community hospital wards. Issues are escalated to the Quality Governance Committee (a subgroup of the Board).

1.9 A safer staffing forum meets monthly to discuss staffing levels and challenges. Risks and emerging areas of concern are discussed, included in the monthly Safer Staffing Report, and escalated to the Quality Governance Group. In the event that the forum identifies an area of risk or the safer staffing team raises concerns about a particular team, support meetings are facilitated to monitor emerging themes and progress.

1.10 Each weekday, the Service Manager for community hospitals facilitates an operational touchpoint meeting to discuss staffing, including forecasted staffing, assess safety, and identify bank/agency needs. Staffing concerns and escalation decisions, such as requests for temporary staffing or potential delays in admissions, are discussed. Where safe to do so, substantive staff are redeployed to support other wards. Additionally, senior staff scheduled for non-clinical duties are expected to work clinically to help reduce reliance on temporary staffing.

2.0 Methodology for Annual Establishment Review Process April 2024 – April 2025

2.1 The annual establishment review, covering the period from April 2024 to April 2025, drew on workforce, eRoster, and financial data. Insights from the Safer Nursing Care Tool (Shelford 2023), professional judgement (Saville et al. 2023), and peer benchmarking formed a key component of the methodology, ensuring a comprehensive and evidence-based approach.

2.2 All reviews were conducted under the oversight of the Director of Nursing, Therapies and Quality.

2.3 The report and recommendations have been reviewed by:

- Cara Southgate, Director of Nursing, Therapies and Quality
- Darren Wickwar, Head of Nursing, Professional Practice and Workforce

- Darren Cox, Service Manager, Community Hospitals

3.0 The ICS Directorate Management Group reviewed the report, but the recommendations were not accepted, given the potential impact of the FutureCare programme on service design.

4.0 Expectation One: Right Staff *(evidence-based workforce planning, professional judgement, compare staffing with peers)*

4.1 *Boards should ensure sufficient and sustainable staffing capacity and capability to provide safe and effective care to patients at all times across all care settings in NHS provider organisations.*

4.2 *Boards should ensure there is an annual strategic staffing review, with evidence that this is developed using a triangulated approach (i.e., the use of evidence-based tools, professional judgement, and comparison with peers), which takes account of all healthcare professional groups and is in line with financial plans. This should be followed with a comprehensive staffing report to the Board after six months to ensure workforce plans are still appropriate. There should also be a review following any service change or where quality or workforce concerns are identified.*

5.0 Registered Nurse to Patient Ratios:

5.1 To ensure compliance with Regulation 18: Staffing, the Care Quality Commission (CQC) requires providers to deploy sufficient numbers of suitably qualified, competent, skilled, and experienced staff to meet the needs of people using the service at all times. While England does not mandate national safer staffing ratios, the CQC emphasises that staffing decisions should be based on individuals' needs, acuity, and associated risks, rather than relying solely on numerical staff-to-patient ratios. This approach supports a more responsive and person-centred model of care.

5.2 There is a wealth of national research demonstrating a link between higher numbers of Registered Nurses and improved patient safety outcomes, including reduced mortality rates (Griffiths et al., Leary., 2016, 2019, 2023, Royal College of Nursing., 2023, Zaranko, 2022)

5.3 The ward establishments across community hospitals allow for Registered Nurse-to-patient ratios during the day to range from 1:5 to 1:8 and on night duty from 1:6 to 1:12 (Appendix A).

5.4 Acuity data and local anecdotal evidence indicate that patients admitted to our community hospitals now present with more complex needs and higher levels of illness than in the past. This increased complexity requires Registered Nurses to make more safety-critical decisions.

5.5 FutureCare is a system-wide transformation programme to improve urgent and emergency care (UEC) services for Dorset residents. It is anticipated that the FutureCare programme will take two years to deliver.

5.6 It started in July 2024 with a diagnostic, during which extensive engagement across the Dorset health and care system was conducted. This included speaking to people who had recently been in hospital to understand the current challenges and opportunities for improvement. It is focusing on 6 workstreams:

- Alternatives to admission
- Home-based intermediate care
- System visibility & active system leadership
- Transfers of care
- Bed based intermediate care – community hospitals
- Change capability development

5.7 The transformation aims to reduce the number of people:

- admitted into hospital when better outcomes could be achieved elsewhere
- waiting in hospital to be discharged while ongoing care is arranged

5.8 The FutureCare programme may lead to changes in how community hospitals operate, creating opportunities for teams to work in new and innovative ways. These changes may also affect existing staffing models and how teams are deployed across services.

6.0 Planned vs Unplanned Nursing Hours (Fill Rates)

6.1 Fill rates are a helpful metric in highlighting wards that are not meeting their planned levels of nursing hours. However, they do not consider the skill mix or the percentage of temporary staffing, all of which contribute to quality and safety.

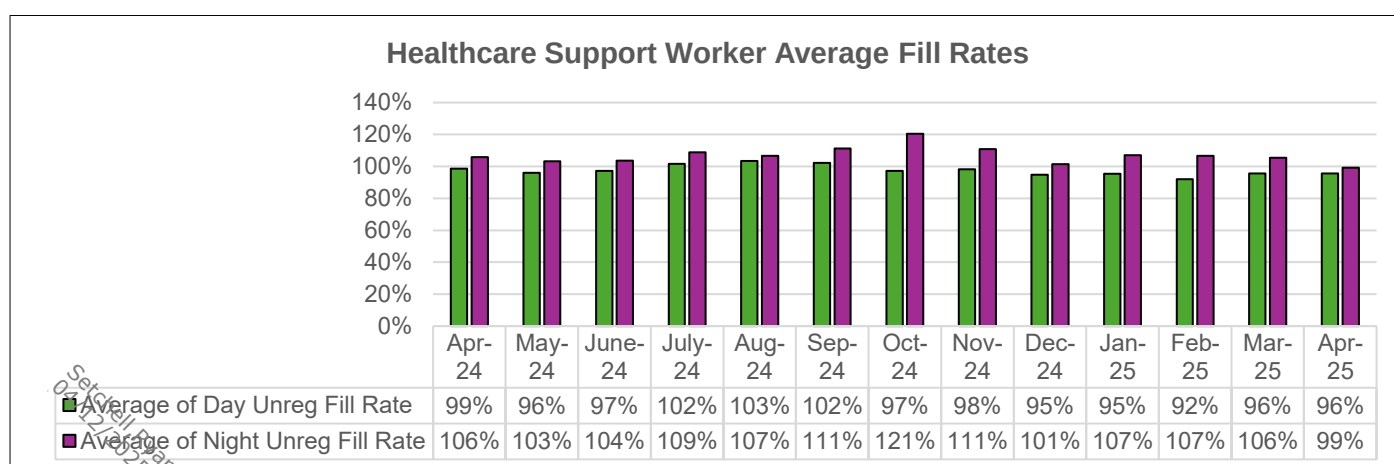
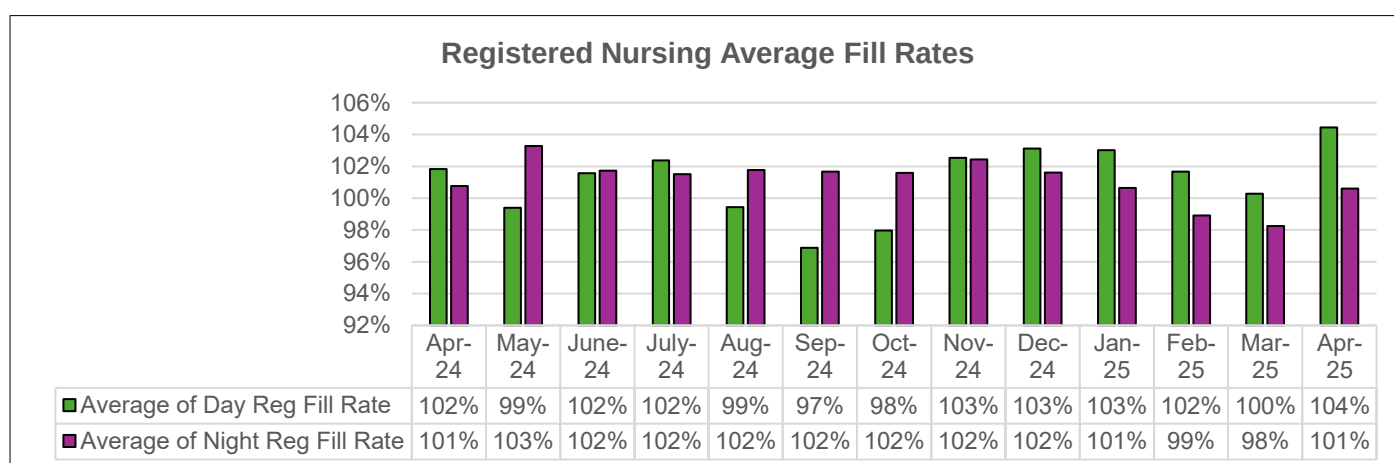
6.2 Professional judgement is applied when reviewing staffing levels, taking into consideration patient acuity, dependency, skill mix, environment and bed occupancy. As a result, planned hours may be adjusted, either reduced (e.g. during periods of low bed occupancy) or increased (e.g. to support enhanced care or patient escorts). These adjustments are reflected in the reported fill rate percentages.

6.3 It is important to note that Beech and Rowan Wards provide cross-cover arrangements; therefore, staffing is considered collectively across both wards.

6.4 Fill rates are reported monthly in the Safer Staffing Report and included in the Integrated Corporate Dashboard within the Trust Board report. When individual ward fill rates fall outside the Trust's agreed KPI of 90–120%, they are flagged as exceptions. The monthly report provides additional detail, including the ratio of substantive to temporary staff, workforce data, and nurse-sensitive indicators.

The following graphs illustrate average fill rates across community hospitals for Registered Nurses and Healthcare Support Workers.

Average Fill Rates



6.5 The data show that average fill rates for RNs and HCSWs exceeded 90% in all months. This is comparable to the previous annual establishment review.

6.6 In October 2024, average night fill rates for HCSWs exceeded 120%. This was primarily due to patients receiving bariatric care on both Guernsey and Jersey wards, which necessitated the deployment of additional HCSWs to meet fire evacuation requirements. Stanley Purser Ward required enhanced care, resulting in increased staffing levels.

6.7 Vacancies, extended periods of supernumerary status or induction (such as for Registered Nurses newly joining the NMC register), short-term and long-term sickness absences impacted fill rates. As a result of targeted efforts focused on enhanced care, the use of temporary staffing for this purpose has decreased.

7.0 Temporary Staffing

7.1 Temporary staffing is used to maintain safer staffing levels when all internal solutions have been explored. The Trust operates a successful bank, and wherever possible, staffing shortfalls are filled with bank workers. Where this is not possible, unfilled duties may be escalated to on-framework agencies initially.

7.2 If on-framework agencies are unable to fill the duty, clinical areas may request to use the 'break glass' process to ensure patient safety is maintained. Agency usage is reported weekly to the Executive Team and NHS England.

7.3 Temporary staffing is noted to be more challenging to source in the West and North of the county. Ward Managers in these areas report a reliance on the substantive workforce to work additional duties.

7.4 Where the ratio of substantive to temporary staffing falls below 60%:40%, this triggers an exception in the monthly staffing report and may prompt a staffing review.

7.5 While some wards may use headroom funding to recruit staff substantively, this does not always eliminate the need for temporary staffing due to ongoing requirements such as annual leave, sickness absence, and training commitments.

7.6 The table below illustrates the proportion of substantive hours worked compared to temporary hours. It is important to note that substantive staff who also hold a bank agreement are recorded under temporary hours when working additional shifts via the Trust Bank. Therefore, the data alone may not provide a complete picture when assessing quality and safer staffing.

Substantive Staff Percentage:

% Of Hours Worked (Substantive)	Apr-24	May-24	June-24	July-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
Beech	80%	84%	86%	83%	75%	76%	84%	80%	83%	74%	76%	81%	80%
Colmers	91%	90%	86%	54%	91%	87%	90%	89%	91%	86%	80%	82%	88%
Guernsey	78%	77%	79%	73%	70%	62%	64%	62%	67%	68%	69%	67%	72%
Hanham	84%	85%	88%	83%	86%	88%	94%	86%	92%	93%	83%	75%	83%
Jersey	73%	73%	71%	124%	54%	54%	56%	62%	74%	79%	81%	72%	74%
Radipole	74%	79%	78%	76%	72%	73%	74%	72%	71%	74%	75%	73%	80%
Rowan	73%	80%	80%	60%	72%	76%	75%	74%	79%	80%	78%	79%	82%
Shaston	80%	76%	80%	60%	80%	87%	86%	91%	84%	77%	73%	69%	76%
Stanley Purser	81%	82%	87%	89%	88%	91%	76%	90%	82%	91%	91%	77%	83%
Tarrant	69%	55%	59%	60%	63%	73%	71%	75%	69%	69%	65%	63%	75%

Temporary Staff Percentage:

% Of Hours Worked (Temporary)	Apr-24	May-24	June-24	July-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
Beech	20%	16%	14%	17%	25%	24%	16%	20%	17%	26%	24%	19%	20%
Colmers	9%	10%	14%	46%	9%	13%	10%	11%	9%	14%	20%	18%	12%
Guernsey	22%	23%	21%	27%	30%	38%	36%	38%	33%	32%	31%	33%	28%
Hanham	16%	15%	12%	17%	14%	12%	6%	14%	8%	7%	17%	25%	17%
Jersey	27%	27%	29%	76%	46%	46%	44%	38%	26%	21%	19%	28%	26%
Radipole	26%	21%	22%	24%	28%	27%	26%	28%	29%	26%	25%	27%	20%
Rowan	27%	20%	20%	40%	28%	24%	25%	26%	21%	20%	22%	21%	18%
Shaston	20%	24%	20%	40%	20%	13%	14%	9%	16%	23%	27%	31%	24%

Stanley Purser	19%	18%	13%	11%	12%	9%	24%	10%	18%	9%	9%	23%	17%
Tarrant	31%	45%	41%	40%	37%	27%	29%	25%	31%	31%	35%	37%	25%
Outside of 60/40% KPI threshold													

7.7 Most wards maintained remaining within the 60/40 KPI threshold. However, Colmers, Jersey, and Tarrant wards recorded substantive staffing levels below 60% during the months highlighted in red.

7.8 In July, Colmers reported 1.79 WTE HCSW vacancies, alongside 4% sickness absence and 16% annual leave.

7.9 Jersey reported sickness absence consistently above the 5% threshold between August and October, ranging from 6% to 10%. Also, during this period, HCSW vacancies remained consistent at 6.76 WTE.

7.10 In May, sickness absence at Tarrant reached 9%, and in June 8%, both exceeding the 5% KPI threshold. Additionally, there were HCSW vacancies of 7.49 WTE in May and 5.80 WTE in June.

7.11 The average substantive staffing rate was 77%, comparable to 2023/24’s figures.

7.12 It is of note that when demand templates are increased to provide additional staffing to meet enhanced care needs, temporary staffing may be used. In this scenario, an increased proportion of temporary staff would be expected to appear in the data.

7.13 Vacancies have contributed to increased use of temporary staffing. Notably, Radipole, Colmers, Beech, Rowan, and Tarrant wards have faced ongoing challenges due to registered and unregistered staff vacancies throughout the year. Additionally, Rowan Ward has been further impacted by staff maternity leave.

7.14 As a Trust, we have continued our work with the Southwest Collaborative, which has enabled us to maintain the use of capped-rate agencies and avoid engaging any off-framework providers since July 2024. This approach has contributed to a reduction in overall agency expenditure.

7.15 A number of agency workers have been successfully converted to bank workers.

7.16 There has been a reduction in the use of non-registered agency workers, with the intention of ceasing their use entirely by the end of the 2025/26 financial year.

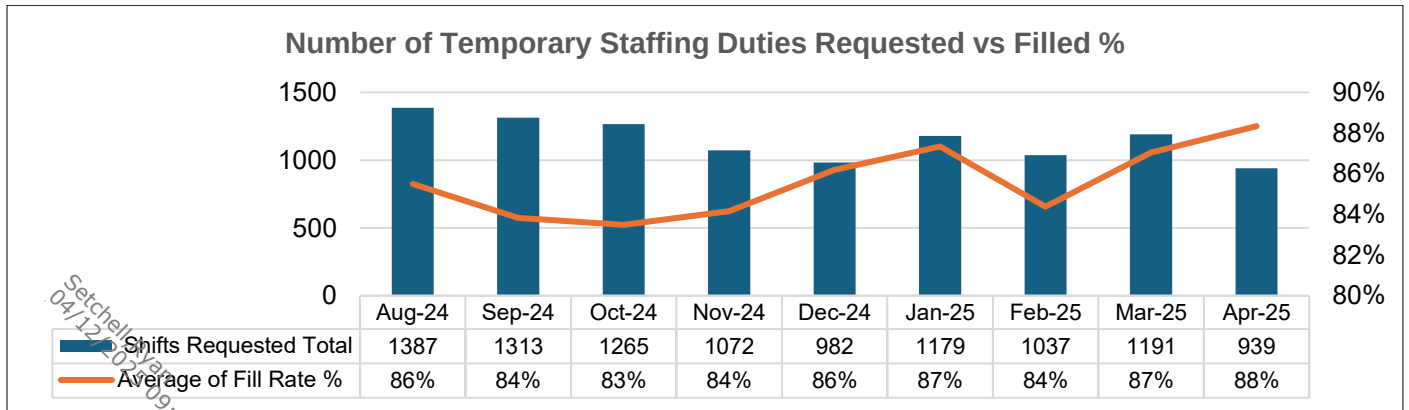
7.17 No negative impact on patient safety has been reported.

7.18 There has also been a reduction in the use of non-registered agency workers with a view to ceasing their use completely by the end of the 25/26 financial year.

7.19 There has been no reported negative impact on patient safety.

7.20 The graph below illustrates the temporary staffing duties requested compared to the number filled:

Number of Temporary Staffing Duties Requested vs Filled %



7.21 Due to changes in the reporting of temporary staffing data, information from April to July 2024 is unavailable and cannot be compared with data from other periods.

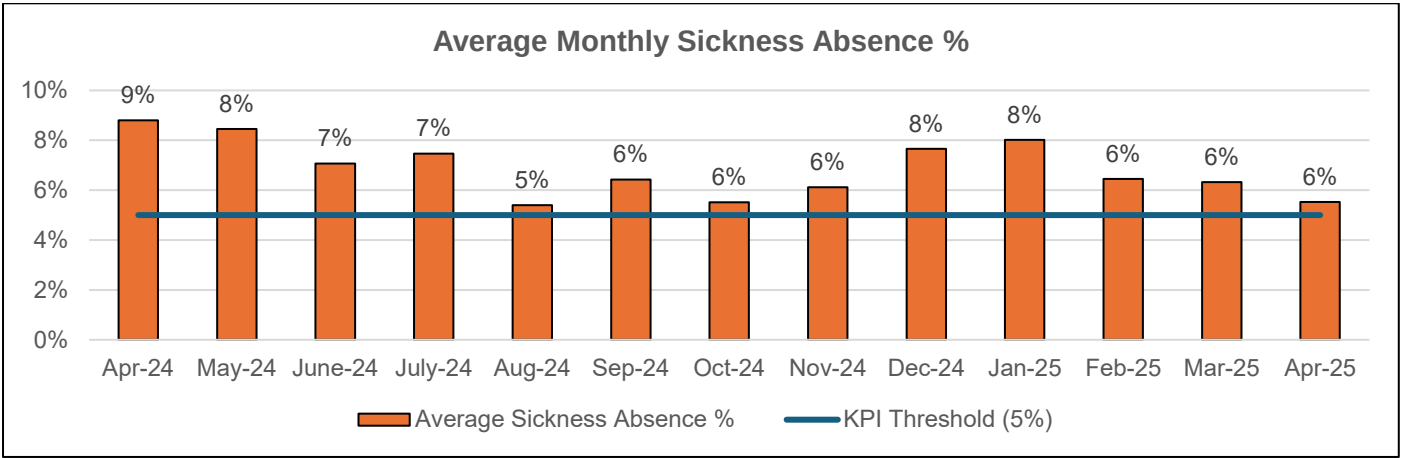
7.22 The data across both 2023/24 and 2024/25's annual establishment review are comparable.

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8.0 Sickness Absence

8.1 The graph below shows the average monthly sickness absence percentages across community hospitals; this includes all staff associated with the ward cost code, both clinical and non-clinical.

Average Sickness Absence %



8.2 Figures are rounded to the nearest whole number, which may result in slight differences in bar heights on the graph

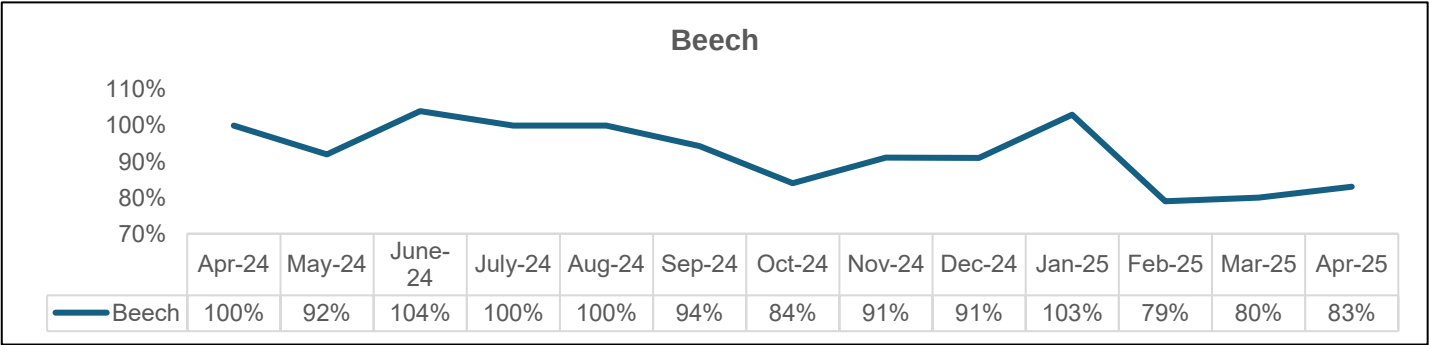
8.3 The average sickness absence for the reporting period is 5%, which aligns with both the Trust's KPI threshold and the 2023/24 data. However, the headroom allocation includes a 4% allowance for sickness absence. This discrepancy could contribute to staffing pressures and the need for additional duties to maintain safe staffing levels. The organisation continues to work on reducing sickness absence.

9.0 Bed Occupancy:

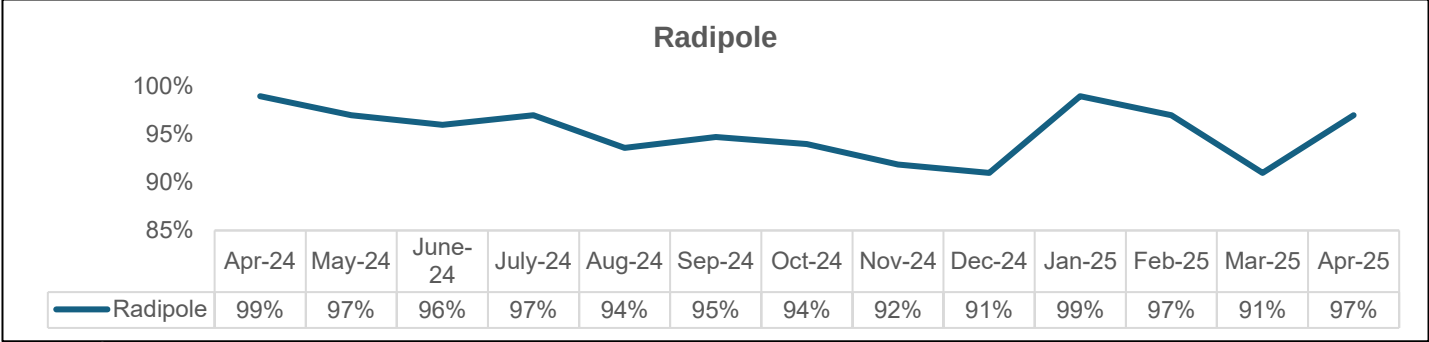
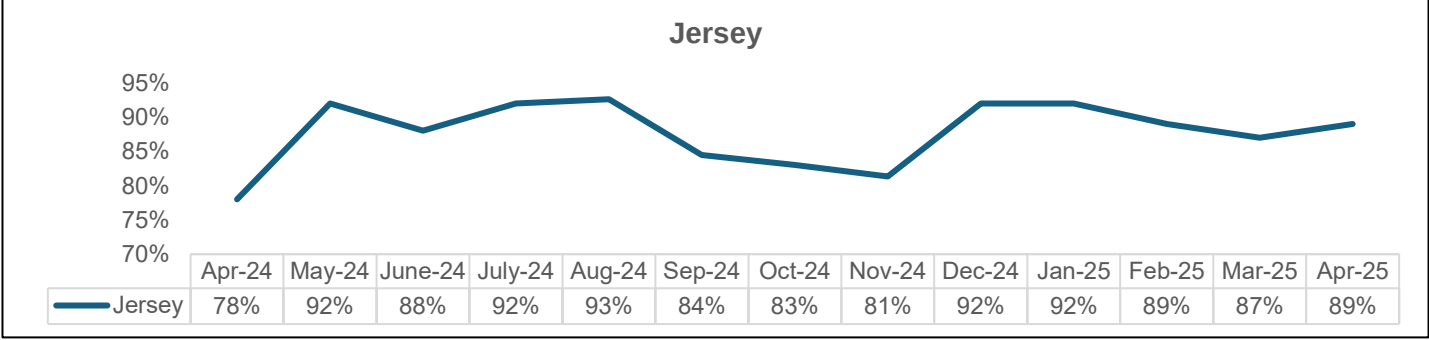
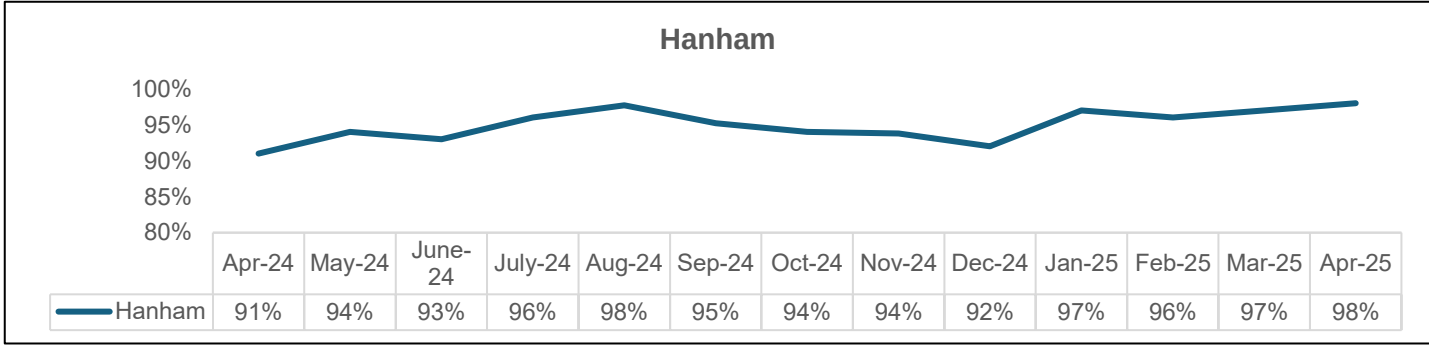
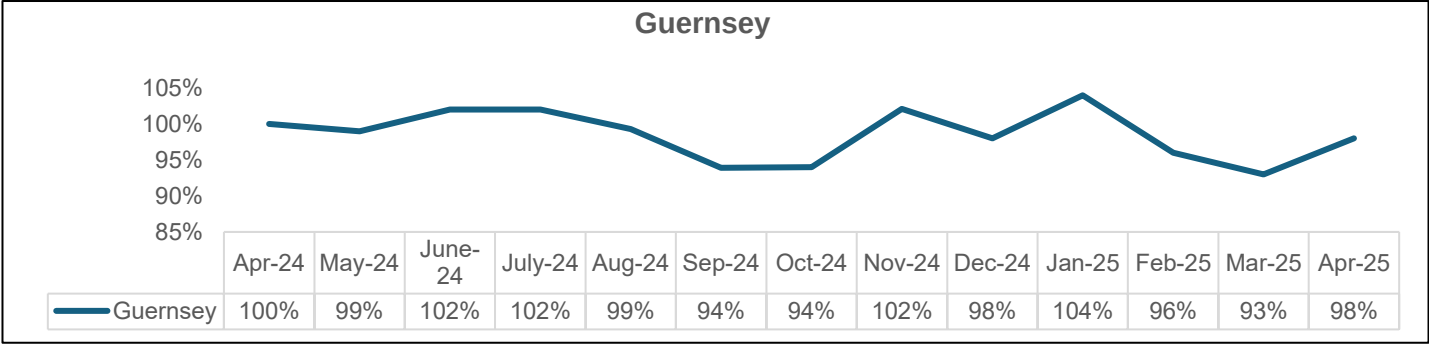
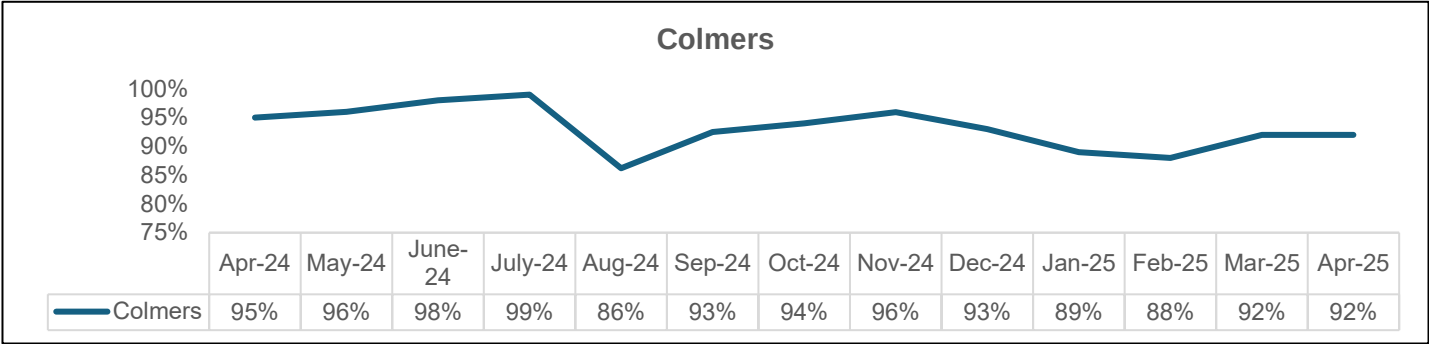
9.1 Professional judgement is applied to assess acuity, dependency, and bed occupancy in relation to the demand template. If bed occupancy is deemed lower than required for full staffing, adjustments may be made to staffing levels and skill mix accordingly.

9.2 Individual ward and average bed occupancy are reported monthly in the staffing report and to the Trust Board through the Integrated Corporate Dashboard.

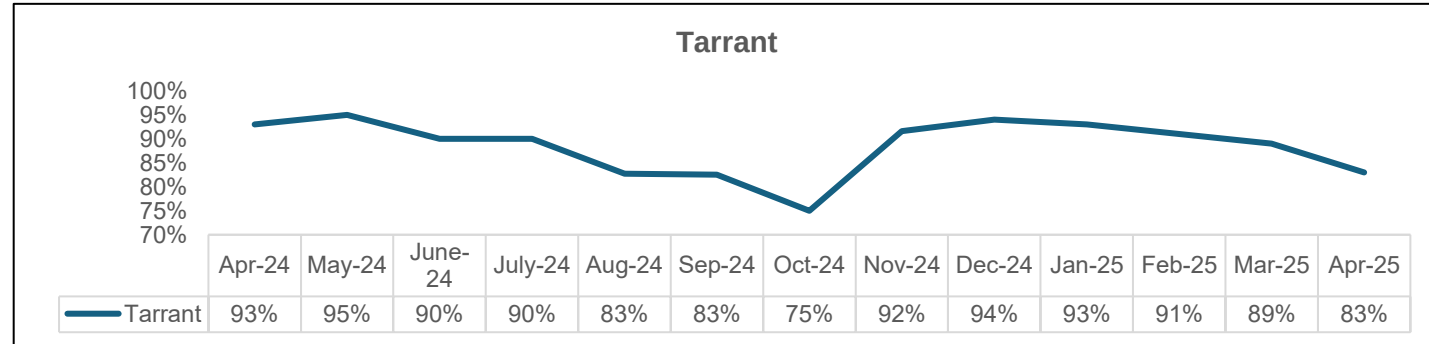
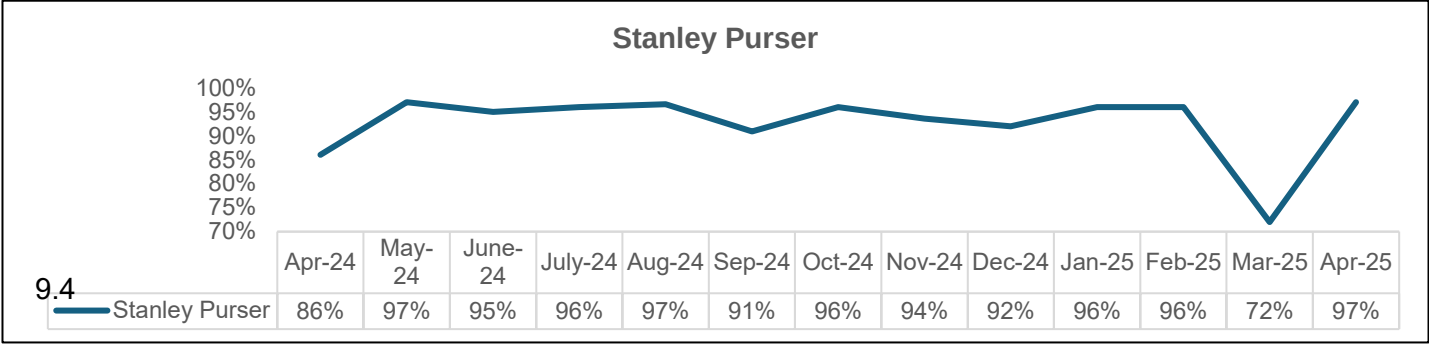
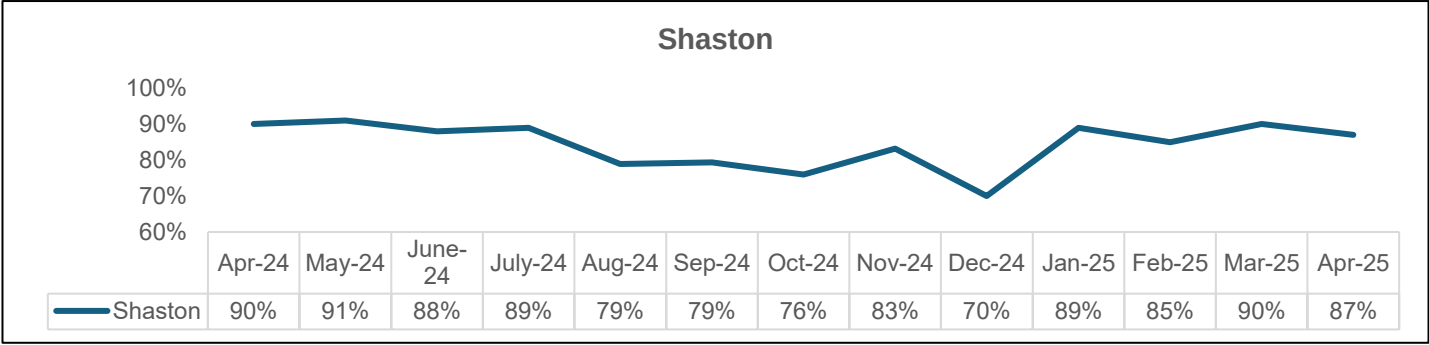
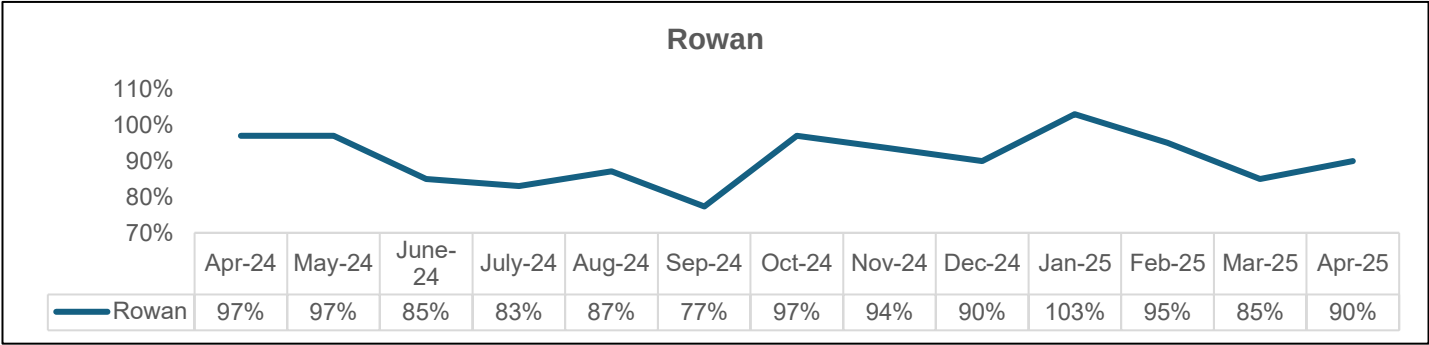
9.3 The following graphs illustrate the bed occupancy figures across community hospital wards for the reporting period. Bed occupancy exceeding 100% is due to incorrect data entry into SystemOne, such as overlapping admissions, unrecorded discharges or miscounted beds.



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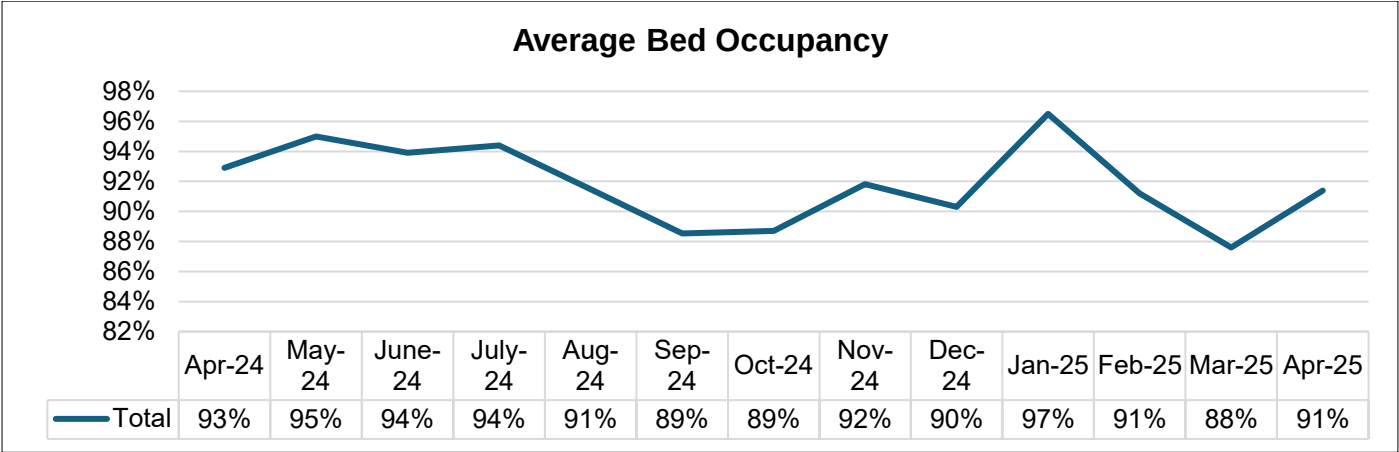
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9.5 The following graph illustrates the average bed occupancy figure:

Average Bed Occupancy:



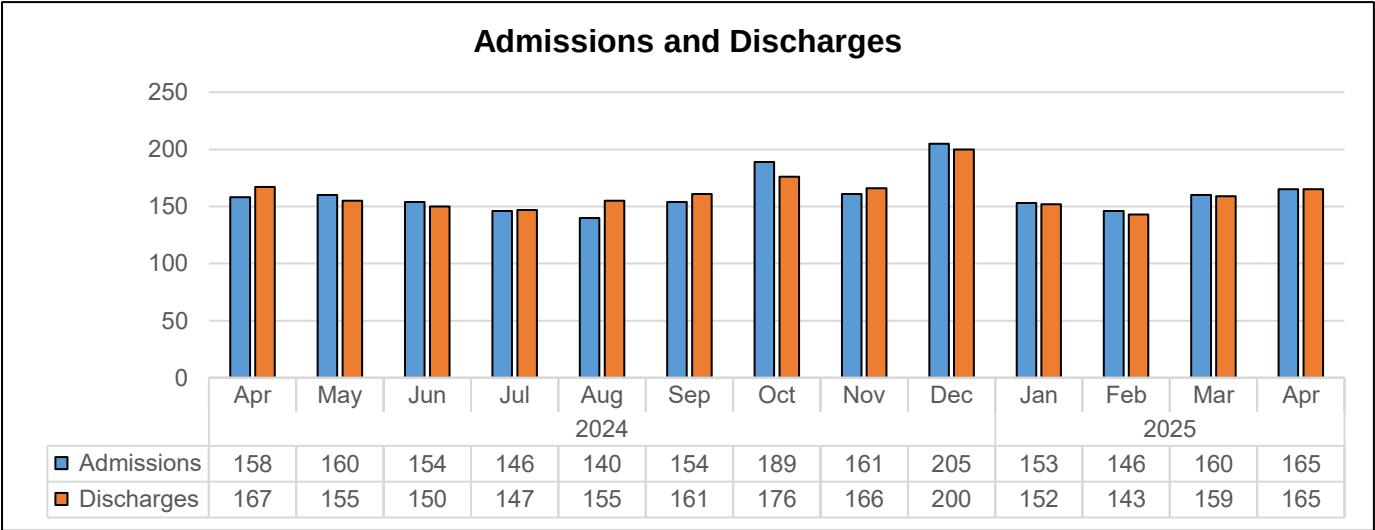
9.6 The average bed occupancy for the reporting period is 87%, which is a 3% decrease from 2023/24.

9.7 Evidence shows that hospitals work most safely and effectively at bed occupancy levels no higher than 85% (Royal College of Physicians). Local data shows that the average bed occupancy has consistently exceeded this due to pressures on the healthcare system requiring patients to be transferred from acute care to community hospitals sooner than they may have been historically, and the pressures faced by social care in supporting patients' safe and timely discharge.

10.0 Admissions, Discharges and Length of Stay

10.1 The following graph illustrates the total of admissions and discharge figures.

10.2 The data was not reported on in 2023/24's annual staffing reviews, so no comparison is available.



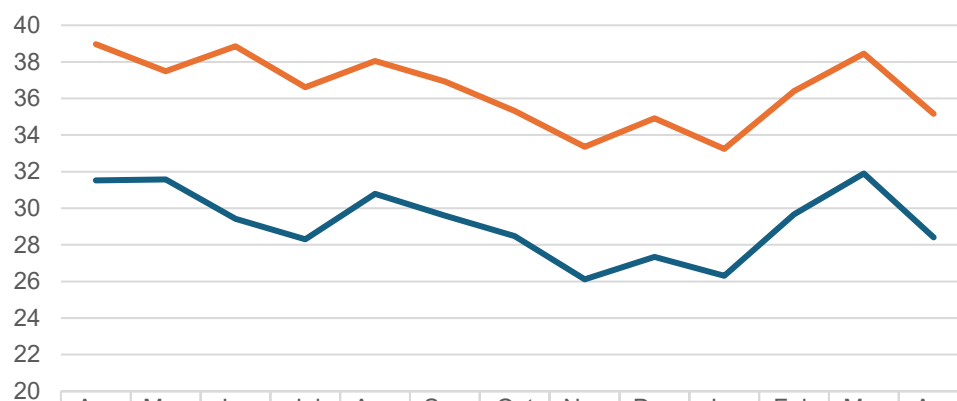
10.3 Admissions ranged from 140 in August 2024 to a peak of 205 in December 2024.

10.4 Discharges peaked at 200 in December 2024. The lowest reported discharges were 143 in February 2025.

10.5 The following graph illustrates the average length of stay figure across community hospitals, including and excluding delays to discharge.

Average Length of Stay

(Including and Excluding Delays to Discharge)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
	2024												
— Average Length of Total Stay (Excluding Delays to Discharge)	32	32	29	28	31	30	28	26	27	26	30	32	28
— Average Length of Total Stay (Including Delays to Discharge)	39	37	39	37	38	37	35	33	35	33	36	38	35

10.6 Excluding delays to discharge, the lowest average length of stay was 26 days in November 2024 and January 2025. The highest was 32 days, occurring in April, May, and March.

10.7 Including delays to discharge, the highest average length of stay was 39 days in April and June 2024, while the lowest was 33 days in November 2024 and January 2025.

10.8 The difference between the two data sets ranged from 5 to 10 days, with the largest gap in June 2024 (10 days).

11.0 Patient Incidents

11.1 The following table illustrates the total number of incidents reported and the timings of the incidents logged.

11.2 The data was not reported on in 2023/24's annual staffing reviews, so no comparison is available.

11.3 The figures exclude staffing incidents as they are reported in section 20.

	Beech	Colmers	Guernsey	Hanham	Jersey	Radipole	Rowan	Shaston	Stanley	Purser	Tarrant	Grand Total
Midnight - 3am	9	24	1	9	2	9	8	3	6		6	77
3am - 6am	15	20	4	9	7	13	3	1	3		4	79
6am - 9am	10	23	15	7	7	21	10	10	18		12	133
9am - 12pm	6	28	20	31	29	24	19	21	20		24	222
12pm - 3pm	5	27	16	13	14	30	19	12	17		17	170
3pm - 6pm	7	26	18	23	21	25	17	13	13		16	179
6pm - 9pm	15	11	7	28	11	28	26	11	17		12	166
9pm - Midnight	15	20	7	9	5	20	16	9	13		9	123
No Time Given	22	94	118	65	92	180	48	124	53		156	952
Grand Total	104	273	206	194	188	350	166	204	160		256	2101

11.4 The 9 a.m.–12 p.m. timeframe recorded the highest number of incidents, with 222 entries accounting for 10.57% of all reported events. This period also typically coincides with the highest number of staff on duty, including both nursing and the wider multidisciplinary team.

11.5 The midnight–3am period had the lowest number of incidents, with 77 entries (3.66% of the total). This timeframe typically coincides with the lowest staffing levels, including both nursing and MDT presence.

11.6 The 3pm–6pm and 6pm–9pm timeframes also showed elevated incident activity, indicating a potential pattern during late afternoon and early evening shifts.

11.7 Of the 2,101 entries, 952 (45.3%) did not include a recorded time for the incident. This significant data gap may lead to the underrepresentation of certain time periods. Therefore, any time-based analysis should be interpreted with caution.

11.8 Tarrant, Shaston, and Guernsey have the highest proportions of incidents recorded with no time entry, all above 57%.

11.9 Beech has the lowest percentage of incidents recorded with no time entry at just over 21%.

12.0 Care Hours Per Patient Day (CHPPD)

12.1 Care Hours Per Patient Day (CHPPD) is a workforce measure used in inpatient care.

12.2 It includes total nursing staff time spent on direct patient care and associated activities such as preparing medicines, updating patient records, and sharing care information with other services. It covers both temporary and permanent registered and unregistered staff but excludes student nurses and staff working across more than one ward.

12.3 CHPPD alone does not capture the full extent of care delivered on a ward, nor does it directly indicate whether care is safe, effective, or responsive. Therefore, as recommended by NHS England, it should be interpreted in conjunction with other measures of quality and safety.

12.4 It is calculated by adding the actual hours of Registered Nurses and the actual hours of Health Care Support Workers (HCSW) and dividing by the total number of patients at midnight. It is reported as a total figure and split by Registered Nurses and HCSWs to provide a complete picture of care and skills mix (NHS England 2021).

12.5 CHPPD is monitored and reported in the monthly Safer Staffing Report. Any unexpected or unwarranted variance between planned and actual CHPPD is explored further.

12.6 All trusts with inpatient wards are required to submit monthly CHPPD data to NHS England to support national benchmarking. This data is published on the Model Health System platform and is accessible to the public via a dedicated website. A link to this site is available on the Safer Staffing page of the Trust's website.

12.7 If a senior staff member undertakes a clinical shift but eRoster is not updated to reflect this at the time, those hours will not be captured in the actual nursing hours data. As a result, these hours are excluded from the CHPPD calculation. This means that, in some cases, the actual CHPPD may be higher than reported.

12.8 The planned and actual average CHPPD for the reporting period was 6.6. For the same period in 2023/24, the planned average CHPPD was 7.6, while the actual was 6.8.

12.9 Although Colmers and Tarrant are the same size wards, differences in CHPPD are to be expected as Colmers has an additional non-registered staff member on night duty. In the 2021, 2022, 2023 and 2024 annual establishment reviews, Tarrant's demand template was recommended to enhance staffing on night duty.

13.0 Benchmarking with Peers

13.1 Identifying directly comparable wards for benchmarking can be challenging, as factors such as ward layout, referral criteria, and geographical location vary significantly. These differences can limit the accuracy of direct comparison.

13.2 While it is recognised that care is delivered by the entire multidisciplinary team, this benchmarking exercise focuses specifically on comparing the core nursing safer staffing levels as defined in the demand templates.

13.3 The following tables show a benchmarking overview of RN and HCSW staffing levels across various service types and shift patterns.

Trust	Service Type	Bed Numbers	Early			Late			Twilight	Night			RN Ratio
			RN	HCSW	Total	RN	HCSW	Total	HCSW	RN	HCSW	Total	
Dorset	Rehab	15	2	3	5	2	2	4	0	2	2	4	46%
		21	3	4	7	3	3	6	0	2	2	4	47%
		23	3	4	7	3	3	6	0	2	2	4	47%
		24	3	4	7	3	3	6	0	2	2	4	47%
		25	3	4	7	3	3	6	0	2	2	4	47%
Trust 1		15	2	3	5	2	2	4	1	2	2	4	46%
Trust 2		14	2	2	4	2	2	4	0	2	2	4	50%
		20	3	4	7	3	2	5	1	2	2	4	47%
		21	3	4	7	3	2	5	1	2	2	4	47%
Trust 3		18	2	3	5	2	3	5	0	2	2	4	43%

- 13.4 Returns for comparable wards to Radipole, Tarrant, Jersey and Guernsey were not received.
- 13.5 Hanham is comparable to early and night duty but has one more HCSW on late duty than Trust 2.
- 13.6 Shaston, Beech and Stanley Purser are comparable to wards of a similar size.
- 13.7 Dorset averages 46.8% RN ratio, slightly below Trust 2 (48%) but above Trust 3 (43%).
- 13.8 Dorset does not staff Twilight HCSWs, Trusts 1 and 2 do.

Trust	Service Type	Bed Numbers	Early			Late			Twilight	Night			RN Ratio
			RN	HCSW	Total	RN	HCSW	Total	HCSW	RN	HCSW	Total	
Dorset	Stroke	15	3	3	6	3	3	5	0	2	2	4	53%
Trust 1		15	2	3	5	2	3	5	1	2	2	4	43%
Trust 2		28	4	5	9	4	5	9	0	3	2	5	48%
Trust 3		28	3	6	9	3	6	9	0	2	4	6	33%

- 13.9 Although Trusts 2 and 3 have a larger bed capacity, they have been included in this comparison to provide a broader context around staffing models on stroke wards.
- 13.10 Dorset HealthCare and Trust 1 share an almost identical staffing structure across all shifts for a stroke ward with 15 beds. The only notable difference is that Trust 1 rosters a HCSW on a twilight shift and one less RN on an early shift. Dorset's RN ratio is higher.
- 13.11 No comparative data were received from wards that explicitly indicated they provide bariatric care.

14.0 Evidence-based Tool: Safer Nursing Care Tool (SNCT)

14.1 SNCT is a nationally endorsed, multidisciplinary, evidence-based tool that enables ward-based clinicians to assess patient acuity. It incorporates a staffing multiplier to help ensure that baseline funded ward establishments align with patient needs. However, it is acknowledged that SNCT does not account for factors such as ward environment, geographical location, or workforce competency, all of which may influence staffing requirements.

14.2 Although originally developed for acute care settings, the tool is considered valid in other hospital environments when applied appropriately. A non-acute version was explored; however, NHS England's Faculty for Safe Staffing confirmed that it did not progress beyond beta testing and will not be further developed.

14.3 SNCT assessments are conducted three times a year—in Winter, Spring and Autumn—to help mitigate seasonal bias. If a data collection period coincides with a month that does not reflect typical ward activity (e.g., significantly higher or lower acuity or bed occupancy), it is recommended that the cycle be extended or repeated to ensure data accuracy.

14.4 It is acknowledged that SNCT recommended staffing levels should not be used in isolation to determine staffing establishments. Professional judgement and data triangulation are essential in informing decisions and outcomes. Once each data collection cycle is verified, the results are shared with the Ward Manager to incorporate their professional insights into the review process.

14.5 Caution is advised when interpreting SNCT recommendations for wards with fifteen beds or fewer, and for night duty, as the tool may not suggest sufficient staffing to ensure safe care. In these cases, professional judgement should be applied to ensure that safer staffing levels provide the appropriate number and skill mix of staff to deliver safe and effective care.

14.6 Significant and persistent discrepancies between SNCT-recommended baseline establishments and Dorset HealthCare's funded establishments, where such differences cannot be justified by professional judgement or patient and staff outcomes, are escalated to the Director of Nursing and the Service Director for review.

SNCT Outcomes January 2025 and April 2025

Ward	Beds	SNCT Recommendation		SNCT Average (Two Cycle)	Funded Establishment (Two Cycle)	WTE Variance +/-
		January 2025	April 2025			
Beech	12	16.18	13.06	14.62	20.34	-5.72
Colmers	24	31.31	28.30	29.81	31.99	-2.18
Guernsey	23	36.67	36.68	36.68	29.79	+6.89
Hanham	21	29.35	31.49	30.42	29.94	+0.48
Jersey	25	41.81	37.83	39.82	29.79	+10.03
Radipole	33	40.98	40.38	40.68	45.32	-4.64
Rowan	15	27.12	25.43	26.28	31.22	-4.94
Shaston	15	15.87	13.80	14.84	22.08	-7.24
Stanley Purser	15	25.95	23.79	24.87	20.64	+4.23
Tarrant	24	38.11	38.95	38.53	30.42	+8.11

14.7 The results above exclude acuity and dependency levels 1c and 1d, which relate to enhanced care. Enhanced care provision is assessed based on individual needs and is not included in the baseline staffing establishment. No temporary staffing has been used for enhanced care since February 2025.

14.8 In summary, all wards except Guernsey, Jersey, Stanley Purser and Tarrant, have funded establishments comparable to or above SNCT recommendations. Beech, Colmers, Radipole, Rowan and Shaston show an increased establishment compared to the SNCT recommendations. However, a reduction in the agreed demand template would not provide the number of staff required to provide safe and effective care.

14.9 This review has incorporated Safe Nursing Care Tool (SNCT) outcomes as part of the decision-making process to support the recommendation to increase nursing establishments on Tarrant, Jersey, and Guernsey wards.

14.10 Stanley Purser ward will undergo quality assurance during the next data collection cycle in October 2025 to ensure consistent application of the SNCT. If variance persists, it will be addressed in the biannual review.

15.0 Professional Judgement:

15.1 Professional judgement was applied using an adapted version of the Professional Judgement Framework (Saville et al., 2023). Due to their size, the templates are not embedded in this report.

15.2 The narrative in italics is directly taken from the Ward Manager's template in answer to the following questions:

- *Does the daily staffing template enable the team to provide safe, compassionate and consistent care? Are there any gaps*
- *Do you have a recommendation that is different to the agreed staffing levels? If your recommendation is for higher staffing levels, please provide your rationale*

15.3 **Beech:** *Yes, but the early is vulnerable. Staff always provide compassionate care, but the template does not lend itself to that. Staff are constantly battling with themselves trying to maintain their high standards, staff at risk of incurring a morale injury.*

15.4 *As highlighted as a team, it is felt that the early is vulnerable due to dependency of patients so having an extra pair of hands for a limited time (not the whole shift) is beneficial. We have been fortunate that we have had SNA on shift but as they move onto their new roles we will not have that buffer.*

15.5 *It is about having that overlap of staff to provide the holistic care, complete relevant assessments and documentation in a timely manner without incurring low morale due to them not meeting their high standards.*

15.6 *Having more support services such as ward clerks, housekeepers, at the weekend is beneficial and alleviate the pressures on the staff. Which some wards have, needs to be equitable for all our services.*

15.7 **Colmers:** Although no template was provided, the Matron confirmed there were no concerns and did not suggest any changes.

15.8 **Hanham:** The Ward Manager reported no concerns regarding the demand template, stating that it provides safe staffing levels and that no gaps have been identified.

15.9 **Guernsey:** The daily staffing template generally enables the team to provide safe, compassionate, and consistent care—when all shifts are fully staffed. However, gaps occur when there is unplanned staff sickness or when shifts are not covered, which can compromise the team's ability to maintain safe staffing levels.

15.10 *As the Ward Manager, I actively support the team during these times by stepping in to assist with clinical duties, particularly during morning shifts, to help ensure that safe and compassionate care is maintained despite the shortfall.*

15.11 *To enhance patient experience—aligned with Trust priorities—I recommend adding an Activity Co-ordinator to the ward. This role would provide therapeutic stimulation and structured activities, promoting mobility, cognitive engagement, and emotional well-being. These interventions are proven to support recovery and may help reduce length of stay, particularly for patients with dementia or long-term conditions.*

15.12 *I recommend increasing HCA staffing on the late shift by one additional post. This shift is particularly busy due to increased care demands, admissions often occurring in the afternoon, and reduced staffing as the day progresses. Currently, three HCAs manage the entire ward—two are typically occupied serving supper, leaving only one to respond to call bells and attend to other care needs. This creates strain on the team and impacts response times and patient experience.*

15.13 *These changes would support safer, more responsive care and reduce pressure on existing staff during peak demand periods.*

15.14 **Jersey:** High volume of call bell demand post lunch. Reduction in mobilisation and rehabilitation by nursing staff, increased reliance on faster transfers. Increased incidents of incontinence due to increased wait times for bell response. Reduction in available staff to provide lower priority care and reassurance.

15.15 *Correlation between SNCT recommended staffing levels and actual funded levels. Higher staff levels (non-registered) or reduction in beds, to meet the increasing dependence levels of patients*

15.16 **Radipole:** I find that our staffing template enables us to deliver safe, compassionate and consistent care.

15.17 No suggestions for change were reported.

15.18 **Rowan:** Staff always provide compassionate care, but the template does not lend itself to that. Staff are constantly battling with themselves trying to maintain their high standards, staff at risk of incurring a morale injury.

15.19 *It is not about having a higher ratio of staff that is required it is about having that overlap of staff to provide the holistic care, complete relevant assessments and documentation in a timely manner without incurring low morale due to them not meeting their high standards.*

15.20 *Having more support services such as ward clerks, housekeepers, at the weekend is beneficial and alleviate the pressures on the staff. Which some wards have, needs to be equitable for all our services.*

15.21 **Shaston:** *The daily staffing template is a good support tool where we can look to see if any other area can support with cover on the wards if a staff member is off sick or you have a vacant shift on the ward.*

15.22 No gaps or recommendations reported.

15.23 **Stanley Purser:** *Yes, most of the time depending on acuity of patients. I believe that due to the location of the hospital and the difficulty staffing the ward, there would be more resilience if we had a Band 4 instead of an HCA at night.*

15.24 **Tarrant:** *It is a challenge to provide the care that we strive for. Patient acuity and frailty has increased – as explained with pressure ulcers increasing.*

15.25 *The night shift requires an additional member of staff. I also believe that the E shift would benefit from an extra HCA.*

15.26 A follow-up discussion with the Matron and Service Manager indicated that historical practices are currently being addressed. They believe these changes will positively impact some of the concerns raised by the Ward Manager. The Service Manager is actively monitoring progress to ensure that the identified improvements are being implemented effectively.

16.0 Staff Experience and Satisfaction

Staff are encouraged to provide feedback on their experience working in the Trust through various means, including line manager supervision, Freedom to Speak Up Guardians, Staff Side Representatives, reporting through the Ulysses incident reporting system, and Professional Nurse Advocates (PNA), in addition to completing the national staff survey.

Staff Survey Results 2024

Staff Survey 2024	Responses	%	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale	All Themes
Hanham	20	45%	68%	44%	58%	58%	45%	46%	54%	45%	40%	56%
Jersey & Guernsey	18	32%	62%	47%	64%	55%	54%	49%	56%	58%	44%	56%
Radipole	14	29%	73%	45%	61%	54%	64%	63%	59%	66%	54%	60%
Stanley Purser	11	37%	79%	69%	64%	52%	58%	43%	73%	82%	45%	63%
Tarrant	19	44%	75%	55%	69%	57%	60%	66%	62%	67%	37%	62%
The Willows	16	29%	87%	68%	79%	70%	75%	81%	81%	85%	72%	77%
vs 2023 Staff Survey			Better	+/- 1%	Worse							

16.1 Wards not appearing in the data above did not achieve a sufficient number of respondents to ensure anonymity.

16.2 Overall, response rates increased compared to the 2023 survey.

16.3 Jersey & Guernsey and Beach and Rowan wards have not been separated in the Staff Survey report. This is to maintain confidentiality, as individual response numbers were too low to ensure anonymity.

16.4 The national NHS Staff Survey reflects staff morale concerns. In response, local action plans have been developed, and progress is reported through the DMG.

17.0 Freedom to Speak Up

17.1 Twenty-two contacts were made by colleagues working within community hospital inpatient services, an increase of six contacts when compared to 2023/24.

17.2 The primary concern across all services (not limited to community hospital inpatients) was colleague behaviour, with the largest group of contacts being RNs followed by Admin and Clerical.

17.3 One staffing contact was raised during the reporting period.

18.0 Expectation Two: Right Skills (mandatory training, development, and education; working as a multi-professional team; recruitment and retention)

18.1 *Boards should ensure clinical leaders and managers are appropriately developed and supported to deliver high-quality, efficient services, and there is a staffing resource that reflects a multi-professional team approach. Staffing decisions should be based on delivering safe, sustainable, and productive services.*

18.2 *Clinical leaders should fully utilise the competencies of the existing workforce, further developing and introducing new roles as appropriate to their skills and expertise, where there is an identified need or skills gap.*

19.0 Headroom

19.1 Headroom is applied to all inpatient establishments to account for cover requirements for time out, such as annual leave, sickness absence, temporary staffing, and training or educational requirements. For 2024/25, the headroom is set at 22.0%.

19.2 A 4% allowance is included within headroom to cover sickness absence. Average sickness absence exceeded this threshold in all months. Additionally, headroom is calculated based on WTE figures rather than actual headcount, which may result in insufficient cover for periods of timeout.

19.3 Dorset HealthCare is committed to ensuring that staff have the appropriate training and competencies to support patient care and the communities in which they work. The Learning & Development Service and Leadership Team offer a wide range of learning activities beyond mandatory training, including clinical skills training, the Care Certificate for all Healthcare support workers as well as a band 2-4 development program, apprenticeship opportunities, a multi-professional preceptorship programme for new registrants, accredited leadership programs and career development options linking in with local education providers.

20.0 Mandatory Training, Appraisal, and Clinical Supervision

20.1 All staff must undertake mandatory training, clinical supervision, and annual appraisal to meet national and local requirements. Compliance is monitored and reported monthly to the Trust Board.

20.2 The table below highlights compliance for April 2025. At the time of reporting, the overall average for mandatory training in community hospitals (94%) was slightly under the Trust's KPI of 95%.

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Compliance Figures (April 2025)

Ward	Mandatory Training	Appraisals
Beech	95%	82%
Colmers	88%	69%
Guernsey	96%	100%
Hanham	95%	85%
Jersey	90%	87%
Radipole	98%	100%
Rowan	91%	86%
Shaston	99%	100%
Stanley Purser	95%	63%
Tarrant	95%	100%

20.3 As of April 2025, the Trust Supervision Policy has changed. Both registered and non-registered staff are now required to record a minimum of one Clinical Supervision session every two months. Therefore, reporting the compliance has also changed from quarterly to bi-monthly.

20.4 The data may not fully reflect the actual practice of clinical supervision. Anecdotal feedback indicates that there is often a delay between receiving supervision and reporting it on Ulysses.

Ward	Registered Staff Clinical Supervision Compliance	Non-Registered Staff Clinical Supervision Compliance
Beech	0%	0%
Colmers	7%	0%
Guernsey	86%	58%
Hanham	23%	11%
Jersey	13%	0%
Radipole	56%	5%
Rowan	7%	0%
Shaston	42%	9%
Stanley Purser	22%	0%
Tarrant	61%	0%

20.5 In addition to clinical supervision, the Trust is now offering restorative supervision with trained Professional Nurse Advocates (PNA) to support the health and well-being of the workforce. The programme is the first clinical model of restorative supervision for nurses in England, equipping PNA-trained staff to listen to and understand the challenges colleagues and teams face, and to provide and deliver quality improvement initiatives in response.

20.6 DHC currently has twenty-eight qualified PNAs, of which four work within community hospital wards.

21.0 Recruitment and Retention:

21.1 During the review period, three internationally educated nurses were recruited to B5 roles in community hospital inpatient settings. Although the organisation is not actively pursuing international recruitment, international colleagues are welcome to apply via the normal recruitment process.

21.2 Dorset Healthcare recognises the national and local challenges with recruitment and the need to develop our people. It has committed significant investment into professional apprenticeships, including the Registered Nursing Degree, Registered Associate, Allied Health Professions, and Advanced Clinical Practitioner pathways.

21.3 There are currently 143 apprentices on clinical professional registration programmes, broken down by programme as below. An additional 17 are due to start in September 2025.

21.4 Although the breakdown reflects apprenticeship placements across various services, not specifically community hospital inpatients, it highlights the breadth and diversity of development currently underway.

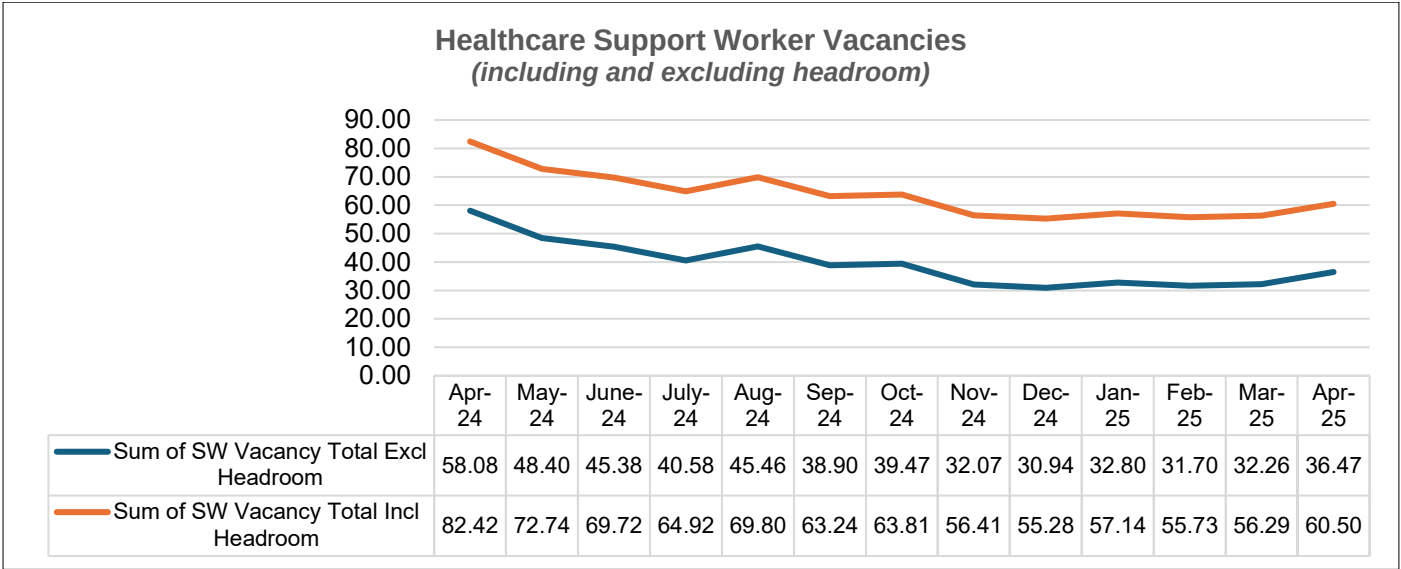
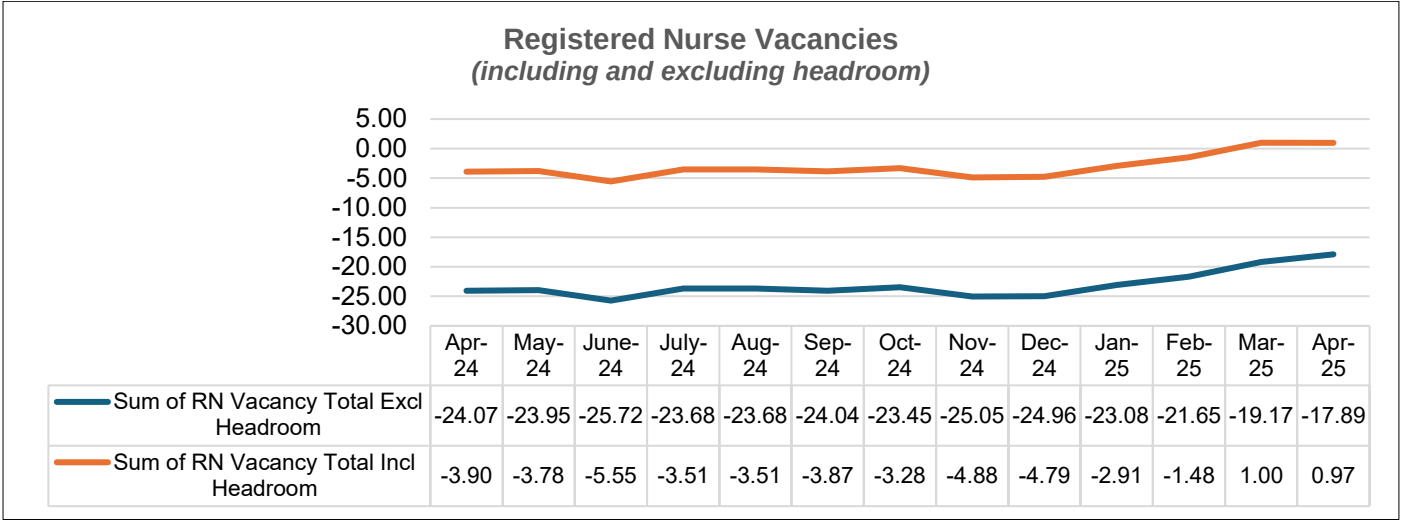
Number of Clinical professional apprentices currently on programme at Dorset HealthCare as at 7th August 2025	
Apprenticeship Programme	No.
Advanced Clinical Practitioner	16
Audiology	3
Audiology Top Up	1
Healthcare Assistant Practitioner	15
Healthcare Science Associate	1
Occupational Therapy	16
Physiotherapy	4
Podiatry	2
Podiatry Masters	2
Registered Nurse Degree – Adult	22
Registered Nurse Degree – Learning Disability	1
Registered Nurse Degree – Mental Health	32
RNA Top-up - Adult Nursing	8
RNA Top-up Mental Health	7
Speech and Language	3
Student Nurse Associate	10
Total	143

21.5 Vacancy data is provided by the Workforce Team using the ward cost centre-funded establishment.

21.6 The following graph illustrates registered nurse and non-registered nurse vacancies.

Community Hospital Registered Nurse and Healthcare Support Worker Vacancies

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21.7 A negative vacancy indicates recruitment into the budget for temporary staffing, often referred to as headroom.

21.8 HCSW vacancies have gradually declined between April 2024 and April 2025, with some fluctuations in between.

21.9 While a comparison between 2023/24 and 2024/25 vacancy figures is possible, it should be approached with caution due to budgetary realignments still in progress at the start of the new financial year.

21.10 Due to a limited local supply of Registered Nursing Associates, wards have experienced difficulties in filling these vacancies. Where possible, Band 5 Registered Nurses have been recruited to maintain safe staffing levels and ensure continuity of care.

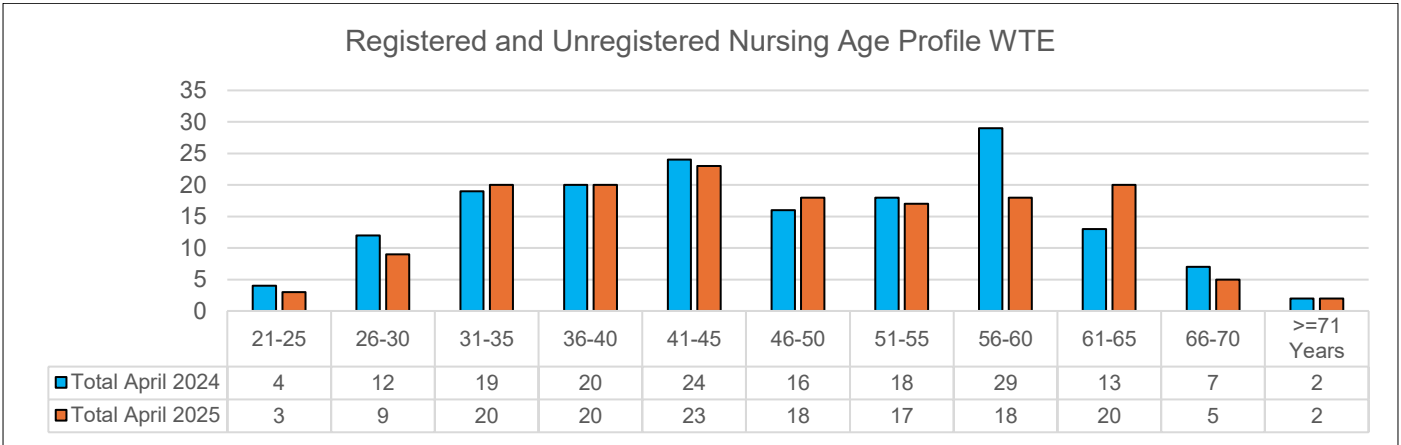
22.0 Revalidation

22.1 In 2024/25, all Registered Nurses working in community hospitals successfully revalidated, apart from one individual.

23.0 Registered Nurse Age Profile:

23.1 Workforce data identifies 45.00 WTE over the age of 55 working in community hospitals as of April 2025. This is an increase of 9.30 WTE when compared to 2023/24's annual establishment review.

Age Profile Position in WTE (as of April 2025)



23.2 The workforce age profile showed an increase in the 61-65 age group, and a decline in the 56-60 age group.

23.3 The 31–35 and 46–50 bands saw smaller growth, and younger age groups such as 21–25 and 26–30 declined.

23.4 As of April 2025, Beech has seven staff over 55, followed by Guernsey, Rowan and Stanley Purser with 5. This age profile has decreased when compared to April 2024’s data.

23.5 Rowan has four staff under 30, followed by Radipole (3) and Guernsey (2). This is comparable to April 2024’s data.

24.0 Multi-professional team working:

24.1 **Allied Health Professionals (AHP)** provide essential care and support for patients' recovery. Many of the therapy staff, including physiotherapists and Occupational Therapists, work across community and inpatient care settings.

24.2 For all the wards, except for Jersey, Guernsey and Rowan, the therapy provision is provided by ICRT Teams, who also cover the community. Therefore, the teams are balancing multiple demands, and it is not always transparent to the ward staff what resources are available, especially when the service is experiencing sickness absences or vacancies.

24.3 A review mapping current therapy provision across all the wards was previously undertaken by the former Clinical Lead for Integrated Care Rehabilitation Teams. This work programme is currently being revisited and will be informed by FutureCare recommendations.

24.4 **Medical and Advanced Clinical Practitioners (ACP):** The Trust recognises the variation in the provision of medical and ACP arrangements and aims to agree on a Medical/ACP Leadership Model to provide a consistent, structured, and planned approach to medical deployment across community hospitals.

24.5 A medical rota coordinator has been appointed to progress this work.

25.0 Workforce Strategy:

25.1 *Trusts must have an effective workforce plan updated annually and signed off by the Chief Executive and Executive Leaders. The Board should discuss the workforce plan in a public meeting.*

25.2 The annual operational workforce plan has been developed and agreed with the Executive Leadership team. It is signed off by the Trust Board and subsequently approved by NHSE. The workforce operational plan is triangulated with financial data and developed in collaboration with operational leads to ensure it is achievable, sustainable, and provides the necessary level of registered and non-registered staff to deliver Trust services.

25.3 Weekly monitoring is in place, with more extensive monthly and quarterly regional reviews. The workforce planning strategy, toolkit, and training are being embedded across the Trust, and the first service-level 5-year workforce plans are in place.

25.4 The Trust also has a People Plan 2025-2028, which is approved by the Board and sets out the key workforce priorities for the next 18-36 months.

26.0 Expectation Three: Right Place and Time (*productive working and eliminating waste; efficient deployment and flexibility; efficient employment and minimising agency*)

26.1 Boards should ensure staff are deployed in ways that ensure patients receive the right care, first time, in the right setting. This will include effective management and rostering of staff with clear escalation policies, from local service delivery to reporting to the board if concerns arise.

26.2 Chief Nursing Officers, Chief Medical Directors, Directors of Finance and Directors of Workforce should take a collective leadership role in ensuring clinical workforce planning forecasts reflects the organisation's service vision and plan, while supporting the development of a flexible workforce able to respond effectively to future patient care needs and expectations.

27.0 Rostering Practices

27.1 Rostering practices have shown that rotas are significantly influenced by the number of formal and informal flexible working arrangements and preferences. This has led to imbalances, with some shifts being overstaffed while others are understaffed. Additionally, higher levels of annual leave were approved in August, February and March, exceeding the agreed recommended upper limit of 17%.

27.2 Work has been undertaken throughout the year to support managers in improving effective rostering. The ERoster team has reviewed all rosters with ward managers to ensure rules are updated and best practices are adhered to. Despite ongoing efforts, gaps in effective rostering remain.

27.3 Key themes contributing to these challenges include, but are not limited to:

- Higher A/L allocation than KPI in February, March and August
- Formal and informal flexible working arrangements
- Introduction of long days
- Unfunded non-clinical time
- Headroom – sickness absence is higher than the allowance
- Unfunded or partially funded apprenticeship roles

27.4 The Service Manager is currently working with Matrons and roster colleagues to address the issues identified.

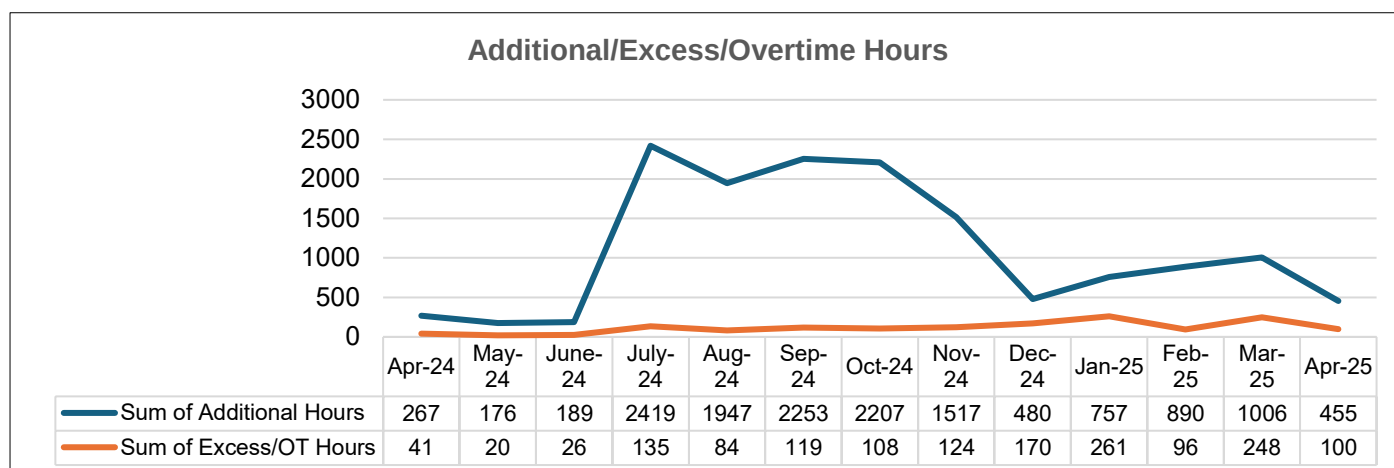
28.0 Additional/Excess/Overtime Hours

28.1 Additional duties/hours are created when professional judgement is applied to increase safer staffing levels in addition to the agreed ward demand template. The most common reasons for requesting additional duties/hours are enhanced staffing numbers for enhanced therapeutic observations of care, bariatric care, and escorts to other care providers.

28.2 The hours and the most common reasons for requests are reported in the monthly right staffing report.

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Additional/Excess/Overtime Hours



28.3 Compared to 2023/24, the number of additional hours decreased by 55 hours and excess overtime decreased by 1327 hours.

28.4 Although there was a gradual increase in additional hours across some wards in March, the notable spike in the data is primarily due to Hanham, where additional hours increased from 363 in February to 692 in March due to enhanced observations.

29.0 Escalating Staffing Concerns

29.1 The organisation has written guidance on managing staffing shortages. The document, *Guidance on the Management of Staff Shortfalls on Wards*, is available on the Safer Staffing intranet page.

29.2 Wards must assess staffing levels on a shift-by-shift basis to ensure they are sufficient and appropriate for patient needs. If a shortfall is identified and cannot be resolved—such as operating below minimum staffing levels, having a non-Dorset HealthCare staff member in charge without ward knowledge, or no Registered Nurse on duty—escalation to a Senior Manager should take place, and an incident must be reported in Ulysses (the incident reporting system) as soon as it becomes apparent.

29.3 While optimal staffing is the goal, teams may sometimes operate at “amber” staffing levels. Persistent amber levels will trigger a dynamic staffing review to assess risks and develop mitigation plans. However, the number of shifts with suboptimal staffing is not always reflected in Ulysses incident reports.

29.4 All incidents of suboptimal staffing should be reported via Ulysses, detailing missed, delayed or cancelled care. The Safer Staffing Team reviews these and includes them in the monthly staffing report. It is acknowledged that anecdotal feedback shared with the Safer Staffing Team may not always match the number of formal incident reports.

29.5 It is recognised that colleagues may feel reluctant to raise concerns via the Ulysses system or may not have time to complete it. To support anonymity, the Safer Staffing intranet page provides a brief online form that enables colleagues to report concerns about staffing levels anonymously.

29.6 As noted earlier in the report, the Service Manager leads a daily operational touchpoint meeting each morning. This meeting reviews staffing levels and discusses temporary staffing needs. Where possible, substantive staff are redeployed to support other wards.

29.7 The monthly reviews of staffing incidents have not found evidence directly linking staffing levels and patient safety incidents. However, delays in attending to patients' needs, the timely completion of documentation, and prioritisation of care have been reported, along with an impact on staff, such as leaving their duties consistently late and not being able to take rest breaks.

Staffing Incidents by Month



29.8 In May 2024, there was an increase in reported staffing incidents, primarily due to high sickness absence levels and existing vacancies on Radipole Ward.

29.9 Overall, the number of reported staffing incidents has declined in 2024/25, with 111 incidents compared to 159 in 2023/24.

29.10 However, it is important to note that anecdotal conversations and analysis of staffing fill rates suggest that incidents are not consistently reported across all wards. These underreporting limits the reliability of direct comparisons and may misrepresent the true extent of staffing pressures.

30.0 Nurse Sensitive Indicators/Red flags

30.1 The National Institute for Health and Care Excellence (NICE) guidance outlines key quality metrics that should be considered in staffing reviews. The safety metrics defined are patient falls, pressure ulcers, and medication administration errors.

30.2 These metrics, plus infection control data, risk assessment completion percentages, complaints received, and workforce data, sickness, vacancies and turnover are monitored monthly and presented in the integrated corporate dashboard and included in the monthly staffing reports where data is triangulated with eRoster.

Nurse Sensitive Indicators

Cost Code	Ward	Falls		Risk assessments			Incident data (based on date reported)							Complaints
		All Falls	Falls Resulting in Harm	Venous Thromboembolism (within 24 hours)	Purpose T assessment (within 4hrs)	Falls risk assessment (within 24hrs)	Deaths	Pressure ulcers Total acquired in hospital	Pressure ulcers Category 3 and above	Medication Incidents	Patient-Patient (physical) violent incidents	Patient-Staff violent incidents (Physical)	Staffing Incidents	
YM012	Beech Ward	18	8	98%	94%	99%	21	7	3	3	0	6	6	0
BR011	Colmers Ward	60	35	98%	98%	99%	26	11	4	21	0	5	8	1
22B10	Guernsey Ward	26	13	95%	96%	99%	5	20	1	17	0	0	12	3
WM010	Hanham Ward	79	30	73%	94%	98%	4	12	2	17	0	5	4	1
22A10	Jersey Ward	38	13	86%	90%	93%	4	13	2	9	0	2	7	1
WH011	Radipole Ward	77	32	89%	94%	97%	34	48	5	19	0	2	51	1
YM011	Rowan Ward	34	18	97%	99%	99%	11	7	1	16	0	1	2	0
WE011	Shaston Wards	39	17	95%	91%	98%	21	38	3	18	0	2	2	1
SW011	Stanley Purser Ward	34	10	85%	93%	95%	7	12	2	19	0	1	12	1
BL011	Tarrant Ward	37	23	100%	99%	100%	15	54	7	25	0	5	7	1

30.3 The total number of falls increased by 80 compared to the previous reporting period, with 63 more cases resulting in harm.

30.4 Pressure ulcers acquired in hospital rose by 68 incidents, while Category 3 and above ulcers decreased by 4.

30.5 The number of deaths increased by 40. Local hospice provision has ceased, resulting in more people being admitted to community hospitals for care at the end of their lives. Medication-related incidents rose by 31. Patient-to-patient violence decreased slightly by 1 incident, whereas patient-to-staff physical violence increased by 7.

30.6 Staffing-related incidents saw a

Healthier lives Empowered citizens Thriving communities

significant reduction, decreasing by 38 incidents.

30.7 Incident forms may not always include details of red flags. When they do, the implications of suboptimal staffing levels may not be fully understood by the author or may not be clearly documented on the form.

31.0 Risk Register

31.1 The corporate risk register currently lists two open risks. Three additional risks, now closed, have been included in this review as they were active during the reporting period.

31.2 The two open risks relate to: (1) a trust-held concern regarding identification fraud within the temporary workforce, and (2) a lack of medical clinical cover across Community Hospitals.

Ward	Risk Number	Date Entered	Description	Latest Update	Risk Rating Score
All Wards (Closed Risk)	1468 v13	30/12/2022	There is a risk that some nursing shifts may be below expected / agreed establishment and many not be able to maintain patient safety due to sickness	Risk score remains. Situation overall also remains unchanged.	2
All Wards (Closed Risk)	1737 v4	10/03/2023	High levels of newly qualified nurses and internationally educated nurses recruit to the Ward (Radipole).	Risk score to remain. Training ongoing.	6
All Wards	1823 v3	08/11/2023	Medical workforce, including medical and ACP staffing levels.	Two ACPs commencing end of February. Induction plan currently in development. Risk score to remain	9
All Wards (Closed Risk)	1846 v3	04/01/2024	High levels of Healthcare Support Workers (Radipole).	Risk score to remain. Recruitment process to be recommenced.	12
All Wards	1983 v5	24/01/2025	Risk of identity fraud in temporary workforce and potential impact on patient safety, patient experience, the workforce, financial implications and reputation of the Trust.	Review of current risk and all actions/ mitigations continue. Compliance checks are not 100% so must continue as described.	12
All Wards	1986 v4	14/01/2025	Lack of clinical cover across all CoHos .	There is a lack of resilience across all CoHos which has the potential to adversely affect patient safety. This could also affect the Trust' reputation.	9

32.0 Recommended Changes to the Funded Establishment for Consideration:

32.1 The Management Accountant has supplied costings, which are inclusive of headroom

Ward	Current	Option	Rationale			
Tarrant (carried forward from 2021, 2022, 2023 & 2024)	Demand Template Night:	Demand Template Night:	Based on the triangulation of the Safe Nursing Care Tool, review of data, professional judgement, and comparison with Colmers Ward—a similarly sized and lone ward—it is recommended to increase the number of staff on night duty at Tarrant Ward.			
	2 RN + 2 HCSW	3 RN+2 HCAs	This aims to enhance patient care and ensure sufficient staffing to support safe evacuation procedures in collaboration with the Fire Safety Team.			
			If this recommendation is not approved, it is suggested that the current staffing establishment be considered safe and appropriate for a 21-bed ward.			
	Current WTE	Current WTE£	Proposed WTE	Proposed WTE£	Difference WTE	Difference WTE£
B5	9.72	516,235	12.23	659,593	143,358	2.51
B3	14.92	586,513	17.43	698,474	111,961	2.51

	Current	Option	Rationale			
Jersey	Demand Template Late: 3 RN + 3 HCSW	Demand Template Late: 3 RN + 4 HCAs	Based on the Safe Nursing Care Tool review of data and professional judgement, it is recommended that the number of Healthcare Support Workers on late duty shifts be increased to better meet patient care demands and support staff well-being. Unlike morning shifts, late duties do not benefit from the support of Allied Health Professionals, making the staffing gap more pronounced and contributing to delays in meeting patients' needs. This is further compounded by the acuity and dependency levels of patients transferred from acute providers, which increase the complexity of care. If this recommendation is not approved, it is suggested that the current staffing establishment be considered safe and appropriate for a 21-bed ward			
	Current WTE	Current WTE£	Proposed WTE	Proposed WTE£	Difference WTE	Difference WTE£
B3						

Ward	Current	Option	Rationale			
Guernsey	Demand Template Late: 3 RNs + 3 HCSWs	Demand Template Late: 3 RN + 4 HCAs	Based on the Safe Nursing Care Tool, review of data and professional judgement, it is recommended that the number of Healthcare Support Workers on late duty shifts be increased to better meet patient care demands and support staff well-being. Unlike morning shifts, late duties do not benefit from the support of Allied Health Professionals, making the staffing gap more pronounced and contributing to delays in meeting patients' needs. This is further compounded by the acuity and dependency levels of patients transferred from acute providers, which increase the complexity of care. If this recommendation is not approved, it is suggested that the current staffing establishment be considered safe and appropriate for a 21-bed ward			
	Current WTE	Current WTE£	Proposed WTE	Proposed WTE£	Difference WTE	Difference WTE£
B3						

Members are requested to:

- Approve the recommendation to ensure safe, effective and compassionate care.
- Receive the report for assurance that Dorset HealthCare is adhering to national safer staffing guidance.

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7. The Shelford Group 'The Safer Nursing Care Tool (2016).
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Appendix A: Funded Establishment and Demand Template

Community Hospitals			Finance Funded Recurrent WTE (Finance Data Apr 2025) Includes substantive, agency, bank funding B2-B6 ONLY)			Staffing Numbers					
Ward	Shift	Total Beds	Funded Nursing (WTE)	Funded RN (WTE)	Funded HCSW Staff (WTE)	Demand RN (count)	Demand HCSW (count)	Total nurse per shift	Skill Mix (RN:HCSW)	RN: Patient Ratio	HCSW Patient Ratio
Beech	Early	12	20.20	11.32	8.88	2	2	4	50 : 50	1:6	1:3
	Late					2	2	4	50 : 50	1:6	1:3
	Night					2	1	3	67 : 33	1:6	1:4
Colmers	Early	24	30.52	10.54	19.98	3	4	7	43 : 57	1:8	1:6
	Late					3	3	6	50 : 50	1:8	1:8
	Night					2	3	5	40 : 60	1:12	1:8
Guernsey	Early	23	29.77	11.23	18.54	3	4	7	43 : 57	1:8	1:6
	Late					3	3	5	50 : 50	1:8	1:12
	Night					2	2	4	50 : 50	1:12	1:12
Hanham	Early	21	29.48	10.85	18.63	3	4	7	43 : 57	1:8	1:6
	Late					3	3	6	50 : 50	1:7	1:7
	Night					2	2	4	50 : 50	1:11	1:7
Jersey	Early	25	29.76	11.22	18.54	3	4	7	43 : 57	1:8	1:6
	Late					3	3	6	50 : 50	1:8	1:8
	Night					2	2	4	50 : 50	1:13	1:13
Radipole	Early	33	44.82	17.26	27.56	4	6	10	40 : 60	1:8	1:6
	Late					4	6	10	40 : 60	1:8	1:6
	Night					3	3	6	50 : 50	1:11	1:11
Rowan	Early	15	31.09	11.79	19.30	3	3	6	50 : 50	1:5	1:5
	Late					3	3	6	50 : 50	1:5	1:5
	Night					2	2	4	50 : 50	1:8	1:8
Shaston	Early	15	21.87	11.22	10.65	2	3	5	40 : 60	1:8	1:5
	Late					2	2	4	50 : 50	1:8	1:8
	Night					2	1	3	66 : 33	1:8	1:15
Stanley Purser	Early	15	19.36	9.21	10.15	2	3	5	40 : 60	1:8	1:5
	Late					2	2	4	50 : 50	1:8	1:8
	Night					2	1	3	66 : 33	1:8	1:15
Tarrant	Early	24	30.21	11.71	18.50	3	4	7	43 : 57	1:8	1:6
	Late					3	3	6	50 : 50	1:8	1:8
	Night					2	2	4	50 : 50	1:12	1:12

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Appendix B: Mandatory training requirements

Topic	Frequency	Time to Complete
Breakaway	3 yearly	2 hours – F2F
Conflict Resolution	3 yearly	50 minutes
Dementia Awareness Level 1 2022	One off	60 minutes
Dementia Awareness Level 2 2022	One off	60 minutes
EPMA Foundation e-learning	One off	60 minutes
EPMA Clinicians e-learning	One off	60 minutes
EPMA Nurses e-Learning	One off	60 minutes
EPMA Prescribers (if applicable)	One off	60 minutes
Equality, Diversity & Inclusion inc. Human Rights	3 yearly	45 minutes
Fire Safety Awareness (e-learning or workbook)	3 yearly	20 minutes
Fire Marshall Warden e-learning Not for all staff	Annually	40 slide presentation to read to 20 minutes
Fire Marshall Warden classroom Not for all staff	Annually	2-hour session – F2F
Health, Safety and Awareness (includes Moving & Assisting Level 1)	3 yearly	30 minutes/45 minutes
Infection Control Clinical	Annually	40 minutes
Information Governance	Annually	30 minutes
BLS 1-1 assessment	Annually	Max 30 minutes
BLS e-learning	Annually	15 minutes
Moving & Assisting Level 2/3 classroom	3 yearly	Max 3 hours – F2F
Prevent Level 3	3 yearly	55 minutes
Safer Caring Interventions of the Older Person	3 yearly	4 hours – F2F
Safeguarding Children & Adults Level 2	One off	1 hour
Safeguarding Children & Adults Level 2 Update	3 yearly	1 hour
Oliver McGowan Mandatory training	One off	1hr e-learning F2F 4hrs (tier 1) or 1 day (tier 2)
F2F = Face to Face		

Appendix C: Training commitment by staff group on a 3-year cycle

Year	Staff group	Induction	Mandatory/updates	Professional development	Totals
1	HCSW	21hrs		15hrs (care certificate)	36hrs (5 days)
	RGN	21hrs		35.5hrs (5 days) 84hrs (11 days) Clinical skills	56.5hrs (7.5 days)*
	NQ/IEN	21hrs		90hrs (preceptorship)	111hrs+ (15 days)
2	HCSW		1.5hrs (BLS, IG & IPC)		1.5hrs
	RGN			5hrs (clinical skills) + 9.5hrs (professional dev)	6.5hrs (1 day) to 16hrs (2.5 days)
3	HCSW		13.75hrs		13.75hrs (2 days)
	RGN			4hrs (professional dev)	17.75hrs+ (2.5 days)
*Completing all of the available extended clinical skills may not be relevant for all registered staff within year 1 either due to local skill mix or consolidation of their clinical practice					

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Appendix D: Competencies for Registered Nurses

Competency	Training method	Training time	Frequency of updates
Clinical skills			
Medication management	E-Hub and workplace competency assessment	2 hours online	
EPMA	E-learning	1 hour	
Venepuncture	F2F and workplace competency assessment	Pre course reading (2 hour) 2.5 hours F2F	No update required
Cannulation	F2F and workplace competency assessment	Pre course reading (2 hours) 4 hours F2F	Online update 1 hour
IV therapy PICC and Mid-line management	F2F and workplace competency assessment	Pre course reading (2 hour) 7.5 hours F2F	2 year- 1 hour
Pressure ulcer toolbox	E-hub and support from TV team		
Diabetes update	E-hub and support from Diabetes team		
Safe caring interventions of the older person	PMVA team, F2F	5 days initial training.	
Bladder scanning	Provider of the device	F2F	
Conducting an ECG	Face to face	F2F 90 minutes	
Syringe driver training	F2F and work-based competency	3 hours	2 years online update
Male and female catheterisation	F2F and competency assessment	7.5 hour (Morning Online theory then F2F practical). Workplace competency	e-learning update 2 yearly (1 hour)
Verification of death	Big Blue button/ F2F and workplace competency assessment	2 hours	As required
Near patient testing INR	Provided by device supplier		
Total		35.5hrs (5 days) – 84hrs (11 days) as indicated by clinical need	
Professional development			
Clinical Supervision	Big Blue Button	2 hours online	
Assessor	F2F	7.5hrs	4hr update annually
Total		9.5hrs	4hr
F2F = Face to Face			

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Report to	Board in Common, DCH	
Date of Meeting	9 th December 2025	
Report Title	Annual Safe Staffing Reports – Inpatients and Maternity Services	
Prepared By	Trudy Goode Safe Staffing Lead & Emma Hoyle Deputy Director of Nursing and Quality (Acute Care)	
Approved by Accountable Executive	Dawn Dawson, Joint Chief Nursing Officer	
Previously Considered By	Quality Committee in Common, 25/11/2025	
Action Required	Approval	Y
	Assurance	-
	Information	-

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

Executive Summary
The papers outline the process and governance to ensure that Dorset County Hospital can meet national workforce requirements for safe staffing within inpatient wards and the Maternity Service (see Maternity and Neonatal Workforce Report). Completion of the bi-annual audit of acuity, dependency and staffing levels (using the Safer Nursing Care Tool) follows the National Quality Board (2016) requirements and the Developing Workforce Safeguards (2018) guidance to provide a comprehensive review and which concludes with a series of recommendations to the Board to ensure statutory obligations are met. The Annual Safe Staffing Report follows a 6 monthly audit and report submitted previously. In addition to the use of the Safer Nursing Care Tool (SCNT), staffing levels, patient acuity and dependency, and effective utilisation of resources is discussed twice daily at the internal bed/operational flow meetings and at twice daily strategic staffing reviews. Staff are requested to move area of work to ensure safe and effective care of our patients. This review is undertaken in conjunction with the Ward Sisters, Matrons and Heads of Nursing responsible for their respective areas. Since the Annual Safe Staffing Report (2024) the Allocate SafeCare module has been implemented, in line with recommendations from the previous report, across all inpatient wards. Acuity census is required 2 times daily. Further consideration has been given to this tool being adapted and utilised in Maternity Services, outside of current licence and requiring amendments to the descriptors. This is as an addendum to the Maternity Professional Judgement framework and to supplement the completion of BirthRate Plus every 3 years. The Safe Staffing Lead has worked with Maternity and E-Rostering teams

to add a modified version for use within Maternity services including the Maternity Services Professional Judgement and Red Flags tools. The Maternity Service has developed its' own descriptors aligned to that of general wards to reflect the acuity and dependency of patients within the Maternity Unit. This was a requirement for Maternity to be working towards to qualify for the Maternity Incentive Scheme (Year 7, will be "live" from November 2025 and follows similar approaches in other Trusts.

A further project involving the Lead Nurse for Safe Staffing, Purbeck ward, the Quality Improvement team, Education, Allied Health Professionals, Dementia Team and colleagues from Liaison Psychiatry is being progressed using a multi-professional approach to the implementation of Enhanced Therapeutic Observation Care (ETOC). The purpose is to provide more meaningful interaction to patients on a one-to-one basis, for those who require such care including those with Mental Health, Dementia and Learning Disability. This is supported as a nationwide development by NHS England. An additional benefit is that of our own in house staff being trained and educated in the management of such patients since it is known that Dorset Health Care cannot provide such staff and our alternative is expensive agency Registered Nurse (Mental Health) provision when, on most occasions, Health Care Assistants are all that is required to support and interact with this patient group.

Summary

The Trust has reviewed the SNCT audits results for the Inpatient wards and has identified the need for additional staff in specific areas.

The Board is asked to:

- Acknowledge and approve the recommendations of the Annual Safe Staffing Report 2025/26.
- Acknowledge the uplift requirements in headroom from **20.5 % to 22.2%** in inpatient areas and in line with a phased approach as outlined in the targeted investment paper (Joint Executives 18th November 2025).
- Note the recommendation for funding of RNDA posts through slippage and allow for recruitment into HCSW vacancies to offset bank and agency spend (Trust targeted investment paper, November 2025)
- Note and support the uplift in staffing levels in accordance with audit findings.

Recommendation

Members are requested to:

- Acknowledge and approve the recommendations of the Annual Safe Staffing Report 2025/26.
- Acknowledge the uplift requirements in headroom from **20.5 % to 22.2%** in inpatient areas and in line with a phased approach as outlined in the targeted investment paper (Joint Executives 18th November 2025).
- Note the recommendation for funding of RNDA posts through slippage and allow for recruitment into HCSW vacancies to offset bank and agency spend (Trust targeted investment paper, November 2025)
- Note and support the uplift in staffing levels in accordance with audit findings.

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Board of Directors**Annual Safe Staffing Review 2025/2026****Inpatient Wards****Executive Summary**

This report provides assurance in relation to Safer Staffing for acute ward-based nursing following the acuity and dependency audit completed June 2025 for a period of 30 days. The last audit was completed in January 2025 and that report was presented to Trust Board May 2025. It is acknowledged that the audit should be twice yearly which is the planned audit programme going forwards.

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

This report outlines recommendations for consideration to meet the patient care and safety needs identified and in accordance with national guidance (Developing Workforce Safeguards, NHS England, 2018). This will be reviewed again in line with NICE requirements in Spring 2026.

1. Introduction

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

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

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- Should incidents associated with staffing occur or increase and mitigations prove insufficient, Trusts must escalate the issue (and where appropriate, implement business continuity plans) to the board to maintain safety and care quality. Actions may include part or full closure of a service or reduced provision: for example, wards, beds and teams, realignment, or a return to the original skill mix. Twice a day and more frequently should the need arise a full review of staffing takes place with senior nursing staff. This formal process ensures mitigations are in place to ensure that clinical areas are staffed according to the acuity and dependency. This is utilising the Safecare tool, professional judgement and recognition of the demand for services and preparedness accordingly e.g. Opel 4. Formal monitoring of these incidents are via the DATIX reporting system and subsequently if required reported and monitored via the Trust Risk Register, This is monitored on a bi-monthly basis via the Director of Nursing Safe Staffing Meeting.

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

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

Critical Care, Special Care Baby Unit (SCBU), Emergency Department have not been included in this report. A separate review of Critical Care staffing and Emergency Department staffing is being conducted in recognition of the New Hospitals Build and remains in progress. Maternity Safe Staffing Report is covered by a separate paper and is reported concurrently with this report. An acuity and dependency audit for the Emergency Department will be completed November 2025 and included in the Bi-annual report 2026. The headroom requirement applies to all clinical areas. Attendance to the SCBU recommendations in the previous Safe Staffing Report are currently being actioned to support the uplift to national recommendations out of hours.

2. Methodology

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

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

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

The Royal College of Nursing has set out detailed expectations for employers, national organisations, and regulators to support patient safety and enable the UK's nursing

workforce to deliver safe and effective care. The 14 workforce standards, launched by the college in May 2021 are intended to bring the entire nursing community in the UK, under one set of standards for the benefit of staff and patient safety. The RCN have recently announced a review of guidance and consideration of best methodologies and benchmarking including nurse to patient ratios and Care Hours per Patient Day. The outputs of this review are outstanding but will form a revision of approaches at Dorset County Hospital to ensure audit against best evidence-based practice.

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

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

All inpatient wards were required to collect data using the SNCT during the same period, to ensure consistency and allow benchmarking across the Trust. The audit took place in June 2025.

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

- Patient Acuity and Dependency
- Professional Judgement
- Quality Indicators

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

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

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

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

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

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

¹ The National Quality Board, Safe, sustainable and productive staffing, [An improvement resource for adult inpatient wards in acute hospitals](#), January 2018.

² The National Quality Board, Safe, sustainable and productive staffing, [An improvement resource for urgent and emergency care](#), June 2018.

³ The Royal College of Emergency Medicine together with the Royal College of Nursing, [Nursing Workforce Standards for Type 1 Emergency Departments](#), October 2020.

Historically, business planning 2023/2024 included a business case to request investment to align to national recommendations and thereby significantly reduce reliance on short-term agency use to cover planned leave and absences and this process continues. This case was not progressed. Since then a targeted investment paper has been developed and presented to Joint Executives in November 2025.

Since the bi-annual review in February 2025, alternative roles in the clinical area have been explored and a pilot project for Ward Housekeepers was undertaken on 2 wards. Early indications are that this was successful with improvement demonstrated during a PLACE assessment during the project. This has particularly been evident with bed area preparation, management of allergens, improved dietary selection, hydration and nutritional intake and the support given to patients to remain on their wards and de-escalate anxiety. Food service and food safety is now a priority with food being seen as medicine (NHS 2023 National Standards for Healthcare Food and Drink) which support delivery of quality indicators such pressure ulcer management and patient experience. It is likely this will be a phased roll out recommendation. This was unable to happen due to current financial and headroom constraints but remains as aspiration to introduce the role across the Trust.

Additionally, a Ward Clerk project to review core competencies was undertaken to both improve the bank administration offer across the Trust with an aim to improve compliance with Trust standards. Improved ward clerk provision is expected to improve Electronic Discharge Summary (EDS) completion, patient and family contacts and communication, appointments made, response times to answering ward telephones as well as meet and greet on the wards. There is a requirement to improve filing of patient notes, scanning and compliance with NHS Record keeping standards, which are currently a risk on the risk register. This was unable to be progressed due to the current financial and headroom constraints. A full ward administration review is in progress Quarter 3.

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

3. Additional In-Extremis Beds

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

below remained open during the acuity audit of Summer 2025. Mary Anning Unit, due to refurbishment plans for the stroke Unit, was reduced from 46 beds to 38 in 2024 as part of a quality improvement project. In June 2025 the Unit split to 10 beds on Maud Alexander and 14 on Mary Anning Unit. Subsequently Mary Anning was increased back to 16 beds and these remain open.

Ward	Extremis Beds	Additional Staff Required
Moreton Ward	3 to 4	Funded
Fortuneswell Ward	3	Partially funded *
Mary Anning Unit	2	Nil

With effect from beginning of November 2024 the extra beds (Moreton and Fortuneswell) have been included into the hospital bed base.

*Fortuneswell remains unfunded for LD HCA weekend cover.

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4. Results

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

Ward	Current WTE Establishment (Excluding Band 7 and Admin Roles)	SNCT Results with 22.2% uplift	Current Vacancies (WTE) as at 30.6.25	Recommendations
Abbotsbury Ward (29 Beds)	39.43 (+ x4 RNDA)	41.50	RN 1.31, HCA 4.09	It is recommended that to improve the nurse-to-patient ratio there needs a roster template change to achieve 5RN's day and 4RN's by night. The implementation of 22.2% headroom and targeted investment to increase RN cover at night will achieve this and improve nurse to patient ratios. Agency expenditure currently in place for RN at night to manage acuity. Recommend increase establishment and 22.2% headroom uplift, recruit to vacancies.
Lulworth Ward (31 beds)	41.64 (+1 RNDA)	36.99	RN 0.92, HCA 3.84	It should be noted that the ward takes CRCU stepdown patients. Whilst the SNCT levels differ to the actual establishment triangulation of data (quality, acuity, professional judgment) identifies the need to support the fluctuation in criticality of patients. Recommend targeted investment to improve night RN from 3 to 4 for cover in recognition of CRCU discharges to ward and improve nurse to patient ratios

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				from 1:11 to 1:8. Agency expenditure currently in place for RN at night to manage acuity. The RN establishment needs to improve to manage this, alongside recruitment into HCA vacancies. Recommend 22.2% headroom uplift and recruit to vacancies.
Ward	Current WTE Establishment (Excluding Band 7 and Admin Roles)	SNCT Results with 22.2% uplift	Current Vacancies (WTE)	Recommendations
Purbeck Ward (27 beds)	36.34 (+2.03 RNDA)	44.51	RN 1.28 RN, HCA 9.73 (Nov now 11.53)	Recommend targeted investment to ensure safe staffing for patients requiring enhanced care (e.g. spinal injuries requiring 5 to log roll, MH trauma patients) and ensure night RN patient ratio cover is improved. The RN establishment needs increasing to enable 4 RN's on ND to improve the nurse to patient ratio and reduce agency expenditure. Additionally, the HCA recruitment is required to enable a reduction of RN MH agency cover when HCA is required for ETOC. Recommend 22.2% headroom uplift and recruit.
Portesham 10 beds + 3 Frailty SDEC + 2 in discharge lounge	33.34	12.99 for 10 beds but often has 3 extra patients in FSDEC and 2 in the	RN 0.45, HCA 6.77	Small ward principles – recommend no change due to extra capacity being utilised. Staff are flexibly managed between Frailty SDEC. 22.2% headroom in place.

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		Discharge Lounge		
Ridgeway 20 beds	39.34 (+3RNDA)	35.82	HCA 6.73 (Nov now 8.85)	No change recommended other than to recruit to HCA vacancies , as ward often increases bed capacity to 24 to manage elective and emergency flow.
Kingfisher Ward (14 beds + PAU)	27.33	14.9 using SNCT specific tool for paediatric	No vacancies	Smaller unit principles applied. No change
Ward	Current WTE Establishment (Excluding Band 7 and Admin Roles)	SNCT Results with 22.5% uplift	Current Vacancies (WTE)	Recommendations
Fortuneswell Ward (17 beds) + 3 additional beds open for the duration of the audit and this continues	27.39 (+x2 RNDA)	34.65 on 20 beds	RN .26, (Nov now 2.38) HCA 5.03, (Nov 3.77)	Recommended increase to establishment to enable 4 HCA's LD at weekends if beds are to remain open. Recruit to HCA vacancies. 22.2% headroom in place.
Moreton Ward 23 beds + additional beds open for the duration of the audit and historically since Covid-19 pandemic began.	39.24 (+3 RNDA)	38.49	RN now 4.29, HCA 5.89, now increased to 5.89	It should also be noted that the ward takes step down patients from CRCU. 22.2% headroom in place. Recommend recruit to vacancies.
Ward	Current WTE Establishment (Excluding Band 7 and Admin Roles)	SNCT Results with 22.5% uplift	Current Vacancies (WTE)	Recommendations
Evershot Ward (14 beds)	21.69	14.81	HCA 2.09	Now utilised as an emergency area with a pull approach from ED and a rapid turnover short stay area. Small

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				ward principles apply. Recommend recruit to HCA vacancies.
Cardiac Care Ward (18 beds)	32.86 (+4 RNDA)	28.58	No vacancies	No change to current establishment – smaller unit principles applied area functions as ward and CCU. Recommend add 22.2% headroom as a critical area.
Ilchester Ward (33 beds)	49.18 (+RNDA 2.60)	57.71	HCA 5.19 (x1 funding RNDA)	Ward remains an acute admission area whilst also retaining patients requiring a longer stay including increased elderly and psychiatric patients. Recommend add 22.2% headroom and recruit to HCA vacancies.
Mary Anning Unit 33 beds audit completed on 33 beds	69.38 (50.28 now on 26 beds for Stroke work) +1 RNDA	49.04	HCA 4.99	Maintain reduced bed base. Bed base since audit has reduced to 26 beds being managed geographically across Mary Anning and MAW to support Stroke HASU works. 22.2% head room in place. Recommend pause and review establishment and compare A&D results in January 2026. Recruit to HCA vacancies.
Ward	Current WTE Establishment (Excluding Band 7 and Admin Roles)	SNCT Results with 22.5% uplift	Current Vacancies (WTE)	Recommendations
Maud Alexander Ward (10 beds). Part of Evershot surge at time of audit, now part of Mary Anning.	19.26 (+2 RNDA)	10.74	HCA 1.0	No recommendations for change and small ward principles applied. No changes required, nil headroom recommended, as ward was part of Evershot surge and is now part of Mary Anning since the audit was completed.

Stroke Unit (24 beds)	50.13 (+4 RNDA) + ACP 9-5 Mon-Fri, Outreach B6 08:00- 20:00 Daily Nurse Consultant M-F	39.84	HCA vacancies 5.07	Unit continues to develop the HASU model to meet national stroke standards. Ward establishment has been adjusted accordingly and compliant with Stroke HASU and ASU recommendations. 22.2% headroom in place. Recommend recruit to HCA vacancies.
Prince of Wales Ward (13 beds)	30.81	20.00	HCA vacancies 3.33 (over established on bands 6 (2.01), 5 (3.24) and 4 (.75)	No change to current establishment – smaller unit principles applied and noting regional emergency dialysis unit status. Recommend 22.2% headroom only.

Summary of Recommendations:

- Targeted investment, subsequent to approved business case May 2024 (was approved but not actioned), required to increase budget uplift, increase substantive posts with direct offset of agency use to manage planned and predicted absence (Annual leave and Mandatory training). A Trust targeted investment paper is subject to Joint Executive consideration and action on 18th November 2025. A review of redeployment opportunities to right size bed and staffing capacity, in line with any planned bed reconfigurations, use of a Transfer Window, was undertaken with the closure of Mary Anning beds. This has ensured headroom and safe staffing levels are in establishment for 4 inpatient wards.

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- Ongoing review and investment of Stroke staffing with planned increases in HASU and Acute Stroke capacity, and in line with national Stroke Standards as measured by SSNAP Sentinel audit, through the Somerset and Dorset Stroke Service commissioning arrangements.
- Uplift of establishments and subsequent review of rosters to ensure nighttime staffing levels are strengthened
- Completion of SNCT audits for ED, noting the workforce requirements for the New Hospitals Programme.
- SCBU – require additional Band 6 BAPM (British Association of Perinatal Medicine) standard as approved in SCBU business case 25/26. 25% headroom recommended and to be included in Tranche 3 of the Trust targeted investment paper if approved. Quarterly audits submitted to the Neonatal Network continue. Transitional care is not currently included in the National audit but from 2025, this will be included to cover SCBU nurses providing care for babies on the Maternity Unit.
- ED headroom uplift to meet RCEM (Royal College of Emergency Medicine) recommendation of 27%, recommend recruit to 25% - currently at 20.5% and have a high agency expenditure due to “corridor care” and the new Timely Handover Process (Tranche 2 of Trust paper)
- CRCU – using 11% of agency expenditure (largely TNS) 25% headroom uplift recommended = 1.54 RN & 0.11 HCA wte. Additionally, this should be considered alongside the NHP Workforce stream and in Tranche 3 of Trust paper.
- Maternity –see separate Maternity workforce and safe staffing report (November 2025). To note, Allocate SafeCare has been introduced and modified for maternity to demonstrate acuity and dependency from 1.11.25 and replicates an approach taken by other Trusts.

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Conclusion

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

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

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

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

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

It should be noted that RNDA nursing staff prohibit the employment of HCAs into the ward establishments leaving the wards short when off base placement and requiring the use of temporary staffing – at times utilising RN cover for an HCA gap.

The 2025/2026 scheme to embed safe staffing methodology was as follows:

- Invest in a Safe Staffing Clinical Lead role to develop and support the Safe Staffing agenda – member of staff appointed as a secondment October 2023 for 18 months, this has now been confirmed as a substantive appointment since April 2025.
 - Embed Allocate 'SafeCare' to complete twice daily acuity and dependency utilising digital software to support and evidence movement of staff around the Trust and to support areas of greatest need, alongside Care Hours Per Patient Day. Safe Staffing Lead commenced the implementation of the Safe Care project with all in-patient wards now "live". In future SafeCare will be used for future safe staffing audits. Dashboards are in the process of being developed. *example below.
 - To continue roster efficiencies at monthly roster clinics.
 - Further training is being set up for Night Sisters and Matrons on the use of SafeCare to support professional judgement and resource allocations.
 - Support Safe Staffing Fellowships by senior nurses – Deputy Director of Nursing completed. Application submitted by the Head of Nursing, Professional Practice & Workforce
 - Lead Nurse for Workforce and Safe Staffing attended webinars throughout the year particularly relating to the Enhanced Therapeutic Observation Care (ETOC) Tool to progress the use of the Tool for use with those patients requiring Enhanced Care.
 - Lead Nurse for Workforce and Safe Staffing has worked with Maternity to introduce a modified version of SafeCare as an audit tool for use by Maternity specifically.
- Through the Director of Nursing Safe Staffing meetings, a fortnightly review of vacancy rate against sickness and absence are to be monitored.

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- Quarterly Night Staff forum set up with the Director of Nursing and Lead Nurse for Workforce and Safe Staffing to meet with the night nursing teams to listen and respond to concerns.
- CHPPD continues to be reported and published on the Trust intranet and Red Flag monitoring continues.

5. Recommendations

To acknowledge and approve the recommendations of the Annual Safe Staffing Report 2025/26.

To acknowledge the uplift requirements in headroom from **20.5 % to 22.2%** in inpatient areas and in line with a phased approach as outlined in the targeted investment paper (Joint Executives 18th November 2025).

To note the recommendation for funding of RNDA posts through slippage and allow for recruitment into HCSW vacancies to offset bank and agency spend (Trust targeted investment paper, November 2025)

- Note and support the uplift in staffing levels in accordance with audit findings.

Trudy Goode, Safe Staffing Lead and Emma Hoyle, Deputy Director of Nursing, November 2025

*Safe Staffing Dashboard

		October 2025	September 2025	August 2025	July 2025	June 2025	May 2025	April 2025	March 2025	February 2025	January 2025	December 2024	November 2024				
		Bed Occupancy		Workforce				Bank & Agency		Incident Data				Feedback			
		occupancy %	average Available Beds	Turnover Rate %	Overtime Hours	Sickness Rate %	Vacancy Rate % - Registered	Vacancy Rate % - A&E	HCA1 Agency Fill Rate %	Housing For Hire %	Deaths	Falls Causing harm	Pressure Ulcers Cat3+	Medication Incidents	Incidents due to Staffing	FFT Positive %	Complaints
A&E	AE1 - EMERGENCY DEPARTMENT	-	0	5%	0	0%	5.6%	0.0%	69%	95%	7	7 (2)	0	10	1	-	27
Inpatient	OAB - ABBOTSBURY WARD	97%	29	11%	0	0%	-2.3%	0.0%	70%	95%	2	4 (0)	0	1	0	100%	6
Inpatient	OCC - CARDIAC CARE WARD	98%	18	5%	0	0%	-5.5%	0.0%	57%	100%	5	2 (1)	1	4	0	100%	2
Inpatient	OCRIT - CRITICAL CARE UNIT	101%	8	6%	0	0%	-2.0%	0.0%	29%	70%	11	0 (0)	0	5	1	100%	2
Inpatient	OEY - EVERSNOT WARD	96%	14	4%	0	0%	-19.3%	0.0%	87%	94%	1	4 (1)	0	1	0	88%	3
Inpatient	OIL - ILCHESTER INTEGRATED ASSESSMENT UT	98%	33	3%	0	0%	-7.3%	0.0%	65%	98%	5	3 (0)	0	1	5	-	5
Inpatient	OKI - KINGFISHER WARD	42%	14	0%	0	0%	-15.2%	0.0%	44%	78%	0	0 (0)	0	5	0	-	1
Inpatient	OLU - LULWORTH WARD	96%	31	6%	0	0%	-2.6%	0.0%	75%	94%	1	2 (0)	0	1	0	100%	1
Inpatient	OMA - MAUD ALEXANDER WARD	101%	10	0%	0	0%	0.0%	0.0%	-	100%	1	2 (1)	0	2	0	-	0
Inpatient	OMAU - MARY ANNING UNIT	100%	16	9%	0	0%	-4.0%	0.0%	75%	91%	3	6 (0)	0	2	0	92%	2
Inpatient	OMO - MORETON WARD	102%	26	15%	0	0%	17.3%	0.0%	82%	92%	10	1 (1)	0	4	0	-	1
Inpatient	OONC - FORTUNESWELL WARD	96%	20	7%	0	0%	8.9%	0.0%	72%	98%	18	3 (0)	1	5	0	100%	0
Inpatient	OPO - PORTESHAM UNIT	130%	10	0%	0	0%	-21.2%	0.0%	70%	96%	2	3 (0)	0	1	0	100%	0
Inpatient	OPU - PURBECK WARD	95%	27	13%	0	0%	2.3%	0.0%	75%	96%	2	3 (0)	0	2	0	100%	3
Inpatient	OPW - PRINCE OF WALES WARD	97%	13	2%	0	0%	-48.1%	0.0%	62%	85%	3	2 (2)	0	0	0	-	0
Inpatient	ORI - RIDGEWAY WARD	104%	20	3%	0	0%	-1.4%	0.0%	72%	86%	0	1 (0)	1	4	1	97%	2
Inpatient	OSU - STROKE UNIT	95%	23	5%	0	0%	15.2%	0.0%	66%	91%	3	1 (1)	0	5	0	-	3
Other	OSDEC - FRAILTY SAME DAY EMERGENCY WARD	-	0	0%	0	0%	0.0%	50.0%	-	-	0	0 (0)	0	0	0	-	0
Other	OMAT - MATERNITY UNIT	43%	32	21%	0	0%	0.0%	0.0%	73%	-	0	0 (0)	0	1	0	-	0
Other	OSDEC - SAME DAY EMERGENCY CARE WARD	-	0	0%	0	0%	13.1%	0.0%	100%	89%	0	0 (0)	0	0	0	89%	2

Occupancy and Average Available Beds (Bed Capacity as per the BedBoss Report and PAS Inpatient Spell Data for Inpatient / Other and A&E for A&E)

Turnover Rate (ESR): [WF005 - Turnover - Power BI Report Server](#)

Overtime Hours (ESR NHS Financial Analysis Dashboard): TBC

Sickness (ESR): TBC

Vacancy Rate (ESR): [WF004 - Workforce Vacancy - Power BI Report Server](#)

Bank & Agency (HealthRoster via Allocator): [AG003 - Fill Rates - Power BI Report Server](#)

Deaths (PAS Inpatient Spell Data for Inpatient / Other and A&E for A&E)

Incident and Complaints Data (Datix): [IP068 - Ward Dashboard - Power BI Report Server](#)

Friends & Family (FFT): [IP068 - Ward Dashboard - Power BI Report Server](#)

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Report to	Board in Common	
Date of Meeting	9 December 2026	
Report Title	Learning from Deaths Report – Quarter 2	
Prepared By	Ellie Lindop, Deputy Director of Nursing, Therapies & Quality	
Approved by Accountable Executive	Lucy Knight Chief Medical Officer	
Previously Considered By	Mortality Governance Group 21/11/2025 Quality Committee in Common 25/11/2025	
Action Required	Approval	Yes
	Assurance	No
	Information	No

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

Executive Summary
The report provides the Trust Quarter 2 update relating to compliance with the National Quality Board Framework (2017) and the Patient Safety Incident Response Framework (2022). In summary: • A total of 29 unexpected deaths were reported (of which four were inpatient deaths). • A total of 29 inquests were heard by the Coroner in relation to the Trust, with no Regulation 28 notices received. • Six child deaths were reported, of which one was identified for a wider investigation via a Local Child Safeguarding Practice Review (LCSPR). • There were 16 Learning and Disability deaths reviewed under the LeDeR process. • In total, 46 expected deaths were reported, all of which were in the Integrated Community Services (ICS). The Board are asked to receive this report as assurance of the processes that are undertaken in relation to the management of learning from deaths and compliance with the reporting requirements associated with the National Quality Board Framework (2017), aligned with Patient Safety Incident Response Framework (PSIRF) methodology. Presented in this report are areas of learning for the Trust, and in some cases the wider Dorset system for discussion, consideration and identification of any further opportunities for improvement.

Recommendation
Receive the report for assurance and information .

Learning from Deaths Report (Quarter 2 2025-26)

1.0 INTRODUCTION

- 1.1 This report provides a quarterly overview of patients who have died whilst under Dorset Healthcare Trust as a primary provider of care (as per the National Quality Board (NQB) framework, 2017).
- 1.2 Where the Trust is not a main provider, there is consideration on identification of the patient/ service users' death, if it would be appropriate to undertake a full learning review process as a Trust, collaborate with the main provider of care and provide insight into the care/ services provided or whether there is no identified need to review further after initial discussion and consideration (as per the NQB framework). Predominantly, service users of Mental health services are more likely to require a review, especially if their death is confirmed or suspected to be a likely consequence of their mental health diagnosis.
- 1.3 Reviews regarding the approach to the management of learning from deaths continues to evolve and is updated within the report.
- 1.4 Expected deaths of inpatients continue to be included for oversight in this report, with a focus on the identification of learning (refer to section 9).
- 1.5 To highlight, data within this report is based on the date of death (incident date).

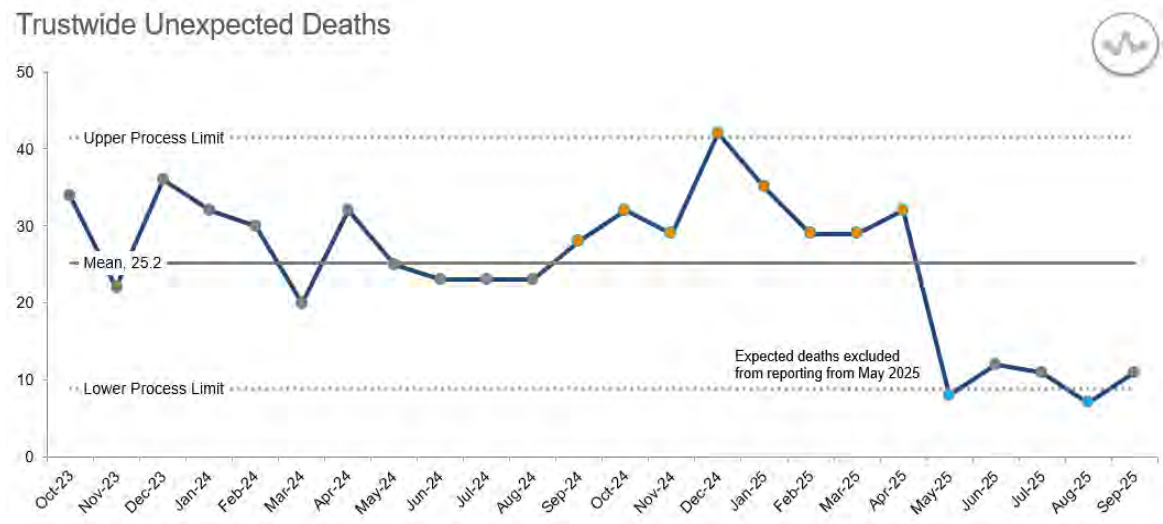
2.0 SUMMARY TRUST REVIEW PROCESS

- 2.1 All inpatients' deaths (expected and unexpected) are reported on the Trust Risk Management System (Ulysses) when identified and a review is undertaken (based on NQB guidance and with the Patient Safety Incident Response Framework (PSIRF) methodology). For deaths of community service users, these are either reported via the service who provided care for consideration, or notification is received from an external source (e.g. the coroner).
- 2.2 There are multiple tools which can be used to support the review and identification of learning from deaths (refer to Appendix 1).

3.0 OVERVIEW OF UNEXPECTED DEATHS REPORTED

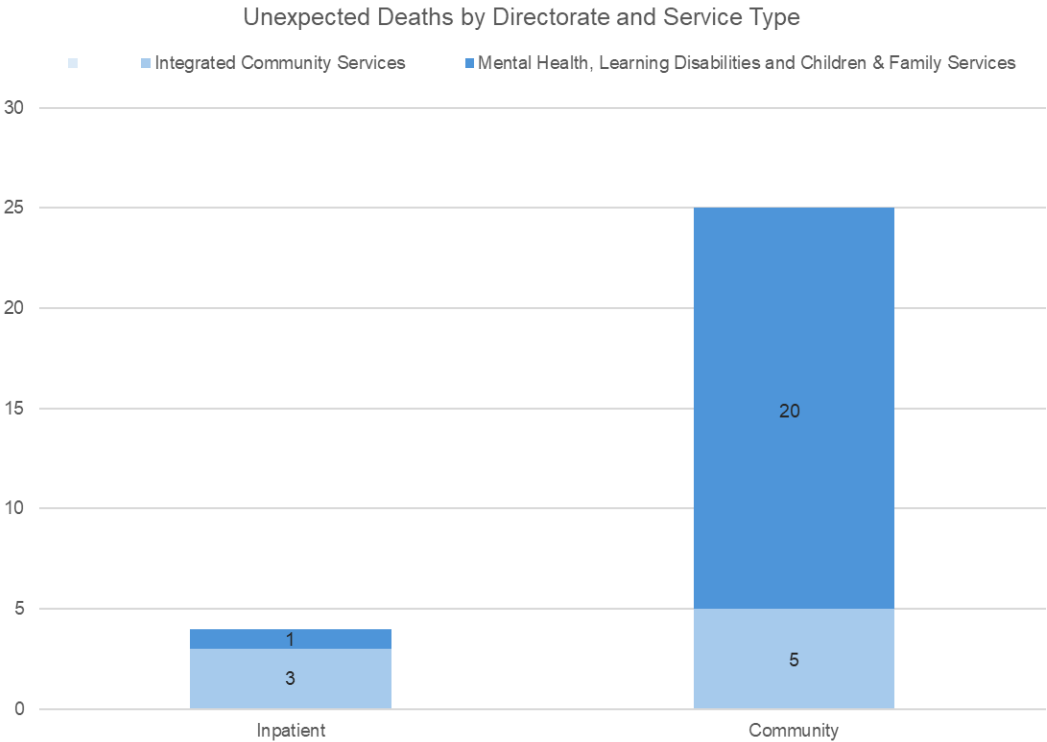
- 3.1 In Q2 2025/26, a total of 29 unexpected deaths were recorded on the Trust's incident reporting system. This metric is reporting below the 24-month average (25.2) and close to, or on, the lower process limit (8.9) since May (see figure 1).

Figure 1 Overview of Unexpected Deaths Reported October 23 – September 25



3.2 Of the 29 deaths, 25 deaths occurred in community services and four were within inpatient services (refer to Figure 2). The majority were reported within the Mental Health, Learning Disabilities, and Children & Family Services directorate (21), with lower numbers reported in Integrated Community Services (8).

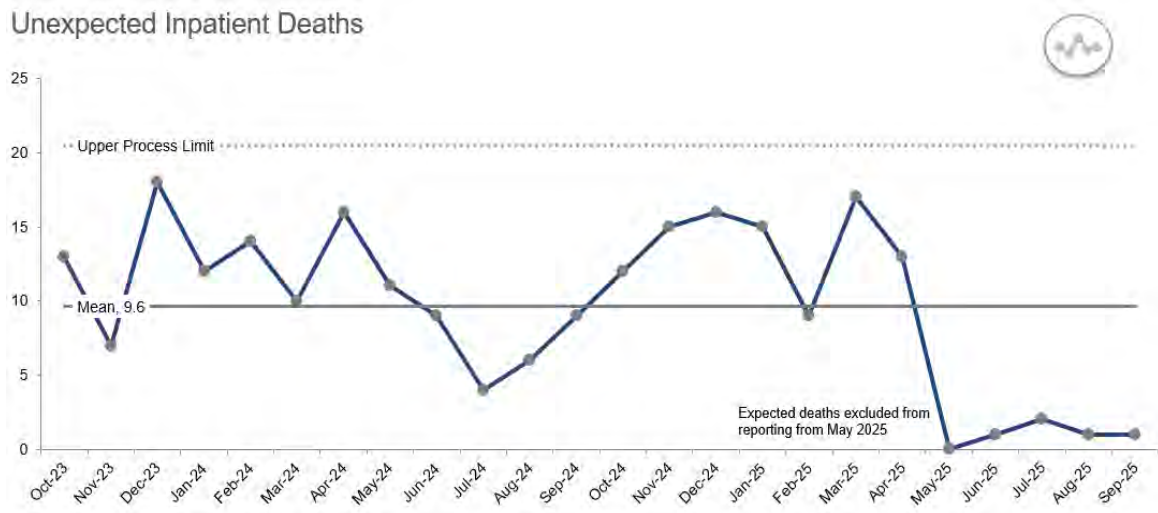
Figure 2 Overview of Trust-wide Unexpected Deaths by Directorate and Service Type



3.3 Four unexpected inpatient deaths were reported in Q2, which is below the 24-month average of 9.6 deaths per month. This metric has reported close to the lower process limit

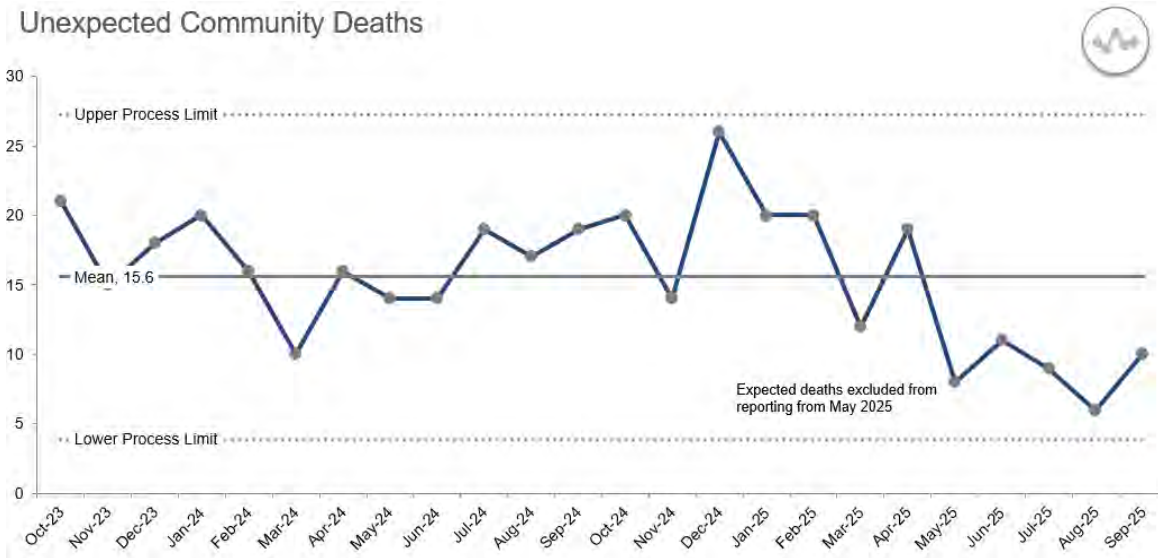
(0) since May (see Figure 3).

Figure 3 Overview of Unexpected Inpatient Deaths October 23 – September 25



3.4 Twenty-five deaths occurred within community services in Q2 2025/26. Although reporting within process limits (3.9-27.3), community deaths have reported below the long-term average (15.6) since May (see Figure 4). This reporting decline reflects the previously noted changes in reporting practice to ensure that the reporting figures is as per the National Quality Board Learning from Deaths guidance (2017).

Figure 4 Overview of Unexpected Community Deaths October 23 – September 25



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- 3.5 Twenty unexpected community deaths were reported by Mental Health, Learning Disabilities and Children & Family Services in Q2. Although showing natural variation, this metric has reported below average (10.5) since May; see figure 5.

Figure 5 Overview of Unexpected Community Deaths for Mental Health, Learning Disabilities and Children & Family Services



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

- 4.1. In Q2 Dorset Health Care did not receive any Regulation 28 reports.
- 4.2. In summary in Q2, there were:
- A total of 29 inquests.
 - There were three Pre-Inquest Review Hearings.
 - No additional learning was identified from the concluded inquests as the recommendations and learning had already been identified following Patient Safety Reviews.
- 4.3. Of the 29 inquests, three had a conclusion of suicide, and two were concluded as drug/alcohol related deaths; see table 1 below.

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Table 1

Directorate	Suicide	Accidental Death	Narrative	Misad-venture	Alcohol/ Drug Related	Not Indicated	Total
Integrated Community Services	1	1	-	1	-	5	8
Mental Health, Learning Disabilities and Children & Family Services	2	-	1	-	2	8	13
Not Indicated	-	-	-	-	0	8	8
Total	3	1	1	1	2	21	29

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

4.4. The following recurring themes from Dorset inquests were identified as:

Mental Health Care:

- Inadequate risk assessments and crisis response.
- Lack of coordinated care across agencies and in house services.

Communication Failures:

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

Systemic Gaps:

- Variability in hospital protocols for record access.

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

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5.0. PSIRF Learning

- 5.1. Currently the Trust Risk Management System (Ulysses) is unable to extract the data required to provide an overview of the type of response undertaken when a death is reviewed. The new PSIRF module, due to now launch in quarter 3, is anticipated to enable effective data extraction to support this overview going forwards which will enhance future reporting and oversight in addition to assurance of the Trust approach to learning from deaths.
- 5.2. There were 29 unexpected deaths reported through the patient safety process in the Trust.
- 5.3. The following thematic learning has been identified as a result of the learning responses undertaken in Q2:

- The timing and quality of Multi-Agency Review Meetings (MARMS) continues to be an area for improvement.

Action taken to date: Whilst this has been an ongoing discussion across partners, there has not been the anticipated change. Therefore, this has now been escalated to the ICB to seek support and guidance.

- The challenge of bringing multiple services together to undertake a collaborated learning response review (internal to the Trust).

Action taken to date: The Patient Safety team take the lead for coordination of multiple service-learning responses and local meetings have now been introduced to aid the facilitation of this approach.

- The challenge of balancing the coronial requirements alongside PSIRF methodology (national issue).

Action taken to date: Different approaches have been undertaken since the introduction of PSIRF in the Trust. It has now been agreed that all unexpected deaths will trigger the clinical legal services team who will coordinate with services. This will then separate PSIRF and the coronial requirements, whilst maintaining a compassionate and supportive approach for all involved. In addition, it will be clearer for staff that if there is an unexpected inpatient death, a After Action Review or a Structured Judgement tool will be undertaken as standard approach. For community unexpected deaths this will be considered case by case This will be updated within the revised Learning from Deaths policy and the new PSIRF policy (new).

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6.0. CHILD DEATHS

- 6.1. The following cases are shared to reflect child deaths across Dorset, whilst they may have not been directly receiving our care, details are included for awareness and shared learning and the family may access the Trust for other services and hence valuable for oversight.
- 6.2. There were six reported child/young person deaths across Dorset in Q2.
- 6.3. On review, four child deaths were due to early gestation/premature birth. Three were within BCP and one within Dorset area.
- 6.4. A Dorset infant died at 21 weeks of age with early indications of a sudden unexpected death in infancy (SUDI). The child was not known to children's social care, and no safeguarding concerns have been identified to date. A joint agency response was undertaken in the Multi-Agency Safeguarding Hub (MASH), and the case is scheduled to be reviewed by the Child Death Overview Panel.
- 6.5. A BCP infant was delivered via emergency caesarean section at 32+5 weeks' gestation following maternal cardiac arrest resulting from a drug overdose. The baby sadly died 21 days later due to complications associated with prematurity and the circumstances of birth. This case will proceed to a Local Child Safeguarding Practice Review (LCSPR).
- 6.6. Initial key lines of enquiry for learning from the Rapid Review described in 6.4 are effectiveness of planning, the assessment of domestic abuse, and the escalation and response to issues of 'drift and delay'. The case also highlighted a significant professional variation in the interpretation of the severity of neglect and how this was experienced by the children.

7.0. LEARNING DISABILITY DEATHS (LeDeR)

- 7.1. In Q2, 16 LeDeR reviews were completed for people with a learning disability known to Dorset Healthcare at the time of their passing. The age range of this group was 20-81 years old. Of these, one was unexpected, with the cause confirmed as Sudden Unexplained Death in Epilepsy (SUDEP). None of the sixteen NHS Dorset LeDeR reviews identified learning that was additional to the Integrated Care Board's identified priorities around health inequalities).

7.2. LeDeR Outcomes

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



Good practice identified included:

- Good communication across agencies.
- Appropriate easy read information enabled the person to understand that they were dying and to engage in their end-of-life planning.
- Continuity of care. One patient had been seen by the same nurse at cardiology appointments for over 20 years.
- Community Learning Disability Nurse persisted in her attempts to engage with a non-compliant patient.

One learning point was identified

- Services using different computer systems to record patient information and notes mean that information is not easily accessible across services. In one instance this led to multiple referrals being declined as the patient was deemed to be more appropriate for the other service. As a result, the patient's declining mobility was not assessed in the seven months prior to death.

Action taken to date: As a result of this learning there has been a discussion between the two services and a sharing of duty contact details to enable the most appropriate service to be discussed and determined.

8.0. SAFEGUARDING REVIEWS (related to learning from deaths)

- 8.1. There were fourteen active Safeguarding Adult Reviews (SARs) on going at the end of Q2. Five in Dorset Council, seven in BCP and two out of area.
- 8.2. Six of the DBCP reviews will be incorporated into two thematic reviews
- 8.3. In Q2, the Safeguarding Adults/MCA Lead made two referrals to the SAR Sub-group involving patients that went through the Trust patient safety process.
- 8.4. Both referrals were accepted and work has commenced to identify the terms of reference for the reviews.
- 8.5. There were eight active Domestic Homicide Reviews/ Domestic Abuse Related Death Reviews (DHRs/ DARDR) ongoing in Q2, as well as two out of area:
 - Dorset Council (DC) DHR 16, DHR 21,
 - BCP – DHR 14, DHR 19, DHR 20, DHR 22, DHR 23, DHR 25,
 - Out of Area – 1- Wyre Council and 2- Hampshire
- 8.6. There were four two new referrals during Q2:
 - DHR 26 DC – To commence. Minimal involvement from DHC services so not requiring agency report, although will be panel member.



- DHR 27 DC – On hold while CID investigate but not known to DHC services
- DHR 28 BCP - Recommendation to the Home Office not to proceed (not meeting criteria)
- DHR 29 BCP – To proceed – involvement from community physical health services.

The Agency report will be requested.

- 8.7. There have been no publications in Q2.
- 8.8. There were no new MAPPA referrals, however one action plan remains ongoing following the last local review.
- 8.9. There were two ongoing Child Safeguarding Practice Reviews during Q2 (one in DC, two in BCP). One new review has been commenced.
- 8.10. Several local learning reviews were ongoing throughout Q2. They did not meet the threshold for a CSPR and not all have died, described as a near miss and learning has been identified:

9.0 END OF LIFE CARE (Expected Deaths)

- 9.1 There were 46 expected deaths recorded within inpatient services in Q2 2025/26, all of which occurred within Integrated Community Services.
- 9.2 On review of learning, the following was identified during Q2:

Areas of Good Practice Identified

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

Areas identified for continued improvement

- Improved documentation of conversations regarding nutrition and hydration/ psychological/ social/spiritual support as identified from the recent National Audit for Care End of Life (NACEL) reports.
- Continued education and support for ward teams to continue to improve conversations with patient and families with Advanced Care Planning to reflect patient wishes.

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

10.0 MEDICAL EXAMINER DEVELOPMENTS

Engagement with the University Hospital Dorset Medical Examiner service has been formalised to strengthen learning and provide improved oversight of themes and concerns arising from ME reviews. From Q3, quarterly summaries of next-of-kin feedback, patient safety issues and PALS cases will be shared with us via our PALS team. This will support triangulation of information across mortality, patient safety and experience processes to consider areas of opportunity to improve future outcomes and experience of patients, families and carers.

11.0 NEXT STEPS

The reporting content and style will continue to be developed to focus on identification of learning, the Trust approach to support the wider learning and any associated actions that are required, including where identified escalation to seek support from the Mortality Governance Group.

The Learning from Deaths policy and the new PSIRF will be completed in Q4 and will provide clarification of roles and responsibilities associated with both requirements.

12.0 SUMMARY

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

Author (Overall): Ellie Lindop



Role: Deputy Director of Nursing, Therapies and Quality

Date: 13.11.25

Appendix 1

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

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

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Report to	Board in Common	
Date of Meeting	09 December 2025	
Report Title	Learning from Deaths Q2 2025/26	
Prepared By	Dr Adam Nicholls – Deputy Chief Medical Officer	
Approved by Accountable Executive	Dr Rachel Wharton – Chief Medical Officer	
Previously Considered By	Quality Committee in Common – 25 November 2025	
Action Required	Approval	Yes
	Assurance	-
	Information	-

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? <i>Delete as required</i>	
Care	Yes	
Colleagues		No
Communities		No
Sustainability		No
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 Safety and Quality	
Financial	No implication	
Statutory and Regulatory	Learning from the care provided to patients who die is a key part of clinical governance and quality improvement work (CQC 2016). Publication on a quarterly basis is a regulatory requirement. An elevated SHMI will raise concerns with NHS E&I and the CQC	
Equality, Diversity & Inclusion	Considered as part of review	
Co-production & Partnership	No implication	

Executive Summary
The purpose of the report is to inform the Quality Committee of the learning occurring from deaths being reported, investigated and appropriate findings disseminated throughout the Trust. To also outline additional measures put in place to assure the Trust that unnecessary deaths are not occurring at DCH despite a previously elevated SHMI. Presentation of the Learning from Deaths report at Quality Committee and Trust Board is a mandatory obligation for all Trusts. • The latest published SHMI data for the rolling year June 2024 – May 2025 is 1.01. • No national indicators of quality of care indicate any concerns with mortality at Dorset County Hospital • Mortality for patients with hip fractures lies in the expected range, although above the national average. There is an ongoing improvement programme to look at how we can maintain and improve our position.

Recommendation
Members are requested to receive the report for approval .

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Learning from Deaths Q2 2025/26

CONTENTS

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

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1.0 DIVISIONAL LEARNING FROM DEATHS REPORTS

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

1.1 Family Services and Surgical Division Report - Quarter 2 2025/26 Report

Structured Judgement Review Results:

The Family Services & Surgery Division had 52 deaths in quarter 2, of which 45 that require SJR's to be completed. Within quarter 2 55 SJR's have been completed from this quarter and previous months.

Outstanding SJR's:

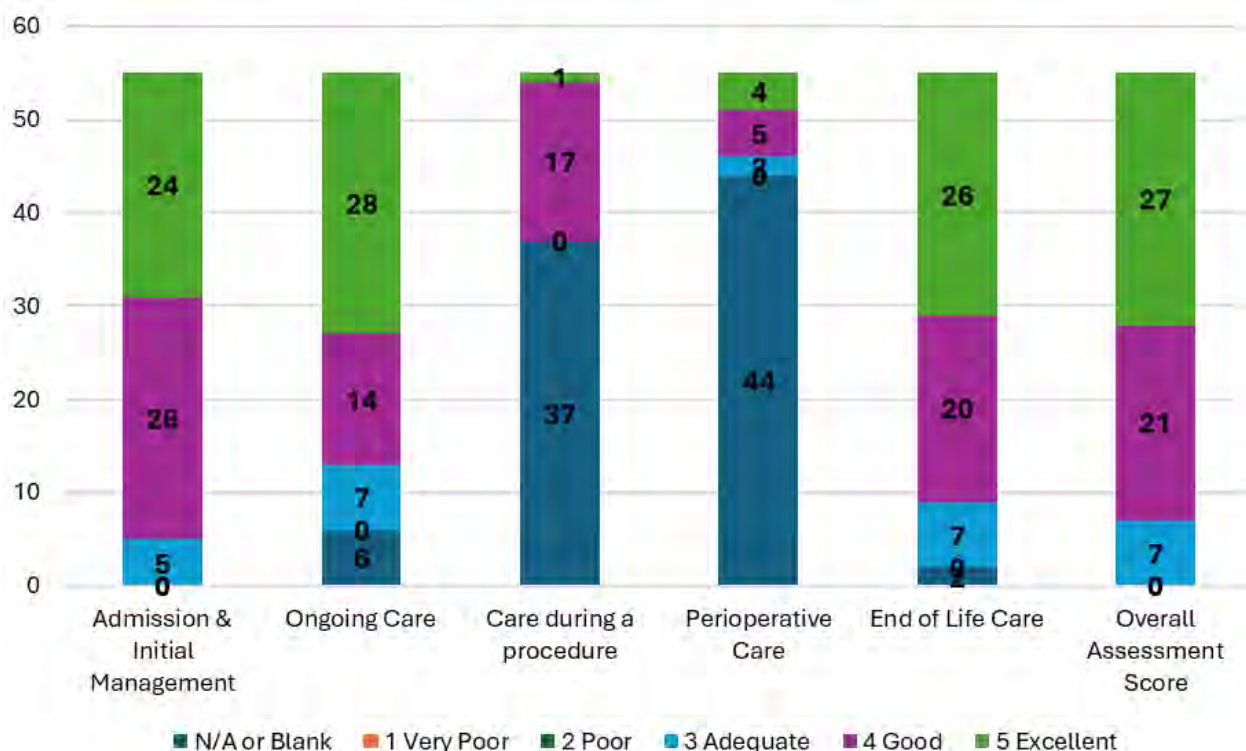
The Division have completed a number of SJR's from previous quarters. The backlog of outstanding SJR's (over 2 months) for the Division as at 30/09/2025 is 2:

July
2

Feedback from SJR's Completed in Quarter 2:

Phase Score	Admission & Initial Management	Ongoing Care	Care during a procedure	Perioperative Care	End of Life Care	Overall Assessment Score
N/A or Blank	0	6	37	44	2	0
1 Very Poor	0	0	0	0	0	0
2 Poor	0	0	0	0	0	0
3 Adequate	5	7	0	2	7	7
4 Good	26	14	17	5	20	21
5 Excellent	24	28	1	4	26	27

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Overall Quality of Patient Record:

Blank	Score 1 Very poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
0	0	1	11	25	18

- Con review Sunday afternoon/ evening ?happen and not documented.
- Good documentation and good clerking documentation.
- Good documentation throughout patient journey of care. Poor surgical clerking noted.
- Good documentation and good clerking documentation.
- No print out of ED notes but this has become the norm. Makes SJR review of ED actions difficult.
- Notes all loose and wrong order. No access to Yeovil notes.
- Overall Good documentation made by urology team. Poor ED documentation- no clerking noted on Agyle.

Avoidability of Death Judgement Score:

Score 1 Definitely avoidable	Score 2 Strong evidence of avoidability	Score 3 Probably avoidable (more than 50:50)	Score 4 Possibly avoidable but not very likely (less than 50:50)	Score 5 Slight evidence of avoidability	Score 6 Definitely not avoidable
0	0	0	2	4	49

Action Required:

Following completion of the 55 SJR's, 7 were highlighted as requiring actions.

Further learning via:

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

Other actions:

- 1 was for review and discussion at Specialty M&M/Clinical Governance meeting.
- 1 was for referral to HMG – scheduled for 15/10/25.
- 1 was for LEDER review and inquest.
- 1 was for Yeovil review and discuss with Orthopaedic re X-rays.

SJR's are routinely completed by both Medical and Nursing staff to provide an MDT approach and ensure all aspects of a case are reviewed.

Areas of good practice:

a) Admission

Excellent Medical Clerking
Appropriate ceilings of care
Seen by ICM consultant promptly
Excellent communication with family
Rapid I+V and vascath
Sick patient attended immediately by A&E and ICU teams

b) Ongoing

Second opinions sought
MDT decision making

c) Procedure

Catheter inserted in ED- Good documentation
Well documented and managed I+V in ED as well as arterial and central line
Good NG tube insertion by nutrition team with excellent documentation

d) Perioperative care

Consultant surgeon and anaesthetist

e) EOL care

Daily palliative care reviews

Areas for Improvement:

a) Admission

ICU initial review to consider future plans – Newsletter
PR bleeding on admission. DOAC held but clexane prescribed for limited reasons – Newsletter
PTWR documentation not done on a number of occasions (ortho and ICM weekend) – Newsletter and CGM

b) Ongoing

Consideration of 3-way catheter for clot retention – Surgical CGM

Hip fracture missed on X-Ray on admission by admitting team. If clinical concern of hip pain- please seek report and or referral to orthopaedics. – Newsletter

c) Procedure

N/A

d) Perioperative

N/A

e) EOL care

EOL care pathway not used when palliated after 94 year old with necrotic bowel laparotomy was abandoned.

A patient was started on NIV with no realistic chance of survival. For consideration of not escalating in these circumstances.

Surgical Clerking

The quality of some surgical clerking has been an issue for a while. Specifically, when nothing or limited information is written in the PMH or DH boxes as well as limited examination. The Clinical Lead and Governance Lead for Surgery have responded to emails from the Interim Deputy Chief Medical Officer.

They feel that they are starting to make progress.

They have recently reaudited surgical clerkings, after introducing a simpler clerking proforma and hopefully this will show an improvement. They have also recently introduced a 'clerking FY1' to the on-call team, so this should also improve things further.

The consultants remind the juniors about this regularly, but with the turnover of residents they end up starting all over again every few months.

Going forward an expansion of the ANP service might help. There should have 4, but at present only have 2 full time and one trainee, with another one off on maternity leave.

Learning from Division

1. Actions taken to address surgical clerking – see above.
2. Fractured NOF mortality above national average but within limits – ongoing work is reported later in this report.

Emerging Themes:

1. Lack of documentation of PTWR - ? did they happen

1.2 Division of Urgent & Integrated Care – Quarter 2 Report 2025 / 26

In quarter 2 there were 156 deaths, 20 SJR's were requested from these deaths, and 16 SJR's were completed during this period (completed SJR's not necessarily from this quarter).

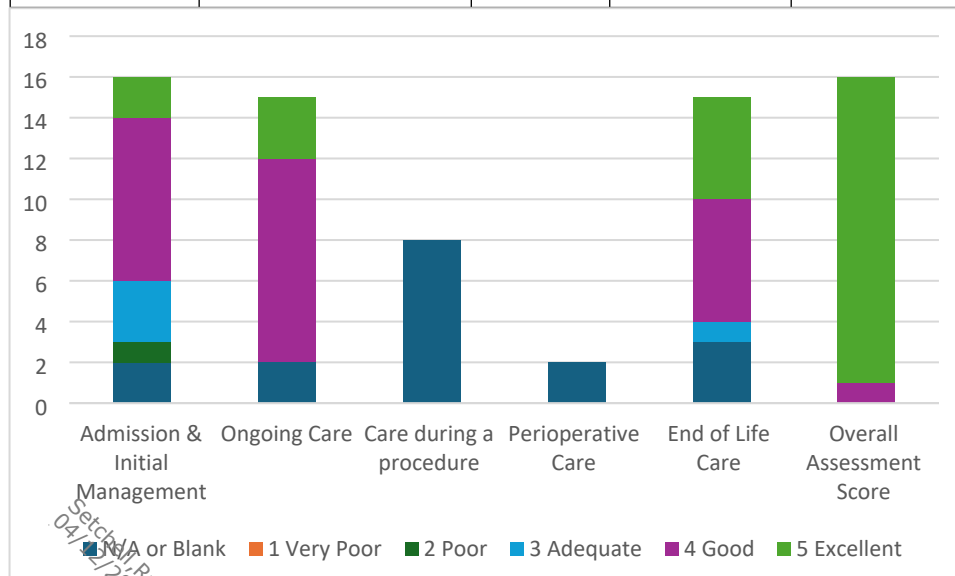
	Q2			Q3			Q4			Q1			Q2		
	Jul	Aug	Sep	Oct	Nov	Dec	Jan - 25	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Deaths	53	52	45	75	105	82	62	61	66	72	81	90	47	57	52
Deaths requiring SJR'S from Month	15	8	15	6	22	26	20	12	7	13	14	7	6	6	8
*Completed SJR'S	1	10	9	1	9	2	0	0	0	13	19	10	11	2	3

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

Jun-24	Jul-25	August	September	October
1	2	1	0	1

Phase score from 16 completed SJR's in Q2 2025:

Phase Score	Admission & Initial Management	Ongoing Care	Care during a procedure	Perioperative Care	End of Life Care	Overall Assessment Score
N/A or Blank	2	2	8	2	3	0
1 Very Poor	0	0	0	0	0	0
2 Poor	1	0	0	0	0	0
3 Adequate	3	0	0	0	1	0
4 Good	8	10	0	0	6	1
5 Excellent	2	3	0	0	5	15



Overall Quality of Patient Record:

Blank	Score 1 Very poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
2	0	0	2	10	2

- Records on DPR reviewed, good.
- Handwriting difficult to read at times
- Comprehensive

Avoidability of Death Judgement Score:

Score 1 Definitely avoidable	Score 2 Strong evidence of avoidability	Score 3 Probably avoidable (more than 50:50)	Score 4 Possibly avoidable but not very likely (less than 50:50)	Score 5 Slight evidence of avoidability	Score 6 Definitely not avoidable
0	0	0	0	1	15

Action Required:

Following completion of the 16 SJR's, 1 required further action which was to share the learning via appropriate governance channels.

SJR Key themes from Areas of Good Practice:

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

SJR Key theme of Areas for Improvement:

- Flow from ED to inpatient bed
- Length of stay in ED – consistent theme in almost every SJR reviewed
- Length of time to verify death – also a theme in last quarter's report
- Poor initial clerking with limited physical examination in some cases

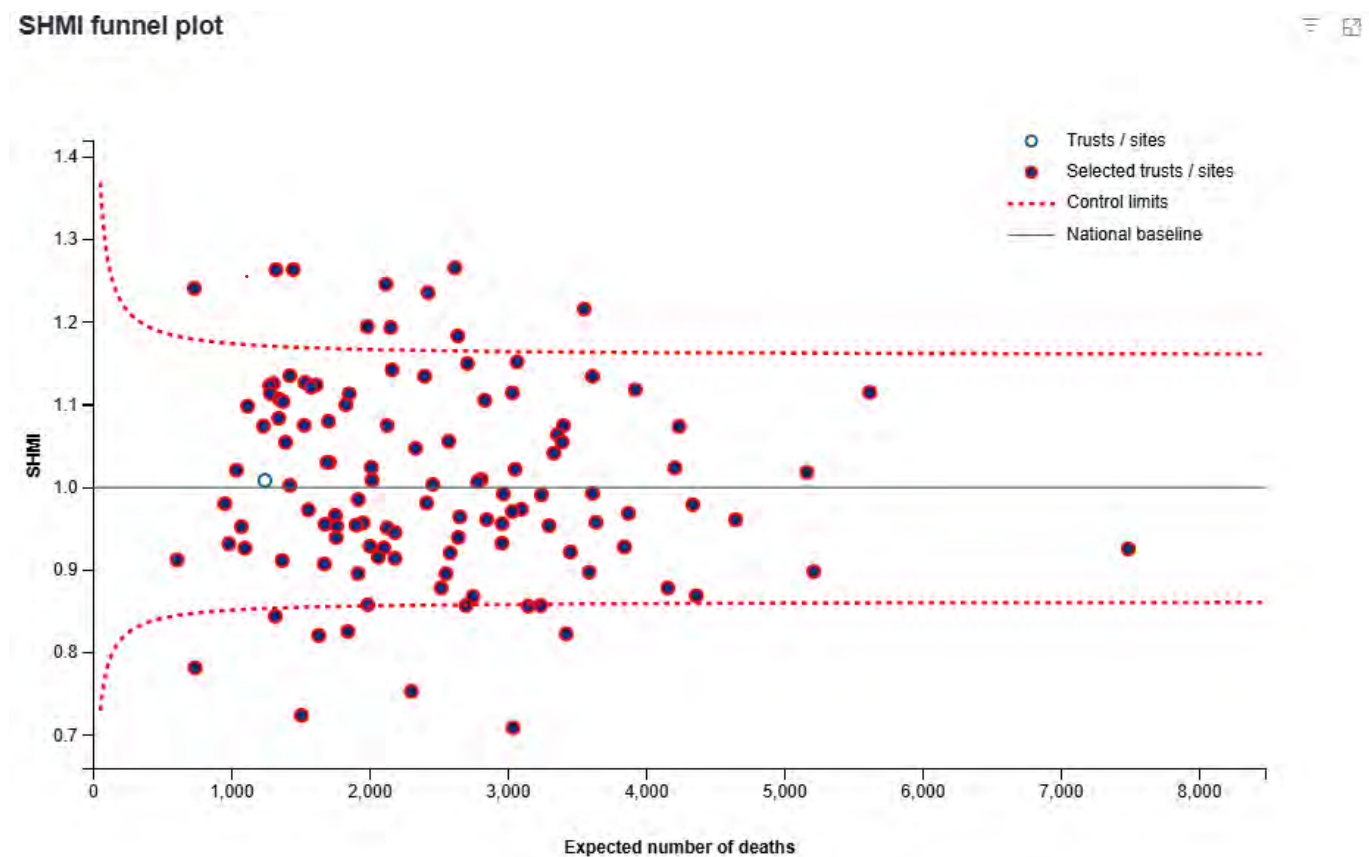
2.0 NATIONAL MORTALITY METRICS AND CODING

2.1 Summary Hospital-level Mortality Indicator (SHMI)

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

The latest SHMI publication is for the period Jun 2024-May 2025. The trust's SHMI value is 1.01 which is as expected.

DCH =White dot

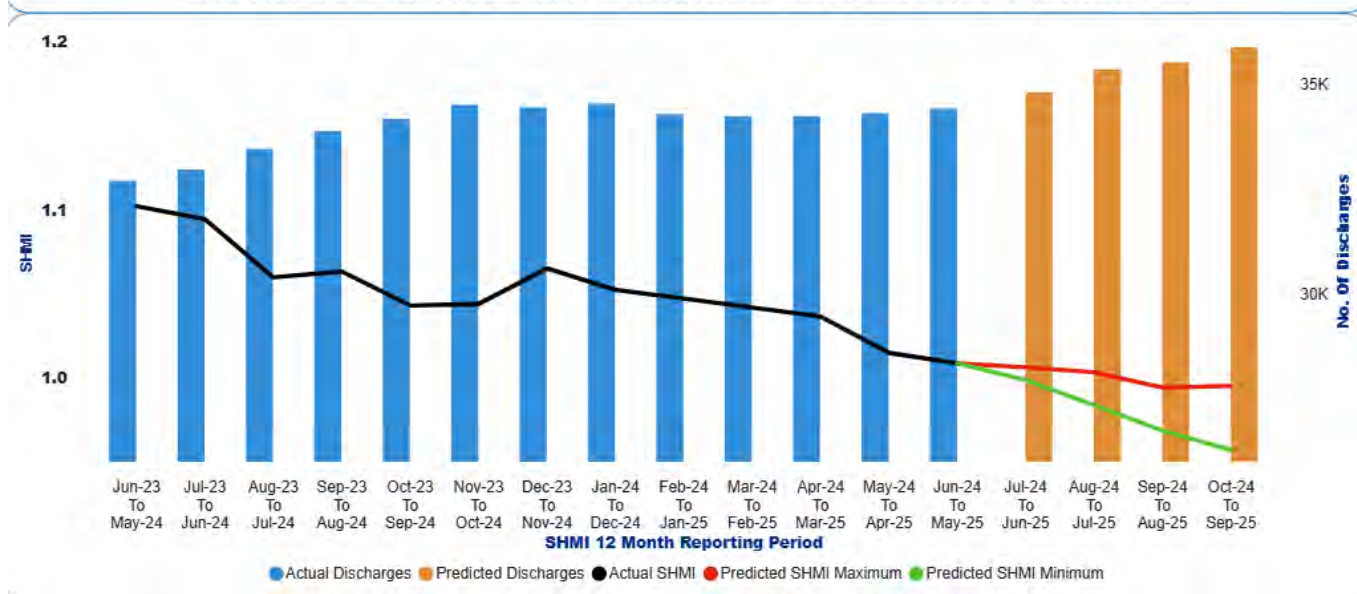


SHMI data is reported with a 5 month data lag. Our business intelligence team have produced a dashboard which predicts our SHMI aiming to give assurance and the chance to act early if we see a predicted rise in SHMI. Our predicted SHMI is shown below:

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SHMI 12 Month Reporting Period Comparing The Number Of Discharges Against SHMI - Latest Publication Jun-24 To May-25

DCHFT SHMI Value Was 1.0086 With 1250 Observed Deaths Against 1239.39 Expected Deaths



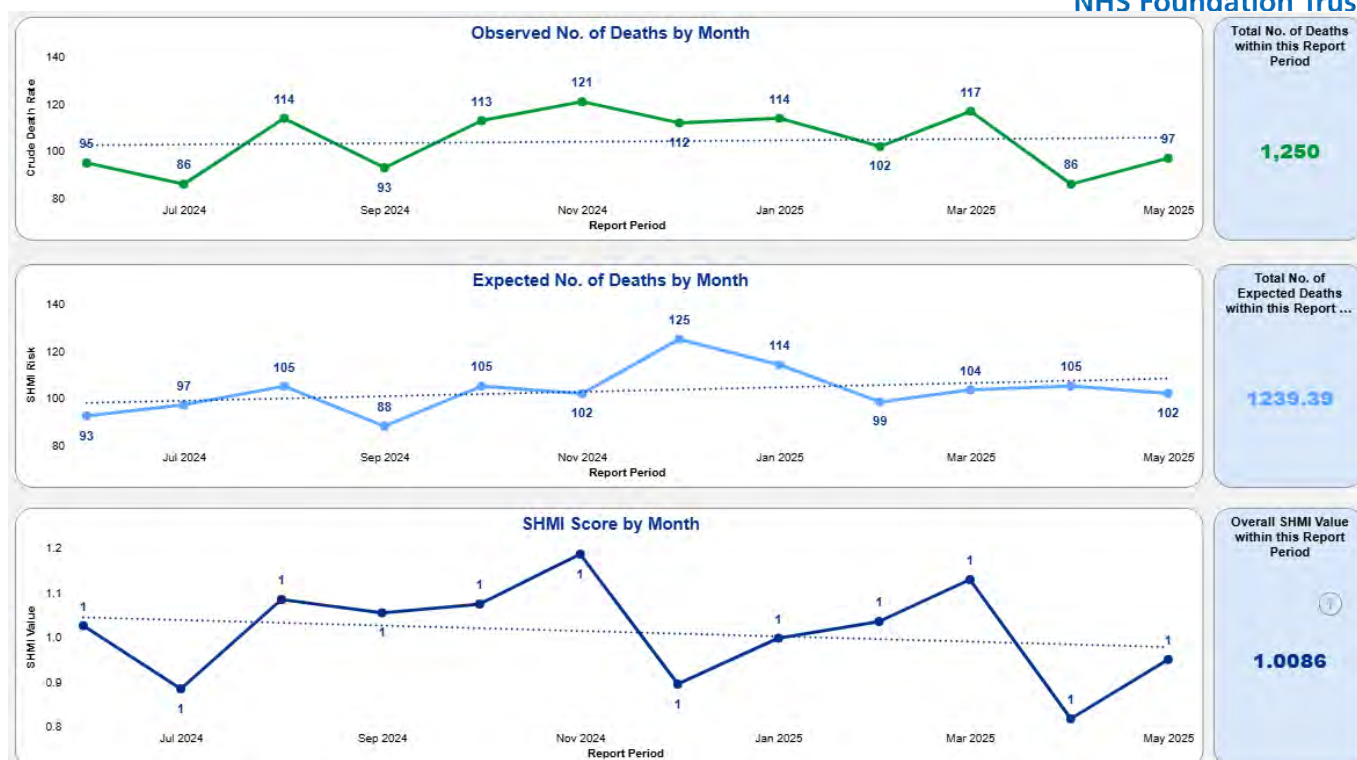
2.2 Depth of coding: NHS Digital states “As well as information on the main condition the patient is in hospital for (the primary diagnosis), the SHMI data contain up to 19 secondary diagnosis codes for other conditions the patient is suffering from. This information is used to calculate the expected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

DCH's depth of coding is 5.4 for elective admissions and 5.8 for non-elective admissions. Both of these values are stable, but below the national average. The coding team continue with mitigations to achieve year end targets – namely the use of bank/agency coders up to the end of October and coding more from the electronic records (with conditions applied to ensure data quality is not effected). The depth of coding and impact on SHMI will continue to be monitored.

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

The chart below shows observed (actual) and expected (calculated by NHS Digital) deaths, the numbers of which are directly influenced by the number of in-patients.

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3.0 OTHER NATIONAL AUDITS/INDICATORS OF CARE

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

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

3.1 NCAA Cardiac Arrest data

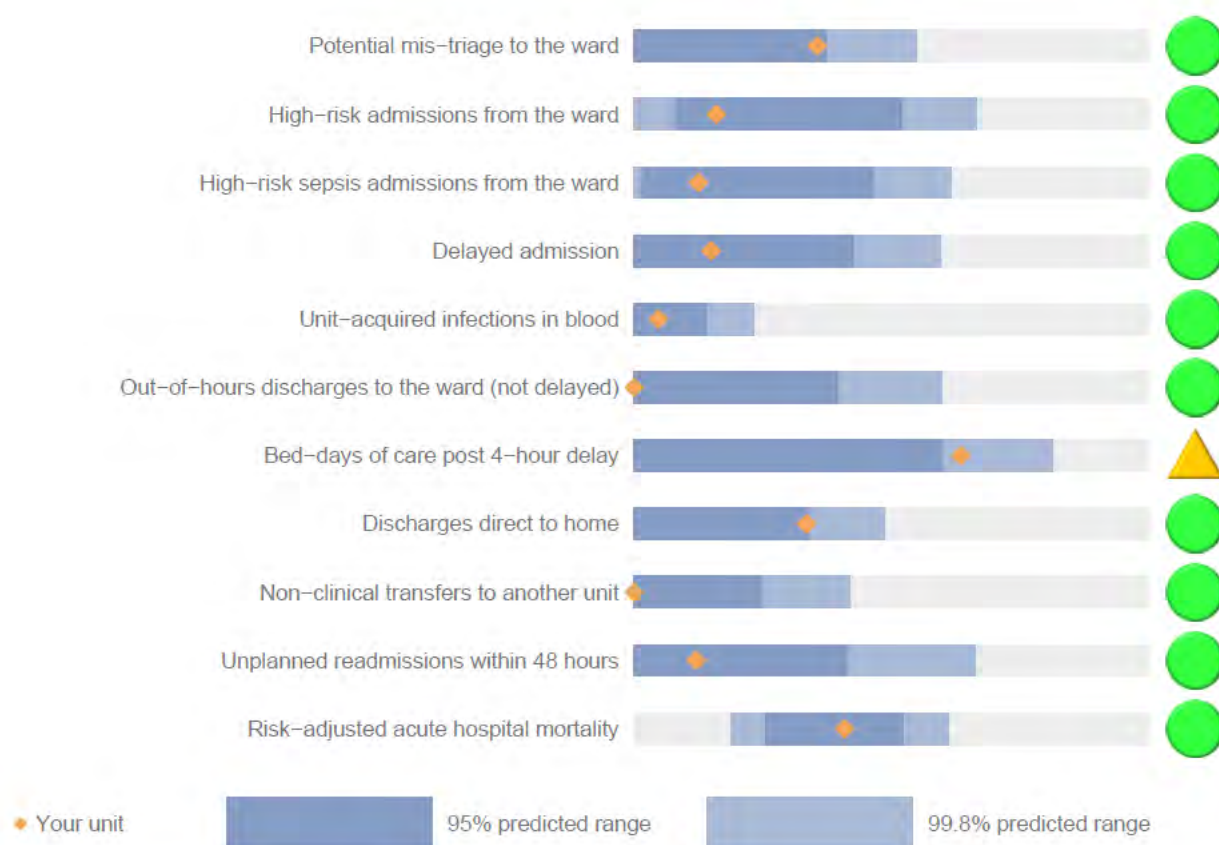
The resus committee now report directly into HMG. This is a change since October 2025. Assurance reports from the resuscitation committee will be reviewed though HMG and reported through LfD starting with quarter 3. The latest update from the resuscitation committee in October 2025 showed no ongoing concerns.

There is a new allow a natural death form across Dorset and the implementation of this will be planned through the resuscitation committee.

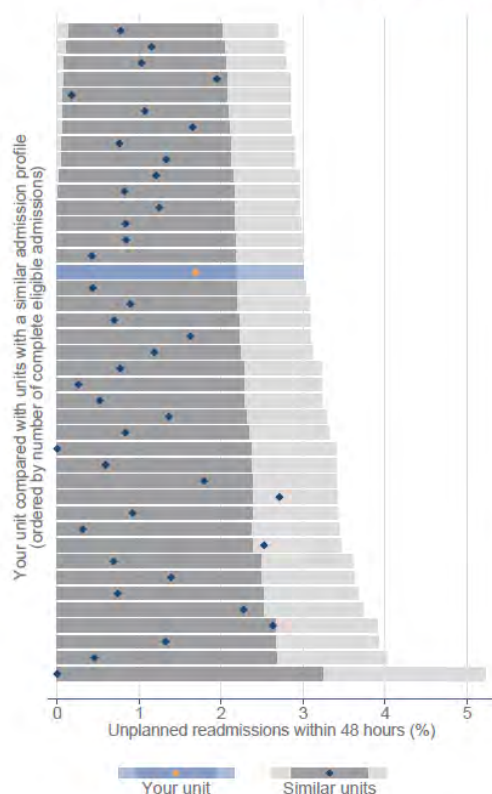
3.2 ICNARC Intensive Care survival data for dates 1 April 2025- 30th June 2025

One indicator is amber (bed-days of care post 4-hour delay). There is a national standard that all discharges from ITU should be made within 4 hours of a clinical decision to discharge from ITU. This maintains capacity/efficiency of ITU units. This indicator is likely to reflect the pressures that inpatient beds are under – such that a lack of flow in the hospital delays discharges from ITU. This will be continued to be monitored in the ICNARC data.

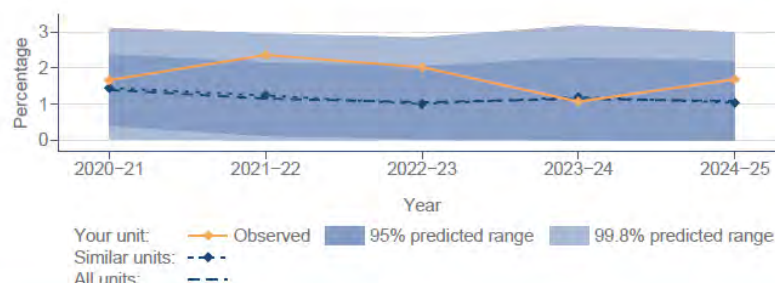
Quality indicator dashboard



Unplanned readmissions within 48 hours



	Eligible n	Complete n (%)	Observed n (%)	Expected %	95% predicted range	99.8% predicted range	
Quarter 1	131	131 (100.0)	1 (0.8)	1.1	(0.0, 2.9)	(0.0, 4.5)	●
Quarter 2	121	121 (100.0)	2 (1.7)	1.2	(0.0, 3.1)	(0.0, 4.8)	●
Quarter 3	114	114 (100.0)	4 (3.5)	1.1	(0.0, 2.9)	(0.0, 4.7)	▲
Quarter 4	107	107 (100.0)	1 (0.9)	1.0	(0.0, 2.8)	(0.0, 4.6)	●
Full year	473	473 (100.0)	8 (1.7)	1.1	(0.0, 2.2)	(0.0, 3.0)	●

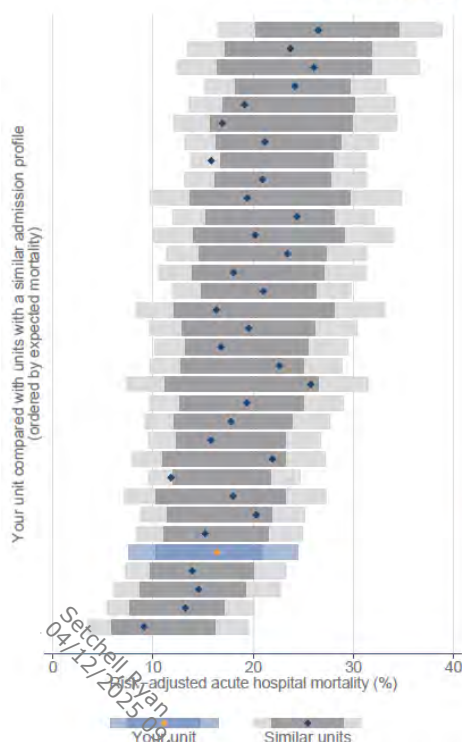


Definition

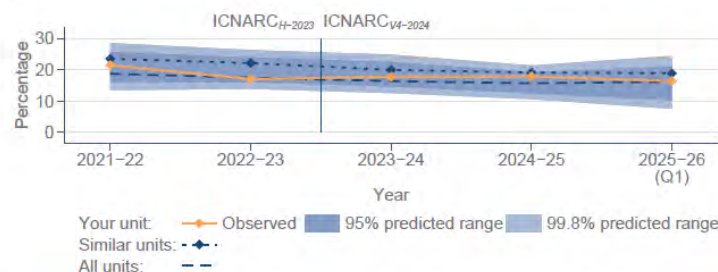
- Eligible: Critical care unit survivors discharged to a non-critical care location in your hospital
- Complete: The number and percentage of eligible admissions with sufficient data to identify unplanned readmissions
- Observed percentage: The number and percentage of complete eligible admissions subsequently readmitted (unplanned) to your unit within 48 hours of discharge
- Expected percentage: The overall percentage of unplanned readmissions within 48 hours across all critical care units participating in the CMP
- Predicted range: We expect a unit's observed percentage to lie within the 95% predicted range 19 times out of 20 and within the 99.8% predicted range 998 times out of 1000

Risk adjusted acute mortality remains within the expected range:

Risk-adjusted acute hospital mortality



	Eligible n	Complete n (%)	Observed n (%)	Expected %	95% predicted range	99.8% predicted range	
Quarter 1	182	177 (97.3)	29 (16.4)	15.7	(10.3, 21.0)	(7.6, 24.4)	●
Quarter 2							
Quarter 3							
Quarter 4							
Year to date	182	177 (97.3)	29 (16.4)	15.7	(10.3, 21.0)	(7.6, 24.4)	●



Definition

- Eligible: All critical care unit admissions, excluding readmissions, patients dead on admission and those admitted to facilitate organ donation
- Complete: The number and percentage of eligible admissions with sufficient data to calculate an ICNARC_{V4-2024} model risk prediction and complete status at discharge from acute hospital
- Observed percentage: The number and percentage of complete eligible admissions that died before ultimate discharge from acute hospital
- Expected percentage: The expected percentage of acute hospital deaths, calculated as the mean predicted risk of death from the ICNARC_{V4-2024} model, among complete eligible admissions to your unit
- Predicted range: We expect a unit's observed percentage to lie within the 95% predicted range 19 times out of 20 and within the 99.8% predicted range 998 times out of 1000

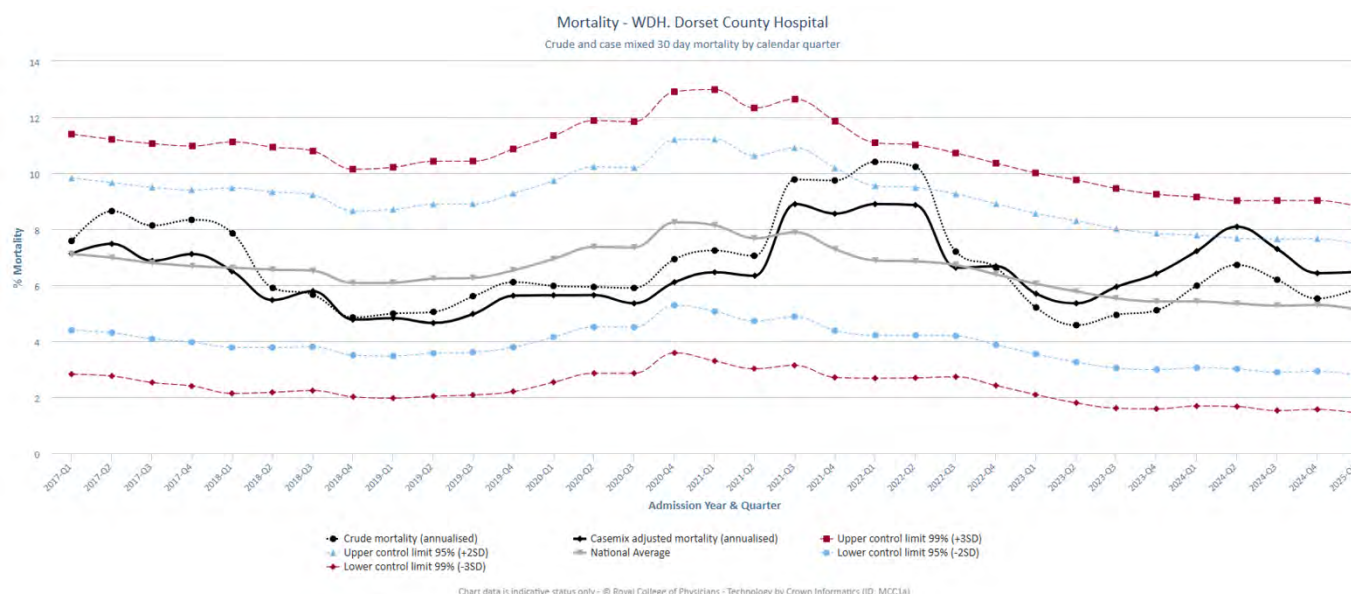
3.3 National Hip Fracture database

The National Hip Fracture database is run by the Royal College of Physicians and includes a range of performance data and mortality which I have focussed on below. The annualised case mix adjusted mortality has been above the national average, and although it was improving has now plateaued. The crude and case mix adjusted mortality fall within the expected limits although above the national average. There is an ongoing programme of work with regards to improvement in hip fracture care and the key points are summarised below:

- **Timely orthogeriatric referral and building capacity within the orthogeriatrics service**
 - o daily reminders on the take lists and Careflow for junior doctors and registrars.
 - o Capacity building is limited by difficulty recruiting to geriatrician posts, but there is an expectation that this will improve over 12-24 months.
- **Surgical prioritisation** – hip fracture patients are prioritised on trauma lists, with delays only where capacity, patient fitness, or fracture complexity dictates.
- **Regular monitoring** – the NHFD team track patients and trends, with monthly summaries shared with leads/management.
- **Education and feedback** – data and outcomes are presented at departmental education meetings to highlight both successes and areas for improvement.
- **Induction and training** – new junior doctors and registrars receive hip fracture care teaching at the start of their rotations.

This provides assurance that although our data is above the national average it falls within expected limits. We are aspiring to improve with an active improvement programme the impact of which can be monitored through the National Hip Fracture Database.

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

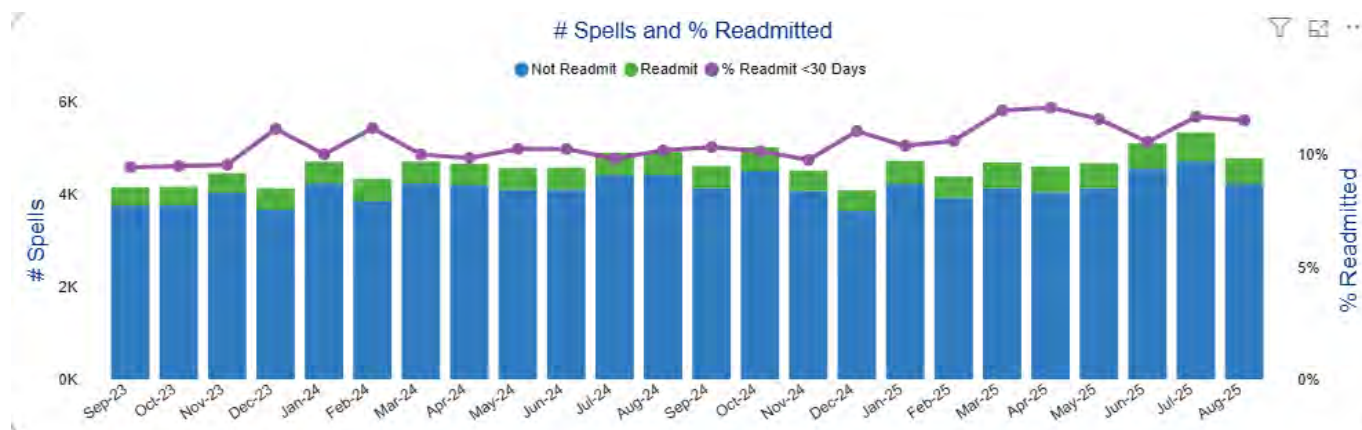


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3.8 Readmission to hospital within 30 days

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

SW regional data demonstrates that our readmission rate is in line with other trusts across the SW. Our readmission rate is shown below. There is a trend for higher readmission rates with increasing number of comorbidities and those with a higher deprivation index.



3.9 National Child Mortality Database

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

Locally the child death annual report was presented at paediatrics clinical governance in August 2025 and reviewed at HMG in September 2025. The number of child deaths are low and the majority of these are categorised as 'expected' and causes vary. Because of the low numbers drawing themes from these are difficult, but themes from the regional meeting are discussed in the paediatric clinical governance meeting. Local learning from these are shared in the paediatric service and discussed at HMG. Particular learning to note highlighted was the presence of risk factors for sudden infant death syndrome. Learning was shared regarding the care of children who die in the organisation and the process to follow.

Further data and updates will be shared as this is presented to HMG.

3.10 MBRRACE data

The maternity and neonatal teams at DCH use the BAPM Perinatal Optimisation Pathway to support improving outcomes for preterm babies. Compliance with PERIPrem is monitored at Perinatal M&M meetings when presenting cases.

There have been 3 perinatal deaths occurring at DCH reported to MBRRACE-UK via the PMRT in Quarter 2. There has been one early neonatal death pertaining to a baby born at home. This case has been referred to MNSI (Maternity & Newborn Safety Investigations) and will be reviewed through PMRT and the child death review process. There have been 2 antenatal stillbirths that will be reviewed through the PMRT process. There are 2 cases from previous quarters that are in progress.

3.11 National Perinatal Mortality Review tool

There have been 13 perinatal mortality cases reported to MBRRACE-UK between 1st January 2024 and 30th June 2025.

When reviewing the cases reported via PMRT the numbers are small to draw thematic conclusions but it has been noted that 64% of cases identified social circumstances or health behaviours such as smoking as a contributory factor. Deprivation features in over 63% of cases.

The full report is reported separately to board via quality committee in the perinatal mortality review report.

4.0 QUALITY IMPROVEMENT ARISING FROM SJRs & HMG

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

- Work to look at the care of people with hip fractures is detailed in previous sections
- Quality of surgical clerking in division B has been a persistent issue raised in SJRs – the division B report includes a section on efforts to improve this and this will be monitored through HMG.
- ED will be bringing an audit of paediatric long wait patients and impact on outcomes through HMG which will be reported in the quarter 3 report.

5.0 MORBIDITY and MORTALITY MEETINGS

Morbidity and mortality meetings are continuing across the Trust, with minutes collated by Divisional Quality Managers. Dates of these meetings are reported to and reviewed by the Divisional Clinical Governance meetings.

Following M&M meetings any learning and actions identified from the cases discussed are highlighted and information collated on an overview slide which is shared at their monthly Care Group meeting and the Divisional Business & Quality Governance meeting. Records of action plans and learning identified are available across departments.

6.0 LEARNING FROM CORONER'S INQUESTS Q2

DCH has been notified of 22 new Coroner's inquests being opened in the period 01 July 2025 – 30 September 2025.

17 inquests were held during Quarter 1. 13 inquests were heard as Documentary hearings, not requiring DCH attendance. 4 required a clinician to attend court in person. 0_remote. 0 inquests were held hybrid (some clinicians attend remotely, whilst others attend in person). 1 pre-Inquest review hearings were held.

We currently have 50 open Inquests. The Coroner has reviewed all outstanding cases to decide whether any can be heard as documentary hearings. No Regulation 28 (Preventive Future Death Notices) have been given during this quarter to the Trust, but there was a Preventive Future Death Notice for a patient who was treated at the Trust (attached). We have not required Representation on any of the cases.

Of the 22 inquests that have opened in Q2, 6 have the cause of death provisionally attributed to malignant or epithelioid mesothelioma.

Significant learning from inquests is shared with teams and divisions and discussed at HMG as required. There are no learning themes arising from inquests.

7.0 LEARNING FROM CLAIMS Q2

Legal claims are facilitated by NHS Resolution, who also produce a scorecard of each Trust's claims pattern and costs. The scorecard is now available, I am happy to disseminate to anyone who wishes to see it.

Claims pattern Quarter 2 FY 25/26.

New potential claims 13 clinical negligence, 0_employee

Disclosed patient records 24 (23 disclosure for claims inc updated records, 1 disclosures to the coroner – the Coroner has reduced the number of records they require)

Formal claims 7 clinical negligence, 0 employee claim

Settled claims 3 clinical negligence, 1 employee claims (2 missed cancers, Ophthalmology care, employee slipped on wet floor, resulting in injury to wrist)

Closed - no damages 2 clinical negligence, 0 employee claims

8.0 SUMMARY

The latest SHMI publication from NHS England is for 12 month period ending May 2025. The Trust's figure remains in the expected range.

There is an ongoing improvement programme in the care of hip fracture patients, and mortality remains within the expected range.

Coding remains a challenge, and the clinical coding risk is rated as high on the risk register. The impact of this on mortality metrics will continue to be monitored through HMG.

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Report to	Board in Common (DHC Board)	
Date of Meeting	9 th December 2025	
Report Title	Patient Experience Annual Report	
Prepared By	Anna Johnson – Head of Participation/Interim Head of Patient Experience	
Approved by Accountable Executive	Dawn Dawson, Joint Chief Nursing Officer	
Previously Considered By	Quality Governance Group 4 th November 2025, Quality Committee in Common 25 th November 2025	
Action Required	Approval	Y
	Assurance	N
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? <i>Delete as required</i>	
Care	Yes	
Colleagues		
Communities	Yes	
Sustainability		
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	<i>SR1 Quality and Safety</i> <i>SR2 Culture</i> <i>SR5 Estates</i> <i>SR8 Transformation and Improvement</i>	
Financial	No implication	
Statutory & Regulatory	Supports compliance with statutory duties relating to patient experience, involvement, and NHS England requirements for Patient Safety Partners and patient feedback.	
Equality, Diversity & Inclusion	Work continues to improve access to feedback and involvement opportunities and ensure a broader representation of voices, including young people, carers and communities who may be under-represented.	
Co-production & Partnership	Demonstrates active partnership with people with lived experience, carers, volunteers and system partners, with co-production embedded across key workstreams.	

Executive Summary
This report provides an overview of patient and carer experience activity at Dorset HealthCare during 2024/25, including feedback received, themes identified, and actions taken to support improvement. Across the year we continued to gather experience through the Friends and Family Test, inpatient surveys, patient stories, complaints and compliments, and through direct involvement of people with lived experience. In total, 20,818 FFT responses were received, with 92% reporting a good or very good experience. We also received 4,514 unsolicited compliments, recognising staff kindness, professionalism and the reassurance they provide.

Feedback also highlighted areas where improvement is required, particularly relating to communication, waiting times and navigation of services. We continued to strengthen how real-time feedback is used in clinical services and governance processes, ensuring concerns are identified early and acted on.

Lived-experience involvement expanded further, with Experts by Experience, Patient Safety Partners and peer workers contributing to quality, safety, training and service development. Work to improve support for unpaid carers continued across inpatient, community and primary care settings, and we strengthened volunteering activity, with 276 volunteers supporting services across Dorset.

This work supports delivery of the joint Dorset HealthCare and Dorset County Hospital strategy *Working Together, Improving Lives*, with a continued focus on person-centred care, culture, learning and improvement aligned to what matters most to patients, carers and families.

Recommendation

Members are requested to:

- Receive the report for assurance.
- To agree publication of this report on the Trust website.

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Patient Experience Annual Report

April 2024 - March 2025

1. Executive Summary

- 1.1 This report provides an overview of patient and carer experience activity at Dorset HealthCare during 2024/25, including feedback received, themes identified, and actions taken to support improvement.
- 1.2 Across the year we continued to gather experience through the Friends and Family Test, inpatient surveys, patient stories, complaints and compliments, and through direct involvement of people with lived experience. In total, 20,818 FFT responses were received, with 92% reporting a good or very good experience. We also received 4,514 unsolicited compliments, recognising staff kindness, professionalism and the reassurance they provide.
- 1.3 Feedback also highlighted areas where improvement is required, particularly relating to communication, waiting times and navigation of services. We continued to strengthen how real-time feedback is used in clinical services and governance processes, ensuring concerns are identified early and acted on.
- 1.4 Lived-experience involvement expanded further, with Experts by Experience, Patient Safety Partners and peer workers contributing to quality, safety, training and service development. Work to improve support for unpaid carers continued across inpatient, community and primary care settings, and we strengthened volunteering activity, with 276 volunteers supporting services across Dorset.
- 1.5 This work supports delivery of the joint Dorset HealthCare and Dorset County Hospital strategy *Working Together, Improving Lives*, with a continued focus on person-centred care, culture, learning and improvement aligned to what matters most to patients, carers and families.

2. Introduction

- 2.1 Improving patient and carer experience remains central to delivering our joint strategy, *Working Together, Improving Lives*. The strategy commits Dorset County Hospital and Dorset HealthCare to working in partnership with people and communities, empowering citizens, improving population health, and reducing inequalities.
- 2.2 A core part of this ambition is ensuring that the voices of people who use our services – and those who care for them – inform how care is designed, delivered and improved. Patient experience, complaints, participation, Experts by Experience, Patient Safety Partners, carers, and volunteering programmes together form a coherent approach to listening, learning and acting.
- 2.3 Throughout 2024/25 we strengthened opportunities for people to influence decisions, improved how we gather and use feedback across settings, and expanded lived-experience partnerships across mental and physical health services. These activities support our strategy's emphasis on compassionate, person-centred care; empowered communities; and a positive experience for colleagues, who benefit from direct insight and meaningful collaboration with patients and carers.
- 2.4 The following report describes progress, impact and learning across these functions over the past year.

3. Gathering Patient Feedback

- 3.1 Hearing directly from people who use our services remains central to how Dorset HealthCare learns and improves. We gather feedback from a range of sources including the Friends and Family Test (FFT), surveys, patient stories, compliments, and through direct engagement with carers and families.
- 3.2 The Patient Experience Team supports services to understand this feedback, identify themes, and act quickly where improvements are needed. Increasingly, this insight is shared across programmes of work so that learning informs improvement at every level.
- 3.3 Together, these mechanisms provide a rounded view of patient and carer experience across settings and support us to maintain focus on what matters most to the people we serve.

4. Friends and Family Test

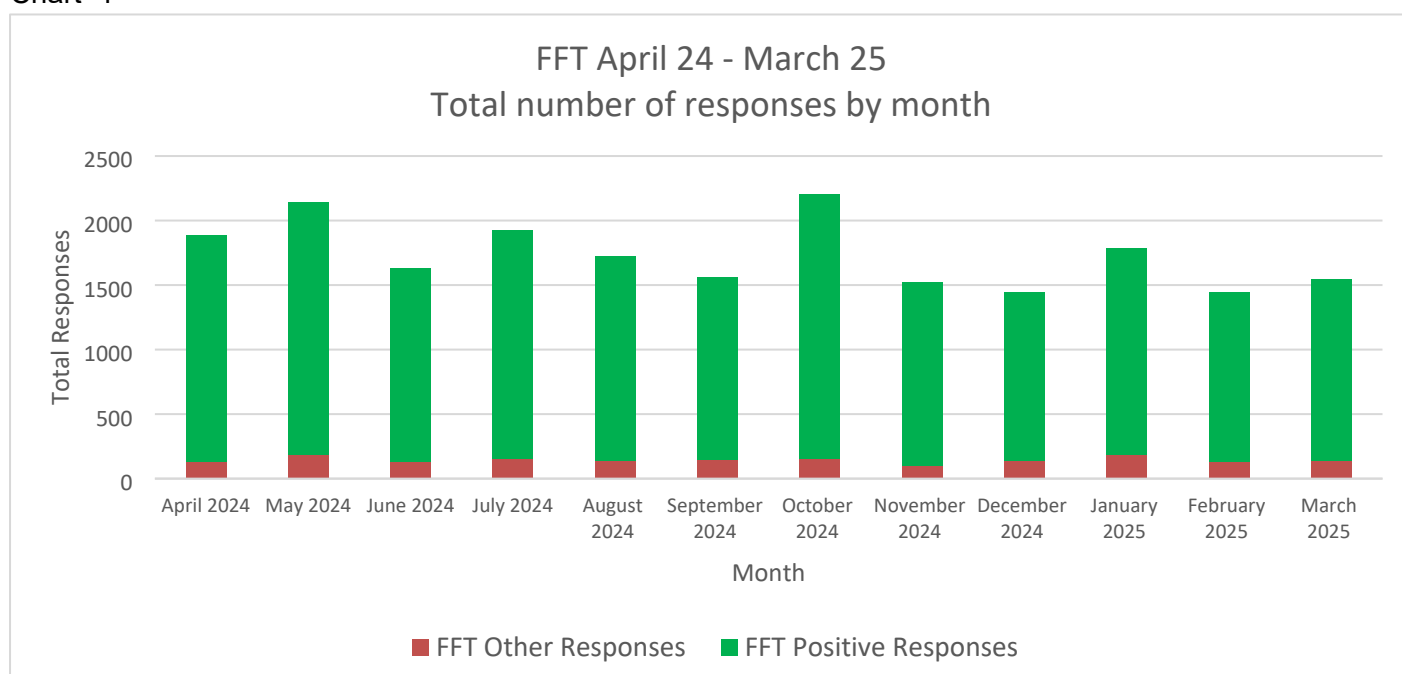
- 4.1 The Friends and Family Test (FFT) remains one of our main mechanisms for capturing real-time experience across inpatient, community and mental health settings. It gives patients who have received care from any of our services the opportunity to provide feedback about their experience at any time.

The FFT question asks:

'Overall, how was your experience of our service?'

- 4.2 During 2024–25, **20,818 responses** were received, with **92%** of respondents rating their care as good or very good. This reflects consistently high levels of satisfaction across the Trust's services.
- 4.3 Refer to chart 1 for an overview of the total responses by month.

Chart 1



- 4.4 Charts 2 and 3 indicate a high level of patient satisfaction across all of the Trust's service areas.

Chart 2

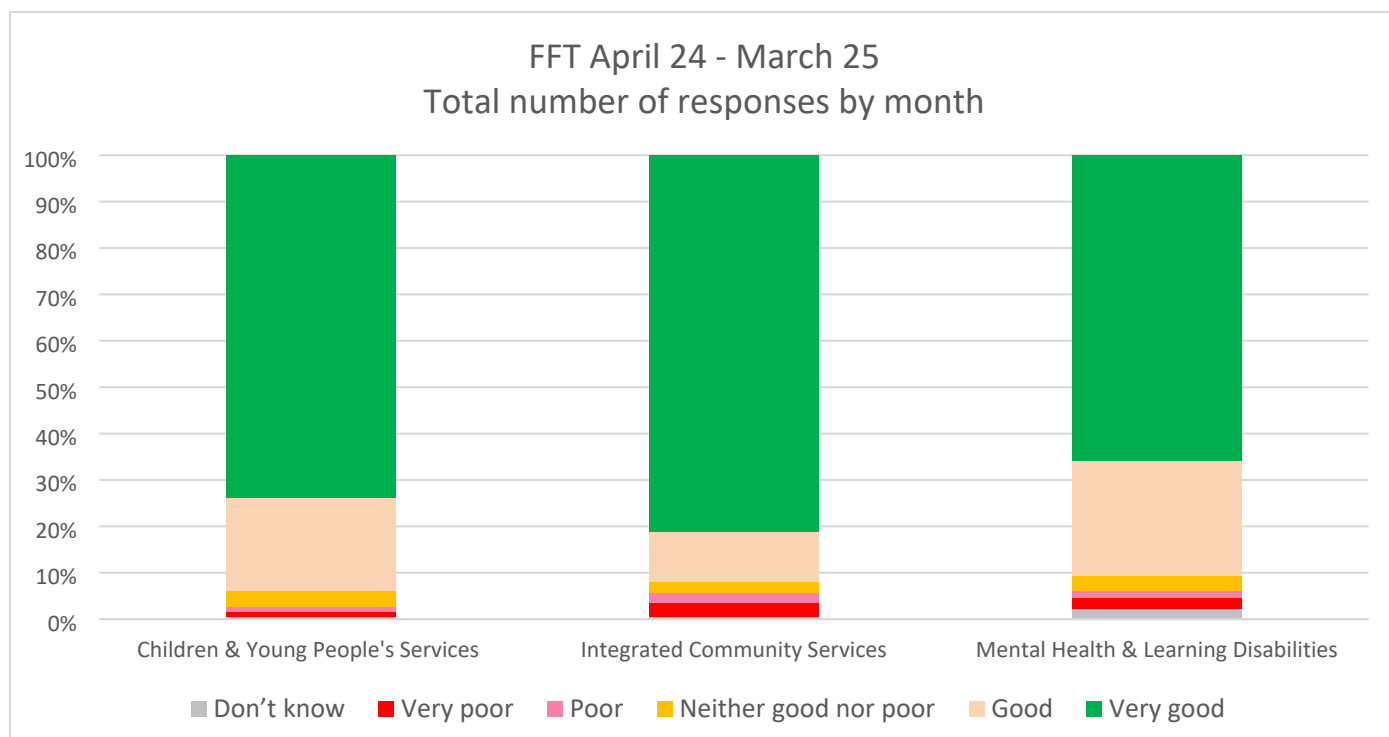
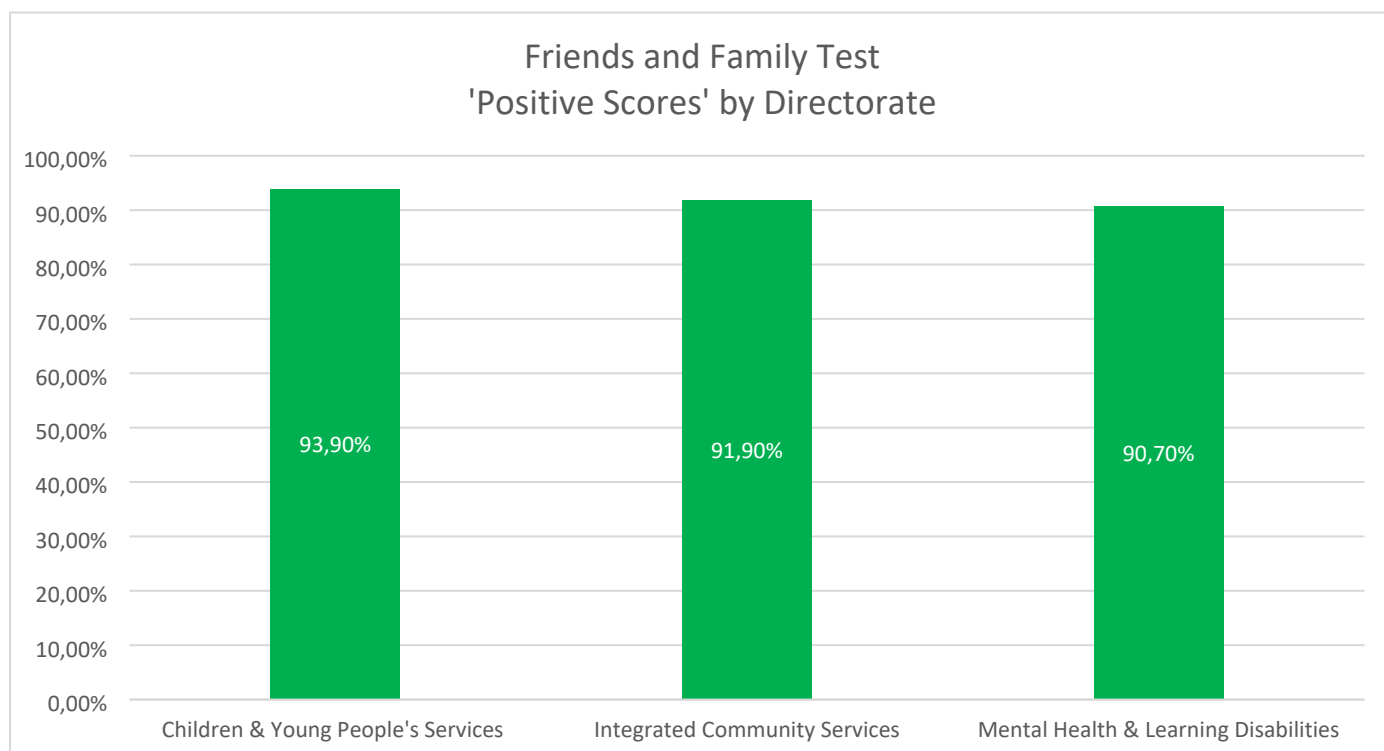


Chart 3



4.5 Alongside the scoring question, we also ask patients what they think we did well, and suggestions for how we might improve the service they received.

4.6 Over the year, we received thousands of free text comments, which offered a rich insight into how people experience our services in their own words. Overall feedback was positive, with strong praise for the compassion, skill and reassurance offered by staff across the Trust. Many people reflected

feeling heard, supported and treated with dignity, particularly during moments of anxiety or vulnerability.

- 4.7 Alongside this, clear themes emerged where systems and communication pressures impacted experience. People were most likely to express frustration when waiting times were long, when next steps were unclear, or when services felt difficult to access or navigate, especially during urgent or stressful moments.
- 4.8 This insight is available live to services and is used to guide improvement work throughout the year, ensuring that the patient voice remains central to how services evolve.

5. Inpatient Surveys

- 5.1 Every month, inpatients are invited to share their experience through our Inpatient Safety Questionnaires. These surveys are an important way for us to understand how safe, supported, and cared-for people feel while staying on our wards, and to respond quickly if concerns are raised.
- 5.2 A key question asks whether patients felt safe on the ward. When someone reports they did not feel safe, an automatic alert is sent to Ward Managers and Matrons, prompting timely review and reassurance or intervention where required.
- 5.3 Throughout the year, the Patient Experience Team has worked closely with our Mental Health and Community Inpatient Wards to build confidence and consistency in completing the surveys and acting on feedback. Training has been delivered to ward staff to support high-quality completion and effective follow-up.
- 5.4 We have also worked with people who have direct lived experience of our inpatient services to refine survey questions so they reflect what matters most to patients, ensuring the tool remains meaningful, respectful and person-centred. This approach enables real-time insight into patient experience and supports wards to respond quickly, celebrate positive feedback, and make improvements where needed.

6. Compliments

- 6.1 During 2024/25, Dorset HealthCare received 4,514 unsolicited compliments from patients, families and carers. Feedback consistently highlighted the warmth, professionalism and dedication of our staff across services.
- 6.2 People frequently praised:
 - Feeling supported, reassured and listened to
 - Kindness and compassion during difficult moments
 - Clear communication and involvement in care decisions
 - Professional, respectful and attentive staff
 - Timely and responsive care
 - Staff going above and beyond to help

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- 6.3 Compliments are shared with teams each month, and services tell us that these moments of recognition are a powerful counterbalance to the pressures of day-to-day work and a reminder of the difference staff make.

7. Patient Stories

- 7.1 All Dorset HealthCare Board meetings begin by hearing a patient story. This helps ensure the voices of patients, carers and families directly shape Board discussions and decision-making about quality, safety and culture.
- 7.2 Stories highlight compassionate, person-centred care and also identify areas where improvement is needed. When themes for learning are raised, the Board seeks assurance that appropriate action is being taken. Experiences from carers, staff and volunteers are also included where relevant to provide a broader understanding of care and culture across the Trust.
- 7.3 In 2024-25 the following stories were presented to Board included:
- Wheelchair Service
 - Homeless Service – new approach to capturing and sharing experience
 - Swanage Physiotherapy
 - Neurodiversity Assessment & Diagnosis Centre (NDAC)
 - District Nursing – Beaminster Team
 - Older People's Community Mental Health Team, Shaftesbury

All patient stories are available on our Trust website after discussion at the Board.

8. Experts by Experience

- 8.1 Experts by Experience (EbEs) work alongside services and leaders to bring insight into how care feels for patients and carers. They contribute across a wide range of programmes and workstreams, including quality, safety, culture and workforce development. EbEs take part in ongoing, practical work as well as one off engagement, offering clear feedback, constructive challenge and lived experience perspective to support decision making and improvement. This ensures lived experience is consistently part of how Dorset HealthCare plans and delivers care.
- 8.2 EbEs met regularly with the Trust Chief Executive during 2024/25. These conversations gave space for lived experience to shape strategic thinking, surface themes from across services, and explore solutions together. Going forward, EbEs and senior leaders will continue this two-way dialogue, with a focus on jointly progressing areas that matter most to the people we support.
- 8.3 An overview of activity included:
- Input into service design, co-production and governance
 - Participation in senior recruitment and staff induction
 - Work on restrictive practice, safety and discharge experience
 - Monthly involvement in therapeutic engagement training for mental health ward staff
 - Bi-monthly health inequalities sessions for preceptees
 - Induction sessions for junior doctors

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- Co-design of visual impairment awareness sessions
- Lived experience video content for Duty of Candour, Suicide Prevention and Patient Safety training
- Regular advisory sessions with clinical and operational teams
- Support for people who find services difficult to navigate, helping concerns be heard and resolved
- Corporate Orientation Day involvement, sharing lived experience with up to 80 new staff each month

8.4 **Young Experts by Experience**

This year saw the expansion of lived experience involvement to young people through the Young Experts by Experience programme.

Young people have contributed to mental health service improvements, resource design and governance discussions, as well as attending and contributing to a Board development workshop. The programme has been developed with safeguarding, accessibility and inclusion at its core, and supports young people to build confidence, skills and future opportunities.

8.5 **Support for EbEs**

To make involvement accessible and sustainable, we offer practical support to EbEs. This includes fair payment and expenses, preparation and training, and access to IT where needed. We also provide regular debrief and reflective spaces, recognising the emotional impact of lived experience work, and opportunities for development and peer connection. These measures help remove barriers to participation and ensure EbEs can contribute confidently and safely.

9. **Overview of our Patient Safety Partners**

- 9.1 Patient Safety Partners (PSPs) work alongside Dorset HealthCare to strengthen how we learn from patient experience and improve safety. Their involvement means people with lived experience are directly supporting the organisation to prevent harm, understand where risks exist, and shape decisions about safe care.
- 9.2 The role reflects national expectations set out in *NHS England's Patient Safety Framework*, which calls for patients and carers to be active partners in safety, rather than observers or commentators. Dorset HealthCare has built a broader and more established model than required, with PSPs now contributing across key areas of our safety governance.
- 9.3 Patient safety relies on transparency, listening and early learning. PSPs help Dorset HealthCare to:
 - See risks from the perspective of people receiving care
 - Ask questions that might otherwise be missed
 - Strengthen openness and candour
 - Support a culture where safety is shared and upheld at every level
 - Keep improvement grounded in lived experience

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- 9.4 We have six PSPs, each bringing lived and living experience of physical and mental health services, caring roles and accessibility needs. All PSPs are also part of our Expert by Experience network and stay closely connected to wider lived experience voices through weekly involvement activity.
- 9.5 Our PSP's draw on insight from their own communities, for example through carer networks and peer support roles, and participate in other lived experience forums within the Trust. This wider connection helps their contributions reflect wider experience instead of individual stories.
- 9.6 PSPs are involved in key forums that scrutinise and improve safety, including:
- Quality Governance Group
 - Suicide Prevention Steering Group
 - PSIRF oversight and learning panels
 - Patient safety incident investigations and thematic reviews
 - Deteriorating patient steering group
 - Site visits with clinical and operational leaders
- 9.7 PSPs also support culture and learning work, for example;
- Duty of Candour training and awareness
 - Reducing restrictive practice
 - Dementia care improvement activity
- 9.8 PSPs are encouraged to raise themes they believe require attention, and they are supported to be actively involved in taking work forward. Examples this year include:
- Highlighting concerns about out of area inpatient placements and meeting with senior leaders to improve oversight and support.
 - Questioning elements of the Electronic Health Record roll-out and Right Care, Right Person, leading to discussions with senior officers to explore risk and impact.
 - Creating a lived experience led training video on the importance of Duty of Candour, now used in staff education.
- 9.9 The Head of learning and Development recently shared "We have had over 600 people do the training since it went live and the feedback on the whole has been incredibly positive. There are some really lovely comments about how useful the training has been and a couple specifically mention understanding the significance of an apology."

10. Dorset Wellbeing and Recovery Partnership (WaRP)

- 10.1 The Dorset Wellbeing and Recovery Partnership (WaRP) is our long-standing collaboration with the Dorset Mental Health Forum, placing lived experience alongside clinical and organisational expertise to improve mental health care. Established in 2009, it is one of the key ways we listen to people who use our services and turn insight into better care, culture and experience. It operates in three main ways:

10.2 *Peer workforce and lived-experience leadership*

The WaRP supports a well-established lived-experience workforce, with over 80 peer specialists working across inpatient and community mental health teams. Peer workers support recovery and wellbeing, help people feel understood and connected, and promote compassionate practice within services. Advanced lived-experience roles continue to provide leadership, supervision and cultural influence.

10.3 *Recovery Education*

Recovery Education remained a core part of the partnership. Co-designed courses helped people build skills and confidence, understand their experiences, and connect with others. Many learners go on to volunteering or work, supporting personal recovery and strengthening lived-experience leadership across the system.

10.4 *Co-production and improvement*

The WaRP plays an active role in shaping service improvement and culture, helping ensure that changes reflect what people say matters to them. This includes contributions to work on trauma-informed care, suicide prevention, crisis and community pathway improvement, and reducing restrictive practice. The WaRP also co-chairs lived-experience forums linked to inpatient care, supporting learning on dignity, safety and discharge experience.

There are multiple current partnership programmes in place and these include:

- Recovery Education Centre
- Peer Specialists in inpatient and community services
- Advanced Lived-Experience Practitioners
- Dorset Work Matters (employment support)
- Discovery Project
- The Retreats (crisis support)
- Dorset Open Door (post-suicide bereavement support and signposting)

11. **Working with Carers and Families**

11.1 Unpaid carers support thousands of people across Dorset every day. Many do not identify themselves as carers, they are partners, parents, friends and neighbours stepping in because someone they care about needs help. In practice, they are often coordinating and providing care, managing medication, and advocating for their loved one. Carers also bring deep knowledge of the person they support, their history, preferences and what helps them feel safe and well. This insight is essential to good care.

11.2 For most carers, feeling supported is about not having to repeat their story, knowing who to contact, getting practical help early, and not feeling invisible when decisions are being made about someone they support. That only works if services join up around them. Carers do not move through neat organisational boundaries, so neither can the support.

- 11.3 It's for this reason that as well as strengthening how carers are recognised and supported within our own services, Dorset HealthCare works with partners across Dorset to build a consistent, reliable experience for carers wherever they first seek information, guidance, or support.
- 11.4 Carers play a vital role in supporting people who use our services. Over the past year, we have focused on strengthening how carers are recognised, included and supported across Dorset HealthCare
- 11.5 In the last year, the following has been achieved in relation to carers and families.
- **Expanded carer awareness training:** co-produced and co-delivered with carers, helping staff understand the impact of caring and how to include families well
 - **Improved support in inpatient services:** including regular carer coffee sessions, peer support and information spaces — for example, St Brelade's Ward introduced dedicated carer meet-ups and wellbeing activities following feedback from families
 - **Introduced carer views into wellbeing plans:** ensuring family insight informs care planning and discharge conversations
 - **Strengthened our Carer Lead network:** offering learning sets, guidance and collaboration with voluntary-sector partners
 - **Created lived-experience training materials:** including carer-led films now used in Duty of Candour, Suicide Prevention and patient safety training
 - **Piloted simpler feedback routes:** for carers through QR codes and tailored questions, recognising the need for fast, accessible ways to share experience
- 11.6 Carer feedback remains hard to gather consistently and in recognition of this new routes have been trialled with the aim of building flexible and accessible ways for carers to share their experience.
- 11.7 In 2025-26, there will be a continued focus on improving support for working carers and increasing consistency across services.
- 11.8 Most carers come into contact with primary care long before any formal support. GP practices are often the first place carers mention feelings of exhaustion, stress or the pressure they are under. Dorset HealthCare hosts the Carer Engagement Facilitator for primary care to help GP practices build consistent, proactive and reliable support for carers.
- 11.9 Highlights from this year include:
- **Dedicated Carer Leads across 94% of Dorset practices**
Carer Leads are now established roles across primary care, often within social prescribing or wellbeing teams where they can use strong community links. We continue to support this network with learning spaces, practical guidance and one-to-one support.
 - **Consistent and confident carer coding**
GP surgeries are now recording carers consistently on their electronic system - this enables automation and proactive support such as flu vaccination invitations, annual health checks and wellbeing contact.
 - **Annual Dorset Carer Leads Network Event**
Held in November 2024, with a focus on young carers and contributions from partners including local young carer support organisations. Feedback was strongly positive, with

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83% finding the session very useful and sharing benefits such as improved connections and confidence.

- **Carer awareness training for primary care teams**

This year we delivered training online and in person. Reinforcing early identification, 'think carer' practice, confident information sharing and flexible support.

11.10 Dorset HealthCare is also delivering a two-year programme funded by the Department of Health and Social Care, alongside Dorset County Hospital, University Hospitals Dorset and VCSE partners, to improve carers' experience of hospital discharge.

- **Volunteer carer awareness training**

Co-designed training helping volunteers recognise carers, listen well and signpost to support.

- **Recording carers on hospital systems**

Mapping how carers are identified across Dorset hospitals and working towards a consistent approach.

- **Supporting use of "This Is Me"**

Raising awareness of the "This Is Me" document and helping staff and carers use it more consistently, so important personal information is recognised and acted on as part of everyday care.

12. Volunteering at Dorset HealthCare

12.1 Volunteers play an important role in enhancing patient experience across our services. They offer time, empathy and practical support, helping people feel welcomed, listened to and connected. Many also bring their own lived experience, providing understanding and reassurance during difficult moments. Volunteering benefits patients, carers and staff, and offers volunteers meaningful opportunities to contribute to their local community.

12.2 During 2024-25 we had 276 volunteers supporting services across Dorset, offering their time, skills and experience in ways that directly enhance the care people receive.

12.3 This year we continued to welcome and support volunteers in a wide range of roles, including:

- Ward-based companionship and activity support
- Gardening and outdoor wellbeing roles
- Pets as Therapy visits
- Trolley services and visitor welcome roles
- Chaplaincy support
- Brain Injury Service support
- Outreach roles with community partners, including Dorset Working Women's Project

12.4 Volunteers also played an important role in our vaccination services, contributing over 2,000 hours across the Spring and Autumn programmes — offering reassurance, guidance and practical support to patients and carers. Positive comments gathered included "I feel like a person who is

listened to, and the volunteers make me feel that way. The service is very lucky to be supported by volunteers."

- 12.5 We also onboarded our first two activity volunteers in our psychiatric mother and baby unit to help encourage patients to participate in group or individual activities. The role aims to enhance the wellbeing of both mothers and their babies, promote social connection, and contribute to a positive environment within the unit.
- 12.6 Looking ahead to 2025-26, we will continue to focus volunteering where it has the greatest impact on patient experience. This includes expanding our roles in community hospitals and mental health services. We also plan to build dedicated opportunities for young people and those interested in future careers in health and care.

13. Summary

- 13.1 During 2024/25 we have continued to embed the patient and carer voice across services, supported improvement based on real experience, and created more ways for people to be involved safely and meaningfully across the Trust.
- 13.2 Overall the Trust received 20,818 Friends and Family Test responses; of which 92% rated their experience as good or very good; deployed 276 volunteers contributing across services, including supporting vaccination clinics and inpatient units; expanded lived experience involvement through Peer Specialists, Experts by Experience, Young EbEs and Patient Safety Partners; and strengthened carer support across both our services and primary care. Together, this work helps ensure services remain compassionate, responsive and shaped by the people who use them, with their feedback driving real improvement
- 13.3 Looking ahead, priorities for 2025/26 include:
 - Continue improving communication and information-sharing, especially during transitions of care
 - Expand lived experience and volunteer roles where they have the greatest impact on recovery, connection and wellbeing
 - Strengthen support for carers, including working carers and those navigating complex systems
 - Improve equity of experience by increasing access, reach and representation in feedback and involvement work
 - Ensure feedback continues to lead to visible, timely improvement across services
- 13.4 The committee are asked to receive this report as assurance of the patient experience and participation activity of the last year and the continued active engagement that is undertaken to ensure that we hear the voice of our patients and carers to ensure that we continue to learn and improve as an organisation, aligned with our strategic objectives. The committee are also asked to approve the report for publication on the Trust website.

Anna Johnson – Head of Participation

03/11/2025

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Report to	Board in Common	
Date of Meeting	9 th December 2025	
Report Title	Complaints and PALS – Annual Report 2024/25 (including Quarter 4 2024/25 data at Appendix B)	
Prepared By	Stephen Churchill, Complaints and PALS	
Approved by Accountable Executive	Dawn Dawson, Joint Chief Nursing Officer	
Previously Considered By	Quality Governance Group, 3 rd June 2025 Quality Committee in Common 25 th November 2025	
Action Required	Approval	Yes
	Assurance	No
	Information	No

Alignment to Strategic Objectives		
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications		
Board Assurance Framework	SR1 Quality and Safety - Improved patient safety and reduced harm - Reduced variation in patient experience and outcomes	
Financial	Potential cost of investigating complaints, correcting errors, and responding to claims for compensation	
Statutory & Regulatory	Complaints should be managed in line with national standards and guidance	
Equality, Diversity & Inclusion	Services and processes are inclusive and consider people's needs so that they can communicate openly and make informed decisions about their care and treatment	
Co-production & Partnership	A complainant should play an active role in resolving their concerns and supporting service development/improvement	

Executive Summary
Dorset HealthCare is committed to providing the best quality care for patients and ensuring that their experience of our services is as positive as it can be. Complaints and concerns help us understand the experiences of those who use our services. They provide an insight into what is not working as well as it might be and create opportunities to learn and improve clinical practice and service delivery. This report provides an overview of complaints and PALS enquiries received by Dorset HealthCare in the 12-month period 1st April 2024 – 31st March 2025, and provides an analysis of trends, causes, and learning outcomes from complaints. In summary: - The Trust received 484 complaints, averaging 40.3 complaints per month, and representing a small increase of 29 complaints (6%) compared to the previous year. - A total of nine complaints were referred to the Parliamentary and Health Service Ombudsman (PHSO) or Local Service and Social Care Ombudsman (LGSCO). - The Patient Advice and Liaison Service (PALS) received 2,007 enquiries, an increase of 201 enquiries (11%) compared to the previous year when 1,806 enquiries were recorded.

Recommendation
Members are requested to receive the report for approval .

SUMMARY OF COMPLAINTS AND PALS

Annual Report 1st April 2024 to 31st March 2025

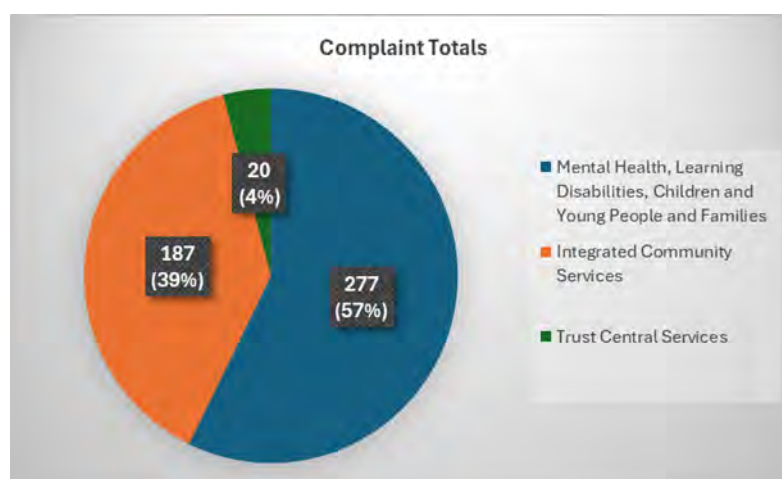
1.0 Introduction

- 1.1 This report gives an overview of complaints at Trust and Directorate level received in the 12-month period 1st April 2024 – 31st March 2025. The information is based on data extracted on 7th May 2025.
- 1.2 A total of 484 complaints were received (455 complaints in 2023/24), representing an increase of 6%.
- 1.3 Mental Health Adult/Older People Community Services received the most complaints, followed by Dorset Integrated Urgent Care Services, and Trust Central Services (see 2.2).
- 1.4 At the time of writing, 442 complaints (91% of the complaints received in 2024/25) had been closed following investigation.
- 1.5 Of these, 286 (65%) were closed within the agreed timescale, and 156 complaints (35%) breached the agreed timescale.
- 1.6 Of the 442 complaints closed following an investigation, 119 (27%) were upheld, 79 (18%) were partly upheld, and 244 (55%) were not upheld.
- 1.7 The Patient Advice and Liaison Service (PALS) received 2,007 enquiries, an increase of 11% compared to the previous year.

2.0 COMPLAINTS

- 2.1 In 2024/25, the Trust received 484 complaints by email, post, telephone, or raised verbally with staff. This is an increase of 29 complaints (6%) compared to the previous year and represents an average of 40.3 complaints per month.
- 2.2 Chart 1 below shows the total of complaints received by the Trust in 2024/25 by directorate:

Chart 1 – Complaints by directorate (number, and as a percentage of total complaints recorded):



2.3 Acknowledgment of Complaints.

- 2.4 The national requirement is for complaints to be acknowledged, verbally or in writing, within three working days of receipt.

2.5 In 2024/25, 99% of complaints were acknowledged within the statutory three working days of receipt, the same as in 2023/24. Breaches were due to delays in clinical teams acknowledging or informing the Complaints/PALS team of complaints that were received locally.

2.6 Investigating managers are expected to telephone or meet with complainants to discuss their complaint and agree a timescale for investigating and responding to their concerns. It is important the timescale agreed reflects the detail of investigation and the response required. The current process for responding to patient and carer complaints is included at Appendix C.

2.7 **Complaint Themes Trust-wide**

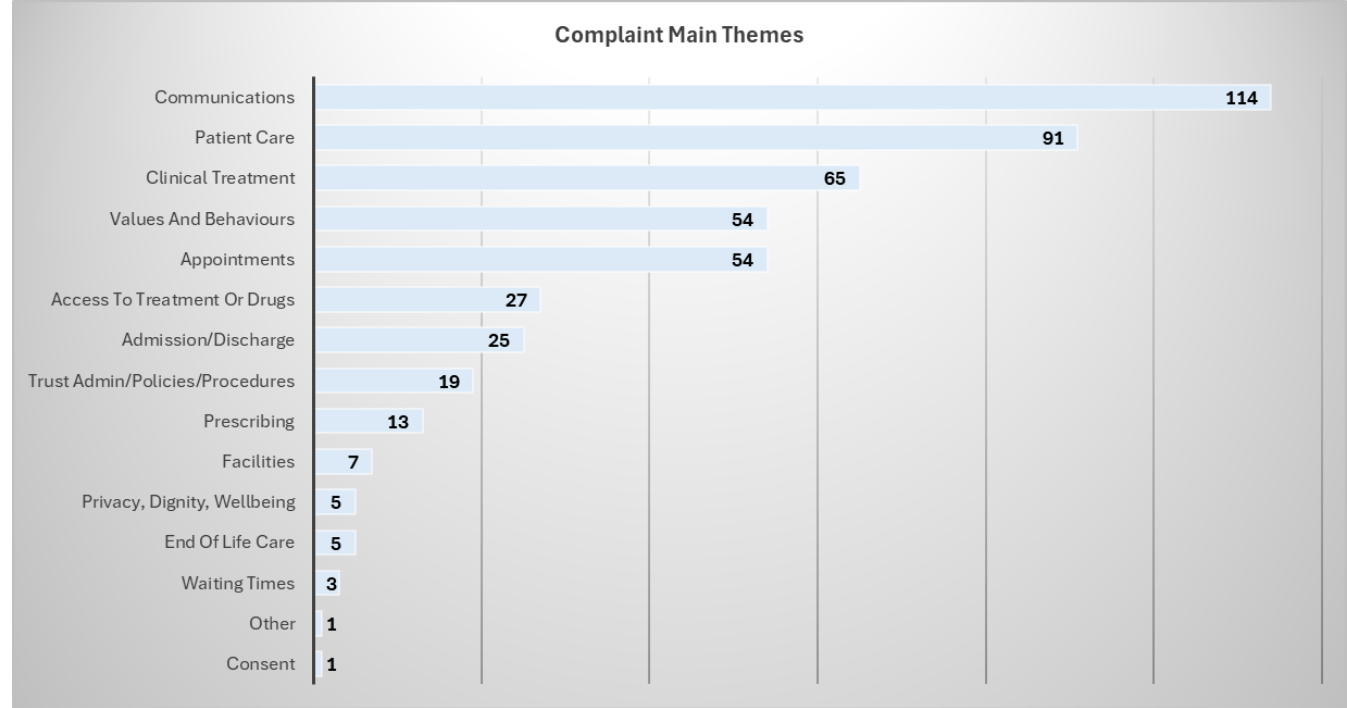
2.8 Complaints are recorded and categorised to help identify themes, trends, and service improvements. Complaints often involve multiple themes, but only the main theme is reportable for mandatory K041a reporting.

2.9 Quarterly reports including themes are produced and discussed at the internal Quality Governance Group. Regular complaints/PALS reports are produced for the Trust Board and the Directorate Management Groups to monitor the themes of complaints and concerns so that any issues can be addressed at both Trust-wide and locality level.

2.10 The Trust is required to submit data for the annual K041a collection to NHS England which records the number and main theme of complaints.

2.11 The graph below shows the main themes for all complaints recorded by the Trust in 2024/25:

Graph 1 – Main themes of complaints:



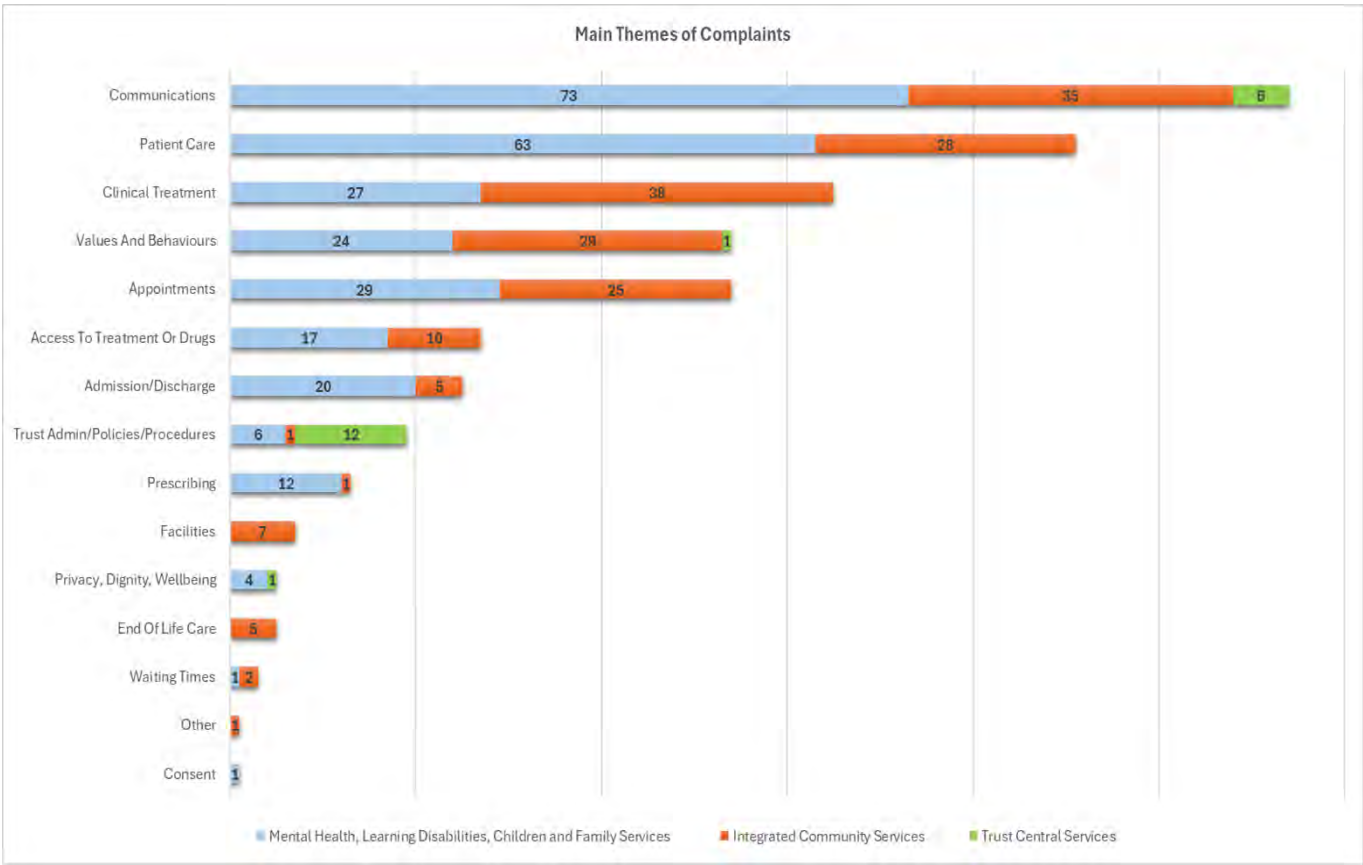
2.12 The top emerging complaint themes remains consistent with previous years. Learning from complaints is reviewed and shared with staff to improve patient/service user experience, the quality and safety of care provided, and complaint handling.

2.13 A significant number of complaints included concerns about the Trust's community mental health services and CAMHS (Child and Adolescent Mental Health Services) from people who had experienced difficulties or delays accessing ADHD (attention deficit hyperactivity disorder) assessments/medication and waiting times for access to autism assessments. This reflects the national picture of a large increase in referrals

for autism and ADHD assessments in recent years which has resulted in much longer waiting times. The Trust is working closely with the Integrated Care Board to address the situation in Dorset.

2.14 The graph below provides a comparison of the main theme of complaints received in 2024/25:

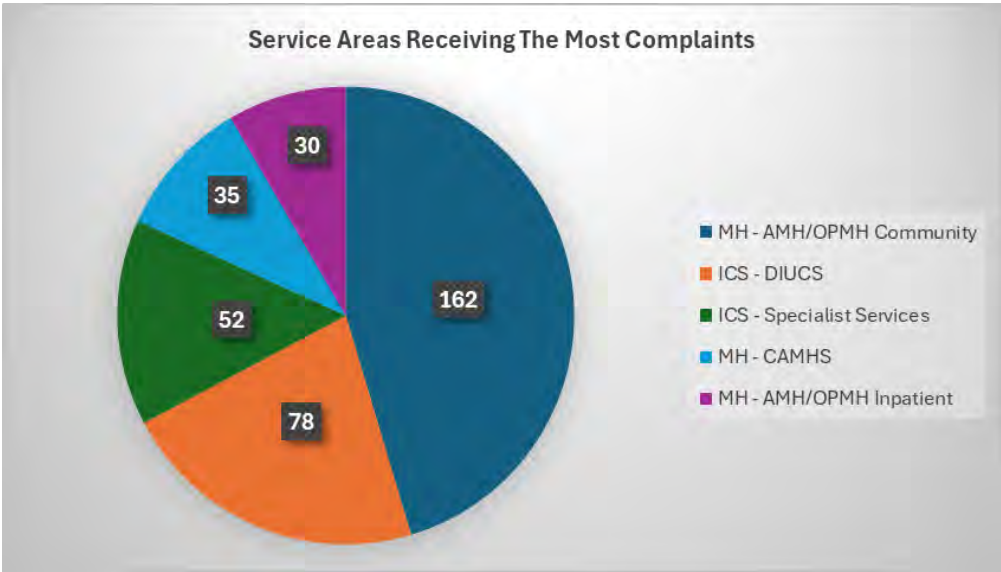
Graph 2 – Main themes of complaints received:



- 2.15 The **Communications** category relates to complaints about communication with patients/relatives/ carers, and can include the patient not being listened to, a lack of communication, the incorrect method or style of communication, timeliness of communication, inaccurate interpretation, and incorrect information on a patient's medical records.
- 2.16 The **Patient Care** category relates to general nursing care including catheter care, acquired infections, acquired pressure ulcers, care pathway issues, inadequate support, care needs not being met, and falls.
- 2.17 The **Clinical Treatment** category relates to various aspects of treatment including diagnosis, pain management, failure to follow up on observations/test results, lack of clinical assessment, and incorrect or inappropriate treatment.
- 2.18 The **Values and Behaviours** category includes complaints about staff attitude, rudeness, failing to act in a professional manner, and breaches of patient confidentiality.
- 2.19 The **Appointments** category relates to appointment availability, booking system issues, delays, cancellations, errors, and issues relating to referrals.
- 2.20 The **Access to Treatment or Drugs** category includes complaints about delays or difficulty accessing clinical services, length of waiting list, delays in treatment, and cancellation of treatment.

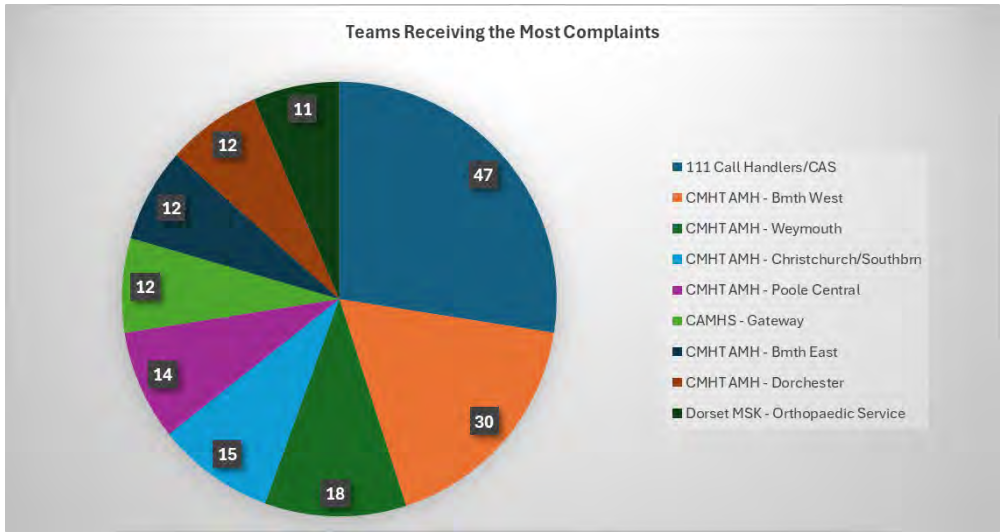
2.21 The chart below shows the service areas that received the highest number of complaints in 2024/25:

Chart 2 – Service areas receiving the most complaints:



2.22 The chart below shows the breakdown of the teams that received the highest number of complaints in 2024/25:

Chart 3 – Teams receiving the most complaints:



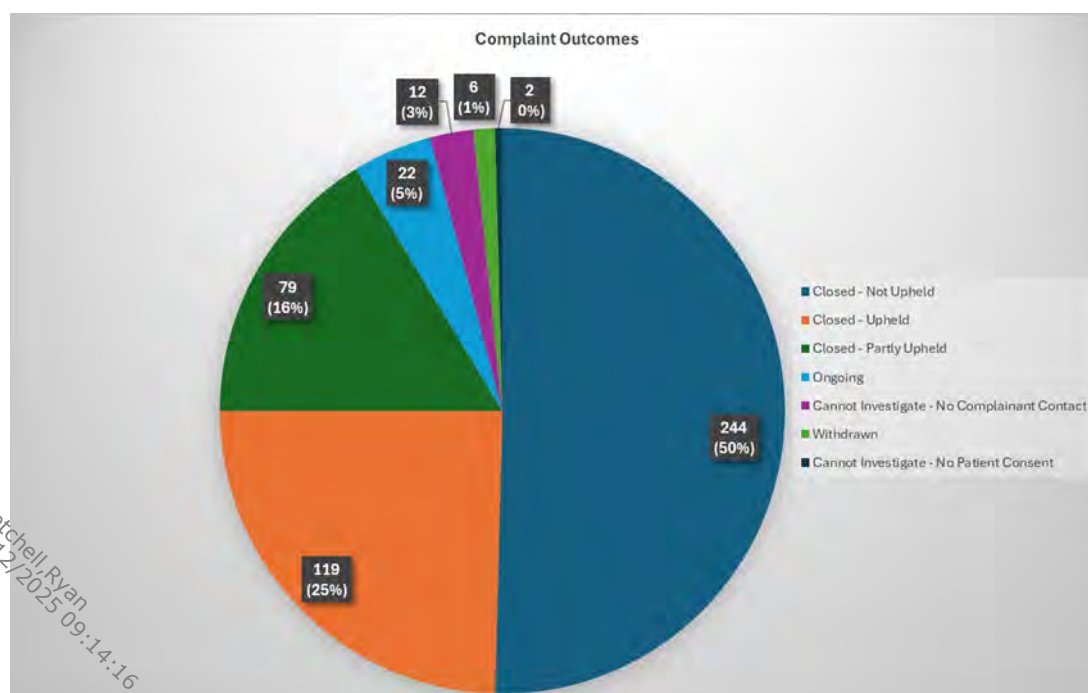
2.23 The service areas and teams identified as receiving the most complaints in 2024/25 are consistent with previous years. Complaints data is regularly reviewed to identify significant changes in the number and nature of complaints received. The above charts do not illustrate activity for these services. Mental Health Community Services and Dorset Integrated Urgent Care Services receive high levels of contact from service users with challenging mental health and physical health conditions and significant, unpredictable medical needs.

2.24 The data shows that across the Integrated Community Services (ICS) localities, district nursing teams received 31 complaints in 2024/25. Of these, 12 were upheld, six were partly upheld, 12 were not upheld, and one case was withdrawn.

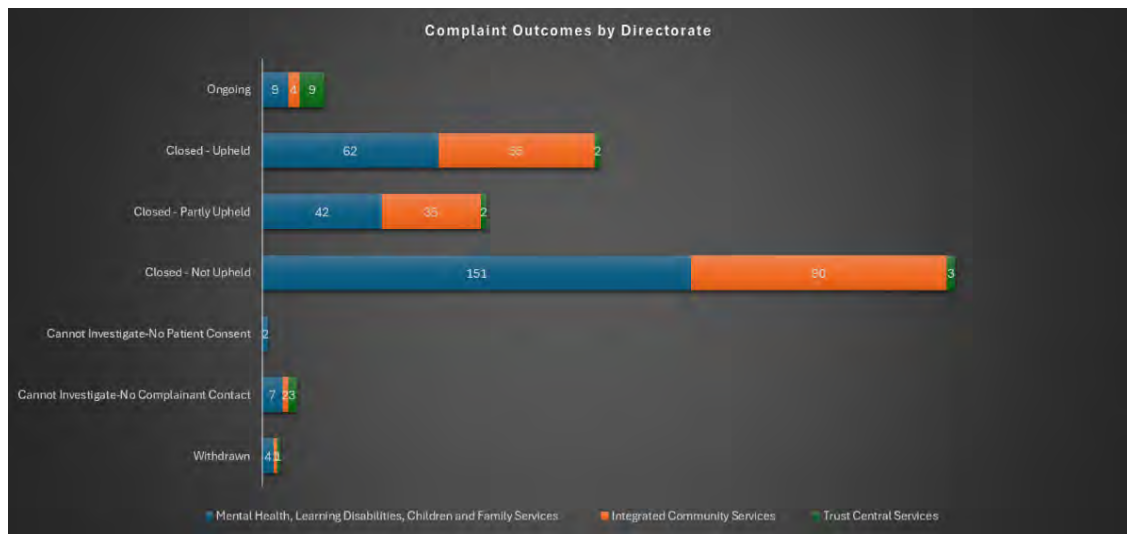
2.25 The Interim Head of Nursing, Therapies and Quality for ICS, is continuing to review potential areas of concern following complaints about district nursing care, and an update is anticipated in Quarter 1 2025/26.

- 2.26 It should be noted that many variable factors can motivate someone to make a complaint, including:
- social and economic factors, such as age, gender, ethnicity, education, income, housing, the local environment, access to and inequalities in local healthcare service provision
 - staff suggesting that making a complaint would be appropriate, and availability of information about how to make a complaint on wards, outpatient areas, the Trust website and on the wider internet
 - conversations with friends, family and wider social network
 - local and national media
 - mental and physical ill health including drug and alcohol addiction
 - a wish to prevent similar things happening to others
 - to receive an apology or an explanation
 - a wish for the staff involved to be held to account
 - frustration and anger following an incident or poor complaint handling
 - to obtain financial compensation.
- 2.27 The Trust aim of responding to complaints promptly and within agreed timescales remained challenging for staff. The Complaints/PALS team regularly reviewed the complaints caseload and escalated delayed responses to senior managers.
- 2.28 Tables showing the breakdown of complaints by organisation, team, complaint status, and the sub-categories of complaints are available on request from the Complaints/PALS team.
- 2.29 Outcome and Response Time**
- 2.30 A complaint is upheld when we identify areas for improvement. A complaint is partly upheld when it is found that some areas require improvement, whilst other areas are as expected/to standard. A complaint is not upheld when it is found the service acted as expected. These classifications are aligned to the PHSO standards.
- 2.31 The chart and graph below provide the breakdown of Trust-wide complaint outcomes and for each service directorate in 2024/25:

Chart 4 – Complaint outcomes



Graph 3 – Complaint outcomes by directorate



2.32 The graph below provides the breakdown of complaint outcomes for the service areas that received the highest number of complaints in 2024/25:

Graph 4 – Service areas receiving the highest number of complaints – outcomes



2.33 The graph below provides the breakdown of complaint outcomes for the teams that received the highest number of complaints in 2024/25:

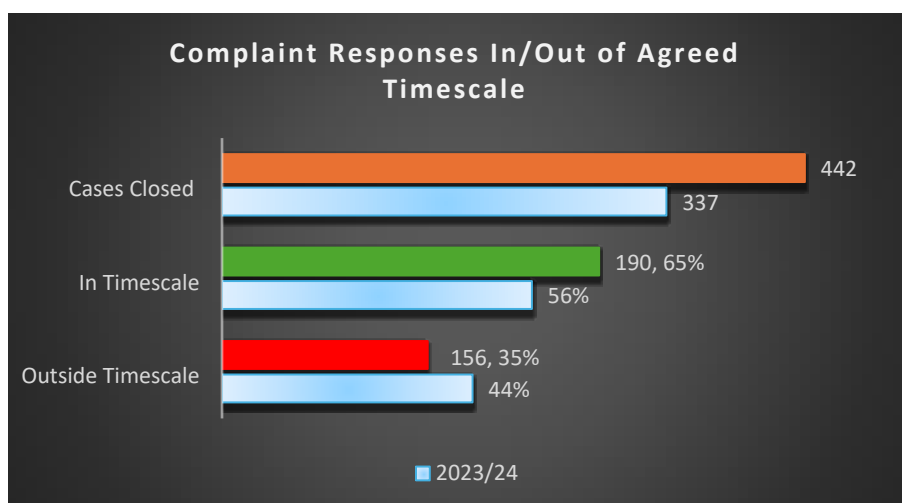
Graph 5 – Teams receiving the highest number of complaints – outcomes

Teams with the Most Complaints - Most Common Complaint Outcomes



- 2.34 There is no national requirement for investigation and response times; however, it is best practice for responses to be timely. Dorset HealthCare aims to respond within 14 working days wherever possible, or within a timescale agreed with the complainant.
- 2.35 At the time of writing, 442 complaints had been closed following investigation. A further 20 complaints were closed without being fully investigated because complainants did not respond to contact and provide more details about their complaint (12 cases), patient consent was not received (2), or complainants subsequently withdrew their complaint (6). There are 22 cases that remain open and under investigation.
- 2.36 The graph below shows the proportion of complaints that were investigated, and a response sent within and outside of the agreed timescale. This demonstrates an improved performance compared to 2023/24.

Graph 6 – Complaint timescales



- 2.37 The graph below shows the number of working days taken to investigate and respond to complaints. There was an increase in the number of complaints closed within 14 working days compared to 2023/24.

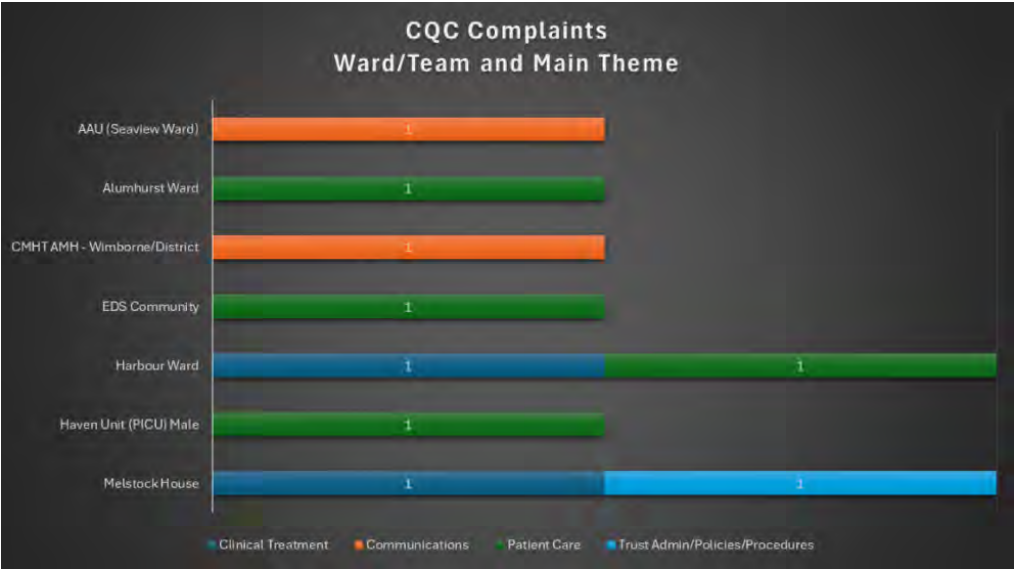


- 2.38 Whilst operational pressures and workforce challenges throughout 2024/25 continued, overall complaint handling performance improved compared to 2023/24
- 2.39 Complaints closed outside of the agreed timescale generally involved complex investigations or where additional issues were raised during the investigation. Investigating managers were responsible for keeping complainants updated when delays occurred.
- 2.40 Locality service managers and team managers received weekly reports identifying open complaints for their service(s) to help them monitor the progress of cases. In addition, managers receive a fortnightly RAG (Red, Amber, Green) report of cases breaching or approaching the agreed response due date.
- 2.41 Reopened Complaints**
- 2.42 Reopened complaints indicate that we have not fully understood a complaint or not fully addressed the issues raised. We encourage people to tell us if they are unhappy with their response because our aim is to always try and resolve their concerns where possible
- 2.43 A total of 11 complaints were re-opened due to complainants being dissatisfied with responses, which represents an improvement of 56% compared to the preceding year.
- 2.44 Complaints relating to seven different services were reopened due to information disputed (4), new questions raised (3), unresolved issues (2), and not all issues addressed (2). The Bournemouth West Adult CMHT (3) reopened the most cases followed by the Bournemouth East Adult CMHT and the Weymouth Urgent Care Centre (2 cases each).
- 2.45 Care Quality Commission (CQC)**
- 2.46 A total of nine complaints were made to the CQC by patients who were receiving treatment under the Mental Health Act 1983.

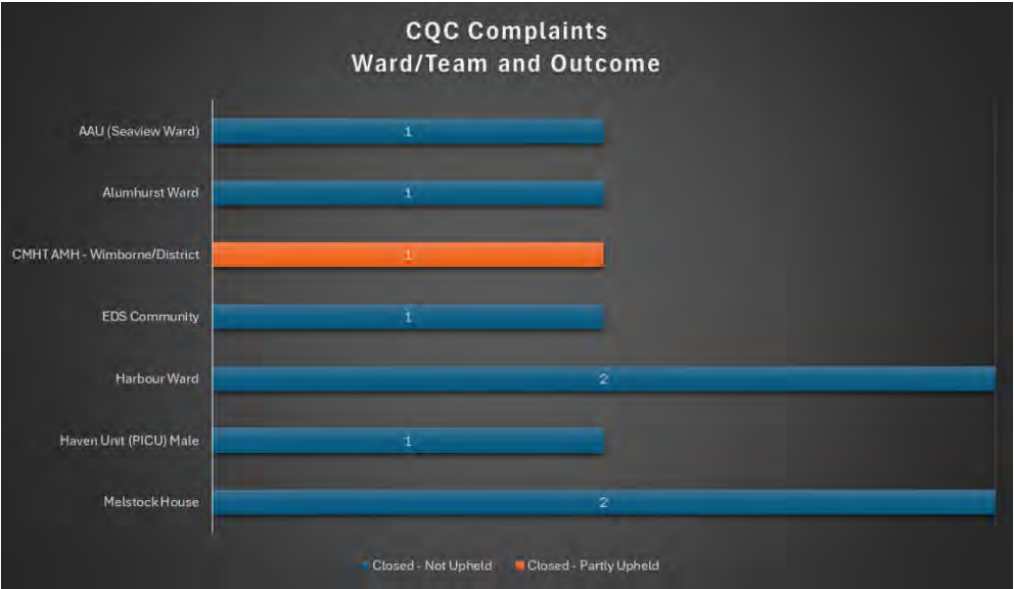
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2.47 The following graphs indicate the wards/teams involved, the main themes and the outcomes:

Graph 8 – CQC complaint themes by ward/team and theme



Graph 9 – CQC Complaints by ward/team and outcome



2.48 **Parliamentary and Health Service Ombudsman (PHSO) and Local Government and Social Care Ombudsman (LGSCO)**

2.49 A person may refer their complaint to the Parliamentary and Health Service Ombudsman (PHSO) or Local Government and Social Care Ombudsman (LGSCO) for review if they are dissatisfied with the outcome of their complaint or with the way it has been handled. The Ombudsman gives the Trust an opportunity to ensure all local resolution has taken place to try and resolve the issues. They will then independently assess the case.

2.50 In 2024/25, nine complaints were referred to the Ombudsman. These cases related to complaints originally received by the Trust in 2022/23 (2), 23/24 (3), and 24/25 (3). All cases remain open at the time of writing this report.

2.51 In 2024/25, the PHSO partly upheld a complaint made in 2022/23 about the Christchurch/Southbourne Adult Community Mental Health Team. It found the Trust did not adequately inform the patient about restrictions made to staff access to their medical records and did not clearly apologise for the service

failure. The Trust sent the complainant a letter of apology and made a small payment to them in recognition of the distress they had experienced.

- 2.52 In 2024/25, the LGSCO partly upheld a complaint made in 2023/24 after a concern was raised by a parent of a patient of the Weymouth Adult CMHT. The LGSCO noted their findings of fault related to a relatively small part of the patient's care. However, the Trust had not accurately recorded the patient's wishes about sharing information about their care with their parents, and this caused the patient and their parents' uncertainty. The LGSCO also found that the Trust did not explain changes in care to the patient in a way that took account of communication difficulties posed by their autism, and that this caused them distress. The Trust sent letters of apology to the parent and the patient, and made small payments to both parties in recognition of the uncertainty and distress that they experienced because of the service failures.

2.53 Learning from Complaints

- 2.54 It is essential that the Trust continues to learn from all types of feedback and ensures that this learning results in effective service improvements.
- 2.55 Senior managers are responsible for using learning from complaints to improve services. As part of this, they regularly review the information that arises from complaints.
- 2.56 Reviews of complaints data and the resulting insight is a regular standing agenda item for team, service, directorate, and senior leadership meetings.
- 2.57 Where learning is identified from a complaint, teams put a clear plan of action in place to demonstrate they have listened and learnt from the complaints received.
- 2.58 Managers discuss complaints with the individual staff member(s) involved who reflect on the concerns raised in clinical/management supervision. Complaints are also discussed anonymously as part of team and service meetings so that the wider team reflect on positive practice and areas of quality, safety, and service provision which require improvement. to improve.
- 2.59 Some of the themes of service improvements implemented by teams in response to complaints are summarised at Appendix A. The information provides tangible evidence of the Trust's commitment to developing services and clinical/administration practice in response to complaints.

3.00 PATIENT ADVICE AND LIAISON SERVICE (PALS)

- 3.1 PALS contacts are categorised as:

- PALS Signposting – enquiries relating to other services including GPs, NHS England and other provider Trusts, Local Authorities, NHS Dorset Integrated Care Board, and Advocacy Services.
- PALS Advice and Enquiry – information and advice given to the enquirer in respect of Trust services e.g., opening times, referral information, appointment times, referral criteria, waiting times, lost property.
- PALS Concern – a difficulty or problem that can be quickly resolved (usually within 48–72 hours of receipt) by local staff, with the support of their manager/team lead and/or the Trust PALS Team.

- 3.2 In 2024/25, PALS received a total of 2,007 enquiries, an increase of 201 enquiries (11%) compared to the previous year.

- 3.3 Of these enquiries, 41% (816) were recorded as PALS Signposting, 42% (841) recorded as Advice and Enquiry, and 17% (350) recorded as PALS Concern.

- 3.4 Common themes were general enquiries about Trust/local health and social care services, appointments, communications, access to treatment or drugs, clinical treatment, admission and discharge, patient care, and staff values/behaviours.
- 3.5 The Complaints/PALS team provided additional support to community mental health services by responding to an increased number of enquiries about waiting times/access to ADHD (attention deficit hyperactivity disorder) assessments/medication and waiting times/access to autism assessments.
- 3.6 The Complaints/PALS team also provided additional support to the Dorset Musculoskeletal Service to help manage an increase in requests for appointments and follow-ups for scans.

4.0 A REFLECTION ON COMPLAINT HANDLING IN 2024/25

- 4.1 The Trust's performance for acknowledging complaints within the statutory three working days of receipt remained the same as in 2023/24 (99%).
- 4.2 Despite significant operational pressures and workforce challenges throughout the year, complaint handling performance for investigating complaints and responding promptly/within agreed timescales improved.
- 4.3 This report acknowledges and thanks staff for their efforts to prioritise complaint and PALS responses and continuing to work closely with the Complaints/PALS team to support service users.
- 4.4 The Complaints/PALS team was able to investigate more complaints on behalf of service managers, and continued to offer advice, support, and training on matters relating to complaints and PALS.
- 4.5 The following table provides an update for the 2024/25 complaints/PALS handling priorities that were identified in the 2023/24 annual report:

	Priority	Update
1	Work collaboratively with clinical services to respond to complaints quickly and wherever possible within agreed timescales, and support services to clear outstanding complaints that have breached the agreed response due date.	Completed and ongoing. When resourcing allows, the Complaints/PALS team investigated complaints and drafted responses on behalf of service managers.
2	Review the Trust guidance for responding to and investigating complaints ensuring our approach is person-centred, responsive, and empowers staff to act to improve services/patient experience.	Review of the guidance was completed. Following this in early 2025, we reviewed and aligned with the Dorset County Hospital process. The final draft has been agreed at the Quality Governance Group.
3	Review complaints and PALS reporting, including the use of the RAG report for monitoring open complaints to prioritise responses and ensure complaints are managed well.	Continued during 2024/25 and is regularly reviewed. The Red, Amber, Green (RAG) report was sent to senior managers fortnightly. The Complaints/PALS team continued to work collaboratively with senior managers to develop reporting to support monitoring of complaints.
4	Review complaints training and resources for staff ensuring that these fully reflect the current Complaints Standard Framework.	Completed and will continue to be reviewed during 2025/26 in response to the adoption of a new Complaint/PALS policy.
5	Review resourcing and capacity of the Complaints/PALS team and consider how the complaints database Ulysses may be better used to simplify processes and improve productivity.	Completed and will continue to be reviewed during 2025/26. Progress in this area will depend on the Trust's potential procurement of an updated/new risk management system.
6	Develop methods to monitor and audit the actions taken in response to complaints to measure how those actions impact patient care and experience and to make sure any improvements are maintained and that the issues complained about do not happen to someone else.	Ongoing. The Complaints/PALS team continues to work collaboratively with senior managers to develop effective monitoring of actions and service improvements.
7	Work collaboratively within QuEST to develop an approach to sharing good clinical practise and learning identified from complaint investigations and consider other sources of feedback on and insight about Trust services.	Completed. The Complaints/PALS team will continue to work collaboratively with clinical and corporate teams across the Trust.
8	Collaborate with local NHS and social care providers to develop a system approach to manage and report complaints, including developing insight and sharing best practise/learning across the Dorset Integrated Care System.	Completed. The Complaints/PALS team maintains regular contact with system partners. This will continue in 2025/26.

- 4.6 These objectives align with the broader Trust priorities and will remain in place during 2025/26, helping to ensure that the work of the Complaints/PALS team contributes to the organisation's overall success in supporting healthier lives, empowered citizens, and thriving communities.

5.0 REPORTING

- 5.1 To ensure shared learning and to identify any lessons to be learnt across the Trust, complaints/PALS information is included within the quarterly Quality Report and is discussed at the Directorate Management Groups.
- 5.2 In addition, key themes and lessons learnt are identified on a quarterly basis to the Quality Governance Group and the Directorate Learning and Review Groups.

6.0 SUMMARY

- 6.1 This report highlights the number of complaints and PALS enquiries recorded by Dorset HealthCare in 2024/25. It shows the number of concerns raised about operational services, the main complaint themes, and highlights evidence of improvement and learning identified from the complaints process.
- 6.2 The data does not suggest any significant changes, trends, or specific areas of concern arising from complaints received in 2024/25 compared to the previous year.
- 6.3 The emerging main themes of complaints received in 2024/25 is consistent with previous years.
- 6.4 However, a number of complaints featured concerns about the Trust's community mental health services and CAMHS (Child and Adolescent Mental Health Services) from people who experienced difficulties/delays accessing ADHD (attention deficit hyperactivity disorder) assessments/medication and waiting times for/access to autism assessments.
- 6.5 Mental Health Adult/Older Peoples Community Services and the Dorset Integrated Urgent Care Service received the most complaints in 2024/25; both services receive a high level of contact from patients and service users with challenging medical conditions and significant, unpredictable needs.
- 6.6 The data also shows that across the Integrated Community Services (ICS) localities, district nursing teams received 31 complaints in 2024/25, of which 12 were upheld and six were partly upheld.
- 6.7 Whilst operational pressures in the Trust remained challenging during the year, overall complaint handling performance held up well.
- 6.8 Performance for acknowledging complaints (99%) remained the same as the preceeding year, while performance for investigating complaints and responding promptly/within agreed timescales improved.
- 6.9 This report provides assurance that services across the Trust used patient and service user feedback in 2024/25 to develop services and improve the safety and quality of care provided and enhance the patient experience.

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1.1 The table below provides details of some common areas of learning and service improvement identified following complaint investigations in 2024/25.

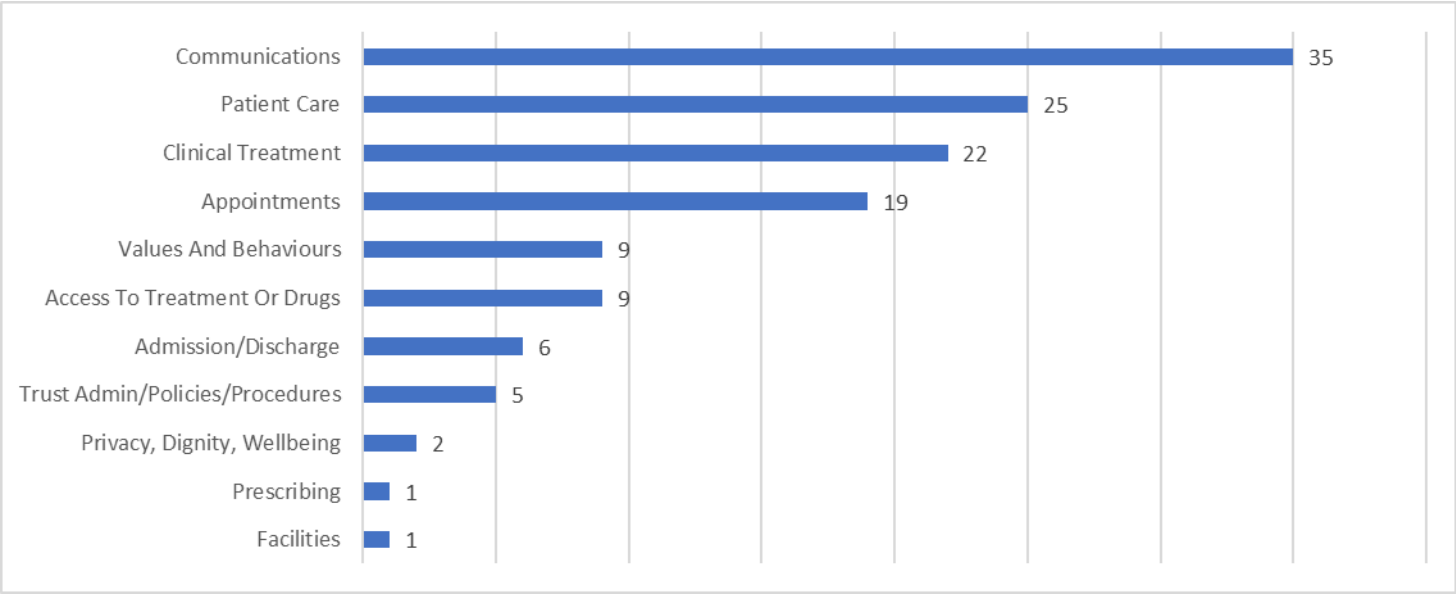
Theme	Common areas of improvement
Communication	• pass on clear and accurate information in a communication style that is tailored to the individual • adapt to the person's spoken and unspoken needs and expectations • regularly check with people that they have understood the information that has been shared with them • be mindful of language and tone of communications • use templated responses to help ensure full and relevant clinical information is captured but personalise this for the recipient • carefully manage people's expectations about the role of services, the level of care and support that are available, and maintain a culture of openness and trust • listen to what patients and service users say about their health concerns/care needs and ask empathetic questions whilst recognising that this is not a one-off 'check' but an ongoing process that enables conversations to flow and evolve • involve relatives in discussions about the patient's care (where the patient consents to this) but being mindful that conversations can still happen so that we can inform/reassure relatives without breaching patient confidentiality • anticipate that people with complex trauma/needs may find certain aspects of an assessment or questions triggering and distressing, and the approach to the assessment may need to be adapted • record clinical information accurately and in a timely way • have efficient processes and ensure staff are fully trained to follow them
Patient Care	• avoid confusion for patients and their families by offering clear information about how health and social care services work together to support people • take the patient's individual circumstances into consideration when finalising care plans • balance nutritional needs, choking risks, and the patient's presentation when developing a food and fluid care plan • regularly ask questions about skin integrity at every visit and complete full skin integrity documentation • have robust handovers to ensure important information is shared • senior ward leaders must be clearly visible and available to relatives during visiting times • arrange multi-disciplinary meetings/ward rounds for times when relatives are on the ward visiting patients • use a formal and consistent consent process around information sharing to support team decision making • monitor and assess bedspace and ward environments and meet regularly with patients to address any issues promptly • have clear and full information about support available to carers • have robust plans for providing personal care for patients, particularly for long-stay individuals, including hair care, as a vital part of their overall well-being • use a consistent process for all clinics with clear information • seek parental/carers consent to hold a discussion about their child and to store information

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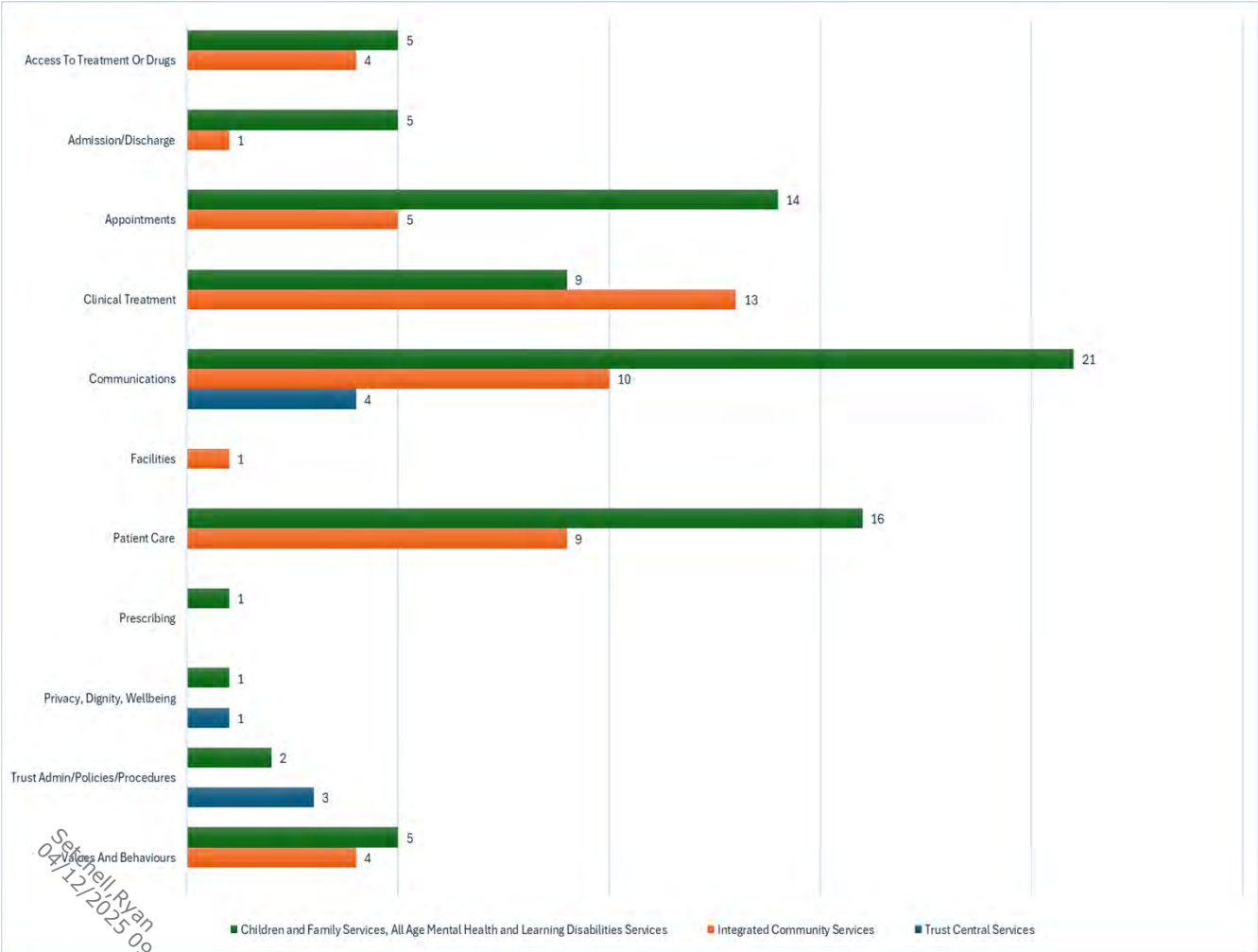
Theme	Common areas of improvement
	- senior team leads work weekend shifts and do regular walkabouts to engage with patients and relatives - ensure staff complete training on Recognizing Patient Deterioration - train and support staff to follow the correct process and care pathway
Clinical Treatment	- use clinical audits to improve clinical efficiency and practise - change process and clinical practise to improve clinical capacity and offer more callbacks to patients to ensure a smoother patient journey - improved process to help administrative staff communicate with clinical leads when supporting patients with clinical enquires - discuss the practicalities of each therapy with a client so they can make an informed decision if the treatment is the right one for them - reviewed and improved care pathways - lower thresholds adopted for elderly/frail patients who present at minor injury units reporting flank pain - educational training provided to clinicians - clear, accurate, and full documentation in the electronic patient health record - clear information given to patients and relatives with contact details should clinical concerns need to be raised or escalated - educate general practitioners so that they give accurate and relevant information so that referrals can be triaged within agreed timescales
Appointments	- new process for cancelled appointments introduced so that patients are contacted in a timely manner to rearrange bookings - clear communication - record clear and full information in the patient's records - improvements made to ensure there is effective communication between health professionals so that the patient is kept fully informed - follow the agreed policy and standard operating procedure to ensure patients are triaged in the optimum time - new handover process introduced to improve information sharing between clinical teams - administration processes reinforced amongst the team to ensure a consistent approach - patients on the waiting list who need to be prioritised are now highlighted and the list is reviewed and checked daily
Access to Treatment/Drugs	- additional training provided to staff on administrative processes - improved process for record keeping allows for better communication between nursing homes and district nursing teams
Admission/Discharge	- training provided to relevant staff so that they follow the correct procedures and liaise with all relevant teams when sourcing a suitable bed - employ a peer family support worker to maintain contact with families and carers of patients waiting to come into hospital. - all clinical site managers now keep inpatient teams up to date with the demand for beds through a daily admissions meeting

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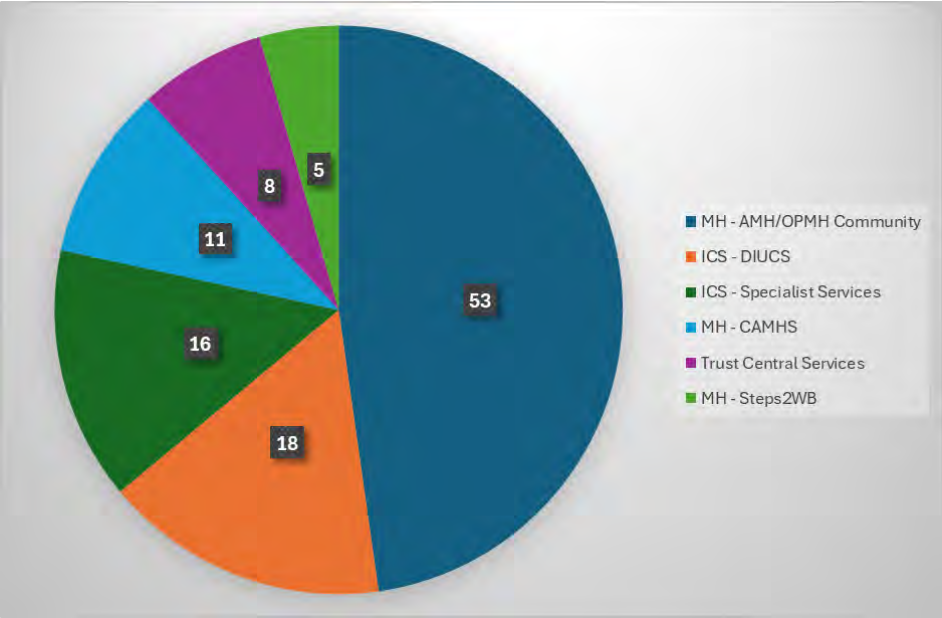
Graph G1 – Complaint emerging main themes Trust-wide



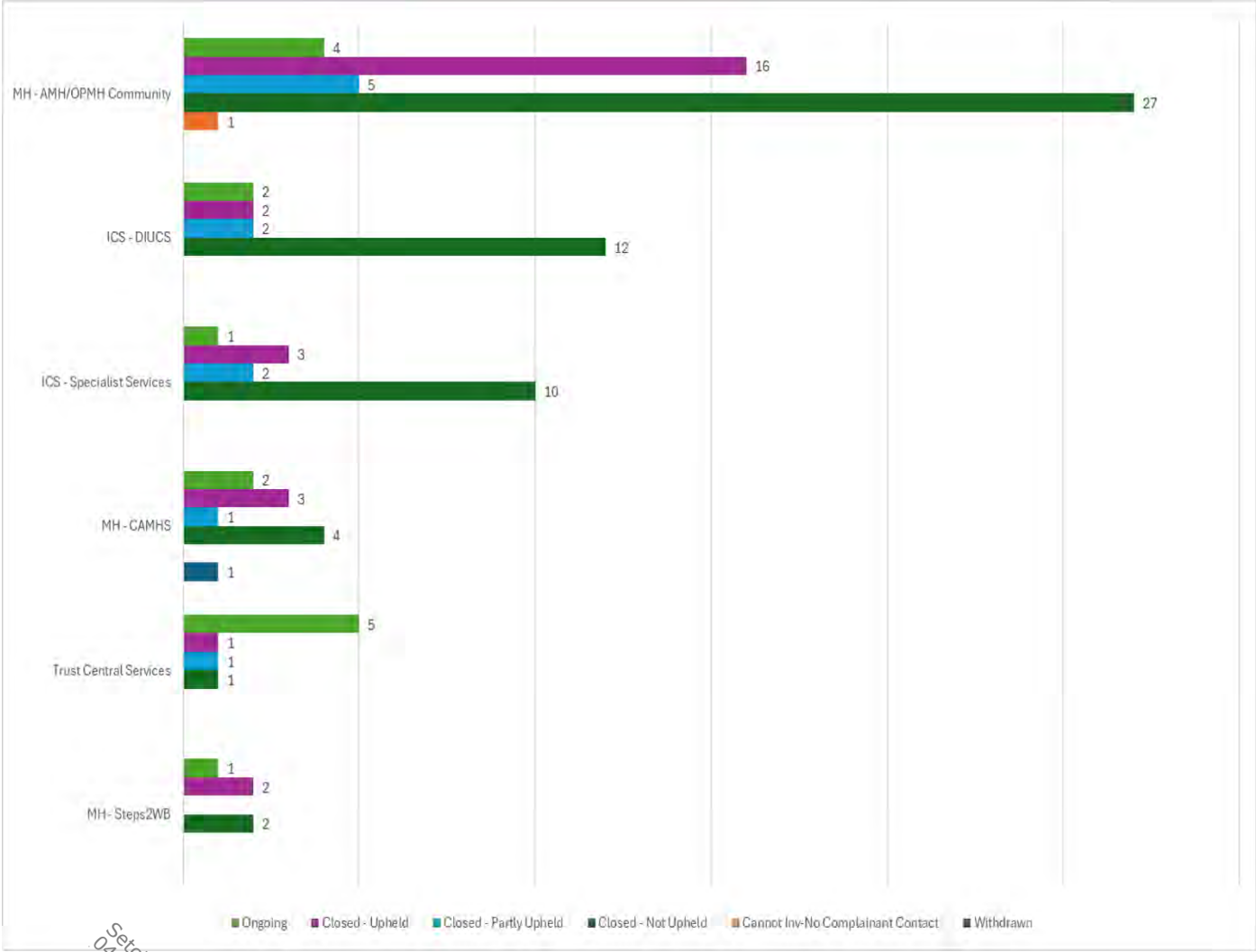
Graph G2 – Complaint emerging main themes by directorate



Graph G3 – Number of complaints by service locality (service localities receiving the most complaints)

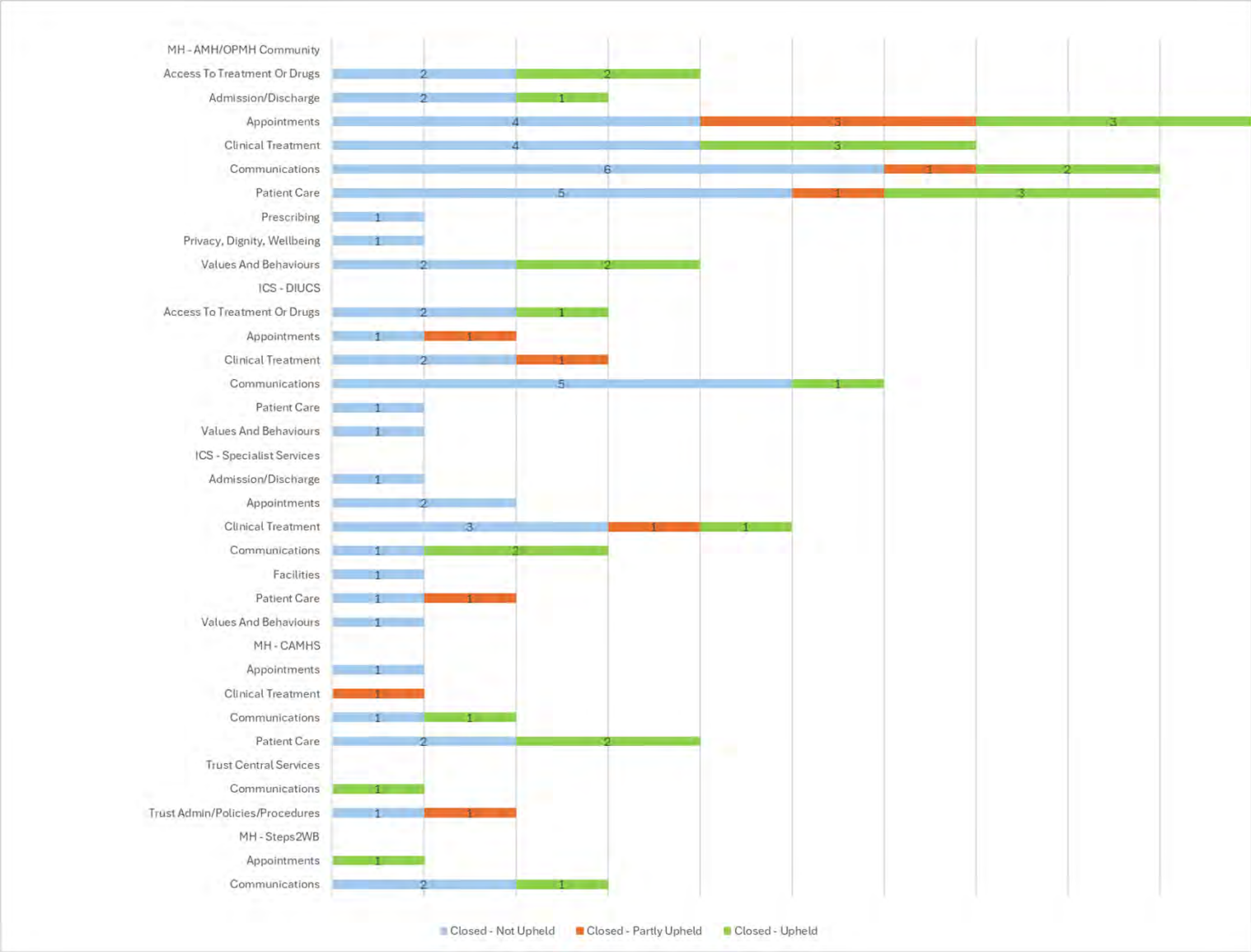


Graph G4 – Status of complaints by service locality (service localities receiving the most complaints)

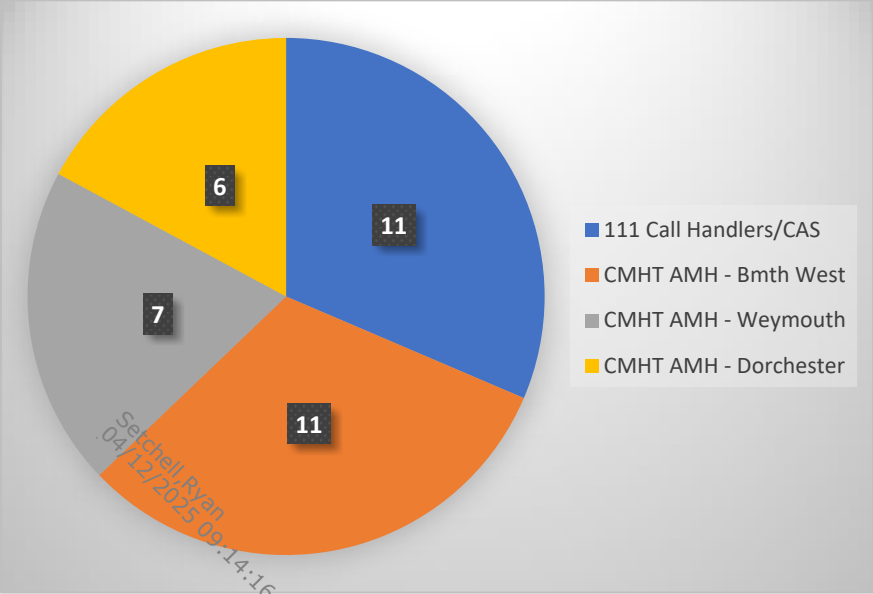


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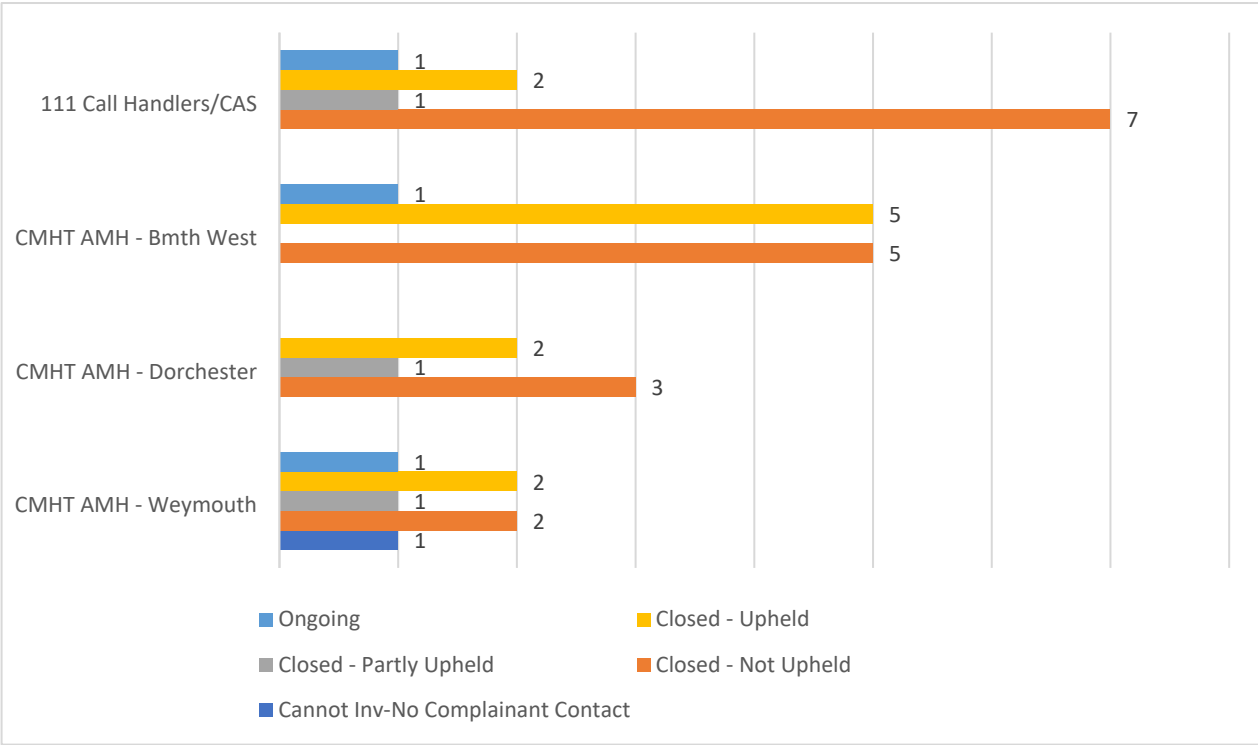
Graph G5 – Breakdown of complaint outcomes by theme (service localities receiving the most complaints)



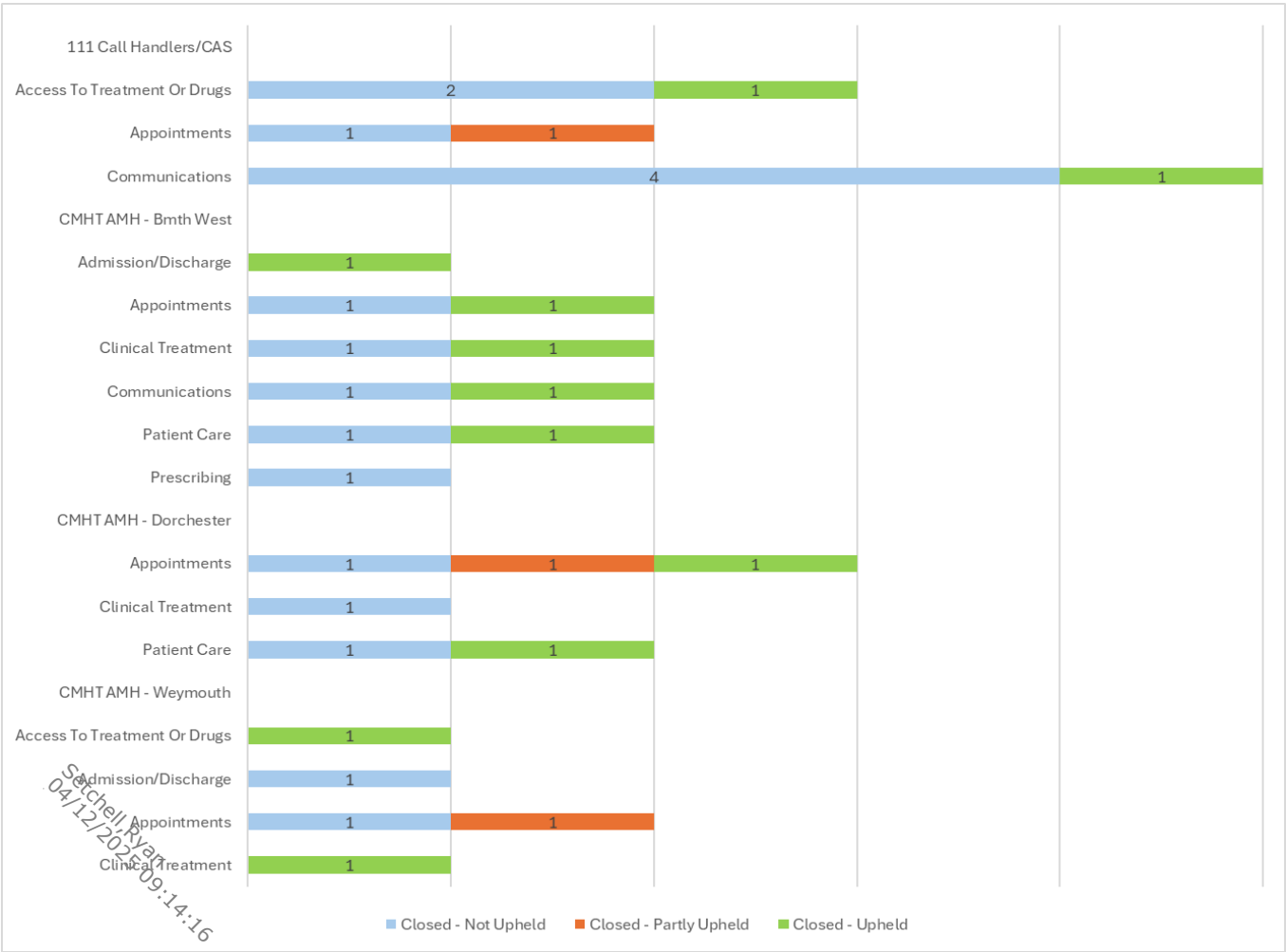
Graph G6 – Teams with the highest number of new complaints



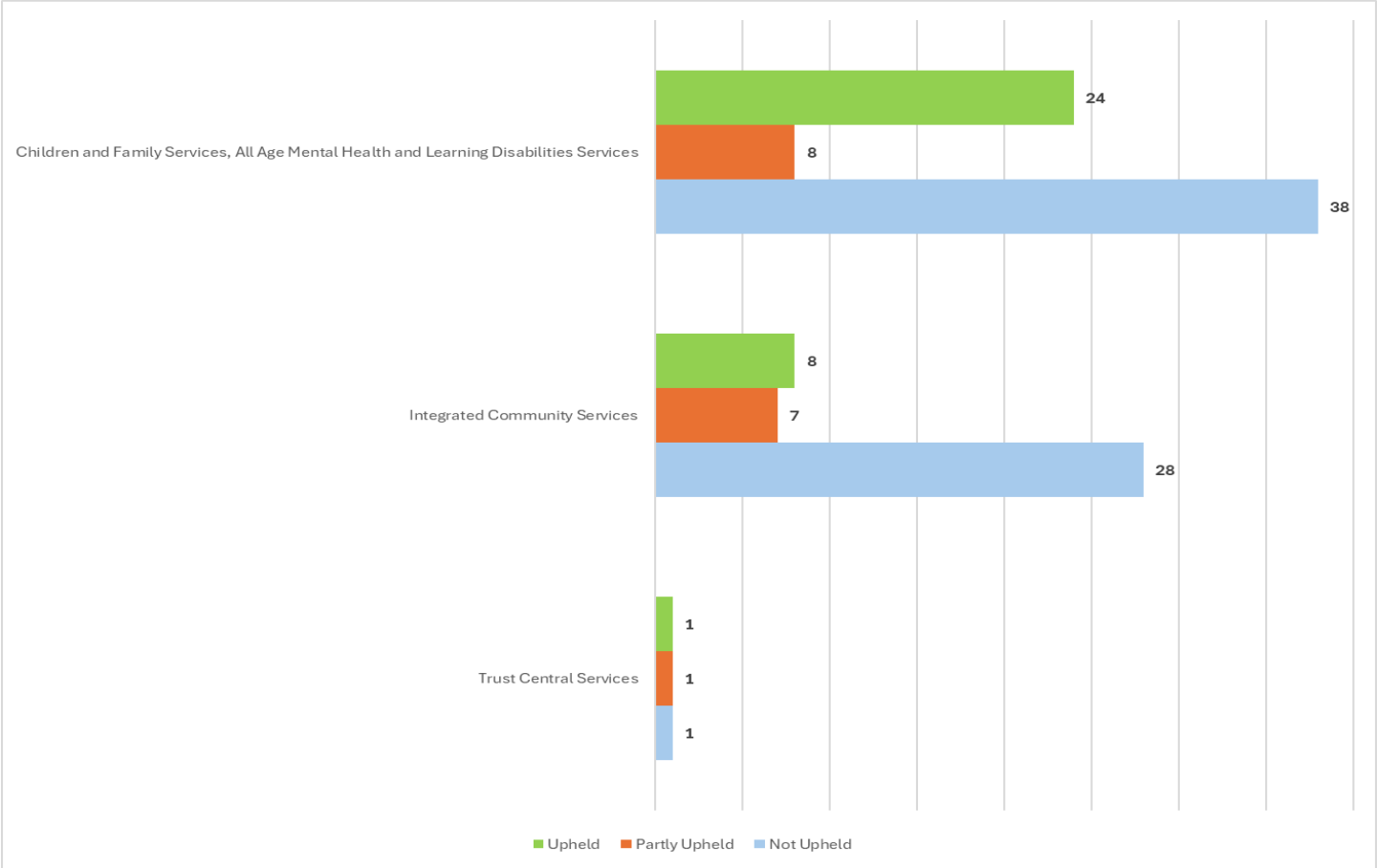
Graph G7 – Status of complaints in teams that received most new complaints



Graph G8 – Breakdown of the main theme and outcome of complaints closed following investigation for teams that received most complaints

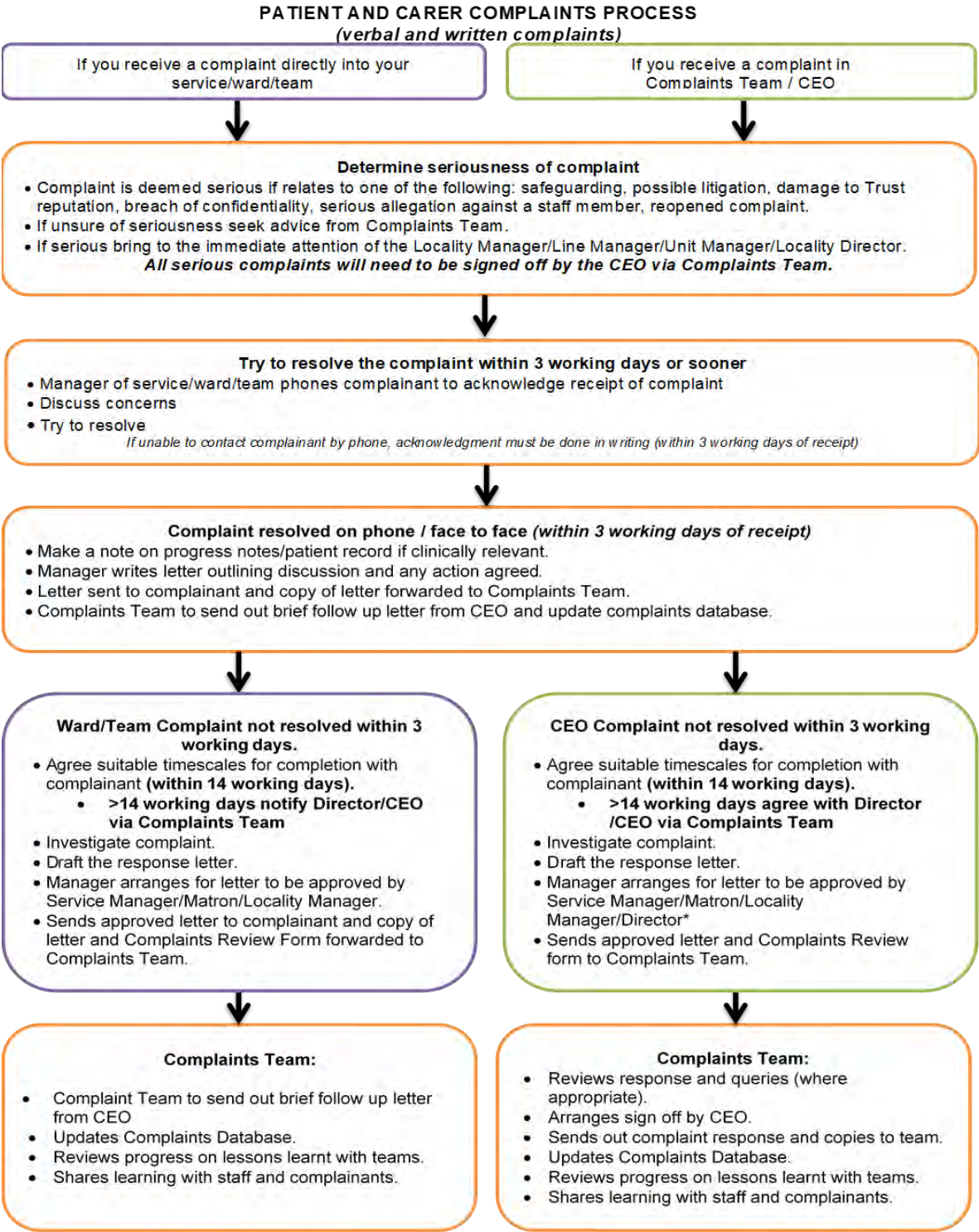


Graph G9 – Breakdown of overarching outcomes of complaints by directorate



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APPENDIX C – PATIENT AND CARER COMPLAINTS PROCESS 2024/25



*Where you have met with the complainant and wish to respond directly in the first instance, please discuss with Complaints Team.

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Report to	Board in Common (DCH Board)	
Date of Meeting	9 th December 2025	
Report Title	Patient Experience (Experience of Care) Annual Report 2024/25	
Prepared By	Hannah Robinson - Head of Patient Experience	
Approved by Accountable Executive	Dawn Dawson – Joint Chief Nursing Officer	
Previously Considered By	Quality Governance Group 8 October 2025, Quality Committee in Common 25 th November 2025	
Action Required	Approval	Y
	Assurance	N
	Information	N

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

Executive Summary
This report provides an annual report on services delivered through the Patient Experience Team for 24/25 financial year. This includes: - patient experience quality priorities, complaints, enquiries and feedback received, patient and public engagement and voluntary services activity. This is the first annual report to combine all services delivered through Patient Experience and recognise a change from Patient Experience to Experience of Care, in alignment with the recently published NHSE framework: https://www.england.nhs.uk/long-read/experience-of-careimprovement-framework/. This change from patient Experience to Experience of Care recognises our responsibilities not just to patients under our care but to the wider community and their experience with healthcare from first contact. Section 2 2024/25 Patient Experience Quality Priority report and progress linking to 202526 QP's detailed in section 7. Section 3 - Annual Complaints report: Highlights total of 1375 Complaints / Enquiries received acknowledging switch to NHS PHSO complaint standards from 1st Dec 24, improvements this has made and challenge of making change. Additionally provides details of learning from complaints, complaint themes and PHSO referrals.

Section 4

- Overview of feedback received via FFT acknowledging change to response rates due to changes in provision mid-year. Overall recommendation rate for year: 92.9%. Additional data on feedback received via Care Opinion, Compliments, In-person feedback and National Survey results.

Section 5

- Volunteer Service report highlighting compliance with NHSE mandatory data collection for voluntary services commenced from Q1 24/25. End 24/25 – total number of volunteers 231, total hours provided through direct volunteers only - 14,085.
- Additional details on service development through 24/25 including:
 - o ongoing delivery of Young Volunteer Programme
 - o review of volunteer experience
 - o new roles included Pulmonary rehab support and Orthodontics,
 - o recruitment of Ukrainian volunteers
 - o success of the Better Impact - volunteer management system – shared by the 3 Dorset Trusts
 - o development of the Activity Volunteer team linked with QP 2 – Activity for Patients
 - o thanking and recognizing volunteer contribution.

Section 6

- Patient and Public engagement report highlighting expansion of activity as a result of team restructure and capacity to delivery engagement in line with statutory guidance on working in partnership with people and communities and our Social Values commitment. Report focuses on:
 - o delivery of Carer support
 - o development of support for the Armed Forces Community including working with the Royal British Legion and the Royal Naval Association
 - o publication of the Communicating with Patients policy and implementation of new processes for Patient Information leaflets.
 - o Your Voice – Patient Voice group activity
 - o delivery of engagement events including 15 step challenges and conversation cafes.

Section 7

- Focus on the year ahead including – Quality priorities set, delivery and opening of The HIVE (DCH Community involvement hub) and team priorities including:
 - o full implementation of the Complaints Policy
 - o development of volunteer roles with focus on the Activity volunteer role and a role to support the delivery of services within the HIVE.
 - o opportunities to deliver quality patient and public engagement through collaboration with departments across the trust, our patients / public voice and external organisations.
 - o creation of a new Patient Experience Learning network to provide a dedicated space to support quality improvement linked to learning from complaints and other feedback including National Surveys.
 - o complete the Experience of Care framework baseline matrix which will inform future planning for Experience of Care across the Trust aligned with national requirements and standards and the 10-year plan for the NHS.

Recommendation

Members are requested to:

- **Approve** the Patient Experience (experience of care) Annual report 2024/25

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Dorset County Hospital
NHS Foundation Trust

Patient Experience

(Experience of Care)

Annual Report 2024/25

First published: October 2025



Healthier lives



Empowered citizens



Thriving communities

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1 Introduction

1.1 Executive Summary

This report provides an annual report on services delivered through the Patient Experience Team for 24/25 financial year. This includes patient experience quality priorities, complaints, enquiries and feedback received, patient and public engagement and voluntary services activity.

Throughout the year, all key performance indicators relating to patient experience and exceptions from the Patient Experience and Public Engagement committee are highlighted at the Quality Governance Group and at Joint Quality Committee, with Executive Director, Non-Executive Director and Governor Representation.

This is the first annual report to combine all services delivered through Patient Experience and recognise a change from Patient Experience to Experience of Care, in alignment with the recently published NHSE framework:

<https://www.england.nhs.uk/long-read/experience-of-careimprovement-framework/>. This change from patient Experience to Experience of Care recognises our responsibilities not just to patients under our care but to the wider community and their experience with healthcare from first contact.

1.2 Patient Experience department staffing, services and core functions.

2024/25 saw the Patient Experience department undergo restructuring with an aim to recognise the services and core functions within the department and give specific resources and capacity to these. The current structure and staffing are provided at figures one and two and the services and core functions at figure three.

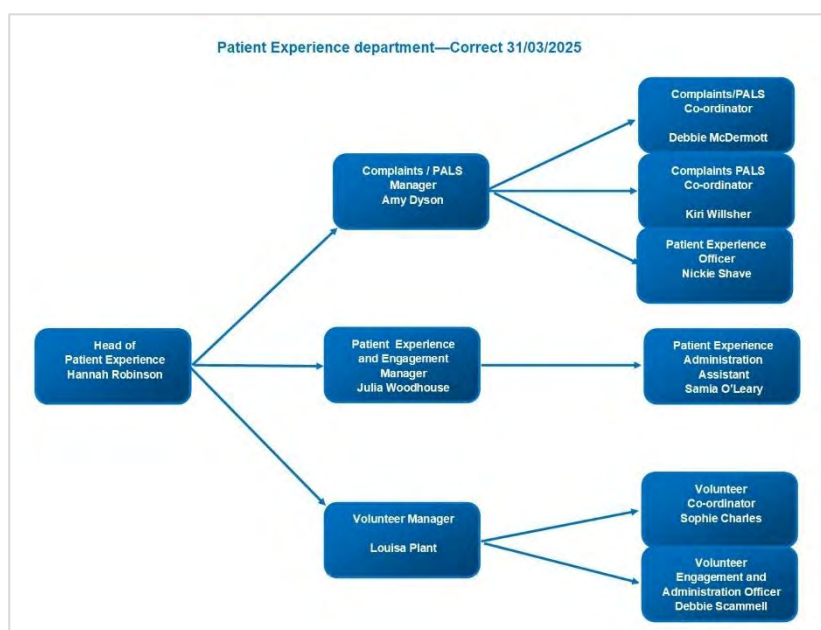


Figure 1 – Patient Experience department structure

Role	WTE	Remarks
Head of Patient Experience (B8A)	1.0	Current post-holder – leaving End Nov 25
Patient Experience Manager Complaints / PALS (B6)	1.0	
Patient Experience and Public Engagement Manager (B6)	1.0	
Volunteer Manager (B6)	0.8	Maternity leave until Nov 25
Complaints Co-ordinators x 2 (B5)	1.0 0.8	
Volunteer Co-ordinator (B5)	0.56	
PALS Officer (B4)	0.8	
Volunteer Engagement and Administration Officer (B4)	0.8	Fixed terms funding for B4 to 06/2026 after which revert to B3 – Admin role only.
Patient Experience Administration Assistant (B2)	0.69	

Figure 2 – Patient Experience department staffing

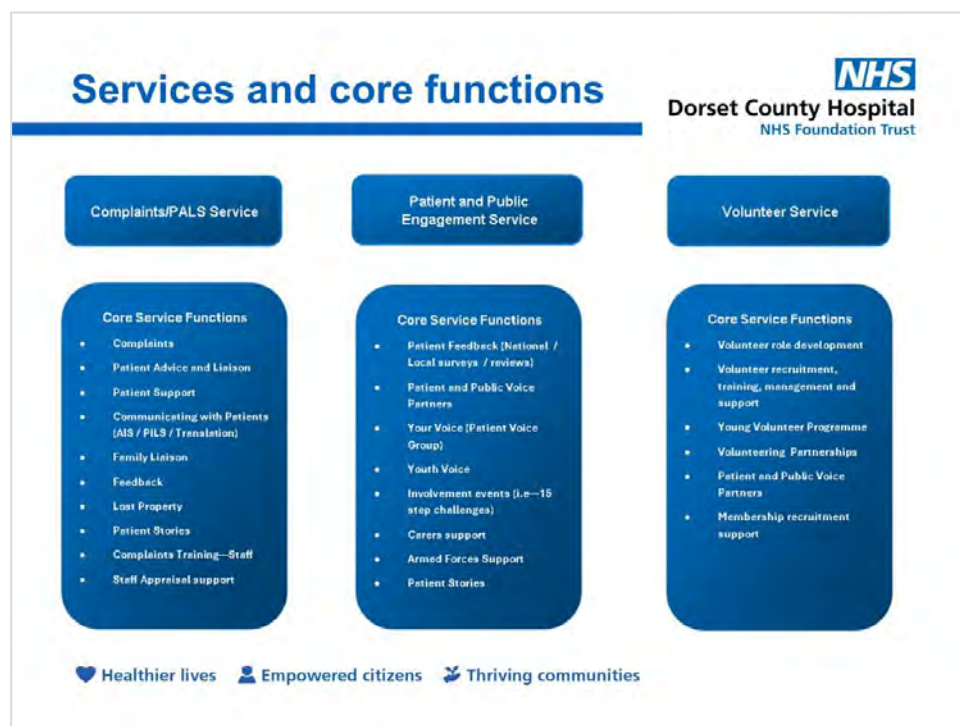


Figure 3 – Patient Experience Department services and core functions

2 Patient Experience Quality Priorities 24/25

2.1 Introduction

Quality priorities for Patient Experience set previously were rolled over to 24/25 to allow work to continue in the areas previously identified. The end-of-year update on these priorities are provided below. Priorities for 25/26 have been adapted but still align with the 24/25 priorities. These are provided in section seven of this report.

2.2 Quality Priority One: In collaboration with the Dorset 100 Conversations programme, increase staff capacity through a Train the Trainer Programme and capture the patient voice to inform service delivery and quality improvement. As measured by training numbers, captured feedback and direct application to targeted programmes and QI projects.

This work is reported through the monthly NHS Dorset engagement leads network which brings together partners from across the system to discuss the engagement agenda and local projects in line with the statutory framework – Working in Partnership with People and Communities. This includes the recently developed, ‘listening better’ website which provides a toolkit on listening approaches: <https://ourdorset.org.uk/listening/about/>.

The next step in this work is to develop an insight bank which will ideally sit alongside the listening or conversational approaches - to show how we are listening, what we are hearing and the outcomes/impact. An initial survey has been conducted among members of the NHS Engagement leads network to capture the insight / engagement work we have completed over the last 3 years, and which will help inform what the insight bank could look like.

The network is also involved in engagement work connected to the 10-year plan and has been busy delivering the 10-year plan engagement to capture feedback on the government’s three main shift changes for healthcare.

Alongside the wider system engagement work, at DCH we have continued to deliver engagement activity across the Trust. This has included:

- Ophthalmology - listening event: This captured feedback from over 70 service users attending outpatient appointments at the REI. This feedback will be used to support service improvements.
- Maternity / SCBU - 15-step challenge conducted with our MNVP and service users in November.
- Conversation Café – Deaf Community: This took place in January 25 and was arranged following a complaint about the negative experience received in the Hospital from a patient who is profoundly deaf. The conversation café brought together 5 service users who are Deaf with staff across the Trust to learn about the challenges they have when accessing our services. The event was supported by BSL interpreters and has provided valuable insight into the barriers service users who are deaf face and the things we could do to remove these barriers. We will continue to work with the participants to help co-design and implement improvements.

- Carers Support events – Our Patient and Public Engagement manager alongside one of the NHS Dorset engagement team attended two Carer support meetings in February 25 in Weymouth and Portland. The purpose of attending these meetings was to provide information about Carer support at DCH and to listen to the experiences of coming into DCH as a Carer and the challenges sometimes faced in both getting recognition as a carer and in ensuring they are involved in the care plan for the person they care for. The feedback from these events will be shared across the Trust and it is our ambition that we will continue to work with these groups to improve our Carer support offer.

2.3 Quality Priority Two: Deliver purposeful, therapeutic activity to patients through a planned programme of work developed by the Active Hospital Group and through the recruitment and delivery of a volunteer Activity Squad. As measured by progress against agreed action plan, training numbers, delivery of targeted activities and calendar of events, patient experience survey and overall incidence of violence and aggression against staff by patients who lack capacity (via Staff Survey)

We have continued to deliver therapeutic activity for patients across the Trust over the last year. Our activity volunteers have continued to be supported by the dementia team, the activity co-ordinator in Purbeck Ward and the Creative Arts co-ordinator. Bournemouth Symphony Orchestra continues to offer weekly music therapy sessions to patients as well as our music volunteer who continues to entertain patients across four different wards each week. How we measure the impact of this activity continues to develop and though working in partnership with the dementia team we are exploring the best ways to do this.

A summary of development of the Activity volunteers service from 23/24 to 24/25 is detailed below.

August 23: Launch of Activity Volunteers

- Aim to provide companionship to patients who could benefit from wellbeing support or who do not receive any or very few visitors. Activity volunteers would provide activities resources to patients – for example, themed crafts, crosswords and reminiscence.
- This would complement the existing specific activity volunteers which included Music Therapy and Therapy dogs.
- Activity Boxes were provided to wards including, – Mary Anning, Abbotsbury, Stroke, Fortuneswell, Lulworth and Evershot.

March 2025: Current offer and delivery of Activity volunteer support

- 19 Activity Volunteers including one music therapy all providing a weekly Rota of support across inpatient areas supporting one-to-one and group activity.
- 6 Therapy dogs supporting patients and staff across inpatient wards and outpatient departments.
- Mobile book trolley service provided by activity volunteers in partnership with the Dorchester Casterbridge rotary club who provided funding for the trolley.
- Training and ongoing support provided by Creative Health co-ordinator to support volunteers to deliver creative activity to patients.
- Closer working with the dementia team providing training to volunteers and referrals for specific patients for volunteers to support.

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2.3 Quality Priority Three: Improve the experience of Children and Young People admitted to hospital with emotional, psychological, and mental health needs. As measured by local and national patient survey, progress against actions, related incidents, and complaints.

Work continues across the system to establish a Youth Referral service to support Children and Young People admitted to hospital with SEMH needs. Work has also commenced to tackle the backlog of CYP waiting for appointments following a Neurodevelopmental assessment referral. This has included providing data on complaints and enquiries linked to assessment delays and will include future engagement activity with Dorchester Youth Town Council to work through the challenges young people face whilst waiting and what we can do across the system to support them better whilst waiting for an appointment. We are additionally now in the early stages of developing a new volunteer role alongside the Transition team to provide familiarisation visits to the hospital for CYP transferring from Pediatric to Adult services.

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3 Complaints Report

3.1 Introduction

The annual complaints report complies with The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, which require each NHS Trust to produce regular reports about complaints received, including an annual report.

This annual report includes an overview of the number and nature of complaints received and how complaints are handled.

3.2 Complaint Response Standards.

The Trust adopted the PHSO NHS Complaint standards in September 2024, (<https://www.ombudsman.org.uk/organisations-we-investigate/complaint-standards/nhs-complaint-standards>) and is currently going through an implementation phase. The ambition for complaint responses is that complaints are dealt with through focus on early resolution, (ERC). This means that in line with statutory requirements we will acknowledge a complaint within three working days. A local target has been set for the relevant service to contact the person making the complaint within 10 working days, with an aim to resolve or put in place a plan to resolve. Where complaints cannot be resolved through early resolution, a Closer Look Investigation (CLI) will be instigated. All complaints should be responded to within the statutory six-month period.

01 December 2024 saw the switch over to the new process in terms of how complaints were categorised on our complaints reporting platform. All complaints are categorised as an Early Resolution complaint (ER) where they will remain for resolution and closure or revert to a Closer Look Investigation (C). This is a marked significant difference from previous categorisation where complaints would be logged as either Formal Complaints, (C), or as a PALS (informal issue) (P). Those complaints now logged as formal complaints would have been recorded and reported alongside enquiries to PALS. Figure four below provides detail of complaints response processes following adoption of the PHSO NHS complaint standards:

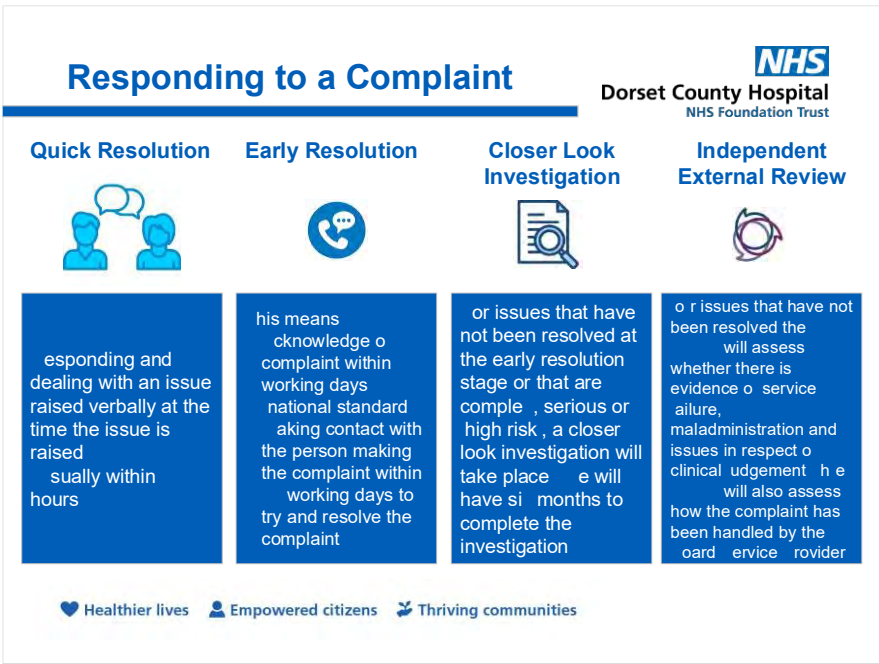


Figure four

For the complaints figures detailed in the data below the switch to the new process mid-year will show a significant increase in complaints from previous years but this should be partly quantified by the changes to the new reporting categories and changes we have implemented. For this year's annual report data, we will report the numbers of complaints by quarter and in total and combine these with total PALS (informal issues) and logged enquiries to provide an overall figure against previous year's data.

3.3 Number of complaints received 2024/25

The total number of complaints received by the Trust for 2024/25 was 414. There were also recorded contacts for PALS informal issues / logged enquiries of 961. Each complaint is treated as well-founded to investigate and a response is provided to the person making the complaint either through our early resolution or closer look investigation processes. Table one below provides a breakdown per quarter and figure five provides an overview of total complaints and PALS/Enquiries against previous years.

Complaints, PALS/Enquiries per quarter – 2024/25			
	Number of Complaints	Number of PALS / Enquiries	Total
Quarter 1 (Apr 24-Jun 24)	82	321	403
Quarter 2 (Jul 24 – Sep 24)	76	255	331
Quarter 3 (Oct 24 – Dec 24)	67	147	214
Quarter 4 (Jan 25 - Mar 25)	189	238	427
Total	414	961	1375

Table one

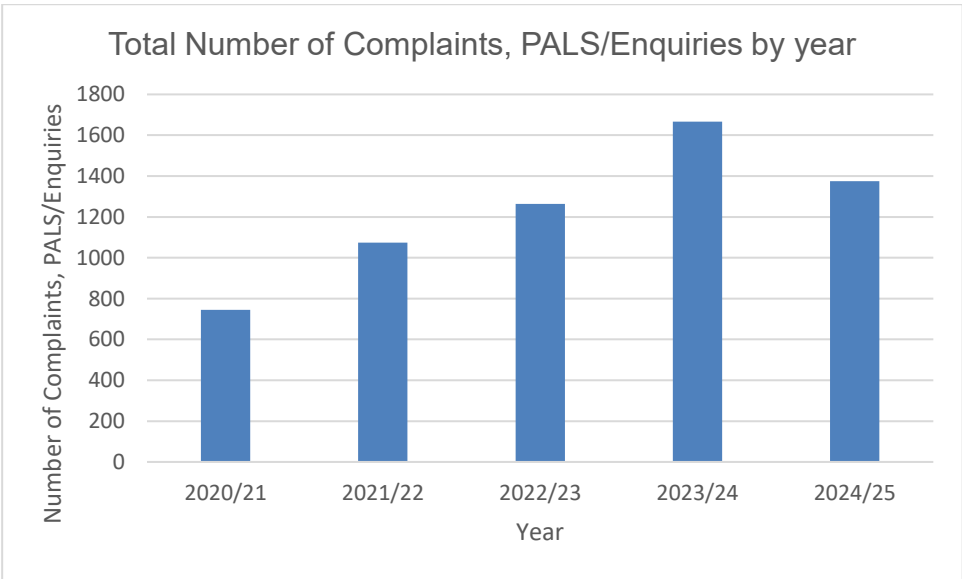


Figure five

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3.4 Reopened complaints

13 complaints have been reopened over the 24/25 period. Complaints are normally reopened for the following reasons:

- Complainants contact us to seek further clarification about the complaint raised indicating that the complaint has not been fully addressed or they disagree with aspects of the response from their perspective.
- Additional questions have been asked following receipt of their response.
- Complainants take up the offer of a meeting with staff to discuss their complaint in more detail.

3.5 Process for complaints handling

- The Trust informs patients and carers how to raise concerns and make complaints by information provided throughout the hospital, (leaflets / notice boards) and on the Trust website. Leaflets promote ways to give positive feedback as well as information about raising a complaint.
- All complaints are co-ordinated centrally. We follow the PHSO NHS complaint standards to define and therefore log a complaint:

“an expression of dissatisfaction - either spoken or written - that requires a response. It can be about an act, omission or decision made, or the standard of service provided. These definitions should be considered within the context of ‘no issue is too big to be a concern, and no issue is too small to be a complaint’”

People do not have to use the term ‘complaint’. We will use the language chosen by the patient, service user, or their representative, when they describe the issues, they raise (for example, ‘issue,’ ‘concern,’ ‘complaint,’ ‘tell you about’ etc). We will always speak to people to understand the issues they raise and how they would like us to consider them. ([NHS Complaint Standards | Parliamentary and Health Service Ombudsman \(PHSO\)](#)).

- Details of complaints are recorded on the Datix system once we have completed required checks including consent, time frame of complaint (we will not usually investigate a complaint for an incident which has occurred >12 months ago) and that the complaint is appropriate for handling through patient experience, (some complaints may be redirected to other processes i.e. patient safety, Human resources). Once logged this enables complaints and concerns to be managed in an open, central and accountable manner.
- The responsibility for investigating complaints is devolved to the Divisions and their respective teams, who are required to provide a comprehensive response within an agreed timeframe. The restructuring of the Patient Experience team has provided additional resources for complaints handling support with two complaints co-ordinators in post, each supporting specific care groups/corporate departments. A PALS officer oversees enquiries coming into the patient experience team and supports the complaints co-ordinators with in-person onsite complaints and organising complaints coming into the main patient experience email inbox. The complaints co-ordinators and PALS officer are supported by a Patient Experience manager.
- Focus in line with PHSO NHS complaint standards is on Early resolution. We ask the service to contact the person making the complaint within 10 working days to either resolve or agree and plan to resolve within a reasonable and agreed timeframe. This may include arranging an in-person meeting with the person making the complaint or agreeing a timeframe to speak to other colleagues involved so that a further conversation can be arranged and the complaint further discussed. Early resolution means that all parties involved are satisfied with the outcome of resolution put in place and that the complaint can therefore be closed. An early resolution summary form is provided to the Patient Experience team which outlines a summary of discussion, resolution and learning.

- At any point in the process a complaint can be changed to a closer look investigation. This may be either because resolution is not achieved through early resolution or the complexity of the complaint will require longer investigation. In this case we have a statutory 6-month period to investigate and provide a response. A lead investigator will be appointed and be the main point of contact with the person making the complaint advising them of the details of the investigation and how long it is likely to take. They will also agree with them how they would like to be kept updated through the process. Closer look investigation reports / responses will be signed off by the Chief executive or nominated deputy. The response will include recommendations regarding learning or actions taken for improvement where appropriate.
- The complaints process allows the Trust flexibility in arranging local resolution meetings with complainants. These meetings usually include the relevant healthcare professionals, including the Consultant or Matron, in order that questions can be answered by the clinicians delivering care and a personal apology given where appropriate. This has proved to be a very positive and helpful process with the openness of the meetings being well received by all participants.

3.6 Responding to complaints

This year our task was to continue to improve the timeliness of responses to complaints through adoption of the new PHSO NHS Complaint Standards and focus on early resolution. Up until the switch to the new process on the 1st of December we continued with a 40 working day response timeframe which was agreed by both Divisions. It is acknowledged that due to operational pressures meeting the agreed timelines has not always been possible. Complaint timescales are monitored via the Patient Experience & Public Engagement Committee and Quality Committee.

To support the Divisions, we continue to meet with Divisions (as per Division capacity /resource) on a regular basis to highlight complaints response times, and complaints in need of urgent response. Our Compliant Coordinators also meet with their Care groups on usually a weekly basis to discuss complaints and provide guidance and support.

Due to the switch to the new process, we are unable to provide accurate comparison of response times. We have provided table two detail of complaints and early resolution response times during Q4 2024/25. This is data we will be monitoring as a focus for 25/26 as detailed in section seven.

Complaints received and response within 10 working days Q4 2024/25	
Metric	Value
Number of new complaints Q4	189
Number triaged for Closer look investigation	10
Number resolved by end of Q4 24/25	86
Number of those resolved within 10 working days	57

Table two

3.7 Learning from Complaints

The opportunity to learn from complaints should not be missed by the Trust and most complainants make complaints for the organisation to learn from what has happened to them. Complaints are an important way for the management of an organisation to be accountable to the public, as well as providing valuable prompts to review organisational performance and the conduct of people that work within and for it.

Staff from across the Trust regularly reflect on complaints at divisional and departmental meetings and support is provided by the Patient Experience Team which enables them to understand the emotional experience from the complainant and staff perspective and reflect upon improvements in relation to aspects of care. Learning and actions from complaints are monitored through the Divisions and Care Groups and where appropriate learning is shared across the organisation. Examples of

learning from complaints are included in the quarterly Patient Experience report and reviewed by the Quality Committee.

We will continue to ensure that we learn when our patients tell us they have not had a good experience with us. Learning from complaints assures our patients that the Trust has taken their complaint seriously and taken the opportunity to learn from their feedback. Examples of the learning points included in the complaint resolutions for 24/25 are detailed below:

- A ward team have implemented a more effective method of documentation, which will help to provide clarity from shift to shift of why mobility or continence aids are being used and the baseline for patients. Longer term as a Trust, we are working on implementing more effective care plan documentation for patients which will provide better evidence of reasons for interventions.
- Regarding a maternity patient with wound dehiscence, the Tissue Viability Nurse Specialist met with the Maternity matron regarding risk assessments for patients that identify as high risk for wound dehiscence and initiating a risk assessment in the ante-natal aspect of the patients' care. This will enable appropriate use of dressings at an earlier stage to avoid other patients having to ensure months of healing.
- Following a complaint relating to a patient with dementia, improvements regarding the use of the "his is e" document was identified his is in progress and being led by the Dementia team
- Improvements were also identified regarding the lack of handovers between ward team and Discharge Lounge team, which has now been reviewed, and a full handover is now received from ward staff to the Discharge Lounge team.

To enhance the learning there is triangulation of Risk Management and Patient Safety information on incidents alongside complaints and PALS enquiries. Where a complaint raises a clinical concern or falls within the realm of an incident, the Risk Management and Patient Experience Team will link and ensure thorough investigation and engagement with the complainant. This is made easier with Complaints being on the same system as incidents and enables proactive analysis of any trends in certain services.

The Patient Experience Team works with the Patient Safety team. The Head of Patient Experience has completed the Patient Safety Incident Response Framework (PSIRF) training. Roll out of new PSIRF processes which will involve patients and families in serious incident investigations and complex complaints have now commenced, and we will see further interaction between the teams over the next year.

3.8 Reporting & Monitoring

A monthly summary of the number of complaints received is reported through the Quality Governance group. A further report which contains a more in-depth analysis of the issues raised in complaints is provided quarterly to the Patient Experience & Public Engagement Committee. Complaints are coded on the Datix system under a variety of categories. The five main complaint themes recorded for 24/25 are shown in figure six below.

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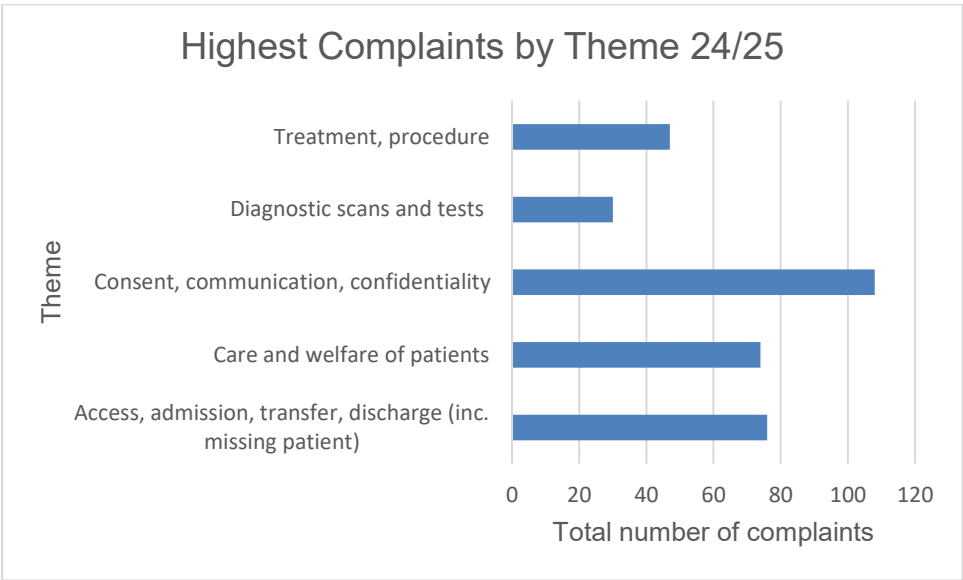


Figure six

3.9 Complaints by staff group

Figure seven below shows a breakdown of complaints by staff group. This information allows us to identify where further support and training can be provided.



Figure seven

3.10 Parliamentary and Health Service Ombudsman Referrals

Contact information for the Parliamentary and Health Service Ombudsman (PHSO) is provided to all complainants should they remain unhappy with the outcome of the trust's investigation and response. During the last year we have been contacted or dealt with ongoing requests for information by the PHSO on 7 occasions. Requests for information and contact for ongoing complaints are detailed in table three below. Note that due to the delay in appointment of the new PHSO there has been a delay in review and conclusion of ongoing investigations.

PHSO Contact 24/25			
	Type / Date	Case / Complaint	Status end 24/25
1	Contact with PHSO August 2024	Family unhappy with discharge arrangements and how these were handled.	Following the PHSO review, an apology was issued by the trust to a patient's family for not including them in the discharge process, leading to the family's wishes not being listened to. £250.00 compensation for family's distress and frustration, poor communication and decision making.
2	Initial Contact from PHSO Jul 2023	Missed Diagnosis – joint complaints with UHD.	Following a meeting with the family, the PHSO requested documents to review on 10/02/2024. Review ongoing at 24/25-year end.
3	Referred to PHSO in Dec 2024:	Patient unhappy with treatment difficulties experienced	Investigation ongoing.
4	PHSO opened an investigation in Jan 2025	Missed / Incorrect Diagnosis	Investigation ongoing.
5	PHSO reviewed 30/9/25:	Family remains unhappy and concerned regarding the delay in diagnosis of cancer. final report received.	The outcome was partially upheld, and no recommendations put forward.
6	PHSO review in October 2023	Family raising ongoing concerns regarding the care of a patient who passed away.	Outcome received in June 2024 and following their initial review of records and documentation, they decided not to undertake a full investigation.
7	PHSO referral June 2023:	Family unhappy with condition of patient on two discharges and the lack of assistance put in place. Joint complaint with SWAST and GP,	The outcome following their investigation was received in July 2024. Following receipt of evidence of the trust's compliance with the recommendations made by the PHSO, the file was closed in September 2024

Table three

4 Patient Experience - Feedback

4.1 Introduction

Key mechanisms for gathering patient feedback, driving quality improvements and enhancing healthcare services at DCH through dedicated Complaints, PALS, Volunteer Support and Patient/Public Engagement services include:

- Complaints (detailed in section 3)
- Friends and Family Test (FFT)
- Care Opinion
- Compliments
- In-Person Feedback
- Patient/Public Engagement events (detailed in section 6)
- CQC National Surveys
- Your Voice (Patient Voice Group. (detailed in section 6)
- Patient Stories

This section of the report will focus on data and processes linked to feedback above for 24/25 with the exception of complaints which are detailed in section three of this report.

4.2 Friends and Family Test FFT

Friends and Family Test (FFT) key metric is an ambition of 90% patient recommendation. Table four below shows the response and recommendation rates for 24/25

Friends and Family Test Response and Recommendation Rates 24/25							
		Q1	Q2	Q3	Q4	Average	Total
ED	Eligible	31,552	8,370	7,896	7,066	2,629	54,884
	Responses	3,400	735	0	1	283	4,136
	Extremely Likely/Likely	2,811	616	0	1	234	3,428
	Response Rate	10.8%	8.8%	0.0%	0.0%	10.8%	7.5%
	Recommendation Rate	82.7%	83.8%	-	100.0%	82.7%	82.9%
Inpatient / Day Cases	Eligible	53,749	13,878	13,078	13,286	4,479	93,991
	Responses	8,625	2,144	1,046	966	719	12,781
	Extremely Likely/Likely	8,146	2,031	1,025	946	679	12,148
	Response Rate	16.0%	15.4%	8.0%	7.3%	16.0%	13.6%
	Recommendation Rate	94.4%	94.7%	98.0%	97.9%	94.4%	95.0%
Outpatient	Eligible	84,913	21,238	21,827	22,297	7,076	150,275
	Responses	8,095	2,162	309	600	675	11,166
	Extremely Likely/Likely	7,601	2,025	290	586	633	10,502
	Response Rate	9.5%	10.2%	1.4%	2.7%	9.5%	7.4%
	Recommendation Rate	93.9%	93.7%	93.9%	97.7%	93.9%	94.1%
Maternity (Q1 Antenatal)	Eligible	1,428	379	349	370	119	2,526
	Responses	69	11	1	3	6	84
	Extremely Likely/Likely	65	10	1	3	5	79
	Response Rate	4.8%	2.9%	0.3%	0.8%	4.8%	3.3%

	Recommendation Rate	94.2%	90.9%	100.0%	100.0%	94.2%	94.0%
Maternity (Q2 - Birth)	Eligible	1,187	311	310	277	99	2,085
	Responses	207	28	26	19	17	280
	Extremely Likely/Likely	198	28	24	15	17	265
	Response Rate	17.4%	9.0%	8.4%	6.9%	17.4%	13.4%
	Recommendation Rate	95.7%	100.0%	92.3%	78.9%	95.7%	94.6%
Maternity (Q3 - Postnatal Ward)	Eligible	1,187	311	310	277	99	2,085
	Responses	123	23	12	9	10	167
	Extremely Likely/Likely	115	23	10	9	10	157
	Response Rate	10.4%	7.4%	3.9%	3.2%	10.4%	8.0%
	Recommendation Rate	93.5%	100.0%	83.3%	100.0%	93.5%	94.0%
Maternity (Q4 - Postnatal Community)	Eligible	1,445	347	379	341	120	2,512
	Responses	93	11	18	9	8	131
	Extremely Likely/Likely	81	10	18	6	7	115
	Response Rate	6.4%	3.2%	4.7%	2.6%	6.4%	5.2%
	Recommendation Rate	87.1%	90.9%	100.0%	66.7%	87.1%	87.8%
Totals	Eligible	175,461	44,834	44,149	43,914	14,622	308,358
	Responses	20,612	5,114	1,412	1,607	1,718	28,745
	Extremely Likely/Likely	19,017	4,743	1,368	1,566	1,585	26,694
	Response Rate	11.7%	11.4%	3.2%	3.7%	11.7%	9.3%
	Recommendation Rate	92.3%	92.7%	96.9%	97.4%	92.3%	92.9%

Table four

FFT is managed within the Patient Experience and Public Engagement service. Results are analysed locally and reported through PEPEC and QGG. We work closely with the Business intelligence teams who collate results each month and reported to NHSE.

Due to increasing difficulties with the FFT provider, we terminated our contract in August 24 reverting to paper questionnaires pending DTI support to procure a new digital system. As anticipated and as reflected in table six above this means that we have received lower response rates since making this change. We have and continue to work and support areas who have a zero or low responses rate. Online surveys have been created for every ward and some outpatient areas, so patients have a choice to complete the paper form or use the QR code to go online.

FFT data including the free text comments are provided to each department each month so that positive feedback can be shared and mixed / negative feedback can be identified and addressed with learning and improvement actions put in place as appropriate.

Current methods of delivering FFT do require more resource from the Patient Experience team, and this currently impacts and restrict other functions for the team.

FFT provision has been added to the Trust corporate Risk Register, and we are currently working through our options for future provision of FFT. This will be carefully considered alongside and in alignment with wider changes to the NHS following publication of the 10 year plan:

<https://www.england.nhs.uk/long-term-plan/>

4.3 Care Opinion

Care Opinion offers a free online service for patients to share their stories and for the organisation to acknowledge and respond, encouraging direct contact for concerns.

Posters displayed around the Trust during 24/25 as a result part of the National Inpatient Survey 2023 action plan encourages patients to feedback on the quality of their care. These posters provide a QR code linked to Care Opinion, who moderate feedback received ahead of publishing on their website as a patient story. Stories are all published anonymously, and we are alerted to

stories which are published for DCH. This level of subscription to Care Opinion is provided to us free of charge on an annual agreement. Examples of shared stories through Care Opinion include:

- I just wanted to register my appreciation of the care and support, that I received from the paramedics who somehow got me downstairs and into an ambulance, the A&E staff who despite being incredibly busy kept me and my family informed as to what was happening, and the staff on the Purbeck Ward who looked after me until I could be discharged.
- I really can't say enough about how professional, caring, and supportive everyone was. Thank you. I am now up and mobile less than two weeks from being completely unable to even get out of bed ”
- The whole process from being rushed in, treated and aftercare on the ward was well beyond what I have come to expect from NHS, then the wheels fell off. Discharge process was totally appalling. For four days I read my booklet (given to me day one) with all the meds I would be given and how and when to take them. Yet had to wait for 3 hours to get them from the pharmacy. Why is this system so bad yet it could be so easy, for inpatients prep them in advance then a quick check on discharge? Whether you spend a couple of days or a couple of weeks in any such environment, you just want to get out and get back to some normality. I would love to receive a response to this.

We can respond to any feedback on the website and those leaving mixed or negative comments are encouraged to contact the Patient Experience Team so we can gain patient details and investigate further.

Previous reporting of feedback through PEPEC has not included Care Opinion up until end of 24/25. As part of changes made at year end 24/25, from Q1 25/26 this data is now included.

4.4 Compliments

Thank you, cards, letters and emails are recorded with the number of compliments reported quarterly via PEPEC. A total of 369 compliments were received and logged during 24/25. Compliments are shared with the relevant department and where appropriate through the weekly celebrating success publication which is sent out to all staff. During 24/25 through PEPEC actions there has been more focus on ensuring thank you cards and letters are sent to the Patient Experience Department so these can be logged and recorded.

4.5 In-person Feedback

Feedback, both positive and concerning, was collected through various channels during 24/25 including via volunteers, patient ward reps, and directly via PALS, with examples and actions shared through PEPEC. This allows the department to receive feedback and /or the patient experience team to take immediate action to resolve any concerns. An example of how this works is provided below:

- Received from Lulworth Ward Leader providing evidence from the Lulworth Ward Patient Representative Volunteer receiving feedback during her twice weekly Ward Round:

“ Sue met with all the patients on the ward to independently ask how their experience is. A patient in one bed expressed some of his concerns to Sue that included a consent for his procedure being incorrectly done and information from the doctors not being given leading him to have his treatment whilst he was semi-conscious and very much aware of this. Had he known he was going to be semi-conscious he would have used his headphones and listened to music. There was miscommunication from the therapy team. They informed him twice they would return in the afternoon and support with a shower – this didn't happen. There were

concerns regarding the ward that were minor, and he gave a list of names of staff that had been excellent. Having read the notes, I met with the patient, heard his concerns personally. I have discussed the concerns directly with the OT and escalated his experience with the consent form and awareness of his procedure happening to the orthopedic nurse practitioner who states she will manage this. Overall, with the support we have promptly managed a complaint in a very productive way.

4.6 CQC National Surveys

Annual or biennial national surveys published during 24/25 included:

- 2023 Adult Inpatient Survey – Published August 2024
- 2024 Maternity Survey – Published November 24
- 2024 Urgent and Emergency Care Survey – Published November 24

These surveys were conducted by Picker as our contracted external provider to gather feedback and identify areas for improvement. Quality improvement plans are developed alongside divisional head of nursing, divisional quality and governance leads and other stakeholders relevant to the specific survey. It is taken into consideration in development of quality improvement plans that the results are based on feedback received from patients who received care more than 6 months before the result publication, and that new initiatives and service improvements which may have been picked up through survey results are already in place. Table five below provides detail of the quality improvement plan put in place because of the 2023 National Inpatient Survey:

National Inpatient Survey 2023 – Quality Improvement Plan	
Focus Area - Care	
Objective	
Improve quality of inpatient care through measures taken to ensure information about how they can get support and raise concerns are well communicated with processes in place to ensure access to basic daily needs.	
What we are already implementing	What we will do
• Lulworth patient rep. Weekly visit, relationship between ward Leader and the volunteer to highlight concerns and good news. • Volunteer team – hydration support • Activities to prevent de-conditioning – painting etc with groups & individuals – working really well on Mary Anning Unit • Ward host role – pilot on Mary Anning and Evershot wards – focus on supporting hydration and nutrition needs. • Information to the kitchen regarding allergies – this is now data fed twice a day from EPMA • Wards working with catering manager to stock more of what they	• Role out of the patient rep role across other wards. • Activity for Patients plan – collaborative approach across teams in line with quality priorities. • Embedding a culture of verbal ward information for patients on admission to a ward. • Ongoing awareness training for staff on the carers passport.

need and less o what they don't using generic ward email addresses • Delivery of Carers Passport	
Focus Area - Discharge	
Objective	
To improve communication with patients around discharge, ensuring the patient, family / carer are involved in conversations around discharge and support post discharge.	
What we are already implementing	What we will do
• Patient Flow transformation group with focus on discharge support and enabling plans in place which will continue roll out through 24/25. This includes development of the patient flow dashboard and intranet page. • EDS working group which may help support knowledge of medication on discharge. • VCS supporting from the Discharge lounge with follow up phone calls post discharge. Feedback from this can highlight where we are doing well and where we can do better • YFW Blood Bikes supporting with medication deliveries for discharged patients allowing them to go home earlier on the day of their discharge. • Implementation of patient discharge leaflet given to patient on admission.	• Plans for Better Care Fund D2A survey to provide further feedback to improve discharge services. • Extensive training packages to be delivered to staff to support confidence in delivering discharge conversations. • Pathway home hub (Frailty SDEC) due to open in autumn 24 providing support to prevent admission and post discharge support. • Capturing of patient stories on their discharge experience to support future service improvements. • Roll out of patient rep roll to support signposting to post discharge services and to help raise any concerns patients may have regarding their discharge.
Focus Area - Admission	
Objective	
Improve communication around waiting times and admission alongside work going on to reduce waiting lists.	
What we are already implementing	What we will do
• Admissions – template letter drafted for teams across the trust to use to provide further information to patients around waiting times.	• Roll out of information letter regarding waiting times. • Adoption of national complaint standards which will support and improve the way we communicate with patients raising complaints about waiting times.

Table five

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5 Volunteer Service

5.1 Introduction

The volunteer service continues to provide invaluable support to patients and staff across the Trust. The service provides a quarterly report to PEPEC and also provides volunteer data including numbers, hours and equality monitoring as part of the NHSE voluntary workforce mandatory data collection which was introduced from Q1 24/25, (<https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/nhs-volunteer-workforce-data-collection>).

This section of the annual report will provide details of volunteer numbers, contribution by hours, (where this data has collected), volunteer roles and service developments over the 24/25 year.

5.2 Numbers of Volunteers

At the end of the 24/25 year the Trust had a total of 231 volunteers broken down as shown below in table six. These figures are provided quarterly to NHSE.

Volunteer Numbers – Correct 31 March 2025	
Number of Direct Active * Volunteers	113
Number of Direct Inactive** Volunteers	8
Number of Indirect Volunteers (FDCH and YFW Blood Bikes)	73
Number of Patient and Public voice partners (Including PRA's, Patient Voice, and Patient Reps)	20
Volunteers in application stage / in process at end of Quarter 4	17
Total	231

Table six

* Direct Volunteers - Volunteers recruited by the Volunteer services team into specific Trust volunteer roles.

** Indirect Volunteers - Volunteers recruited by independent organisations who carry out a voluntary role on behalf of their parent organisation in support of the Trust and in line with Trust volunteer policy.

5.3 Volunteer Hours

Volunteers tend to carry out shifts on a weekly basis lasting from two to four hours. This can vary with some volunteers opting to carry out more than one shift per week and others committing to a fortnightly or monthly shift.

Volunteer hours are currently collected and reported to PEPEC and NHSE. Hours are only collected for direct volunteers currently not including patient and public voice partner activity.

Figure eight below provides a breakdown of hours per quarter for 24/25.

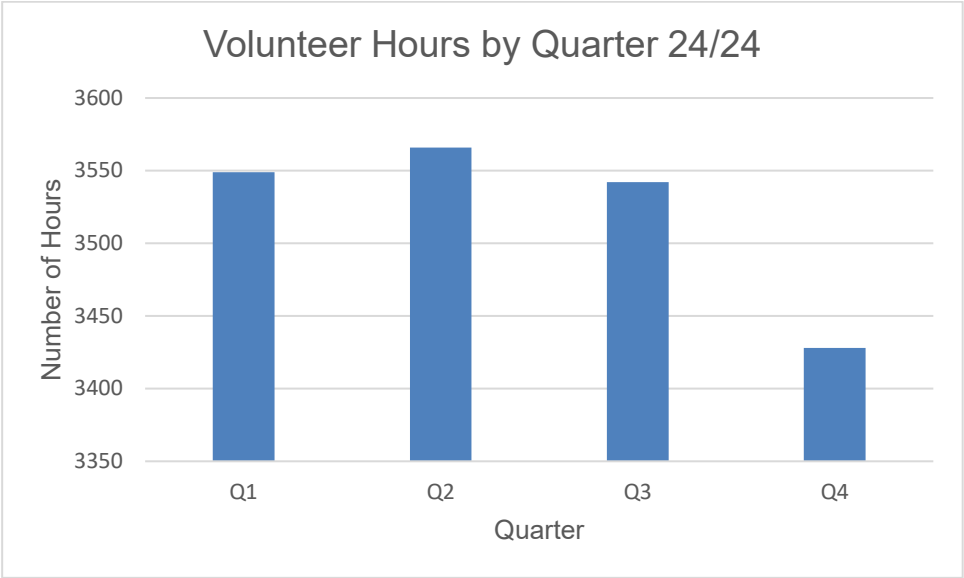


Figure eight

A total of 14,085 volunteer hours has been recorded during 24/25 for direct volunteer service.

5.4 Volunteer Roles

The volunteer service provides a range of roles to support the hospital. Numbers of volunteers in each role by quarter for 24/25 are provided at figure nine below:

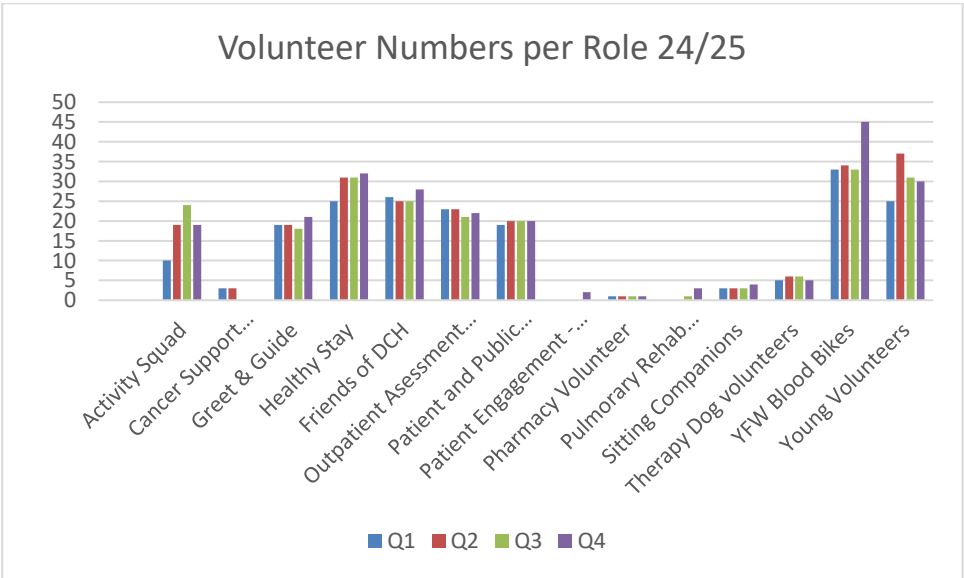


Figure 9

*Note that some volunteers carry out more than one role.

Our core roles include our Healthy Stay volunteers– supporting staff on wards with tasks including hydration rounds and mealtimes, our Activity team who work closely with the Dementia team to deliver patient activity across the hospital and our newly renamed Greet and Guide team who continue to ensure patients, visitors and staff are able to find their way around the hospital and at our Outpatient Assessment Centre at South Walks House.

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.

5.5 Voluntary Partnerships

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.

5.6 Young Volunteer programme

The Trust Young Volunteer programme established in 2019 through the Pears #iWill funding continues to develop and support Young People aged 16-19 into volunteer roles. Expansion of Programme under a refreshed model, launched in September 24 with a move back to single ward placements for new recruits. The decision to revert to single wards has proved successful and helped the volunteers become more confident in their roles. This would not have been possible without the support of staff on these wards providing the support they need in the first few weeks of their role to enable them to thrive and become an asset to the team. Initial wards included Purbeck, Ridgeway and Mary Anning with expansion into the Stroke Unit during Q3.

Recruitment of 19 new Young Volunteers was completed for the Autumn programme. The volunteer services team carried out engagement events volunteers' visits at local sixth forms and colleges as part of this process. Numbers were capped to ensure capacity to support and the model for delivery of the programme was further adapted to enhance pastoral support provided to the young volunteers.

The volunteer services team works closely with the Trust widening participation team to link young volunteers to opportunities to learn more about careers in healthcare and to support them with advice on apprenticeships and career pathways.

Alongside the onsite volunteer programme, the team continued to work with Budmouth Sixth form to support them with their employability diploma providing them with healthcare challenges. This year challenges have included looking at delivery activity for patients, improving experience of accessing healthcare for young people with mental health conditions and delivery of the NHS Young People Health Challenge as detailed in section 7.

5.7 Volunteer Service Developments

- **New Volunteer Roles:** During 24/25 the volunteer service has worked with department to develop new volunteer roles supporting the Pulmonary rehabilitation team with the community based pulmonary rehabilitation workshops and with the Orthodontics team supporting with patient calls ahead of appointments. Both of these roles were successfully piloted with volunteers recruited into these new roles.
- **Review of volunteer experience, policy and processes:** This commenced during 24/25. A modular approach to conducting this has been put in place to allow flexibility to support day-to-day operational commitments of the service. There have been some significant changes made

during 24/25 to the recruitment process with further digitalisation of processes to support efficiency. All changes are being made with consideration to impact on volunteer experience.

- **National Association of Voluntary Services Managers (NAVSM) Conference:** The Trust were represented at this two day conference in February which saw NHS volunteer managers from across the county come together to receive updates and learn and share best practice around a number of topics – including volunteering and the law and the Investing in Volunteers accreditation, and news from NHSE Experience and Partnerships team and the Department of Culture Media and Sport who presented on the new Youth Strategy and details of new digital tools to support volunteering. The conference also included an update from NHSE Chief Nurse-Duncan Burton whose presentation focused on the promotion of kindness in the workplace and how we should not underestimate the role and importance of volunteers in this and in all they do for the NHS
- **Review and relaunch of the Healthy Visit Role, now Greet and Guide Team.** This has been completed to support the ED front door move. The team are additionally piloting weekend greet and guide shifts on South 1 to establish if it is busy enough to require volunteer permanent support at weekends.
- **Recruitment of Ukrainian Volunteers:** Three volunteers from Ukraine have now been recruited and are actively volunteering in roles across the hospital with another two currently going through recruitment and induction. All three have qualifications in a healthcare setting and have approached us for volunteering opportunities to improve their English and gain experience working in a UK healthcare setting. We have also linked them in with the Widening participation team.
- **Better Impact:** 24/25 saw us move into Business-as-Usual phase with our volunteer management system Better Impact. The system has been a huge success and is allowing us to provide an almost fully digital onboarding and induction service with no paper forms required. It has enabled our service to be more efficient and enabled us to complete mandatory reporting with ease. This system is shared with DHC and UHD and our current contract will expire in 2026 so we will be looking at procurement again during 25/26 to ensure we can continue to use this system.
- **Outpatient Assessment Centre (OAC) team:** Our volunteers supporting the OAC have continued to show resilience and the ability to adjust to the changing services offered during 24/25. Reviewing the rota, we established that some shifts were hard to fill, while others were over-established. From May 24 we decided to reduce the volunteer numbers from 3 to 2 per shift. This seems to have had a positive effect on the volunteer experience, as well as spreading the resource more evenly.

5.7 Patient Activity Volunteer Support

With Activity for patients identified as a quality priority for 24/25, development and expansion of this team have been a key focus. Recruitment of activity volunteers has increased from 10 at end of Q1 to 19 at end of Q4, increasing capacity and contribution to the Activity for Patients programme. We have worked closely with the creative arts therapist who is helping to train activity volunteers to deliver creative arts activities to patients in Mary Anning Unit. The pictures attached show an example of volunteer led activity session with patients on Mary Anning Unit. We have continued to work closely with the Dementia team who have supported Activity volunteers providing targeted patient activity



support in both individual and group settings. This has proved successful both in terms of supporting a growing and evolving team and in provision of more clinical input to the team. Through working with the dementia team, we have been able to demonstrate the full effectiveness of this role and in contribution to the Trust Wide Quality priority around providing therapeutic activity to our patients.

Our activity range has continued to grow. This includes the launch of our Book Trolley which was funded by the Dorchester Casterbridge Rotary Club. The trolley is organised and run by our volunteers who provide weekly ward rounds offering books and magazines, which have been donated, to patients. We have received some positive feedback from this initiative and have also received a donation of puzzle books and pens for the trolley from a family who was so grateful to have seen this service in place.

Activity Volunteer Impact: We continue to collect feedback from our Activity Squad volunteers who provide insight into volunteering sessions they have completed with patients. Examples of feedback we see is shared below:

- **Example one**

We worked with six patients today all at various times lots of laughter and socialising and interaction between patients which was good to see. One gentleman came into the room quite tearful and did not take part in the activity but wanted to talk and so sat and chatted with one of the volunteers for a good hour. Another lady who had broken one of her wrists found it hard to hold onto the pens but with support and handholding did make lots of marks on one of the Chinese dragons, so she was chuffed with her achievement. Another lady who was very reluctant to move from her bedside last week Actually did take part this week albeit by us bringing the activity to her, but she sat very self-contained and coloured in a beautiful dragon for another hour.

Annie did a wonderful thing for a very distressed patient who was fixated on staying warm she was shouting out, very agitated Covered in lots of clothes but very distressed. Doctors had tried to tempt her with a cup of tea, but she was too distressed. She kept saying she was cold despite having lots of layers on, but Annie sat holding her hand, snuggled her up with more blankets until she drifted off to sleep when Annie extracted her hand! Not only did that comfort that individual patient but it calmed the rest of the Bay who were getting distressed at that patient shouting out and discomfort.

- **Example two**

atient was with a member o the security when volunteer arrived and was a bit ' eisty ' Security said the patient was bored. Volunteer did a drawing session with the patient and he was notably calmer afterwards.

Alongside testimonials and collation of qualitative feedback we have introduced patient activity labels for our volunteers to complete and add to patient care notes. This follows a similar system the Dementia team use and will help to provide information to clinicians regarding patient activity and impact this may have.

5.9 Thanking and Recognizing Volunteers

Thanking and recognizing contribution made by our volunteers is a core part of the volunteer service objectives. During 24/25 two key thank you events were held for volunteers including the summer tea party, and the annual mince pie mingle. Both events offer the opportunity to say thank you and celebrate volunteer achievement.

Volunteer contribution is also highlighted during national Volunteer Week held during the first week

of June annually. For volunteer's week in June 24, as well as showing our volunteers how much we appreciate them, we used the opportunity to highlight the valued roles we have on offer. Using social media and a stand in Damers, we wanted to raise awareness regarding the contribution our volunteers make and the need for our numbers to grow. We also showcased our new book trolley for the first time.

Service certificates are presented to volunteers to recognise long service starting currently from three years. We have additionally introduced Young Volunteer recognition certificates based on numbers of hours achieved

Nominations were made for specific volunteers and volunteer groups for the annual Dorset Volunteer celebration with all those nominated invited to attend and receive a certificate recognizing their service at the annual awards dinner.

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6 Patient and Public Engagement

6.1 Introduction

Patient and Public Engagement emphasis is on active involvement of the community and patients through events and feedback mechanisms (like listening events, 15 step challenge and conversation cafes), with metrics tracking engagement activities and their resulting findings and action plans via quarterly reports to Patient and Public Engagement Committee (PEPEC).

This section of the annual report will give an overview of Patient and Public Engagement activity over 24/25 and include detail on core functions within this service including:

- Carers Support
- Armed Forces Community Support
- Patient Information Leaflets
- Accessible Information Standards
- Your Voice – Patient Voice Group and Patient and Public Voice Partners.

6.2 Patient and Public Engagement Activity.

In line with the statutory guidance for, Working in partnership with People and Communities, (<https://www.england.nhs.uk/long-read/working-in-partnership-with-people-and-communities-statutory-guidance/>), we continue to work closely with colleagues across the ICS to develop models for doing this better through a systemwide approach. This includes sitting on groups including the Dorset Engagement Leads, Dorset Youth Representatives, Dorset Armed Forces Covenant board and Dorset Carers groups, where we build relationships and create the opportunity for better working together and engagement across our community. The work we do through both this activity and our volunteer activity also report into the Trust Social Values steering group and informs the objectives around the Social Values commitment for involving our community.

Within the Trust through our team restructure we have been able to significantly increase our engagement activity supporting staff with patient surveys and engagement events. This included in January 25 a conversation cafe with representatives from our Deaf Community. This brought staff from across the Trust together with the representatives 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.

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6.3 Carers Support

we have continued to promote the Carer's passport across the Trust, and this year have worked closely with VCS colleagues supporting patient discharge to support identification of Carers. This has allowed us to extend the passport offer into our Emergency Department. We have additionally continued to support Pan-Dorset carers programmes, worked closely with PCN carers leads to understand how we can better support carers across organisations and engaged with local carers groups in Weymouth and Portland to learn what we are doing well and what we could do better to support carers. This engagement will continue into 25/26 so that we can develop co-designed improvements.



6.4 Armed Forces Community Support.



Our work with the Armed Forces Community was recognised through reaccreditation as a Veteran Aware trust with the Veterans Covenant Healthcare Alliance in October 24. Focus on supporting our patients who are members of the Armed forces community has been central to work carried out over the last year. Through our new partnership with the Dorset Royal British Legion, (RBL), who have provided funding for care packs for veterans, we are now able to provide personal care items to patients who are RBL beneficiaries. The care packs are co-ordinated by our Dementia team and delivered in RBL bags which then help staff to identify veterans easier which in turn can aid delivery of care and potential post discharge support. We have also delivered patient experience presentations to the Dorchester branches of the RBL and the Royal Naval Association which has allowed us to share the services we can provide alongside listening to the feedback and challenges individuals have in accessing healthcare service. We have been able to provide answers to questions

and support not just those present but additionally the wider community as they share information they have learnt from us and understand better how we can provide that support and advice.

6.5 Communicating with Patients Policy Accessible Information Standards (AIS)

Our communicating with patients' policy was published in March 25 following a programme of collaboration across the Accessible Information Standards Steering group to review, rewrite and amalgamate the Interpreting and Translation Policy and Policy for the production of printed information (Patient Information Leaflets) and incorporate Health Literacy and AIS policy. The programme of work has allowed us to reestablish the AIS steering group and identify priority areas for compliance with AIS and wider communication with patients.

Patient Information continues to be overseen by the Patient Experience team and co-ordinated by the PALS officer. We have reviewed and streamlined this process over the last year and worked closely with colleagues in the Library team and Communications team to do this. Patient Information Leaflets are reviewed by one of our Health literacy Champions and feedback to authors is provided.

Our conversation cafe with members of the deaf community has additionally helped to inform the final policy rewrite and implementation plan with a priority to ensure that access to translation services is well communicated across the Trust.

6.6 Your Voice – Patient Voice Group / Patient and Public Voice Partners

Your Voice is the Trusts Patient Voice group and is represented by Trust Governors, Volunteers and Patient and Public voice partners attached to specific steering groups / work programmes. Meetings have been carried out bi-monthly and a report is then produced for the quarterly PEPEC meetings which is attended by the Your Voice Chair. Your Voice meetings provide an opportunity for staff from across the trust to present on projects and gain feedback providing patient / public voice. During 24/25 feedback and presentations have included:

- Input into the Health inequalities work
- The new Trust strategy
- Youth Representative presentation – providing feedback on the 15 steps challenge on Kingfisher ward.
- Presentation from the Patient Representative on Lulworth ward highlighting the difference the role makes on ensuring quick resolution to any concerns and sharing of positive feedback.
- The new visiting policy focuses on longer visiting times and ensuring consistency in visiting hours across the trust.
- The new Complaints policy implementation plan with early resolution of issues at the heart of this policy.

Concerns raised through the group over the last year have included:

- Quality of outpatient letters – looking at opportunity to work with the Access team to provide some feedback and potential solutions.
- Ongoing issues with signage with feedback showing the distress and concern this causes our patients. Question raised as to who in the senior leadership team has responsibility for signage and whether there was any funding assigned to improve this.
- Highlighted that although the patients that attend South Walks House have a very positive experience, it is very quiet and concern this is underutilised at present.
- Rubbish and low lighting around the area of the multi storey carpark along with slippery steps to access the hospital.
- Negative response to name changes of the clinics/ outpatient's area. This was discussed and feedback from volunteers / patient experience team was that names were more accepted once explanation for the changes had been given.

Concerns raised are escalated at PEPEC but also populated on an Action tracker for the Patient Experience team to report to relevant departments and help inform quality improvements. This has included over the last 12 months Your Voice involvement in the Wayfinding group to support improvements to signage across the hospital.

The Your Voice group also approved changes to its Terms of Reference which will be implemented from the start of the 25/26 year. The new ToRs will see a move to a quarterly meeting of the Your Voice meetings which will act as a reporting and planning session for Your Voice activity. An introduction of Your Voice sessions to provide a space for staff to present on current work and new initiatives to gain feedback will be opened to a wider and more public audience to increase feedback and opportunities for people to get involved.

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7 Patient Experience and Quality Priorities 25/26

7.1 Quality Priorities 2025/26

The Patient Experience Quality Priorities for 2025/26 are:

1. To build our Patient and Public engagement activity contributing to Trust strategic objectives and system wide engagement priorities supporting patient / public involvement in service developments.
2. To expand therapeutic activity support to patients, recognising and demonstrating the positive impact and benefits linked to specific measures including slips, trips, falls and violence and aggression incidents.
3. To continue to deliver our Children and Young People programme to improve the experience of Children and Young People admitted to hospital with emotional, psychological, and mental health needs.

Focus Areas for Priorities:

- Patient Flow (Access and Discharge)
- Inpatient Environment – Internal and External
- Transition – child to adult services.
- CYP Neurodevelopmental Referral waiting lists.
- End of life Care
-

Target groups for priorities:

- Dementia Patients
- Veterans
- Carers
- Children and Young People
- Deaf Community

Key Measurement of Priorities

- Reduction in numbers of Complaints
- Improved patient satisfaction rates
- Increased compliance with Accessible Information Standards.
- Experience of Care framework self-assessment to provide baseline data and inform future priorities beyond 2025/26.
- Increase in patient/ public and volunteer engagement linked to all three priorities.
- Measures aligned with health inequality action plan for target patient groups and identified patient populations.

7.2 The HIVE

In addition to the priorities above one of the big developments for patient experience this year will be the opening of, The HIVE. The HIVE is our new patient experience and community involvement hub which, following award for funding from the DCH charity, is now on track for opening in May 25. The HIVE stands for Health and Wellbeing, Information, Volunteering and Engagement and will

bring together all aspects of Patient Experience alongside our Charity and opportunities for organisations to come and hold information events. Our ambition is for The HIVE to be a space which feels welcoming, and which will offer support to our community and a space to form connections which will help us to build thriving communities in which we can help to support and improve experience of care.

7.3 Team Focus

Patient Experience team focus this year, in addition to and in conjunction, with delivery of quality priorities and opening of The HIVE will include:

- Full implementation of the Complaints Policy – focus on training staff in early resolution complaints and working closely with divisional management to implement processes for closer look investigation.
- Development of volunteer roles with focus on the Activity volunteer role and a role to support the delivery of services within the HIVE.
- Opportunities to deliver quality patient and public engagement through collaboration with departments across the trust, our patients / public voice and external organisations. Initiatives will include the introduction of a Carer Café in the HIVE providing a space for carers of current inpatients to connect with carers support services and work to focus on identification of our Armed Forces Community.
- Creation of a new Patient Experience Learning network to provide a dedicated space to support quality improvement linked to learning from complaints and other feedback including National Surveys.
- Complete the Experience of Care framework baseline matrix which will inform future planning for Experience of Care across the Trust aligned with national requirements and standards and the 10-year plan for the NHS.

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8 Summary and Recommendations

8.1 Summary

During the 2024/2025 financial year we have made significant strides in enhancing patient experience. This has been achieved by implementing improved complaints handling aligned with NHS standards, strengthening and broadening voluntary services, and conducting targeted, meaningful engagement with key community groups, including carers, the Armed Forces community, and the deaf community. These efforts underscore the trust's commitment to learning from patient feedback and tailoring its services to meet the diverse needs of the Dorset population. The restructure of the team and closer working together across the team has enabled us to think more ambitiously about what we can achieve, and this will be further recognised through delivery of priorities for 2025/26.

8.2 Recommendations

The quality committee is recommended to:

- Receive the report for information, assurance and approval

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Finance and Performance Committee in Common Assurance Report
for the meeting held on Wednesday 26 November 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 <i>Setchell, Ryan 04/12/2025 09:14:16</i>	• Community waiting lists – Dorset HealthCare provide a wide range of planned and elective outpatient services. – Waiting times for all services are reported and monitored at directorate level, with key KPIs reported though committees to Trust Board via the Integrated Corporate Dashboard. – There is a high level of assurance of being able to deliver zero over 52 weeks waiters for the services that are reported on the Community SitRep – Dorset HealthCare sustainably delivers waiting times within current national guidelines. – Dorset HealthCare is well placed for the planned introduction of RTT monitoring for Community Services and is currently delivering performance that exceeds the draft planned 28/29 requirement. – Teams at Dorset HealthCare are patient focused and continue to develop innovative approaches to improving productivity and use of available resources to deliver the best possible patient wait times and experience. • Financial Recovery Board The focus is now on delivery of the recovery plans and the need for project management resource to support delivery. The timeline and governance arrangements to deliver the medium-term financial plan within tight deadlines was highlighted to the Committee • EPRR Commended to the Board both Trusts being fully compliant against the standard noting DHC is the only Trust in the Dorset to attain full compliance for 4 years running. • Recommended approvals for Board – Digital Contracts – DCH – Successful Bids Report (£10m+ See below)

**Key issues / matters
discussed at the
meeting**

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The committee received, discussed and noted the following reports:

Board Assurance Framework Assigned Risks

Committee members received the report for assurance. There are no changes in the scores to the 3 assigned risk to the committee for DCH and DHC. Updates have been received for all overdue actions outlined in the report. A Risk appetite draft has been completed to go through Audit Committees and Board for approval.

Corporate Risk Register Assigned Risks

The DCH and DHC reports were summarised highlighting the high-risk areas, and assurance was provided on the mitigating actions. Committee review and discussion resulted in some risks requiring update for next iteration of report.

DCH Performance Report

The committee accepted the report for assurance with the following highlights:

- Demand is increasing within the emergency and non-emergency portfolio
- 12-hour breaches noted as area of concern primarily attributed to bed availability
- Ambulance handover performance remains stable
- RTT performance and waiting list improving
- Decrease in the elective follow-up backlog and increase in patient-initiated follow-up which was commended by the committee.
- Theatre delays were discussed and inter-case delays noted.
- Improved data intelligence relating to 'no reason to reside' which has supported improvement conversations internally and externally.

DHC Performance Report

The committee accepted the report for assurance with the following highlights:

- Mental health related metrics appeared worse than reality due to a data upload issue and timing of the national data refresh
- CAMHS gateway waiting time performance has recovered.
- Dementia related performance and Serious Mental Illness health checks continue to be an area of concern
- Average length of stay
- The committee was given advanced notice that the Mental health average length of stay metric will increase as data quality issues are corrected.
- IUCS Call-Back performance is improving.

Community Service Performance/Waiting List Metrics (DHC)

A summary of the paper was provided covering several performance domains relating to community service delivery. The report was well received for assurance, providing good insight and improved understanding for committee members.

DCH Finance Report

At Month 7, DCH is in line with plan with YTD deficit of £17.4m. There is verbal agreement to mitigate the £30.5 system risk (that was attributed to shared service programme ceasing), through national funding. Pay expenditure is above plan by £2m largely driven by Bank expenditure. The committee accepted the report for assurance.

DHC Finance Report

At Month 7, DHC is ahead of plan with a YTD surplus of £1.3m. The committee accepted the report for assurance with recognition that the financial position for both Trusts is fully understood.

Financial Recovery Board Progress Update

The financial recovery process and approach was re-summarised, providing assurance to committee members on progress being made to meet the £12m recovery in the second half of the year. This centres around slipping investments, workforce controls and asset disposal. The focus is now on delivery of the plans and the need for project management resource to support delivery. The timeline and governance arrangements to deliver the medium-term financial plan within tight deadlines was summarised.

Results of National Benchmarking Exercise

The report outlining the national corporate benchmarking results highlighting areas in which DCH and DHC may be outliers was received by the committee for assurance. The results will potentially help the financial recovery board identify efficiency opportunities in the coming year.

Key Worker Housing – Strategy Implementation (DCH)

The committee received a detailed summary of the development of a keyworker housing solution that addresses critical accommodation challenges and aligns with the asset disposal strategy as part of financial recovery. The paper was noted for information in advance of full consideration by the committee for approval in December 2025.

Estates Compliance Report

Compliance reporting for DCH and DHC has become more aligned. DHC compliance is at 94%. The Premises Assurance Model report has now been received with no inadequate ratings. DCH compliance is at 83%. The committee commended the progress on the alignment of process and reporting for both Trusts which provided a firm foundation for transparency.

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and committee assurance. Clarification was provided on risk areas including Electrical Safety and the mitigations that are now in place.

Successful Bids Report (DCH & DHC)

Expenditure of external funding (£10m+) resulting from successful bids was approved by the committee for the remainder of the financial year and recommended for Board approval.

Emergency Planning, Response and Resilience DHC Annual Assurance Report and DCH ICB Review Outcome

DCH and DHC achieved 100% compliance against the standards which has been confirmed by the ICB. The Committee commended the teams on their approach and achievement, and received the reports for assurance.

Digital Contract (DCH)

The approach to digital contract was outlined and the associated benefits. The committee approved the approach recommending Board approval (P2 due to commercial sensitivity).

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

- DHC - Capital Investment Meeting Efficiency Delivery Group
- DCH - Capital Planning and Space Utilisation Group
- DCH - Value Delivery Board
- DCH - SubCo Ltd - Escalation report and performance report
- Ridgway Ward Redesign– Return on Investment**
- Received for Assurance under Consent section

Decisions made at the meeting

Approvals by DCH and DHC committees:

- Digital Contract – DCH
- Successful Bids Report (£10m+) – DCH & DCH

Issues / actions referred to other committees / groups

- None

Quoracy and Attendance

	29/05/2025	30/07/25	24/09/25	
Quorate?	Y	Y	Y	Y
Dave Underwood	Y	Y	Y	Y
Frances West	N	Y	Y	Y
Stephen Tilton	Y	Y	Y	Y
Andreas HAIMBOCK-TICHY	Y	Y	N	N
Chris Hearn	Y	Y	Y	Y



Nick Johnson	N	N	N/A	N/A
Rachel Wharton	N	N	N	Y
Anita Thomas	Y	Y	Y	Y
Lucy Knight	Y	N	N	Y
Rachel Small	N	Y	Y	Y

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Report to	Board of Directors	
Date of Meeting	09 December 2025	
Report Title	Integrated Corporate Dashboard – December 2025	
Prepared By	Daniel Cunningham Corporate Performance Business Partner	
Approved by Accountable Executive	Chris Hearn Chief Finance Officer	
Previously Considered By	Senior Leadership Group (draft) 19 November 2025	
Action Required	Approval	N
	Assurance	Y
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? <i>Delete as required</i>	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1: Safety and Quality SR3: Workforce Capacity SR4: Capacity and Demand SR6: Finance	
Financial	Finance metrics for assurance.	
Statutory & Regulatory	Many of the metrics within the report are statutory or regulatory and so these are provided for assurance.	
Equality, Diversity & Inclusion	Completeness of Patient Ethnicity Data for assurance.	
Co-production & Partnership	No implication	

Executive Summary		
This paper is to provide the Board with insight and foresight concerning Trust performance. It summarises key messages and the current position against the Trust strategic priorities. It aims to support effective decision making, highlighting key areas of exception and good practice.		
Strategic Objective	Total Metrics	No. focussed on in detail in report
Care	52	34
Communities	4	3
Colleagues	8	7
Sustainability	4	4
Grand Total	68	48

Recommendation
Members are requested to: Receive the report for assurance

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Section			Page No.
1.0		Performance	
		Integrated Corporate Dashboard Analysis	3
		Care	5
		Communities	52
		Colleagues	59
		Sustainability	71
2.0		National Reporting Frameworks	
	2.1	CQUINs (Quarterly) paused for 2024/25 by NHSE	N/A
	2.2	External Benchmarking (as appropriate)	N/A
	2.3	NHS Oversight Framework	N/A
	2.4	Research and Development Metrics (Quarterly)	72
	2.5	Inpatient Nursing Staffing	73

Integrated Corporate Dashboard Analysis – December 2025 (based on October data)

This paper summarises key messages and the current position against the Trust strategic priorities. Detailed reports are provided for metrics that meet the following criteria:

- Metrics with SPC charts where the chart shows:
 - special cause
 - that the metric is unlikely to achieve the threshold
 - that the metric will not consistently hit the threshold AND the threshold was missed in the last month
- Metrics without SPC charts that have missed the threshold
- Metrics where occurrences are rare and there has been an occurrence in the last month
- Metrics where changes are rare and there has been a change in the last month e.g., CQC rating
- Workforce metrics
- Finance metrics

Statistical Process Control (SPC) analysis is used within this report to determine whether processes are stable and predictable by looking at variation. ‘Natural/ Standard variation’ is regular or ordinary predictable variation. ‘Special cause variation’ is unexpected or abnormal variation which warrants further investigation. Special cause variation is shown by coloured dots; blue dots show areas of improvement and orange dots show areas of potential concern. The assurance icons show whether the process is capable of achieving a target.

Assurance			Variation						
									
Consistently Pass target	Pass and fail target subject to random variation	Consistently Fail target	Special Cause Concerning variation either Higher or Lower		Special Cause Improving variation either Higher or Lower		Special Cause Neither improving nor concerning variation		Common Cause

STRATEGIC OBJECTIVES

CARE



We provide compassionate, safe, person-centred care.

- Improved access to the right care, at the right time, in the right place
- People are equal partners in their care and have a positive experience
- Patients and service users are always safe in our care

COMMUNITIES



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

- Improved population health and wellbeing through joined up working across health and care
- People staying well through prevention, detection and early intervention, with more control over their own health
- People and communities involved in shaping health and care services

COLLEAGUES



We are empowered, skilled, caring colleagues who can thrive at work.

- Colleagues are positive about their experience at work
- All colleagues feel they belong and are included
- A sustainable workforce with the right skills now and for the future

SUSTAINABILITY



Our services are sustainable environmentally and financially and we make best use of resources.

- Releasing time to care through improved processes, skill mix and digitally enhanced technology
- Sustainable models that optimise use of the available resources
- Using our size, scale and reach to make a positive difference to the economic and social wellbeing of Dorset
- Minimise our negative impact on public health and the environment



Description of icons

Assurance			Variation						
Consistently Pass target	Pass and fail target subject to random variation	Consistently Fail target	Special Cause Concerning variation either Higher or Lower		Special Cause Improving variation either Higher or Lower		Special Cause Neither improving nor concerning variation		Common Cause

Care Metrics	In Month	Assurance	Variation	Data Quality
Methicillin resistant Staphylococcus aureus (MRSA) bacteraemia infections (blood stream infection)	0			High
Clostridioides difficile infections	1			High
E. coli bloodstream infections	0			High
Other significant HCAI – number of patients affected	0			High
NHS England Patient Safety Alerts Outstanding	0			High
Patient Safety Events (excludes falls & all no/low harm)	124			High
Falls on inpatient wards per 1,000 OBD	6.1			High
Medication incidents	68			High
Violent incidents - patient on patient in hospital	18			High

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Care Metrics (continued)	In Month	Assurance	Variation	Data Quality
Falls Assessment within 24 hours	98.4%			High
Venous Thromboembolism (VTE) risk assessment within 24 hours	88.9%			High
Pressure ulcer risk assessments (Purpose T) within 6 hours	97.4%			High
MUST risk assessment within 24 hours	94.2%			High
Bed occupancy rate community hospital wards	91.7%			High
ICS in-patients not feeling safe	0.0%			Medium
MH in-patients not feeling safe	4.6%			Medium
OOA Incidents (MH only)	1			Low
Prone Restraint (Adult)	4			Medium
Supine Restraint (Adult)	10			Medium
Seclusion (Adult)	2			Medium
Rapid Tranquilisation (Adult)	3			Medium
Prone Restraint (<18 y.o.)	1			Medium
Supine Restraint (<18 y.o.)	4			Medium
Seclusion (<18 y.o.)	0			Medium
Rapid Tranquilisation (<18 y.o.)	0			Medium

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Care Metrics (continued)	In Month	Assurance	Variation	Data Quality
IUCS Proportion of call backs by Clinician in agreed timeframe within 20 minutes	44.9%			High
IUCS Proportion of call backs by Clinician in agreed timeframe over 20 minutes	65.8%			High
Community Waiting List sitrep - numbers waiting	12,103			Medium
Community Waiting List sitrep - numbers waiting over 52 weeks	0			Medium
Friends & Family Test - positive experience feedback	91.7%			High
Number of complaints	72			High
Number of complaints with Ombudsman involvement	1			High
Reopened complaints	4			High
Duty of Candour	70.3%			TBC
Percentage of 2-hour Urgent Community Response referrals where care was provided within two hours	80.0%			High
Maximum 6-week wait for diagnostic procedures	93.9%			Medium
Virtual wards bed occupancy rate	73.8%			TBC
Right to reside (CHS)	35.6%			High
Patients reporting being involved in their care	97.0%			High
Number of compliments	446			Medium

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Care Metrics (continued)	In Month	Assurance	Variation	Data Quality
Children & Young People (CYP) Access 1+ Contact, DHC Under 18s rolling 12 months	6,383			High
Community Mental Health (CMH) 2+ Contacts, Local Provider Data rolling 12 months	9,095			High
Children & Young People Eating Disorders (CYPED) Urgent - 1 week rolling 3 month	80.0%			High
Children & Young People Eating Disorders (CYPED) Routine - 4 weeks rolling 3 months	82.0%			High
Talking Therapies Courses of Treatment	914			High
Talking Therapies 1st to 2nd treatment (Dorset only)	29.2%			High
Talking Therapies Reliable Recovery	397			High
Talking Therapies Reliable Improvement	621			High
Talking Therapies Waiting Times - 6 weeks (Dorset only)	95.9%			High
Southampton Priory Placements - Appropriate Out of Area Placements (number of active placements at end of month)	10			High
Out of Area Placements - Inappropriate Placements (active placements at end of month)	4			High
Perinatal & Maternal Mental Health Access rolling 12 months	733			High

Satchell, Ryan
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Clostridioides difficile infections

CQC Question: Are We Safe?

Analysis

Description of metric

One case of Closteroides difficile was reported in October on Radipole Ward. The patient had previously been admitted to Dorset County Hospital.

Year to date 2025/26, there have been seven C. Diff cases reported.

NHS Oversight Framework

Number of Clostridioides difficile cases identified on a hospital ward in the month. This includes those which are found not to be due to a lapse in care.

Threshold: 13 or fewer cases per year.

Actions

From Radipole Ward Swarm Huddle (multi-disciplinary team discussion) on 7 October:

Added to handover for staff to complete risk assessments when patients have loose stools and no sample has been sent.

Month	Ward
May 2025	Stanley Purser
June 2025	Jersey
July 2025	Tarrant, Radipole
September 2025	Tarrant, Radipole
October 2025	Radipole

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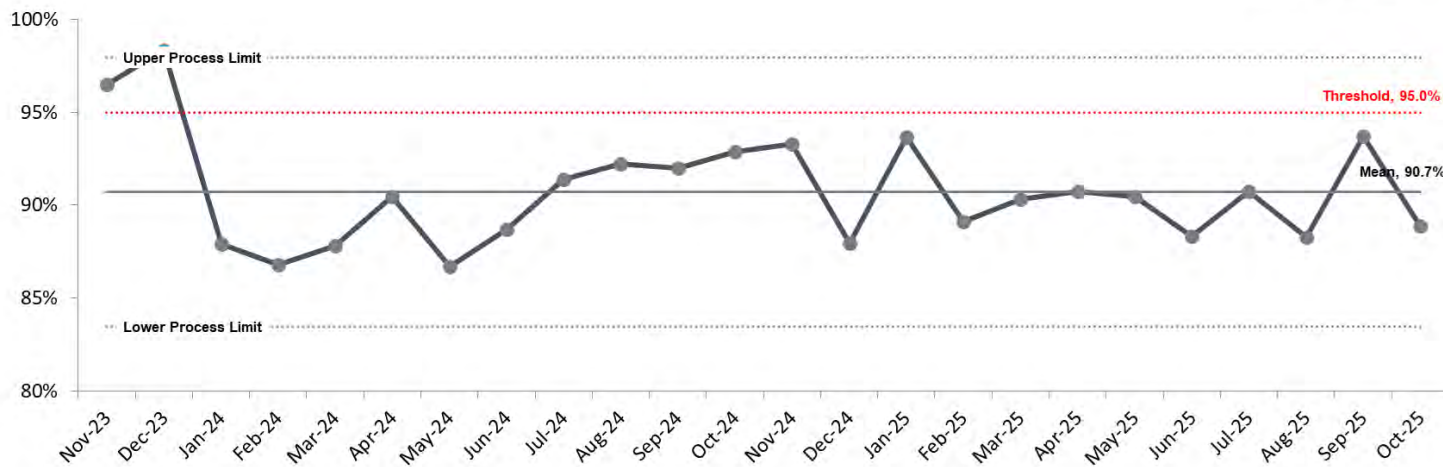
Venous Thromboembolism (VTE) risk assessment within 24 hours

CQC Question: Are We Effective?

Description of metric

Percentage of applicable patients who receive venous thromboembolism risk assessment within 24 hours of admission to hospital. Community hospital patients and mental health patients.

Contractual target: $\geq 95\%$



Analysis

The Trust reported 88.9% against a threshold of 95%, 184/207 (23 breaches).

Mental Health, reported compliance of 87.0% against a target of 95% with seven breaches out of 54 admissions:

- Seaview Ward (1/13)
- Alumhurst Ward (1/7)
- Haven Ward – Female (1/4)
- Herm Ward (1/5)
- Kimmeridge Ward (1/2)
- St Brelade's Ward (1/4)
- Waterston Ward (1/7)

Two assessments were completed prior to the patients being admitted to bed

Actions

Mental Health One ward manager has raised with the ward consultant the VTE breach and the need to complete at time of admission and the other ward managers have reminded staff to admit patients to bed state prior to updating the risk assessments in the patient's electronic record.

The Business and Performance Team has followed up with the other ward manager to identify the reason for the breaches, the Head of High Acuity has oversight of all inpatient risk assessment breaches.

Community Services continue to have a clear focus on this and escalate through Matron and team meetings.

Venous Thromboembolism (VTE) risk assessment within 24 hours (Continued)	
CQC Question: Are We Effective?	
Analysis (cont.)	Actions (cont.)
state. One assessment was not completed as part of the medical clerking at time of admission. One assessment was completed by the duty doctor at time of admission however the patient electronic record was updated using the incorrect date/time. Completion of one assessment was delayed as the patient was transferred general hospital for review, staff completed the assessment once the patient had returned to the ward which was outside of the 24-hour target time. Two assessments were not completed no reasons have been given to why. Community Services reported compliance of 89.5% against a target of 95% with 16/153 breaches, all of which were completed outside of the target time • Beech: 3/6 breaches • Guernsey: 1/19 breaches • Hanham: 5/14 breaches • Jersey: 5/15 breaches • Shaston: 1/11 breaches • Stanley Purser: 1/6 breaches Setchell, Ryan 04/12/2025 09:14:16	

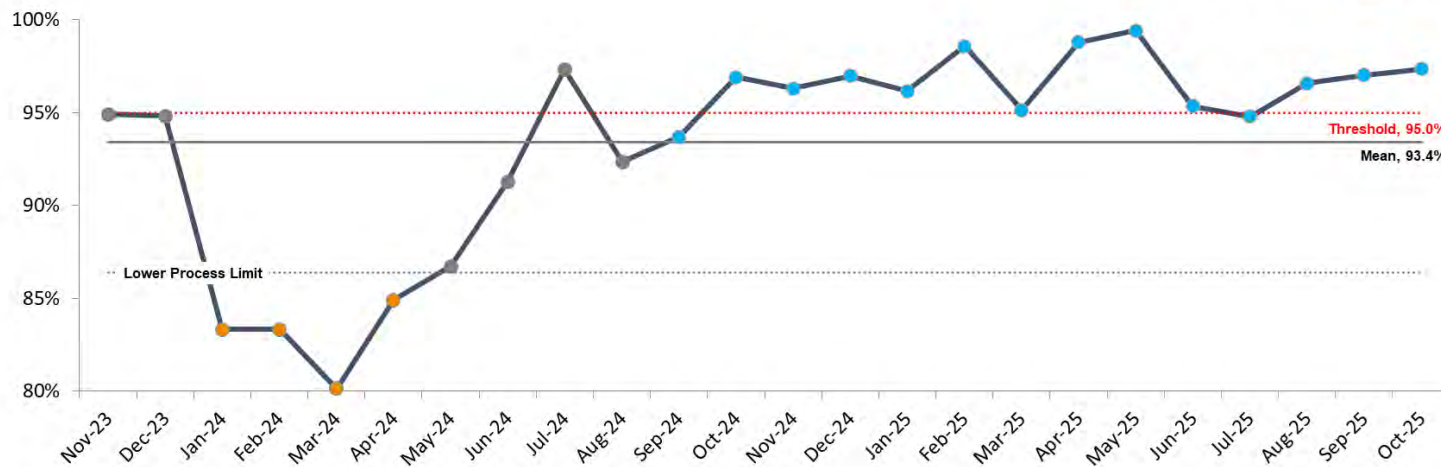
Pressure ulcer (Purpose T) risk assessments within 6 hours

CQC Question: Are We Effective?

Description of metric

Percentage of applicable patients who receive pressure ulcer risk assessment within 6 hours of admission to hospital. Community hospital patients and mental health patients >=65 years old.

Contractual target: >=95%



Analysis

The metric is showing a sustained improvement, reporting three consecutive months above the 95% threshold and in October the Trust achieved 97.4%, 184/189 (four breaches).

Mental Health reported 100% compliant.

Community Services reported compliance of 97.1% against a target of 95% with 5/173 breaches, all of which were completed outside of the target time

Colmers: 1/28 breaches

Guernsey: 2/19 breaches

Hanham: 1/16 breaches

Radipole: 1/30 breaches

Two of these breaches were evening admissions and another two were weekend admissions.

Actions

Mental Health Breaches mainly occur when a patient declines the skin inspection, staff will then complete the assessment once the patient is more settled on the ward, this tends to be outside of the 6-hour target time. The Head of High Acuity has oversight of all inpatient risk assessment breaches, which are shared at the monthly High Acuity Managers Meeting.

Community Services Risk Assessments continued to be raised during Matrons meeting

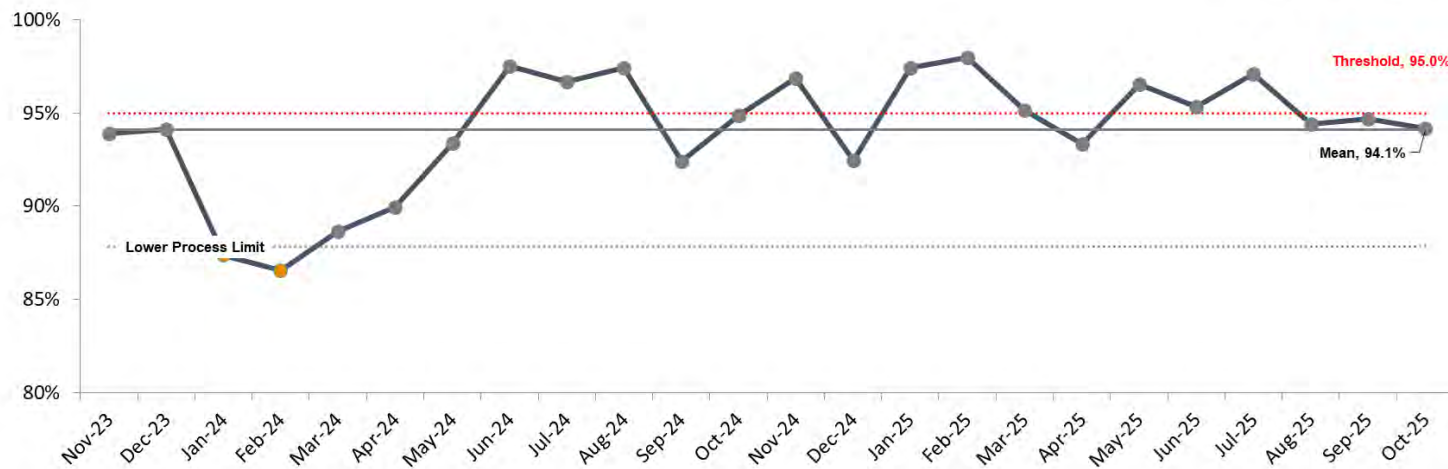
MUST risk assessment within 24 hours

CQC Question: Are We Effective?

Description of metric

Percentage of applicable patients who are screened using the MUST within 24 hours of admission to hospital. Community hospital patients and mental health patients ≥ 65 years old.

Contractual target: $\geq 95\%$



Analysis

The Trust reported 94.2% compliance against a threshold of 95%, 178/189 (11 breaches)

Mental Health Three breaches out of 16 admissions:

Three breaches out of 16 admissions:

- Haven Ward – Female (1/4)
- Melstock Ward (1/1)
- St Brelade's Ward (1/4)

All three assessments were not completed. For one assessment the patient was discharged within the 24 hour assessment target time. The other two assessments no reasons have been given as to why these were not completed on time.

Actions

Mental Health The Business and Performance Team has followed up with the relevant ward manager to identify the reason for the breaches. The Head of High Acuity continues to have oversight of all inpatient risk assessment breaches.

Community Services Risk Assessments continued to be raised during Matrons meeting.

MUST risk assessment within 24 hours (Continued)

CQC Question: Are We Effective?

Analysis (cont.)	Actions (cont.)
Community Services reported compliance of 95.4% against a target of 95% with 8/173 breaches, 7 of which were completed outside of the target time with 1 not showing completed on S1 • Beech: 2/6, completed outside of target time • Jersey: 4/17, 3 completed outside of target time, 1 showing as not completed • Rowan: 1/16, completed outside of target time • Shaston: 1/13, competed outside of target time	

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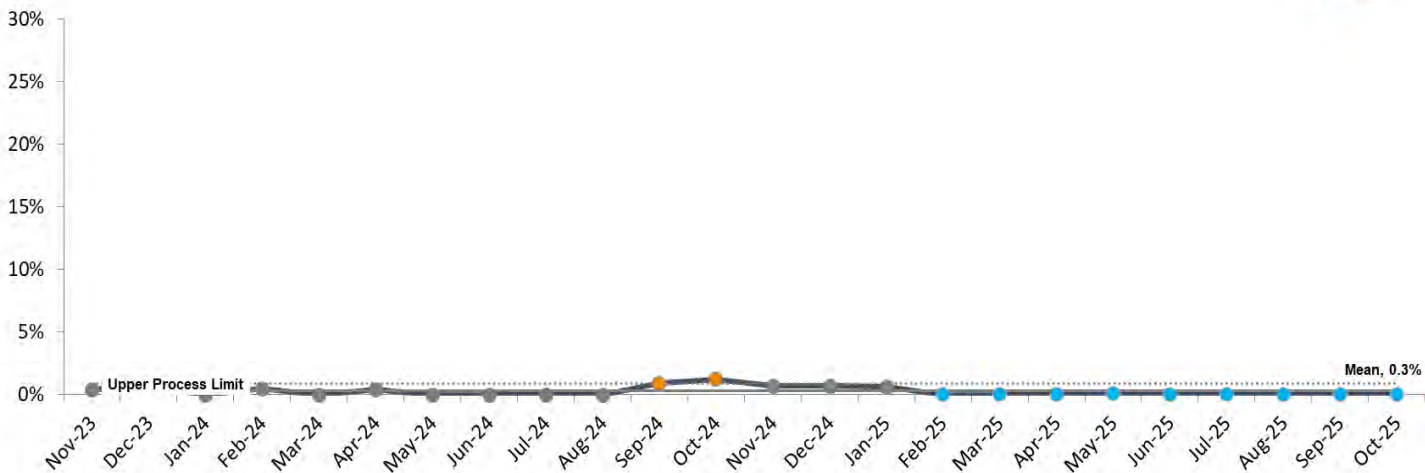
Community Health Services patients not feeling safe

CQC Question: Are We Safe?

Description of metric

Percentage of respondents in our Community Health inpatient wards, answering that they did not feel safe (via Friends & Family Test survey).

Threshold: None



Analysis

In October, 105 patients completed the survey. Of these, 87 patients (82.9%) reported feeling safe to a large extent, and 18 patients (17.1%) reported feeling safe to a moderate extent. This indicates that patients generally state they feel safe within the service, and no immediate concerns have been identified.

Actions

Setchell, Ryan
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Out of Area incidents (Mental Health)		CQC Question: Are We Safe?
Analysis	Description of metric	
One Out of Area (OOA) Incident was reported in October, relating to Physical – Abuse (No Injury), Patient on Patient. In February 2025 the patient was placed in an out of area Rehabilitation bed due to the acuity of their mental health. Since the placement commenced the OOA provider has reported a number of incidents. October’s incident related to an interaction with another patient, that was quickly de-escalated by staff. Setchell, Ryan 04/12/2025 09:14:16	A count of all incidents involving OOA patients, reported to DHC by OOA providers and recorded on Ulysses.	
	Threshold: None	
	Actions	
	The OOA provider and DHC staff follow incident reporting and policy procedures for all the incidents and escalate when appropriate. The DHC Community Rehab Team are in regular contact with the OOA provider, have visited the patient at the placement and a member of the team attends the monthly OOA patient Multi-Disciplinary Team (MDT) meeting. The OOA provider reports that the use of verbal de-escalation with the patient and redirection to their bed space has worked to good effect.	

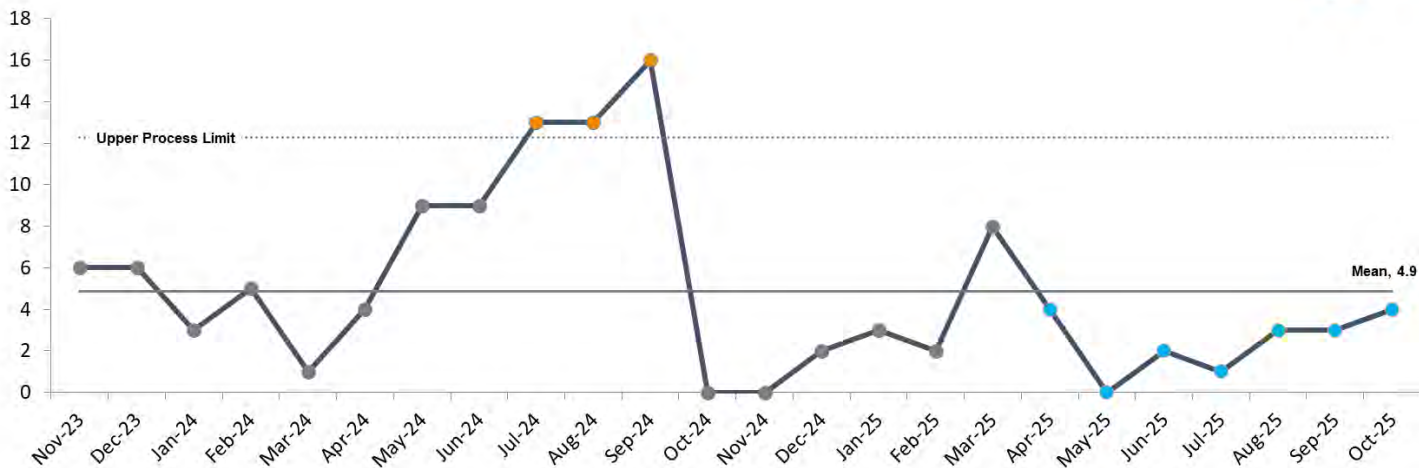
Prone Restraints (Adult)

CQC Question: Are We Safe?

Description of metric

Number of prone restraint incidents reported on Ulysses for adult patients.

Threshold: None



Analysis

The metric has reported below the mean (4.9) for seven consecutive months, showing special cause improvement.

Initially staff use verbal de-escalation techniques before moving to using restraint, however in most situations Prone restraint is utilised to ensure patient and staff safety.

Actions

Wards continue with their quality improvement projects which aim to reduce the use of restrictive practice in their areas.

Following an incident of prone restraint a review by the ward takes place, learning events are scheduled and care plans updated accordingly. The Reducing Restrictive Practice (RRP) Group has oversight of restrictive interventions across mental health inpatient services.

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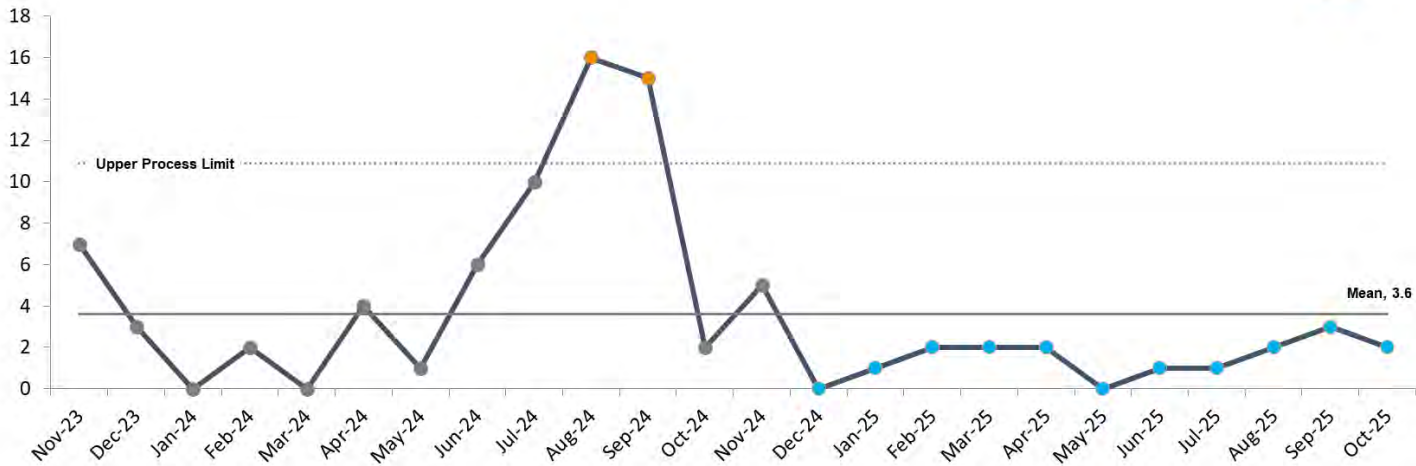
Seclusions (Adult)

CQC Question: Are We Safe?

Description of metric

Number of seclusion incidents reported on Ulysses for adult patients.

Threshold: None



Analysis

The metric has reported below the mean (3.5) since December 2024 showing sustained special cause improvement.

In all incidents of seclusion staff use de-escalation techniques prior to any decision being made to seclude. Seclusion is utilised as the least restrictive practice option of Prevention and Management of Violence and Aggression (PMVA)

Any prolonged periods of seclusion are overseen by the Medical Director for MH, LD, and CYPF and the Service Director for additional assurance.

Actions

Wards continue with their quality improvement projects which aim to reduce the use of restrictive practice in their areas.

Following each seclusion a review by the ward takes place, learning events are scheduled and care plans updated accordingly. The Reducing Restrictive Practice (RRP) Group has oversight of restrictive interventions across mental health inpatient services.

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Sketchell, Ryan

Under 18 Restrictive Interventions

CQC Question: Are We Effective?

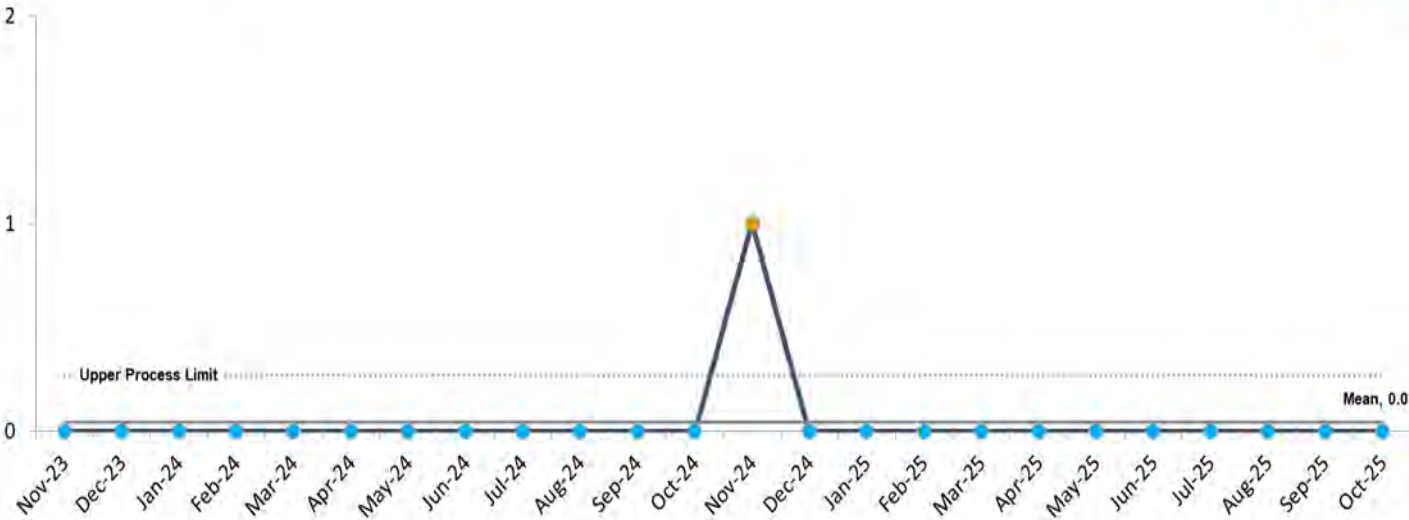
Description of metric

Seclusion (<18 y.o.) - Number of seclusion incidents reported on Ulysses for patients under the age of 18 years.

Threshold: None



Seclusion (<18 y.o.)



Analysis

Pebble continues to have no seclusions on the ward.

Actions

The staff work to reduce restrictions on the ward and approach violence and aggression with the least restrictive options.

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Integrated Urgent Care Service: Proportion of call backs by Clinician in agreed timeframe within 20 minutes

CQC Question: Are We Effective?

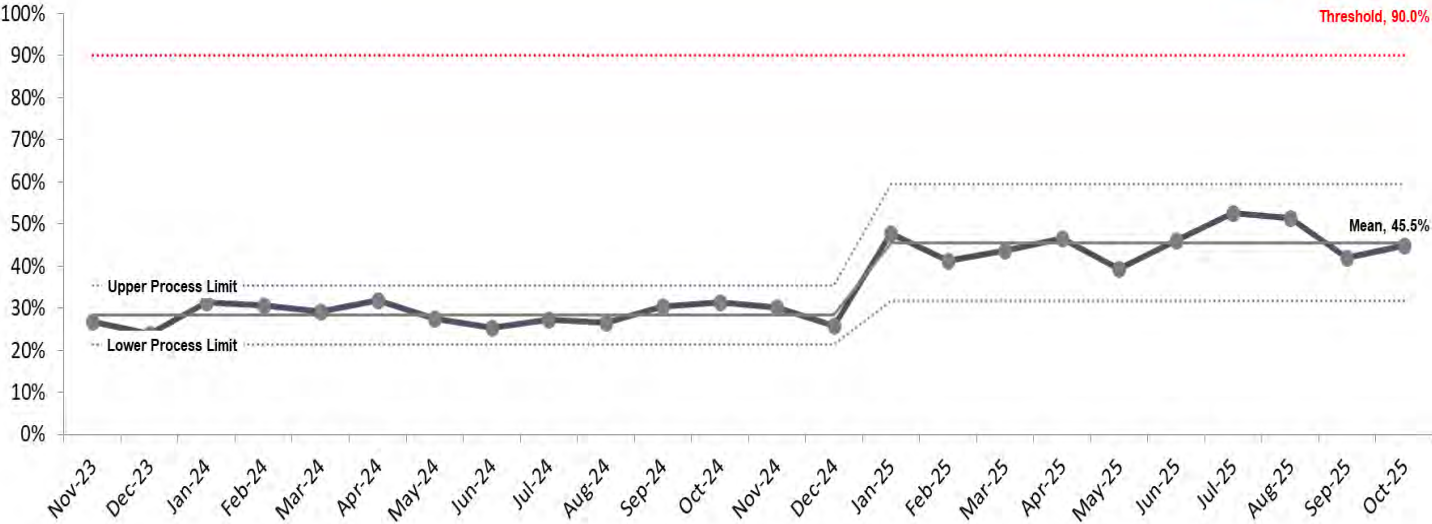
Description of metric

Proportion of call backs by Clinician in agreed timeframe within 20 minutes

Threshold: 90%



Threshold, 90.0%



Analysis

Performance has increased to 45% in October. Call demand increased by 5% month on month which led to an increase of 17% in 20-minute calls partly due to the 56% increase in cold/flu type calls.

Currently the Dorset 111 service is performing in the top quartile of this metric against all provider areas in England.

Integrated Urgent Care Services (IUCS) have seen increased sickness absence continue into October.

Actions

New service model designed for IUCS procurement process aims to reduce cases reaching the queue, reviewing current demand/capacity including SWAST referrals as not currently within the model.

High Absence within IUCS including clinical teams, being managed as per policy and wellbeing resources to be re-shared.

Clinical performance meeting reinstated, set agendas, clear objectives and actions reviewed, commencing 17 November.

Attend Anywhere video consultation accessible to IUCS advanced clinical team. Focus for UCPs/ ACPs trained and utilising systems by 30th November.

Schell, Ryan
14/12/2025 09:14:16

Integrated Urgent Care Service: Proportion of call backs by Clinician in agreed timeframe within 20 minutes (Continued)

CQC Question: Are We Effective?

Analysis (cont.)	Actions (cont.)
Setchell, Ryan 04/12/2025 09:14:16	Due to complex clinical acuity of patients not applied to whole shift, would be an additional tool available to senior clinicians for see and treat benefit. Photo imaging now live with our GP team, next phase to roll out with the Night Nursing/CAS team. Re introduce and promote the comms annexe workstream, utilising text messaging for long waiting patients, comfort calling. Trial of complex clinical advice line delayed, due to go live beginning of December providing dedicated clinical support for HA's to seek advice on patient pathways. Pilot to identify any reduction of clinical queue activity. Recruitment of clinical team continues, focus rotas on OOH periods to meet demand. Action to request DOS profile only presents first option service is not possible through the systems (ICB confirm) - action closed. DHC IUCS raised concerns to ICB regarding acuity and prioritisation of the 20-minute endpoints. Integrated Urgent Care Services made previous recommendations to NHSE which were not accepted. Integrated Urgent Care Services is meeting NHSE and the ICB in November to re explore these recommendations. Integrated Urgent Care Services to make recommendations through DHC Governance processes to go ahead with the changes recommended, paper will detail the risks in regard to pathways license compliance and reporting of risk. Regular meeting arranged with SWAST to discuss Ambulance validation referrals sent to the CAS queue through the agreed MOU process.

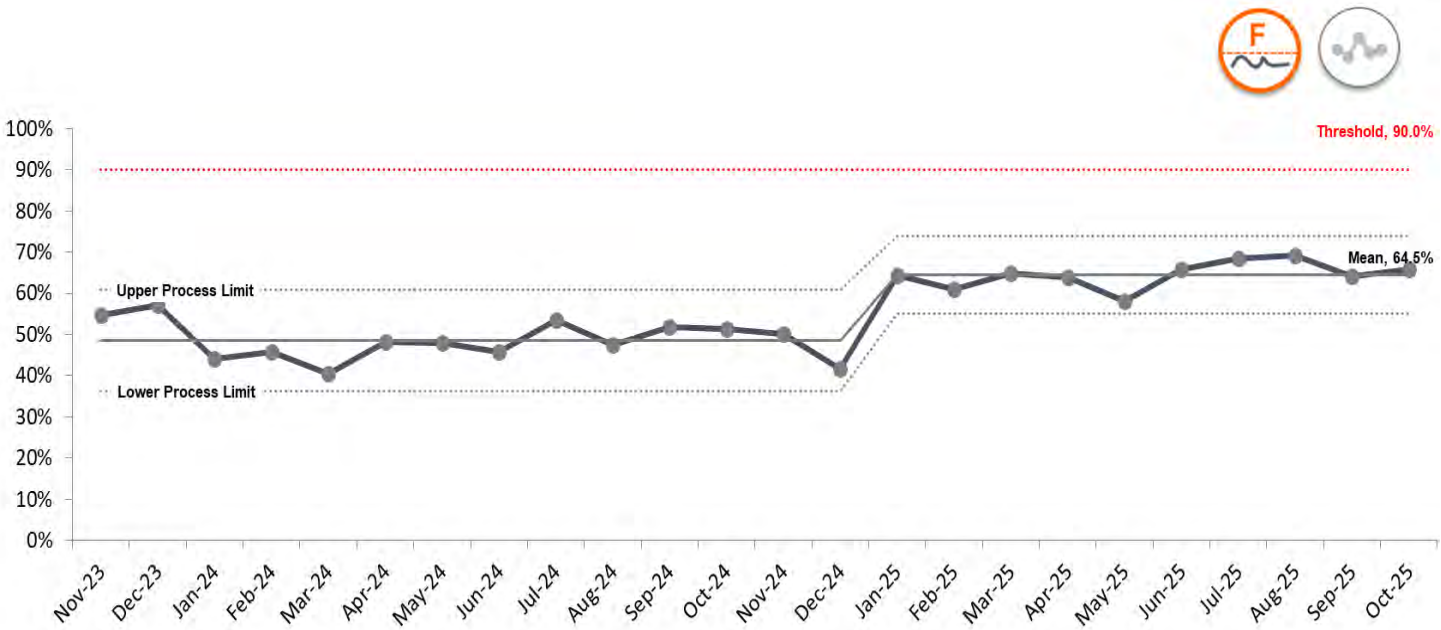
Integrated Urgent Care Service: Proportion of call backs by Clinician in agreed timeframe over 20 minutes

CQC Question: Are We Effective?

Description of metric

Proportion of call backs by Clinician in agreed timeframe over 20 minutes

Threshold: 90%



Analysis

Performance increased to 66% For October. Due to a change in national Key Performance Indicators (KPIs), we are no longer able to accurately benchmark our performance against other providers for this indicator. Please see 5a analysis for further information.

Actions

Please see KPI 5a for actions.

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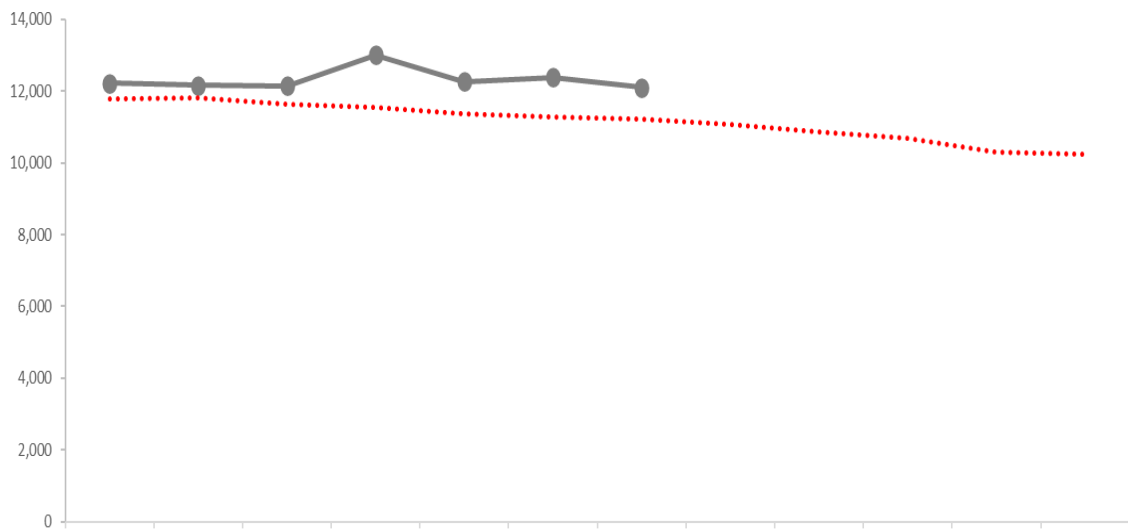
Community Waiting List sitrep - numbers waiting

CQC Question: Are We Effective?

Description of metric

Community Waiting List sitrep - total number waiting

Threshold: None



Community Waiting List sitrep - numbers waiting

Operational plan target 25/26

Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
12,222	12,154	12,138	12,996	12,259	12,380	12,103					
11,793	11,819	11,636	11,541	11,378	11,269	11,206	11,075	10,873	10,679	10,283	10,231

Analysis

Total numbers waiting reduced in October and although this remains behind the stretch target set for 2025/26, it shows progress.

Physiotherapy and Rehab services continued to show sustained reductions. Most other services showed only minor changes.

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Actions

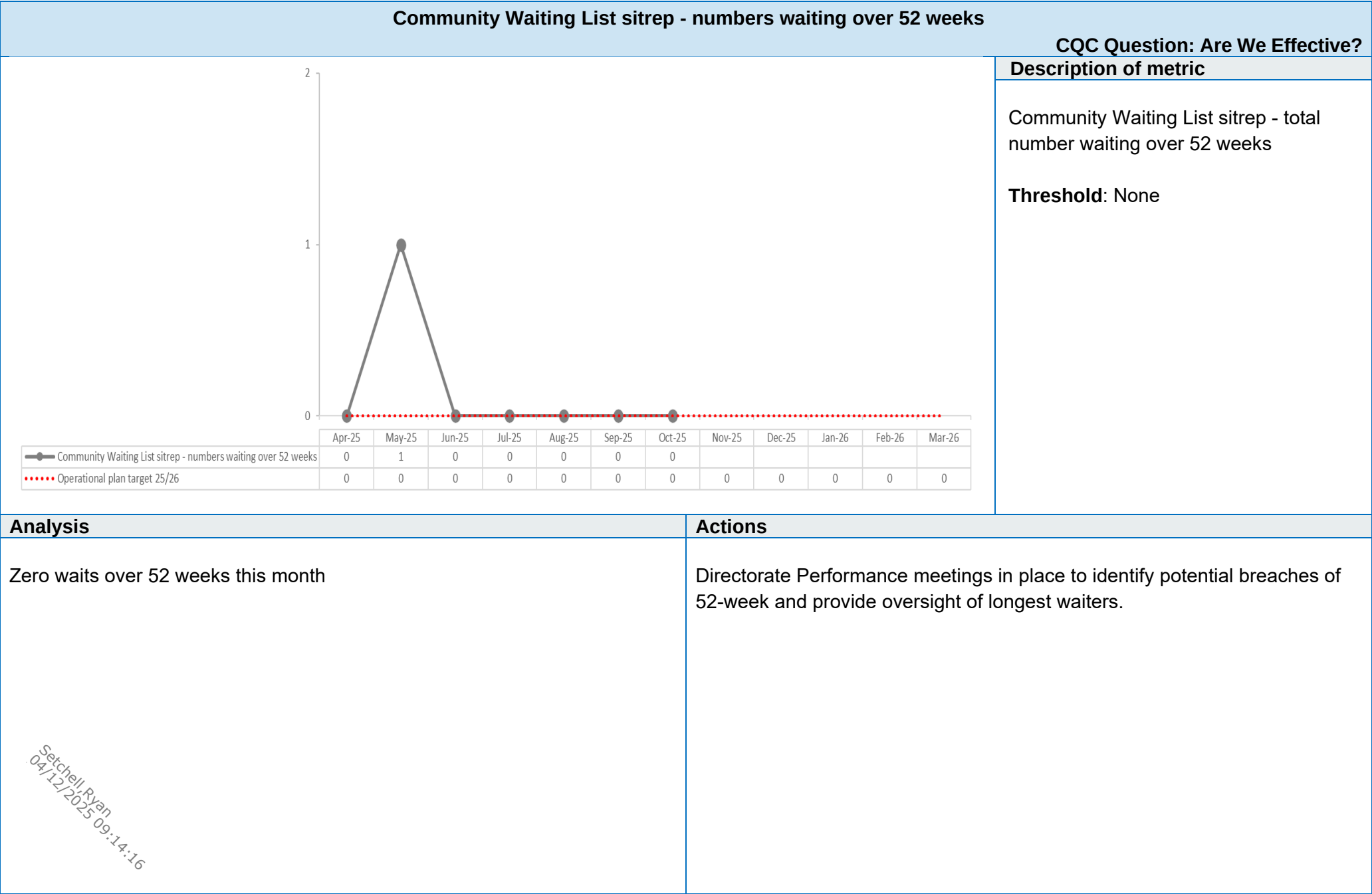
Physiotherapy workforce turnover continues to be of concern but recent recruitment to roles is starting to impact the wait list.

Community appointment days took place in Podiatry and in west Dorset ICRT seeking different ways to approach wait lists

Audiology and Adult Speech and Language Therapy both remain under considerable pressure to reduce longest waiters, and their performance has only been maintained due to locum usage.

Community Waiting List sitrep - numbers waiting (Continued)		CQC Question: Are We Effective?
Analysis (cont.)	Actions (cont.)	
	Focused work continues with the B&P Community Rehabilitation team on considering how to separate caseloads into stroke/neuro and trauma/falls cases. The work will require time to progress but also provides a focus for the team on considering different ways of working to address differing needs such as the model tried in Musculoskeletal for community appointment days. Validation of the longest waits is being addressed.	

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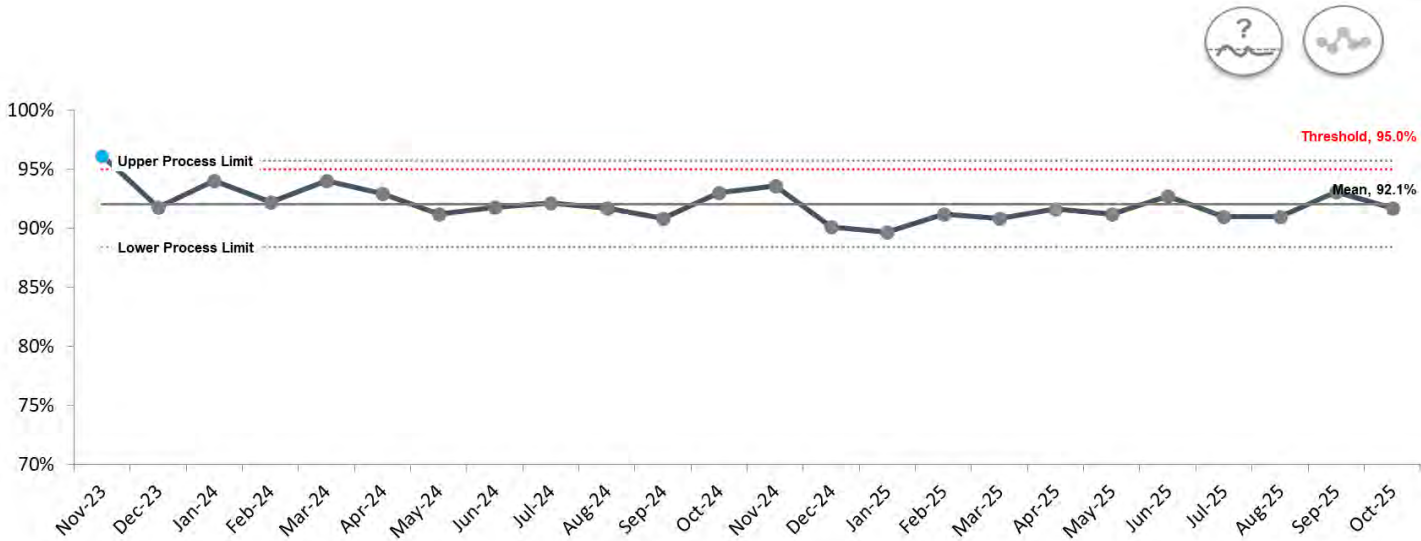
Friends and Family Test (FFT) - Positive Experience Feedback

CQC Question: Are We Safe?

Description of metric

Those responding 'very good' plus those responding 'good' as a percentage of all responses in the month.

Threshold: 95%



Analysis

In October, Trust performance dipped slightly below the mean compared with September. The Patient Experience team continues to provide knowledge sharing, training, and service reviews to support services in improving how feedback is gathered. While there is no overall concern at this stage, any service reporting below 90% is reviewed monthly, with the Patient Experience Lead meeting directly with Service Managers to support improvement.

Actions

It is established that the response rates from discharge surveys, within the mental health wards is extremely low. Patients should be offered the survey at the point of notification or discharge, as well as a QR code included within discharge papers. The Patient Experience Lead has raised this within DMG meetings and this will be raised further in the next MH&LD review group meeting. A meeting is also arranged with the Ward Managers to raise awareness of the survey and the importance of gathering feedback, reviewing it and assessing any themes and trends to learn from, or an opportunity to develop improvements.

You Said / We Did / Impact – Access to Online Course Example

You Said

A participant told us they were unable to join an online course because they

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Friends and Family Test (FFT) - Positive Experience Feedback (Continued)

CQC Question: Are We Safe?

Analysis (cont.)	Actions (cont.)
Setchell, Ryan 04/12/2025 09:14:16	did not have access to a suitable device. They also felt the attendance requirements were presented as inflexible, and were unsure how to seek support when circumstances changed. What We Did • Updated course invitation letters to clearly state that a device with internet access is required. • Included contact details for the admin team so participants can request alternative arrangements if needed. • Confirmed that, where feasible, a one-to-one session may be offered to ensure equitable access to support. Impact for Patients and Families • Clearer expectations set out in advance, reducing barriers and anxiety for participants. • More flexible and personalised options, improving access for people with digital limitations. • Enhanced experience and fairness by ensuring no one is disadvantaged due to technology or circumstance. You Said / We Did / Impact – End-of-Life Care Feedback Example You Said A family member told us they were worried their loved one was in pain due to difficulty passing urine. They felt their observations and concerns needed to be taken into account more quickly when a patient may be uncomfortable or distressed, and asked that staff remain alert to possible causes of pain, even when the picture is not immediately clear.

Friends and Family Test (FFT) - Positive Experience Feedback (Continued)

CQC Question: Are We Safe?

Analysis (cont.)

Actions (cont.)

What We Did

The feedback was shared with the Bridport East Team Lead for reflection and learning

- Staff were reminded of best practice in end-of-life care, including:
 - o Considering urinary retention as a cause of pain and agitation.
 - o Using bladder scanning where appropriate to support decision-making.
 - o Ensuring strong communication with families when they raise concerns.
- Learning will be discussed across the wider team to support consistency of approach

Impact for Patients and Families

- Increased confidence among staff in recognising and managing urinary retention as a contributing factor to distress.
- Strengthened communication and validation of family insight.
- Improved comfort and reduced avoidable distress for patients at the end of life.

Setchell, Ryan
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Complaints

CQC Question: Are We Responsive?

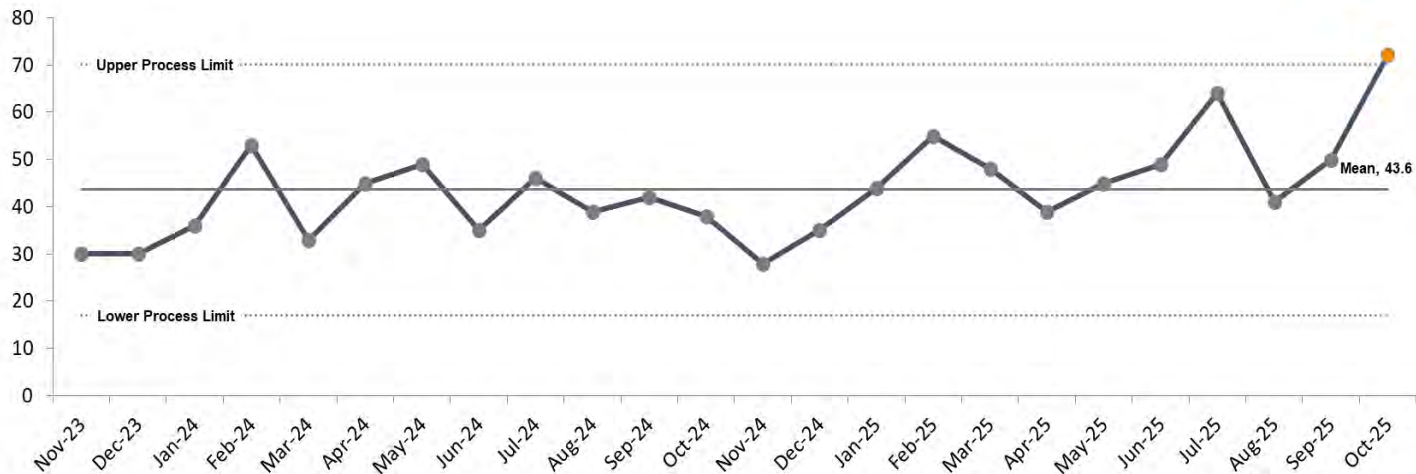
Description of metric

Complaints - Number of complaints received, both written and verbal, including any themes identified.

Number of complaints with Ombudsman involvement - The number of complaints that, the Parliamentary and Health Service Ombudsman has notified the Trust, have been referred to the Ombudsman.

Reopened complaints - The number of complaints, both written and verbal, that have been reopened during the month.

Threshold - None



Analysis

A total of 72 complaints were reported in October, with the metric indicating special cause concern. The emerging pattern suggests a combination of clinical quality, interpersonal factors, and system/process challenges.

The main themes were Patient Care (17) and Communications (16), indicating that clinical quality and the way information is shared are the leading drivers of complaints. Values and Behaviours (9) highlights concerns around staff attitude or professionalism, while operational issues such as Appointments (8) and Access to Treatment (6) also contributed.

One complaint (Mental Health Community Services / disputed diagnosis) was referred to Ombudsman. Ongoing.

Actions

Performance pressure: Increased complaints, breaches and delays signal systemic capacity and workflow pressures requiring urgent review. This has been compounded by Ulysses system downtime and Complaints/PALS staff redeployment for Patient Safety Incidents Response Framework (PSIRF) and participation projects, which may affect complainant trust and regulatory compliance.

Mental Health Services need attention: High proportion of complaints, escalations, and reopened cases.

Persistent communication and care quality issues risk patient confidence and safety.

A focus on Communication and Patient Care improvements could reduce complaint volumes.

Complaints	
CQC Question: Are We Well Led?	
Analysis (cont.)	Actions (cont.)
Four complaints reopened (disputed information (2), new questions (1), not all issues addressed (1), involving Mental Health Community Services (3) and Integrated Community Services (1). Fifty percent (50%) of cases were acknowledged within the mandatory three working days. Most breaches were acknowledged within four working days. Delays were due to resourcing pressures and unreliability of the Ulysses complaints database. Twenty-seven complaints were closed following investigation, 18 of which were within agreed timescale. At time of writing, 45 complaints are open with 13 breaching agreed timescale. Setchell, Ryan 04/12/2025 09:14:16	Process efficiency (acknowledgement and closure times, reliability of Ulysses Risk Management System) needs strengthening. Complaints/PALS Team focused on prioritising new complaints and responses and is reviewing processes.

Maximum 6-Week Wait For Diagnostic Procedures (ICS)

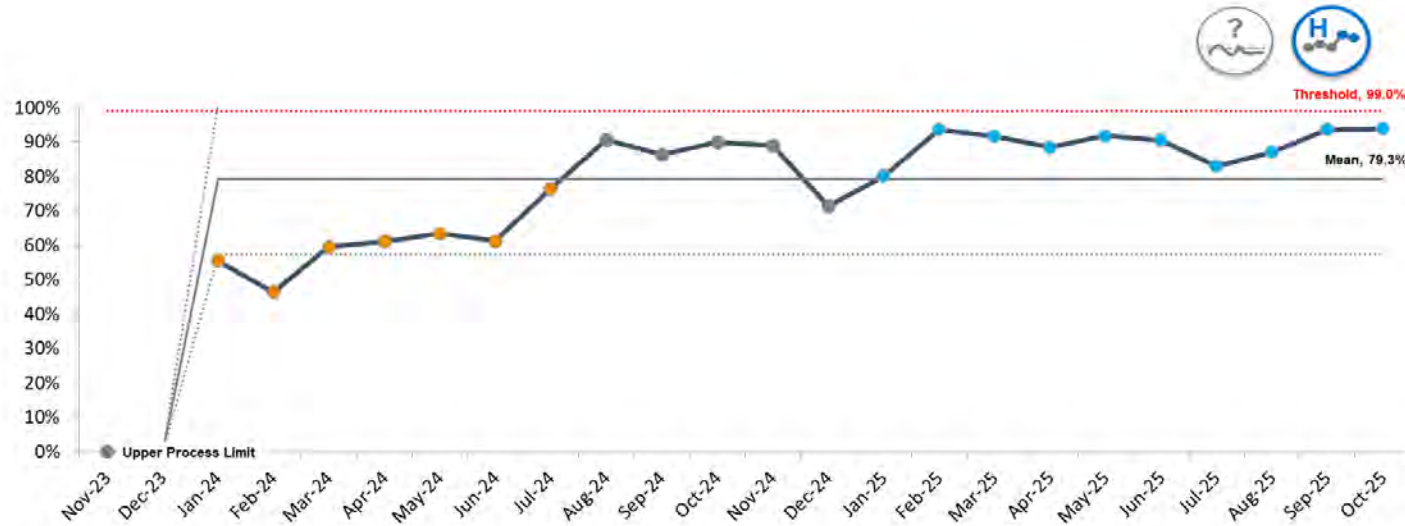
CQC Question: Are We Effective?

Description of metric

The purpose of this metric is to measure waits for key diagnostics tests. Diagnostic services in the Trust include audiology, echocardiography and ultrasound.

This metric includes all patients and is a contractual target.

Threshold: >=99%



NB data not available in November & December 2023

Analysis

Overall Trustwide Compliance: 93.9%, 92/1,501 breaches (Sept 93.6%, 86/1335, breaches)

Audiology performance this month is 93.7%, 92/1,456 breaches (93.4%, 86/1310 breaches).

Operational plan forecast (Updated) 90%, 160/1,600 breaches (compliant).

Longest waiters:

- Longest waiter 19 weeks (Sept longest waiter 19 weeks).
- 14 waiting 13+ weeks (Sept 7 waiting 13+ weeks).

Actions

Already in place:

- Locums are in place - 2.4 wte as agreed via Vacancy Control Panel. A further locum 1.0 wte is starting in December 2025 to cover 2.0 wte maternity leave.
- Locum provision remains important to maintain performance due to a loss of some clinicians who were working on Bank contracts. The service is seeking to replace as much locum cover with bank cover through work with Southampton University students, encouraging them to join the bank, once they have gained key skills and within their scope of practice.

Maximum 6-Week Wait For Diagnostic Procedures (ICS) (Continued)		CQC Question: Are We Effective?
Analysis (cont.)	Actions (cont.)	
Setchell, Ryan 04/12/2025 09:14:16	Further actions planned/underway: • Service is working with secondary care ENT providers across Dorset to ensure best use of audiology activity. This currently continues to be a challenge for underutilised audiology activity in the West. Unused audiology (ENT) appointments (West hub) and DNAs have increased – concerns have been escalated to DCH ENT managers to try to maximise clinic use • The service went live with self-referral for over 50-year-old hearing related referrals, on 22 September.	

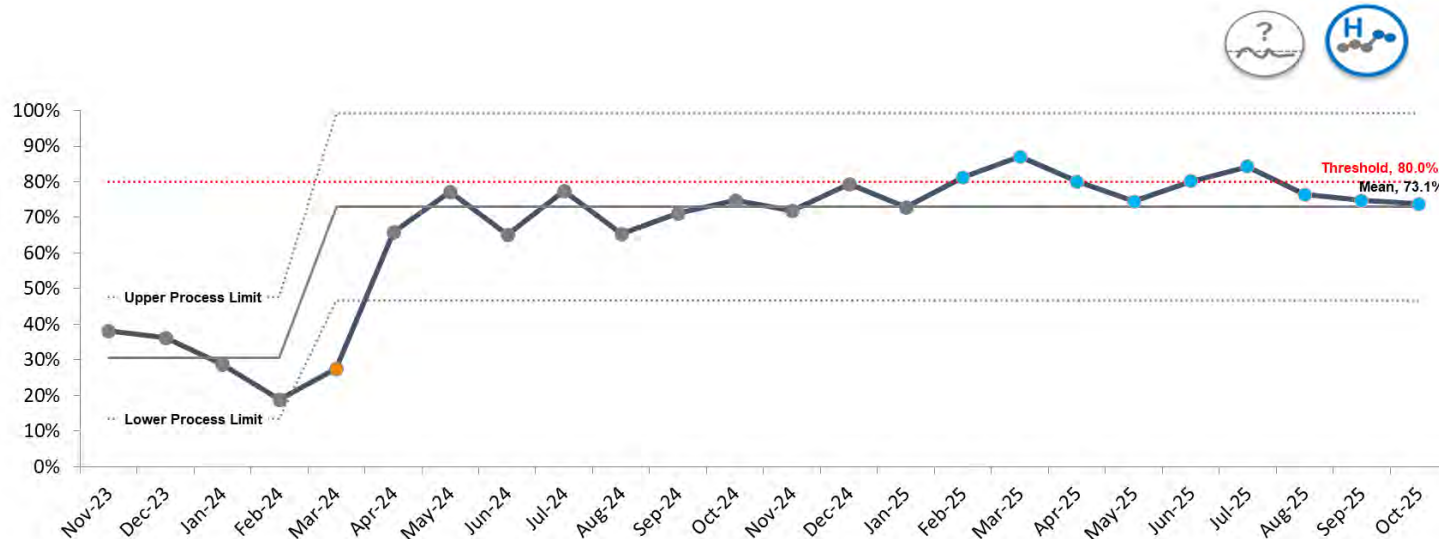
Virtual Wards Bed Occupancy

CQC Question: Are We Well Led?

Description of metric

The reported virtual ward occupied capacity divided by the total available virtual ward capacity (the number of patients who can simultaneously be managed within a virtual ward service) across all such existing services.

Threshold: 80%



Analysis

The metric is good/improving. The target lies within the process limits so may or may not be met. Compliance for the combined (MH & CHS) trajectory of over 73.8% has further declined slightly in October.

There were 3,007 bed days available during October of which 2,219 beds were used against the national target of 80%.

Mental Health (ICSD): 47 Beds for 1,457 Bed days in the reporting period of which, 1,021 used (70.1%). There were 38 admissions (mean LoS 42, median 25 days on the ward).

Community Frailty: 50 Beds for 1,550 bed days in the reporting period of which, 1,198 bed days used (77.3%). There were 240 admissions (mean LoS 4, median 3 days on the ward).

Actions

The frailty H@H offer is currently slightly under the 80% national target at 77.3%, sickness has been a challenge during this period. The Vertical alignment programme for both East and West via the provider collaborative continues to evolve to support this change in practice and workstream being developed and working through next steps. A pilot is running to increase referrals from SWAST in Bournemouth and Weymouth/Portland and is looking to expand to other areas.

The operational plan for Mental Health ICSD West Services was based on successful recruitment to provide the additional activity to meet the planned capacity. The Mental Health Support Workers in the West team (MHSWs) resumed working 7.30am – 10pm. However, due to unsuccessful recruitment registered staff are working 9am-5pm, with ICSD East covering from 5-8pm.

Virtual Wards Bed Occupancy (Continued)

CQC Question: Are We Well Led?

Analysis (cont.)

Actions (cont.)

1.6 WTE registered staff have recently been recruited.

The registered staff commenced a revised shift pattern (7.30am – 10pm) from 10 August 2025, with telephone support from ICSD East when only one registered staff is on duty. However, since this change was planned, 2.4 WTE registered staff have resigned. Recruitment adverts have been placed and the new shift pattern will continue to be monitored. Interview taking place on 11 November for 1WTE band 5-6 development post, if successful would commence March 2025. ICSD East are supporting gaps in the new shift system. A Quality Impact Assessment (QIA) Business Continuity Plan (BCP) to merge the east and west teams was put forward and currently under review. Human Resource services are supporting from January 2026 on a wider recruitment scheme for Band 6 nurses.

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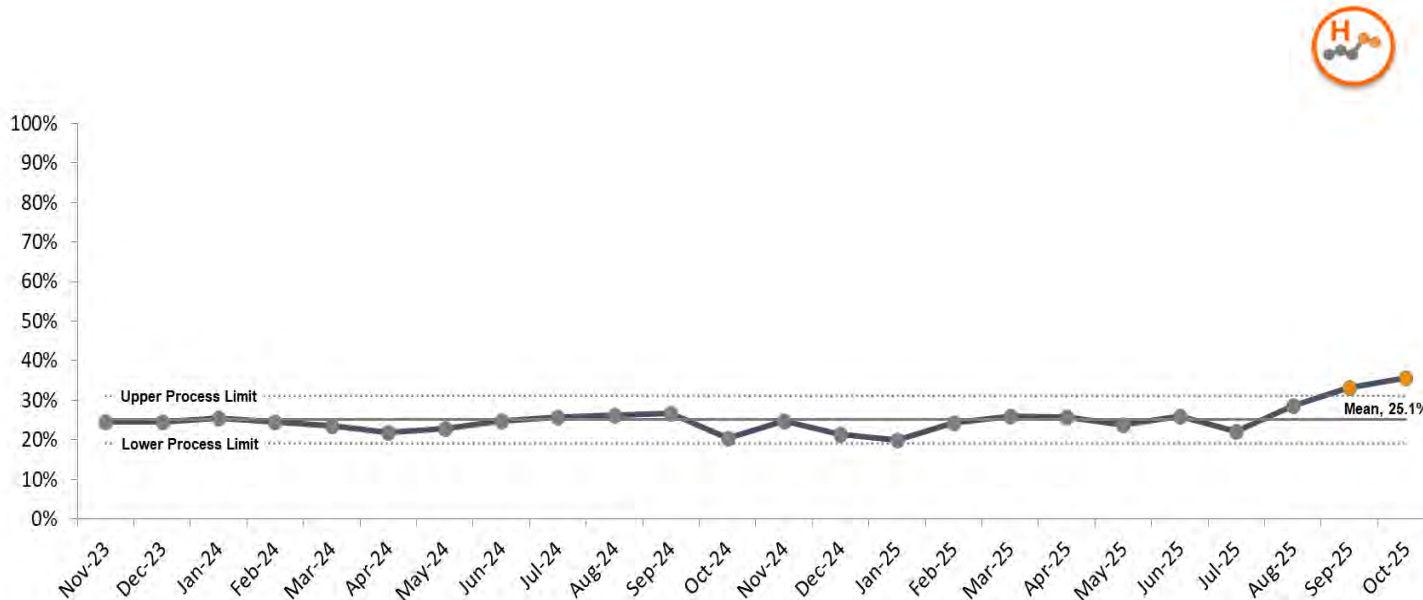
Right To Reside (Community Hospitals)

CQC Question: Are We Responsive?

Description of metric

Percentage of Occupied Bed Days where patients in Community Hospitals are marked as fit for discharge during the month.

Threshold: None



Analysis

The percentage of Occupied Bed Days where there was no Right to Reside increased, and was 35.7% at the end of October, with 60 inpatients with no Right to Reside at the end of the month.

Percentage of No Criteria to Reside (NCTR) has increased during October in line with system flow pressures and increase in patient numbers awaiting discharge from a community hospital.

Satchell, Ryan
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Actions

System Future Care workstreams continues to evolve and aiming to improve flow through Intermediate Care and discharges back into the community. Dorset HealthCare have requested support from local authorities with discharges, the majority of whom are waiting for assessment or care on discharge, however, there has been no improvement in the numbers waiting to leave.

Several escalation meetings and senior reviews have taken place to support the reduction in NCTR patients. This has taken a system approach escalation of this was completed appropriately with local robust reviews.

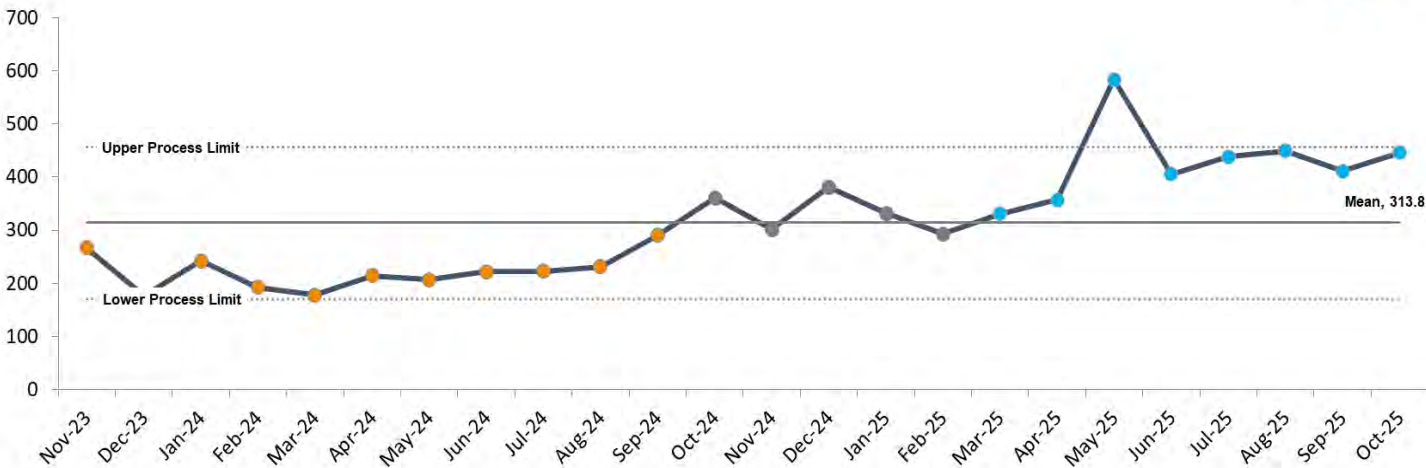
Compliments

CQC Question: Are We Effective?

Description of metric

Number of compliments received.

Threshold: None



Analysis

In October, there was a small increase in the number of compliments recorded compared with September. When compared with the same period last year, the Trust has seen a significant improvement, supported by increased awareness, knowledge sharing, and service reviews led by the Patient Experience team. Compliment levels have also remained consistently above the long-term mean for the past eight months.

Actions

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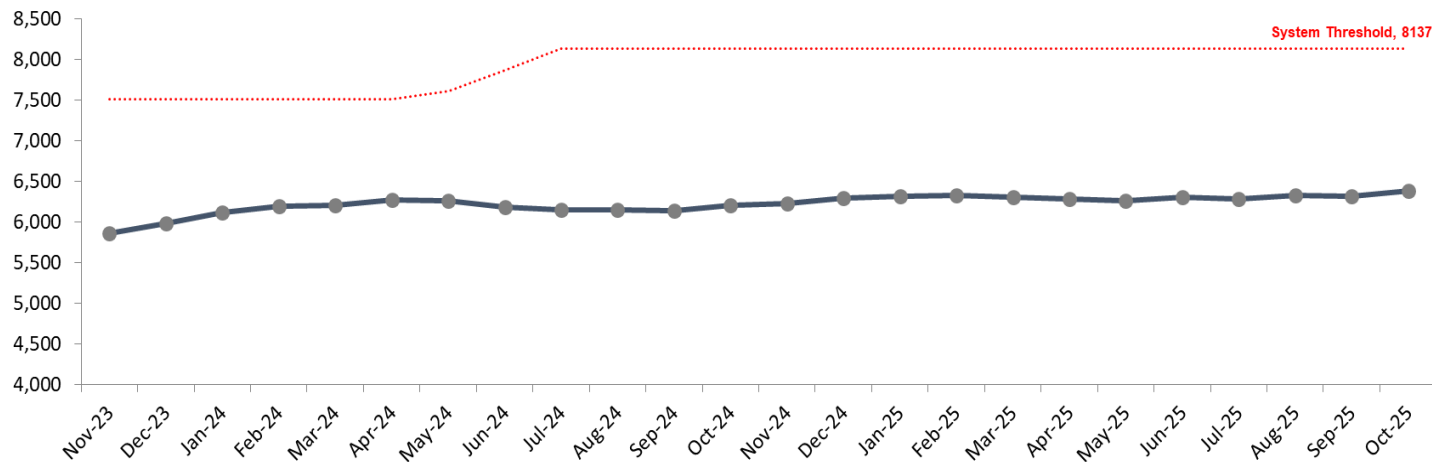
Children & Young People (CYP) Access 1+ Contact, DHC Under 18s – rolling 12 months

CQC Question: Are We Effective?

Description of metric

Number of CYP aged under 18 supported through NHS funded mental health with at least one contact. This is a count of people aged 0 to 17 who have had at least one contact (either direct or indirect) in the previous 12 months. 12 month rolling period.

Threshold: 8,137



Analysis

This is DHC's contribution towards the system level (ICB) target (8,137) by end of March 2026, based on a 12 month rolling period. National reporting is taken from the MHSDS reported via Future NHS Mental Health Core Data Pack. DHC's activity accounts for 84% of the system level trajectory (6,835 by end of March 26). October's position equates to 96% of DHC's target delivered (6,383/6,615).

The Kooth Counselling Service commissioned by the ICB accounts for 16% of the 8,137 target (1,302 by end of March 26). The latest data shows them delivering 68% of their trajectory.

Actions

CAMHS is about to commence the implementation of its transformation programme, which will see a move to a delivery model which provides significantly increased access for CYP and families. The "Thrive model" is based on need, with the following assumptions:

- 100% of the population would benefit from receiving advice and guidance (for some this would be received alongside more individualised help).
- The needs of 60% of the prevalent population would be effectively met by the targeted help offered in Getting Help services.
- The needs of 40% of the prevalent population would be effectively met by the more extensive help offered in Getting More Help services.
- At any one time there are 5% of the prevalent population in need of risk management only (Getting Risk Support).

Children & Young People (CYP) Access 1+ Contact, DHC Under 18s – rolling 12 months (Continued)

Question: Are We Effective?

Analysis (cont.)

Actions (cont.)

With the addition of the Getting Help quadrant, which includes a new integrated front door with the Local Authority (place-based), the service will operate a “no wrong referral model”, which means more CYP will be able to access help based on their need, and the service will not be bound by exclusion and inclusion criteria.

The recruitment for phase 1 is due to commence imminently, which will increase capacity for access to services, and this trajectory will continue to improve as recruitment and implementation of the new model continues.

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Community Mental Health (CMH) 2+ Contacts, Local Provider Data - rolling 12 months

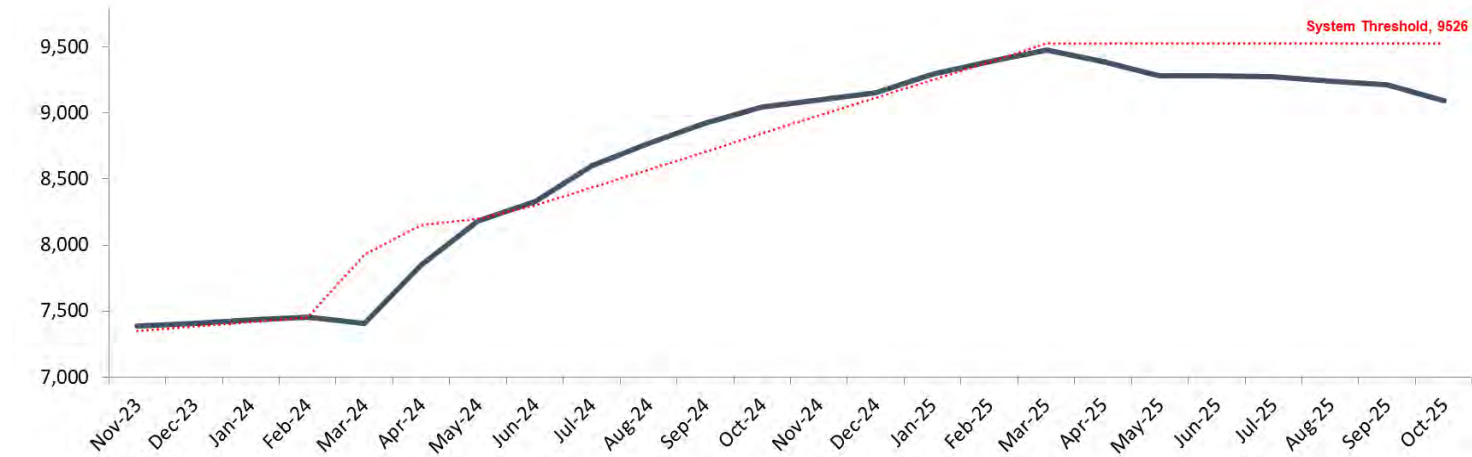
CQC Question: Are We Effective?

Description of metric

Number of people accessing community mental health services for adults and older adults with serious mental illness who received two or more care contacts within the Reporting Period.

Patients who had an inpatient stay have been removed from the count. From April 2023 this measure includes IPS and EIP.

Threshold: 9,526



Analysis

This metric is no longer an Operational Planning KPI and therefore has no associated target for 2025/26, although the ambition is to maintain 9,526. Compliance has dipped since March 2025 but is relatively stable and no current cause for concern. Data reconciliation has been completed between local (MHSDS) and national (Future NHS) reporting to ensure all appropriate data is being captured. Data is assured and now includes the Access Wellbeing activity captured via the IAPTus System.

This metric forms part of the clock stop for the new Adult Mental Health 4 Week RTT indicator which is currently being worked up.

Actions

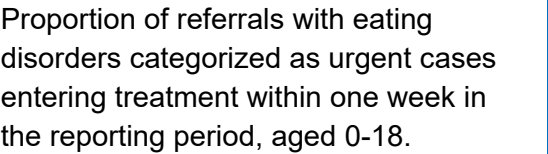
No action required.

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Detchell, Ryan

Children & Young People Eating Disorders (CYPED) Urgent – 1 week

CQC Question: Are We Responsive?

Description of metric



Threshold: 95%

Analysis	Actions

Actions

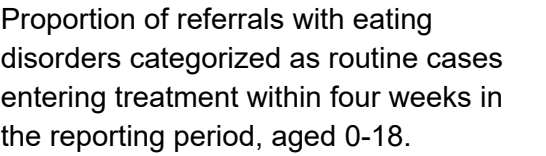
No action needed.

No action needed.

No action needed.

Children & Young People Eating Disorders (CYPED) Routine – 4 weeks		CQC Question: Are We Responsive?

Description of metric



Analysis

Compliance for routine referrals in October was 86%, this returns a 3 month rolling period compliance of 82%. There is an average wait of 21 days. There are 14 CYP waiting to access the Dorset All Age Eating Disorder Service of which 4 have waited longer than 28 days. The metric continues to improve.

Setchell Ryan
04/12/2025 09:14:16

Actions	
1	Identify the problem and its scope.
2	Research the problem and gather data.
3	Develop a plan of action.
4	Implement the plan.
5	Evaluate the results.
6	Adjust the plan as needed.
7	Communicate the results.
8	Document the process.
9	Review the process.
10	Repeat the process.

Multi-Family Therapy cohorts continue, creating capacity for individual Family Based Therapy and the triaging of CYPs on the waiting list. The triage calls confirm that they are appropriate for the service with an aim of preventing inappropriate referrals being added to the waiting list.

The waiting list is being closely managed, a small proportion of longer waits are regularly contacted by phone and/or letter however are not engaging or responding to an offer of an assessment.

It is anticipated that the service will continue to report an improved Referral To Treatment compliance due to comprehensive waiting list management.

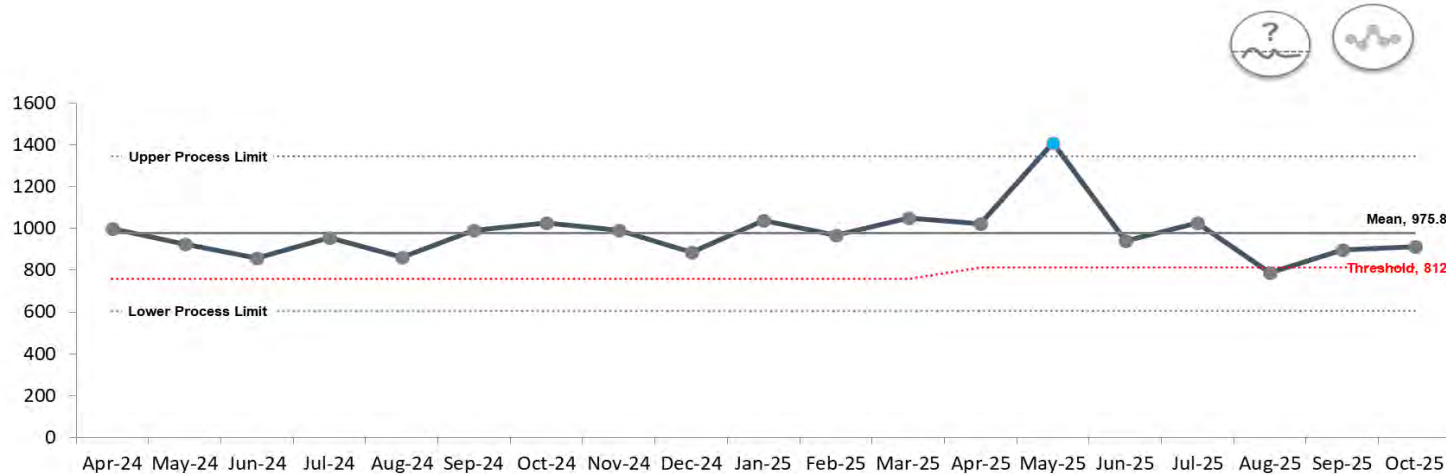
Talking Therapies Courses of Treatment

CQC Question: Are We Effective?

Description of metric

The number of people who have a course of treatment (2+ contacts).

Threshold: 812



Analysis

NHS Talking Therapies offer free psychological support to adults, addressing common mental health issues such as anxiety and depression. Challenges persist in meeting increasing demand and ensuring equitable access for all communities. The programme was due to have expanded in 2024/25 however the Dorset system did not allocate the ring-fenced funding, despite this the national targets have been set based on the planned expansion.

The primary purpose of this indicator is to measure the number of people who have been treated by NHS Talking Therapies Service and represents a shift from the number of patients being assessed, to the number of people being discharged following a course of psychological treatment.

The access targets for Dorset NHS Talking Therapies Service (in-year target 2025/26) is to fully treat an additional 650 patients (9,741) compared to the previous year (9,091). This represents a 7.1% increase in the service size.

Actions

The government has committed to achieving full national coverage for Talking Therapies by 2028, with a focus on addressing inequalities, improving service outcomes, and integrating mental health support into primary care networks. This investment proposal outlines the steps needed to future-proof the service, emphasising that only through immediate investment can it keep pace with national expansion goals.

The service was due to receive some funding, but not to the level of that which was modelled by the service to achieve all KPIs. This was confirmed in August 2025, meaning implementation has been significantly delayed. In October 2025 this funding too was pulled.

This KPI threshold for courses of treatment is currently being met, however other areas are where the pressure will be noticed.

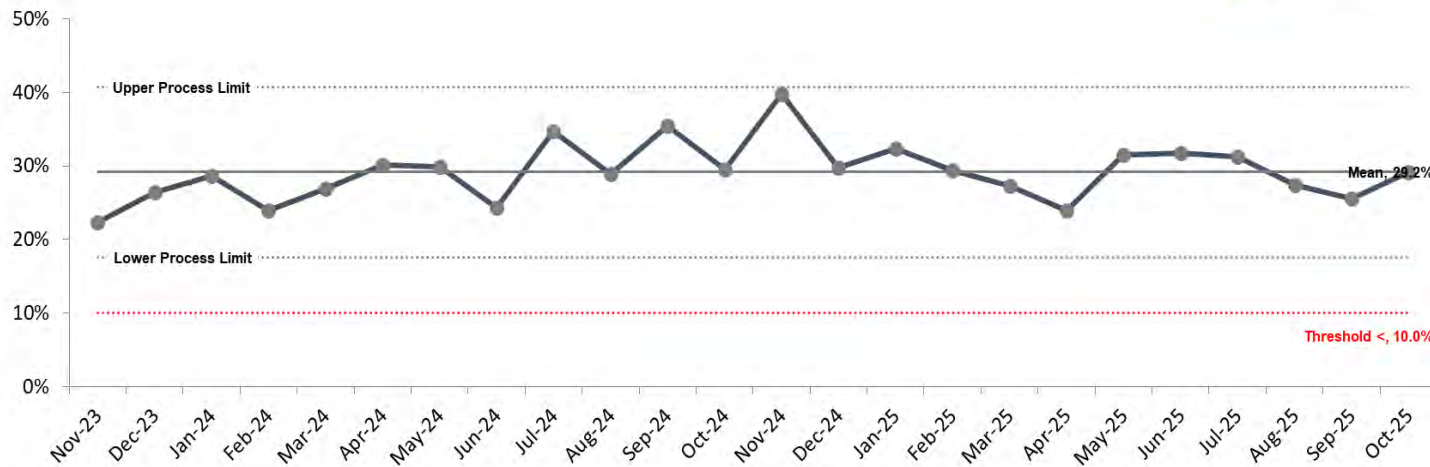
Talking Therapies 1st to 2nd treatment (Dorset only)

CQC Question: Are We Responsive?

Description of metric

The proportion of people who waited over 90 days between first and second treatment appointment (where the second treatment appointment occurred within the month) in the reporting period.

Threshold: 10%



Analysis

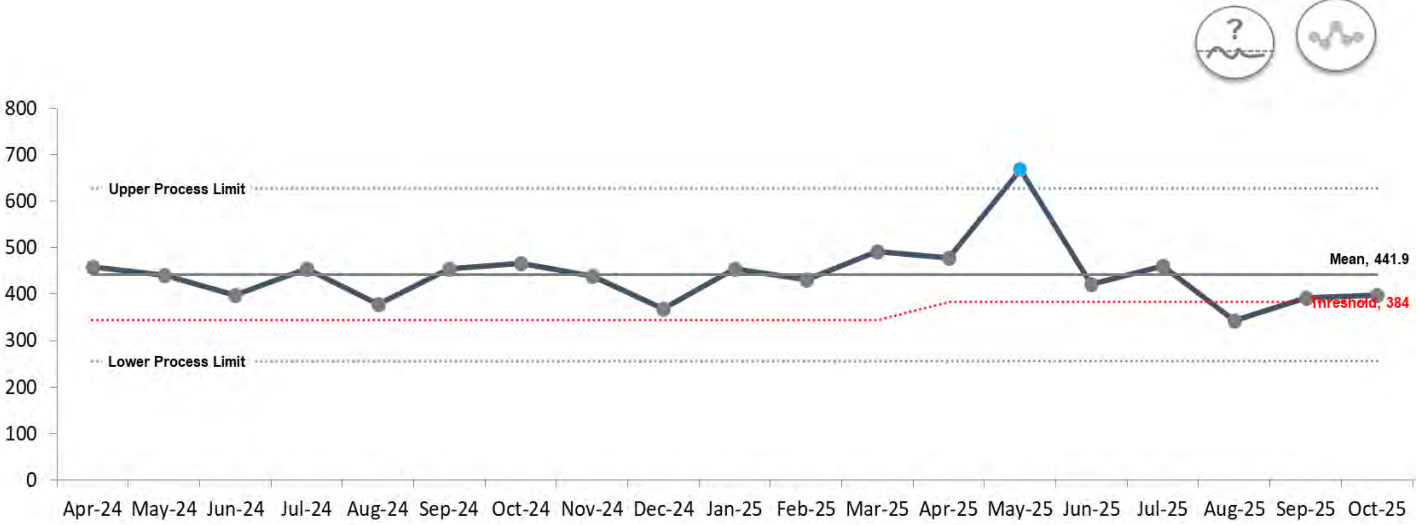
The primary purpose of this indicator is to measure the number of people who have waited more than 90 days between first and second appointments. There should be no in treatment pathway waits (where the person has an early appointment but is then put on an 'internal' waiting list before a full course of treatment starts). There should be appropriate measures taken to reduce the numbers of people who have waited over 90 days for a second appointment.

This indicator remains above the 10% target. The service has made significant efforts in reducing wait times for treatment through a service improvement project. Wait lists for counselling and Guided Self Help have significantly reduced in the last six months.

Actions

Service wide project to reduce wait times to treatment is ongoing, this includes working with assessors to offer least intrusive interventions, adherence to a new attendance policy and reviewing treatment in supervision. Service Leads are currently working with the assessors who are performing best at getting patients into the least intrusive interventions, with the plan for them to help those putting high rates of patients into 1-1 waiting lists.

It is the high intensity 1-1 waiting lists that are above the 90-day threshold, so this measure essentially shows the percentage of patients going into 1-1 high intensity each month. The current expansion of Talking Therapies services was supposed to be tailored towards the expansion of the High Intensity workforce, and this would have naturally helped to reduce waiting times. However, with the required funding not being received, it is unlikely that this measure will improve.

Talking Therapies Reliable Recovery		CQC Question: Are We Effective?
 Mean, 441.9 Threshold, 384		Description of metric The number of people who have been discharged having achieved recovery. Threshold: 384
Analysis In 2024/25, NHS Talking Therapies has recorded a reliable recovery rate of 45.4%. A key part of the planned expansion is to increase the therapeutic dosage by an average of one session per patient. This is therefore a significant increase in prescribed service size. In 2025/26 the threshold has increased from 344 per month to 383.5 (+39.5), which is a 2% increase in compliance 50% threshold and is set to increase by 1% year on year to 2028/29. The primary purpose of this indicator is to measure the number of people who have been discharged having achieved recovery by NHS Talking Therapies. The service is performing well compared to the numerical target so far this year.	Actions The government has committed to achieving full national coverage for Talking Therapies by 2028, with a focus on addressing inequalities, improving service outcomes, and integrating mental health support into primary care networks. This investment proposal outlines the steps needed to future-proof the service, emphasising that only through immediate investment can it keep pace with national expansion goals. The service was due to receive some funding, but not to the level of that which was modelled by the service to achieve all KPIs. This was confirmed in August 2025, meaning implementation has been significantly delayed. In October 2025 this funding too was pulled. Part of the expansion plan involved increasing treatment dosage (number of sessions) for patients. Evidence suggests that this in turn would improve the service's outcomes. However, without the ringfenced funding the service will be unable to commit to this dosage increase and therefore recovery rates are likely to remain below target.	

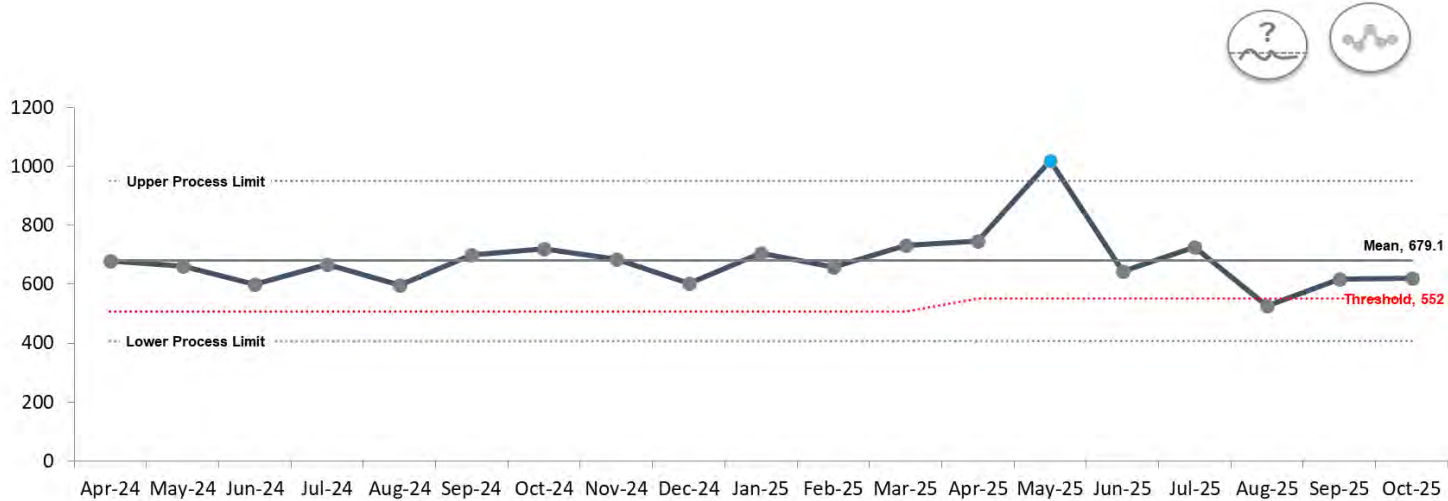
Talking Therapies Reliable Improvement

CQC Question: Are We Effective?

Description of metric

The number of people who have been discharged having achieved reliable improvement

Threshold: 552



Analysis

A key part of the planned expansion is to increase the therapeutic dosage by an average of one session per patient. This is therefore a significant increase in prescribed service size. In 2025/26 the threshold has increased from 507.5 per month to 552 (+44.5), which is a 1% increase in compliance 68% threshold and is set to increase by 1% year on year to 2028/29.

The primary purpose of this indicator is to measure the number of people who have been discharged having achieved reliable improvement. The service is performing well compared to the numerical target so far this year.

Actions

NHS Talking Therapies are confident of achieving the 68% reliable improvement target (6,624) with the current levels of investment. However, by 2027/28 this is likely to be difficult to achieve based on the target trajectory, unless further investment is received to allow dosage increase. By increasing the therapeutic dosage, the reliable improvement rate should increase.

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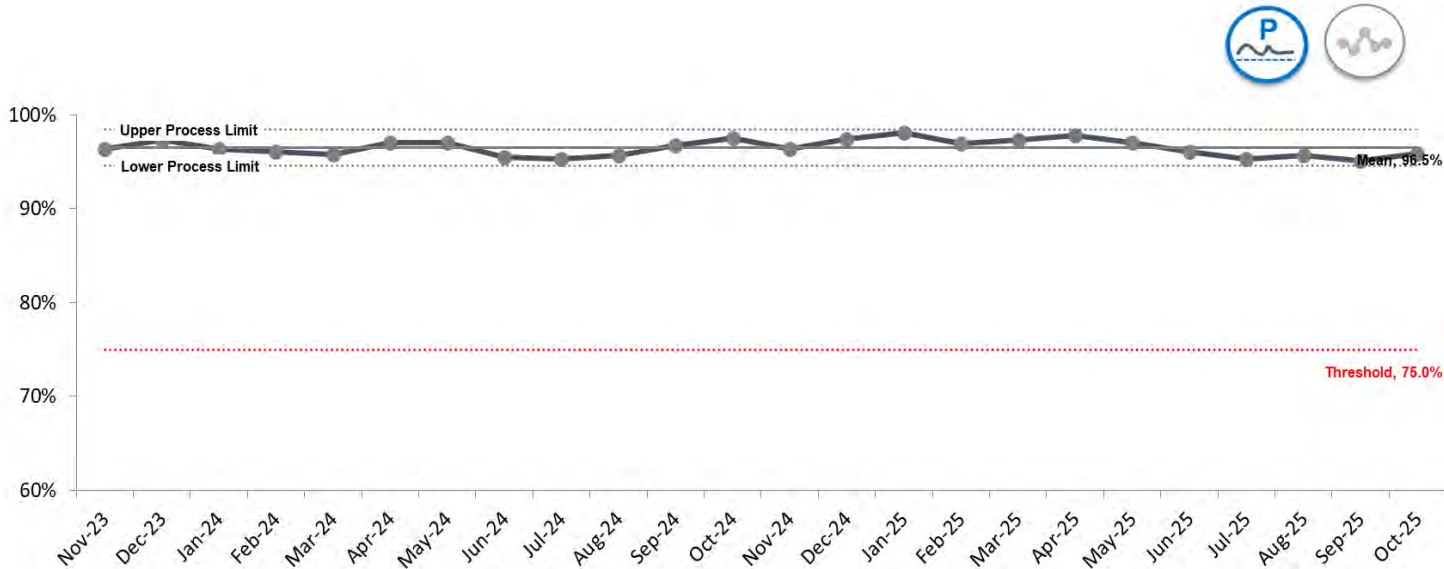
Talking Therapies Waiting Times - 6 weeks (Dorset only)

CQC Question: Are We Responsive?

Description of metric

Proportion of referrals that finished a course of treatment in the reporting period that waited 42 days or less for first treatment.

Threshold: 75%



Analysis

Threshold is consistently exceeded each month and within standard variation meaning the indicator is stable and will continue to meet the required target.

Actions

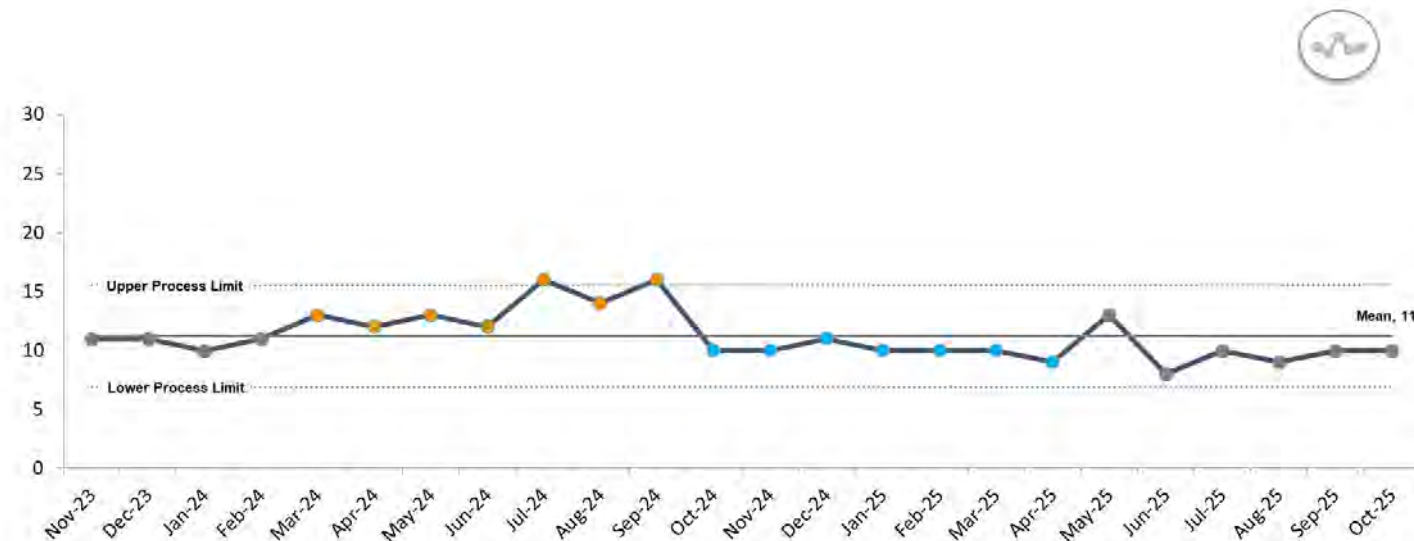
No action required as consistently above threshold.

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Southampton Priory Placements - Appropriate Out of Area Placements (Number of Active Placements at End of Month)

CQC Question: Are We Responsive?

Number of people admitted to DHC Priory Beds at end of month



Description of metric

The total number of days in which patients have been placed out of area due to unavailable beds in their usual network. A person with assessed acute mental health needs who requires adult mental health acute inpatient care is admitted to a unit that has been agreed as part of the Trusts footprint but is located outside of Dorset. Meets the criteria for being an appropriate admission.

Threshold: None

Analysis

Patients placed within Marchwood Priory have been designated as appropriate admissions and part of DHC's inpatient footprint by NHSE/NHS Dorset. This is a 10-bed block contract arrangement (commenced December 2022). Data is for oversight of admissions to the Priory Southampton; they do not fall under the definition of "inappropriate".

At the end of October there were ten patients still admitted to the Priory. A total of 314 Occupied Bed Days were utilised.

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Actions

Block contract with Priory commenced in December 2022 originally based on 12 beds. Increased to 13 beds April 2023, block purchase reduced to 10 beds from September 2024, in line with those due to be delivered from the New Hospital Programme in 2026/27.

Building work continues at St. Ann's hospital to increase DHC MH Inpatient bed stock as part of the New Hospital Programme – Due 2026/27.

The 10 block purchased beds at Southampton Priory are being appropriately and fully utilised. Additional beds used may also be used on a spot purchase basis (for admissions over the commissioned 10), the forecast for the use of spot purchasing has reduced from eight beds to four as at September 2025. The block contract agreement is currently being re-negotiated.

These are classified as 'appropriate' admissions due to the close proximity to DHC but are in addition to the block purchased beds.

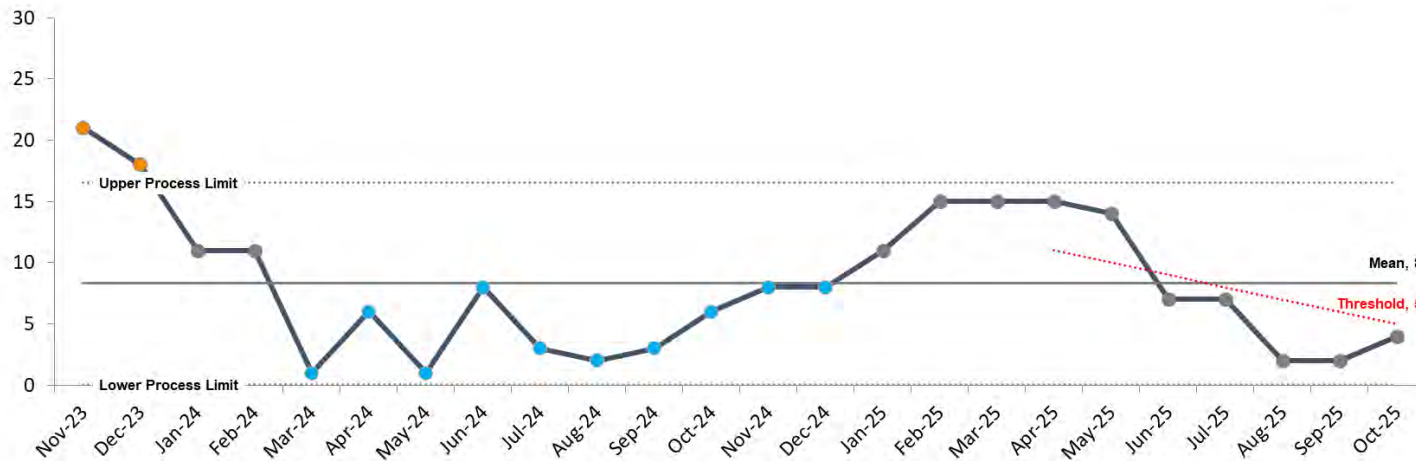
Out of Area Placements - Inappropriate Placements (Active Placements at End of Month)

CQC Question: Are We Responsive?

Description of metric

The number of days which patients have been placed out of area due to solely and primarily because of unavailable local beds (Inappropriate). A person with assessed acute mental health needs requires acute inpatient care is admitted to a unit that does not form part of their usual network of services, that does not usually admit people living in the catchment of the person's local community mental health service, where they cannot be visited regularly by their care coordinator to ensure continuity of care and effective discharge planning.

Threshold: 5



Analysis

These admissions do not form part of the trust's usual local network of services. These are deemed "inappropriate out of area placements".

At the end of October there were four people admitted to an inpatient bed placed outside DHC's inpatient footprint – one adult acute and three Psychiatric Intensive Care Unit (PICU). Five people were admitted to an out of area mental health placement during the month and three were either discharged/repatriated to an appropriate setting. A total of 166 occupied bed days (OBDs) were utilised. This is in line with the Trust Directive to reduce Out of Area Placements to zero under the new Peri Hospital Mental Health Transformation initiative launched 2 June.

Actions

Internal oversight implemented for inappropriate Adult Acute Out of Area Placements with robust reporting, monitored by the Inpatient Bed Flow Managers and Directorate Management Group. Nursing, Quality, and Therapies undertake regular audit of the providers and the contact with DHC.

An Executive Directive rolled out the Peri Hospital Mental Health Transformation Programme from June 2025. The aim of the programme is 'to care for Dorset patients in Dorset, providing a high quality inpatient experience and optimising recovery times. With the intention that no person who is ready to go home remains in an inpatient setting, and no person who needs mental health inpatient care, is kept waiting in suboptimal care settings'. It is anticipated we will rapidly have no inappropriate out of area patients, without carrying unacceptable levels of risk in the community.

Out of Area Placements - Inappropriate Placements (Active Placements at End of Month) (Continued)

Analysis (cont.)	Actions (cont.)

Patient flow remains a challenge, whilst the new process is embedded and until the New Hospital Programme has been delivered. Mental Health Inpatient services have engaged with the South West Learning Improvement Network (LIN) and is in the process of bidding for funding to support an in depth review of patient flow. The LIN is supporting projects to reduce length of stay of inpatient care and DHC are working with the Local Authority and ICB to support this. Additionally, work is ongoing to review "stuck" patients as a system due to the increasing number of CRFD patients. Both of these items of work will contribute to continued focus on reducing/preventing use of inappropriate Out of Area beds.

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Perinatal & Maternal Mental Health Access rolling 12 months

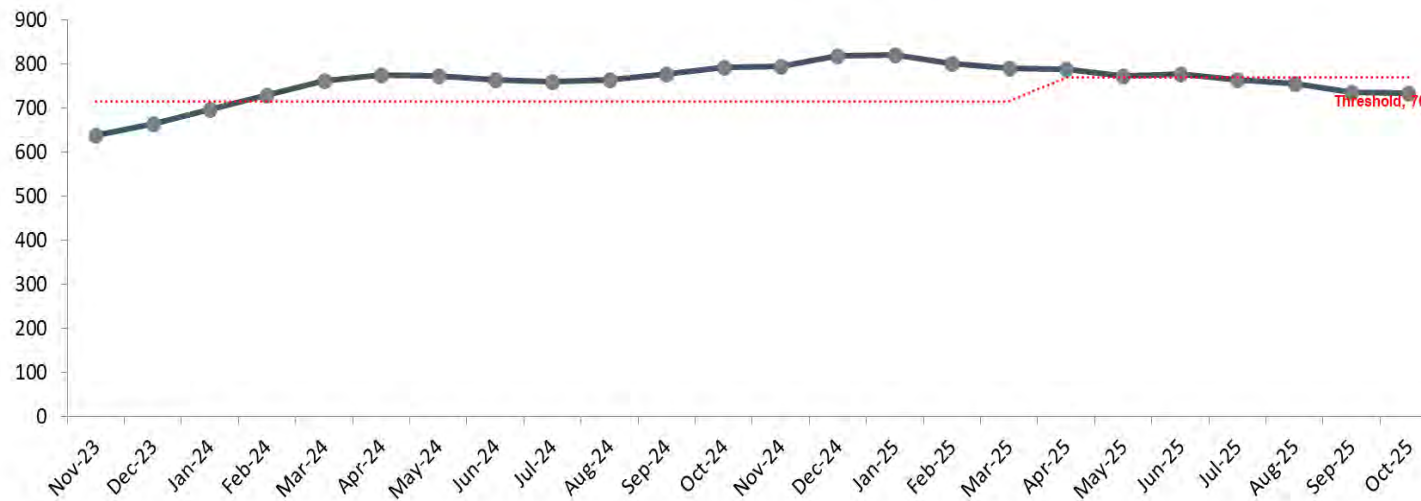
CQC Question: Are We Responsive?

Description of metric

This is a count of females who have had at least one attended contact with Specialist Perinatal Mental Health Community Services in the previous 12 months. This count includes trans patients from April 2023.

The LTP committed that at least 66,000 women with moderate to severe or complex perinatal mental health needs will have access to specialist community care, from pre-conception to 24 months after birth, with increased availability of evidence-based psychological therapies.

Threshold: 769



Analysis

Compliance has dipped below the required threshold. There was an issue with the August 2025 data submission which means August's data was based on 11 months data (not a 12 month rolling period). The DHC local data reported 756 for August's 12 month rolling position. However, the compliance has continued to decline in September and October which is currently under investigation with the service. Initial data suggests this is due to a reduction in referrals during these months.

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Actions

Investigate drop in compliance and maintain current and planned position during 2025/26.



Description of icons

Assurance			Variation						
Consistently Pass target	Pass and fail target subject to random variation	Consistently Fail target	Special Cause Concerning variation either Higher or Lower		Special Cause Improving variation either Higher or Lower		Special Cause Neither improving nor concerning variation		Common Cause

Communities Metrics	In Month	Assurance	Variation	Data Quality
Completeness of Patient Ethnicity Data	92.7%			TBC
Dementia Diagnosis Rate	57.6%			High
Serious Mental Illness (SMI) Physical Health Checks	67.0%			High
Learning Disabilities Annual Health Checks YTD	35.5%			High

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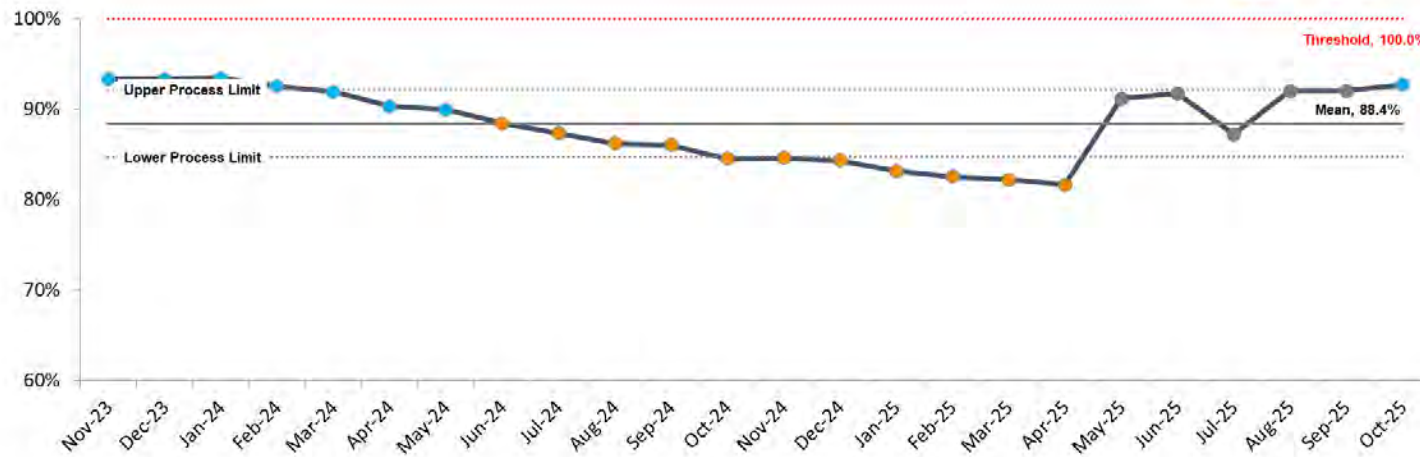
Completeness of Patient Ethnicity Data

CQC Question: Are We Responsive?

Description of metric

The percentage of service users who have their ethnic category recorded on a source system and which can be used for reporting purposes.

Threshold: 100%



Analysis

Without intervention this metric will consistently fail to meet the threshold.

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Actions

Already in progress:

- Business & Performance data quality project to review quality & completeness of patient demographics
- current focus on protected characteristics (Ethnicity, Age, Postcode) to improve by the end of financial year.
- ongoing testing dashboard to ensure timeliness of third party (DiiS) data
- exploring aligning reporting with Dorset County Hospital on protected characteristics

Planned:

- engagement with services where Ethnicity is not consistently recorded

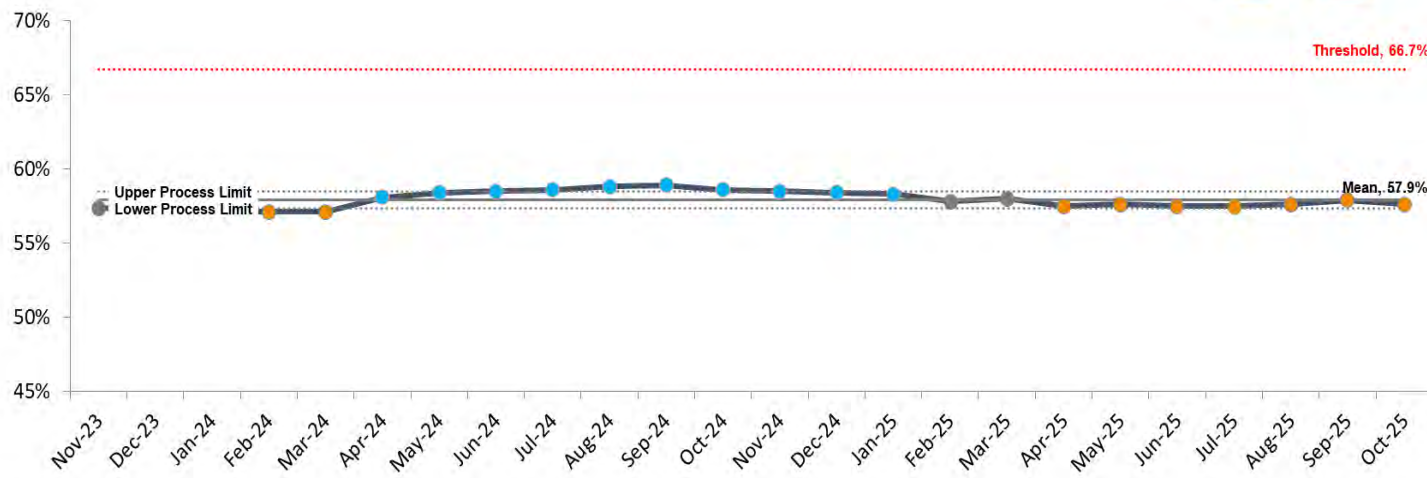
Dementia Diagnosis Rate

CQC Question: Are We Responsive?

Description of metric

Not everyone with dementia has a formal diagnosis. The indicator compares the number of people thought to have dementia with the number of people diagnosed with dementia, aged 65 and over. The target is for at least two thirds of people with dementia to be diagnosed.

Threshold: 66.7%



Analysis

The DHC Dementia service is commissioned for a total of 3,200 referrals p.a. and modelled to provide 2,400 diagnosis slots. It has capacity for 2,940 slots (+540 based on job plans). Approx. 80% of referrals (conversion rate) are eligible for assessment/diagnosis this equates to 2,560 referrals per annum. Achieving 66.7% equates to 1707 diagnoses per annum. From 1st April – 31st October, 949 people have been discharged with a diagnosis of Dementia. If this trend continues, it projects to 1,627 diagnoses over a 12-month period, which is close to the target.

There were 307 discharges from the Dorset Dementia service in October. After excluding medication reviews (13) and inappropriate referrals (39), 255 discharges were eligible for assessment/diagnosis. Of these:

- 63% (160 individuals) were diagnosed with dementia.
- 8% (21 individuals) were diagnosed with Mild Cognitive Impairment (MCI).

Actions

The ICB report this metric via the DiS Dementia Report. The CFAS II estimated prevalence for Dorset is 14,832 there are 8,443 people on the GP dementia register, which is 1.04% of the Dorset Population. 2/18 PCNs are reporting above 66.7% compliance (Shore Medical 69.1% and South Coast Medical 83.7%). The lowest performing PCN is Jurassic Coast 40.0%. An additional 1,407 diagnoses coded in the S1 GP register are required to meet the national 66.7% threshold.

Following the recommendations made from NHS Dorset Dementia Review, data quality validation and reconciliation completed between RiO (diagnosis), S1 GP Register recording/national submission and published National Data, the review highlighted a number of data quality issues where people have a Dementia related ICD10 code on RiO/diagnosis provided by DHC but no Read coded Dementia Diagnosis on S1 in Primary Care.

Dementia Diagnosis Rate (Continued)

CQC Question: Are We Responsive?

Analysis (cont.)

- 29% (73 individuals) were discharged without a diagnosis. This includes people who died, moved, Patient non-engagement etc

In total, 71% (181 individuals) of eligible discharges received a diagnosis.

Once a diagnosis has been given this data is sent to the patients GP to be entered into the GP Dementia Register (QOF), this needs to be accurately updated in the GP clinical record (System1) with the correct codes associated to be reflected in local and national reporting.

Actions (cont.)

This is supported by the DHC provisional diagnosis data outlined above. Updating the data used for national reporting (DDR) sits within Primary Care. The ICB had agreed to a number of actions to support Primary Care improve compliance reporting.

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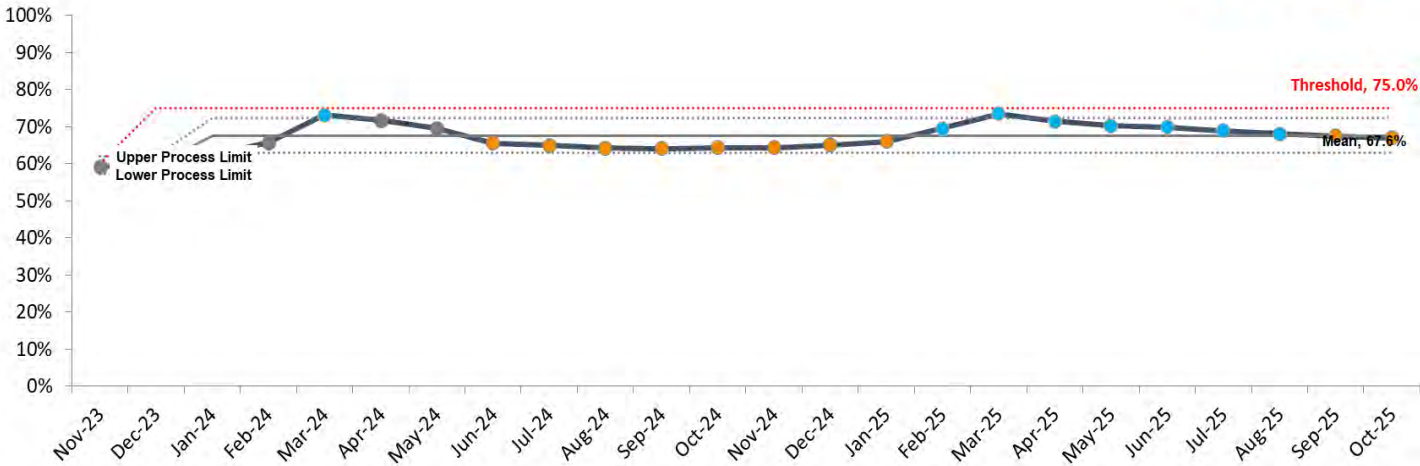
Serious Mental Illness (SMI) Physical Health Checks

CQC Question: Are We Effective?

Description of metric

The count (expressed as a percentage) of the number of people on the General Practice (GP) SMI register at the end of the reporting period that have had a full physical health check in the preceding 12 months. A full physical health check includes 6 components: a measurement of weight, a blood pressure and pulse check, a blood lipid including cholesterol test, a blood glucose test, an assessment of alcohol consumption, an assessment of smoking status.

Threshold: 75%



Analysis

The Serious Mental Illness (SMI) population as recorded in the GP SMI registers is 8,929 (total register), of which 5,985 (67.0%) have had the full six health checks completed in the past 12 months. This is monitored via PCN compliance and is within standard variation, no cause for concern, however the target may or may not be met as the target lies outside the process limits.

Four PCNs are below 60% due to recruitment and vacancy issues:

- Central Bournemouth 58.1%
- Shore Medical 57.5%
- Crane Valley 58.2%
- Mid Dorset 56.2%

Actions

The National Target is 60% with an ambition to meet 75% by 31 March 2026. Data submission is via the GPES which is the primary care equivalent of MHSDS. National compliance is reported via NHSE MH Core Data Pack (quarterly %). NHSE are reporting via the 'Active' SMI register instead of 'Total' register which is used for local reporting (includes those in remission), work is underway to ensure the same methodology is being applied.

SMI PHSW vacancies have been successfully recruited (3 new starters) and there is confidence that figures will start to increase, two have started running clinics this month. Additionally, 1.0FTE peripatetic SMI PSHW has been recruited and started in post to support with cover across Dorset. DNA rates have been higher than usual due to no Health engagement coordinator in post year to date (now recruited into and due to start in December which will improve attendance rates).

Serious Mental Illness (SMI) Physical Health Checks (Continued)		CQC Question: Are We Effective?
Analysis (cont.)	Actions (cont.)	
Compliance is showing a decline (unvalidated data at the time of publishing) but remains above the 60% minimum requirement but is slightly off track against the 75% ambition. Setchell, Ryan 04/12/2025 09:14:16	August and September has seen high rates of annual leave and other leave across the service which contributed toward temporary decline in compliance. New admin recruited and will support with identifying and targeting missing checks.	

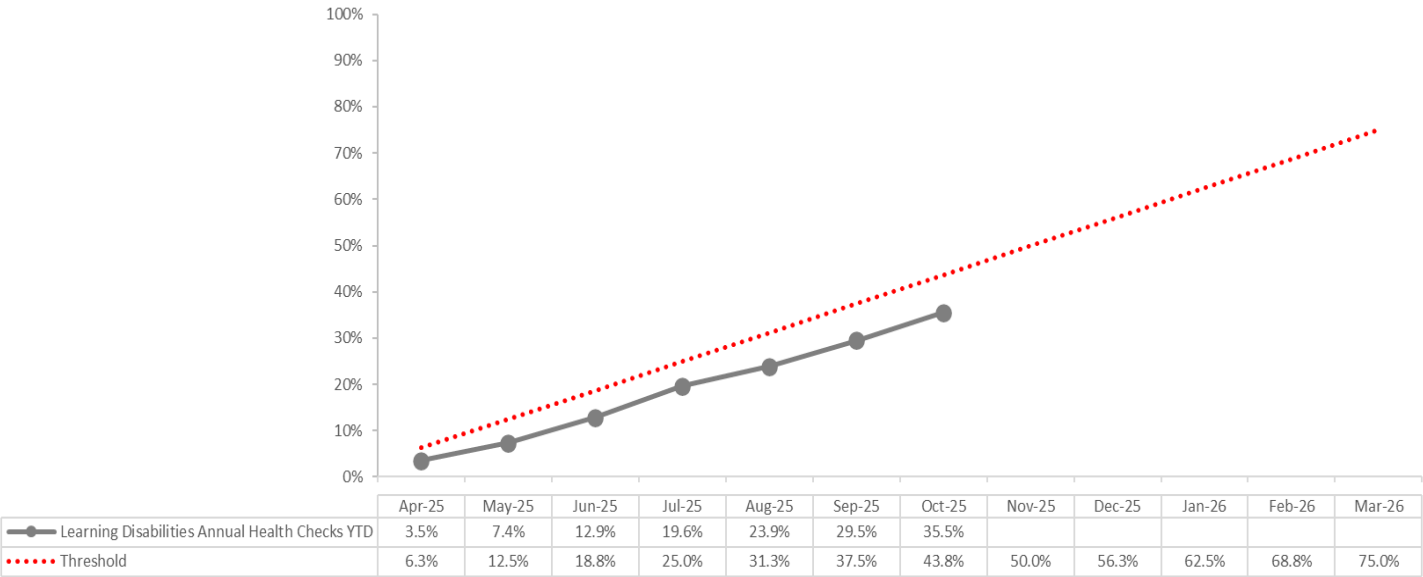
Learning Disabilities Annual Health Checks YTD

CQC Question: Are We Effective?

Description of metric

Compliance with the uptake of Health Checks completed for people on the GP Learning Disability register within Primary Care and how they are performing in relation to the target. Data Source is the LD Report from the DiiS. Based health checks completed by PCN/GP Surgeries per month.

Threshold: 43.8%



Analysis

Actions

There are 5,022 people (aged 14 and over) in Dorset recorded on the Learning Disability Register. This is approx. 0.6% of the Dorset population. The LD Annual Health Check is a reasonable adjustment that can be effective in detecting unmet health needs and leads to the treatment of health conditions which may be serious or life threatening.

Health checks are delivered and recorded by Primary Care, there is no action for DHC.

This is a cumulative target of which 75% (3,758) people on the general practitioner (GP) Learning Disability Register should have an annual health check completed by 31 March 2026. 1,784 checks have been completed YTD 2025/26, (73 people have declined).

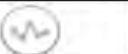
This is on track based on previous years trend analysis and no cause for concern.

COLLEAGUES



Description of icons

Assurance			Variation						
									
Consistently Pass target	Pass and fail target subject to random variation	Consistently Fail target	Special Cause Concerning variation either Higher or Lower		Special Cause Improving variation either Higher or Lower		Special Cause Neither improving nor concerning variation		Common Cause

Colleagues Metrics	In Month	Assurance	Variation	Data Quality
Violent Incidents - patient on staff all settings	80			High
Mandatory training completed	92.6%			High
Completed Appraisals last year	70.3%			Medium
Employee Relations cases (current live cases)	42			High
Staff turnover (monthly)	0.8%			Medium
Leaver rate	6.1%			High
Vacancy rate	7.7%			High
Sickness absence rate (monthly)	5.5%			High

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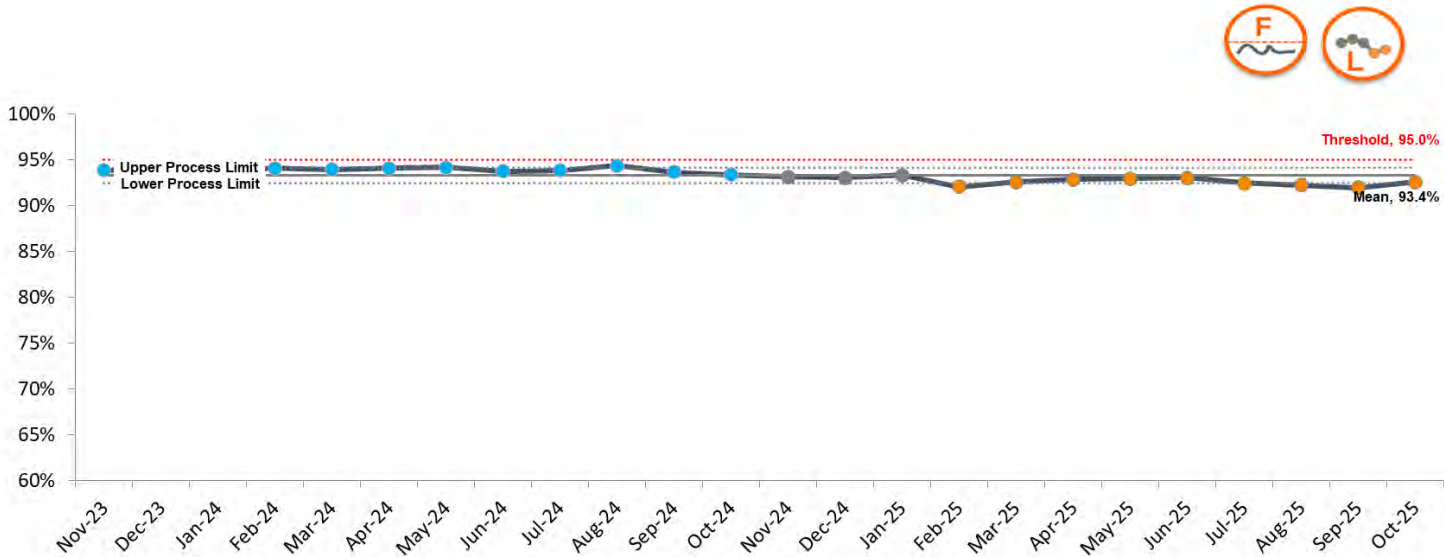
Mandatory Training Completed

CQC Question: Are We Safe?

Description of metric

Percentage of staff at month end having completed the Mandatory training requirements, as set nationally by the UK Core Skills Training Framework (2013). This is Conflict resolution, Equality diversity and Human Rights, Fire, IPC, IG, Health and safety, Manual Handling, Preventing radicalisation, Resus, Safeguarding adults and Children. The required level of training is dependent on profession and workplace and staff group requirements are decided locally.

Threshold: 95%



Analysis

Eleven topics saw an increase this month with only seven topics seeing a slight decrease and five topics remaining the same. Seven topics achieved over 95% compliance with a further five topics achieving over 90%, a further five topics with over 85% and a further six topics under 84.9% compliant. This resulted in an increase this month from 92% to 92.6% which was pleasing to see. Patient Safety Level 1 continued to show a slight increase and achieved 96.5% and Oliver McGowan Tier 1 Part 2 remained the same this month on 96.9%.Healthcare Scientists saw a slight decrease in compliance but still achieved 96.7% compliance, Additional Clinical Services, and Administrative and Clerical staff groups both achieved over 95% with 95.4% and 95.3% respectively. A further three staff groups achieved over 90% compliance with only two staff groups below 80% compliance. Estates and Ancillary saw an increase from 77.7% to 79.3% and only Medical and Dental saw a slight decrease from 79.8% to 79.4% this month.

Actions

Pleasing to see an increase especially as we are in the winter flu and covid season, with all the additional pressures that staff are under, ensuring they continue to provide the best care to our patients. Continuing to signpost staff to the correct tools to support them in completing their mandatory training including eHub, the mandatory training booklet and Doris. This month saw the change from an annual completion of Information Governance to a two yearly repeat going forward and this saw an increase in compliance from 93.8% to 98.7% with only 79 staff outstanding as at 31 October 2025. Reminder emails for all core topics continue to be sent to individuals with positive feedback and appreciation received.

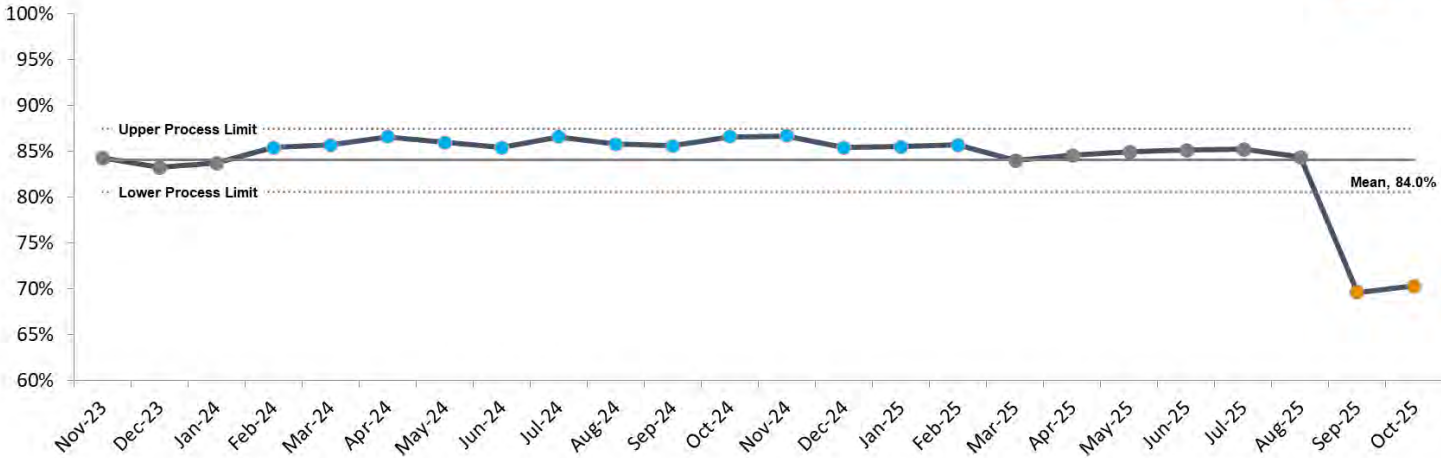
Completed Appraisals (last year)

CQC Question: Are We Safe?

Description of metric

Percentage of staff having recorded an appraisal conversation within the past 13 months.

Threshold: None



Analysis

The Trust has implemented a new appraisal system and it is now on the EHub platform. As we transition from the old to the new platform we expected to see a significant reduction in compliance rates as the way appraisals is reported has changed; the report is now only including fully completed and signed off appraisals (the previous process showed as completed only if the appraisal had been started – not completed).

There has been a very marginal increase in compliance this month to 70.3% from 69.6% as staff become accustomed to using the new appraisal system on eHub and are signing off appraisals on the system.

More staff groups achieved over 70% compliance, increased to five staff groups this month. With another group achieving 64.2% and Estates and Ancillary on 55.5% which was a decrease on last month's figures but not unexpected.

Actions

Ongoing comms to ensure all staff are aware and familiar with the new appraisal system on eHub. The L&D reporting and eHub teams are providing support and signposting as rapidly as possible to reduce any delays in appraisal completion.

Individual training sessions for teams is available on request and we continue to send out the information and links to guides, eHub and the My Appraisal Conversation page on Doris to help staff familiarise themselves with the new process and system. Further discussions regarding the process for Estates and Ancillary staff who piloted a paper appraisal system on Ulysses are taking place to understand whether they can transition to the new process son EHub.

Employee Relations Cases						CQC Question: Are We Safe?
	Discipline	Grievance	Sickness	Mediation	Total Cases	Description of metric
Case number in rolling 12 month period	48	45	138	9	240	Disciplinary, grievance, sickness absence and mediation cases in the rolling 12 month period and Number of weeks that live cases have been open. Threshold: None
Live Cases: Number of weeks open (so far)	Discipline	Grievance	Sickness	Mediation	Total Cases	
0 – 4 weeks	0	4	4			
5 – 8 weeks	3	2	3			
9+ weeks	6	2	14			
Live Cases: Total	9	8	21			
Analysis			Actions			
Overall, there has been a decrease in the number of live cases since the last report. Breakdown by case type shows: - Disciplinary cases have decreased from 11 to nine cases. - Grievance cases have increased from five to eight cases. - Sickness absence cases have decreased from 39 to 21 cases. - Mediation cases have remained at four cases. Whilst the aim is to resolve all cases as expediently as possible and avoid unnecessary delays, it should be noted that the management of sickness absence cases are, by their nature, more long-term. Suspension: There were two live suspensions at the end of October - one within the IUCS service and one RMN. Disciplinary cases: - Three cases have been live for more than four weeks but less than eight weeks. - Six cases have been live for eight weeks or more. Of these: four are at the investigation stage and two have a hearing date scheduled.			We have recently introduced a new triage form to support the initial assessment of potential conduct concerns. This tool has been developed to promote a fair, transparent, and consistent approach to managing such matters. A panel is set up to guide early decision-making, ensure consistency across cases, and reflect our commitment to a Just and Learning Culture. The process has been informed by the Mersey Care Decision Tree. Feedback from the Equality Diversity Inclusion group has been included. The Respect and Resolution Policy and Procedure is now being embedded across the organisation. It replaces the previous Grievance Policy and Procedure and the Dignity at Work Policy. The new policy, along with its supporting toolkit and process flow, is available to all staff via a dedicated page on the intranet. An addendum is included, specifically focused on managing allegations of discrimination, bullying, harassment, and victimisation. In addition, a standalone Sexual Safety Policy - aligned with the national framework - was ratified by the Trade Union Partnership Forum in April 2025. Feedback from staff networks has been actively incorporated into its development. An interactive online training module is now available to all staff, complemented by informal, action-learning style sessions held via MS Teams. These sessions are open to managers who have completed the training and wish to explore the content in greater depth.			

Employee Relations Cases (Continued)

CQC Question: Are We Safe?

Analysis (cont.)	Actions (cont.)
Grievances: - The eight grievances relate to working relationships, working conditions, breach of confidentiality and failure to follow policy and procedure. - One is at the informal stage; six are at the hearing stage; and one is at the investigation stage. Mediation cases: Four mediation cases have mediators allocated to support the parties to reach a resolution. Employment Tribunals: A further employment tribunal claim has been received, bringing the total number of active claims against the Trust to six: - Claim 1 (Mental Health Services): Two respondents identified (the Trust and an employee). The claims have been agreed to be combined. A telephone preliminary hearing on 6 May 2025 was inconclusive, and a full-day video Case Management Preliminary Hearing was held on 2 September 2025. The claim against the employee has been dismissed; judgement on remaining elements is reserved and yet to be received. - Claim 2 (Mental Health Services): Telephone preliminary hearing held on 27 August 2025. Directions have been set, with a full hearing scheduled for 21 September to 2 October 2026. - Claim 3 (Integrated Community Services): Proceeding to a 12-day hearing starting on 19 November 2025.	The online reporting form has been modified to support anonymous reporting. The HR team continues to collaborate with the Patient Safety team on implementing the Patient Safety Incident Reporting Framework (PSIRF). This partnership ensures alignment with the principles of a Just and Learning Culture and supports a clear, consistent approach to addressing staff-related safety concerns. In parallel, we are working closely with Organisational Development (OD) colleagues to co-design training and approaches that promote a Restorative and Learning Culture. This content has now been incorporated into the new Manager's Induction Programme, which is delivered monthly. To promote consistency, early resolution, and continuous improvement, monthly Employee Relations (ER) case meetings are held with the HR team. These structured sessions provide oversight and enable discussion of casework to ensure fairness, compliance, and shared learning. Additionally, monthly review meetings are held between the Head of HR, HR Manager, and the Service Director for People and Culture to monitor cases open for more than eight weeks, as well as those identified as complex or high risk. Strong collaborative relationships continue with the Director of Nursing, Freedom to Speak Up Guardian and Medical Leads. Regular monthly meetings support alignment and coordination across all areas. We also actively participate in the Chief Nursing Officer Advisory Group, the Responsible Officer Advisory Group, and Fitness to Practice meetings. Recognising the importance of robust investigations to support formal processes we have established a cohort of Investigating Officers from each directorate.

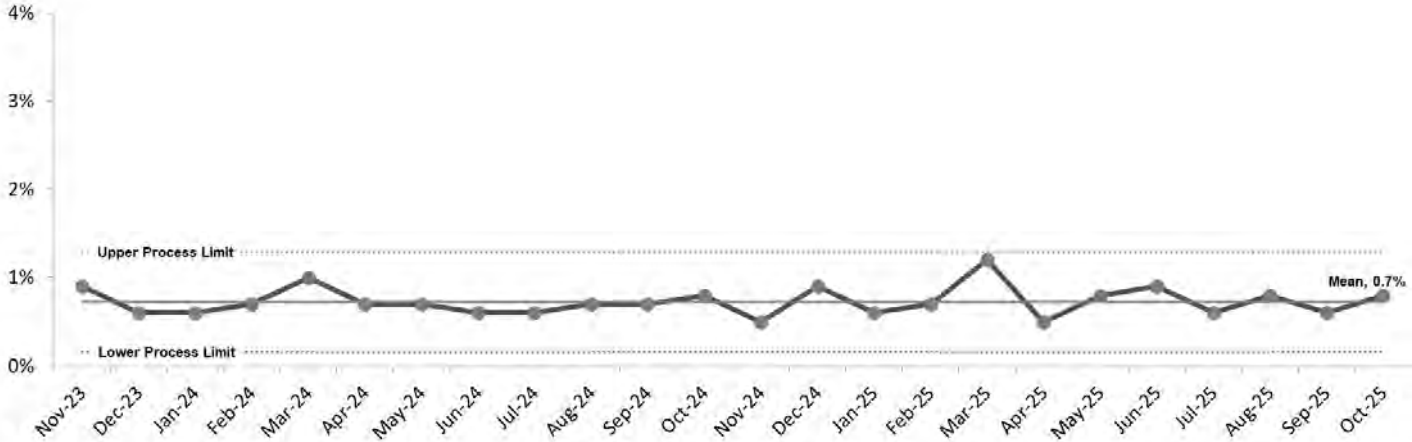
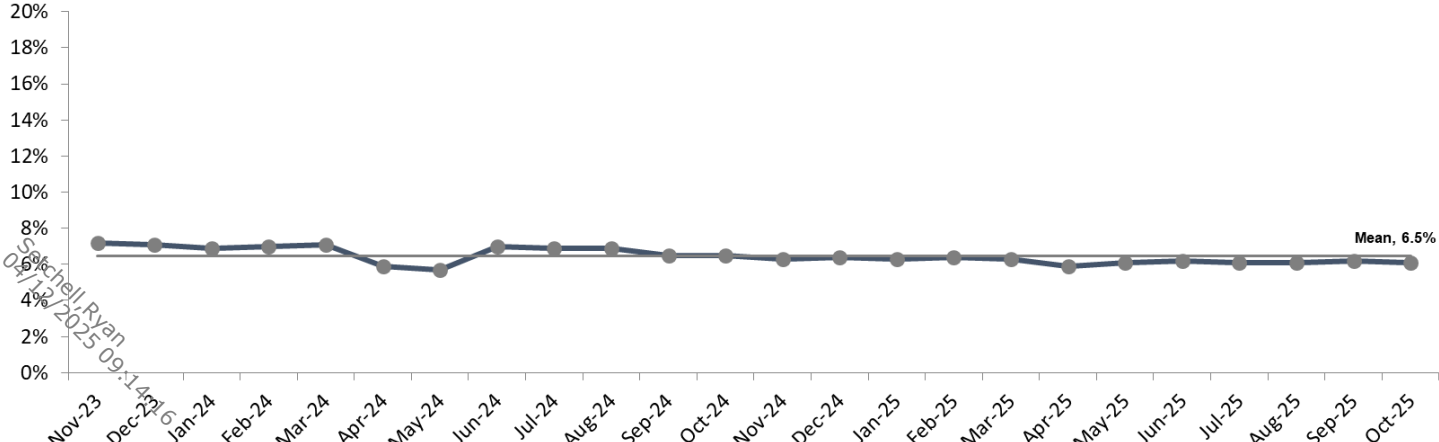
Employee Relations Cases (Continued)

CQC Question: Are We Safe?

Analysis (cont.)	Actions (cont.)
- Claim 4 (Mental Health Services): Listed for a 2-day preliminary video hearing. Extensions have been granted to enable compliance with directions. - Claim 5 (Mental Health Services): Relates to pregnancy/maternity discrimination. Holding response filed pending the outcome of the modified grievance procedure. Preliminary hearing scheduled for 14 April 2026. - Claim 6 (Nursing and Quality): Received 22 October 2025 from a bank worker claiming unfair dismissal, victimisation, and unfair treatment. Response required by 17 November 2025. Setchell, Ryan 04/12/2025 09:14:16	The first cohort of 11 received their training in September and a further cohort of 18 are scheduled for October. We will introduce a rota system for investigations, and it is hoped this will avoid delays.

Staff Turnover and Leaver Rate

CQC Question: Are We Caring?

Staff Turnover (monthly)	Description of metric
 Voluntary Leavers headcount in the period / Average Headcount in period. Threshold: None	
Leaver Rate (monthly)	Description of metric
 NHS Oversight Framework FTE of all staff leaving the NHS during the 12 month period / FTE of all staff in post at the beginning of the 12 month period (percentage). Threshold: None	

Staff Turnover and Leaver Rate (Continued)

CQC Question: Are We Caring?

Analysis	Actions
This report presents two key workforce metrics: - Monthly turnover is calculated using the total headcount of staff who voluntarily left the Trust, compared to the total staff headcount. - Leavers rate is a nationally defined measure based on all WTE leavers from the Trust. For October 2025, the monthly turnover rate was 0.8%, an increase on September's figure of 0.6%, which puts us in the centre of process control limits. Whilst some month-to-month variation is expected, the monthly leavers rate has remained fairly stable at 6.1%. However, overall turnover for the rolling 12 months has increased from 8.4% in September to 9.1% in October. It is concerning to see this inflation after last month's downward trajectory and we will continue to monitor this trend carefully. In October 2025, there were 43.4 WTE leavers, equating to a headcount of 63, with seven departures due to non-voluntary reasons. By staff group, the highest number of voluntary leavers in October were from the administrative and clerical staff group (17), followed by additional clinical services (16) and nursing and midwifery (12). In terms of age distribution, the highest number of leavers were aged 51-55 (11), followed by 31-35 (10) and 56-60 (10). Of those leaving, 16 individuals indicated they were moving to another role within the NHS, while 29 reported having no further employment arranged. Setchell, Ryan 04/12/2025 09:14:16	Leavers data is routinely shared at key meetings, committees, and working groups to provide meaningful insights into staff departures. While completion of the leavers questionnaire remains voluntary, ongoing promotional efforts are in place to increase response rates across the Trust. A dedicated career conversation is part of the new appraisal scheme with the aim of promoting staff engagement and retention, as well as succession planning and more broadly ensuring we have a highly skilled workforce. The Stay and Grow service, launched in autumn 2024, supports staff in Bands 2–4 who are considering leaving or changing careers by offering access to career guidance and development opportunities within the Trust. This builds on the existing career conversation service for support workers. Further communications have been issued to raise awareness of the service. Retention remains a key area of system-wide collaboration, particularly in relation to Health Care Support Workers and the development of structured career pathways. A Redeployment Framework for the Dorset system, and associated implementation processes, are currently being developed. The Pay and Reward Policy provides a more agile and responsive reward framework, designed to support staff retention, promote high performance, and enhance recognition. Application of the policy is monitored by the People and Culture Directorate, with analysis of applications and approvals by protected characteristics, reasons for requests, and process adherence. This information is regularly shared with the Trade Union Partnership Forum.

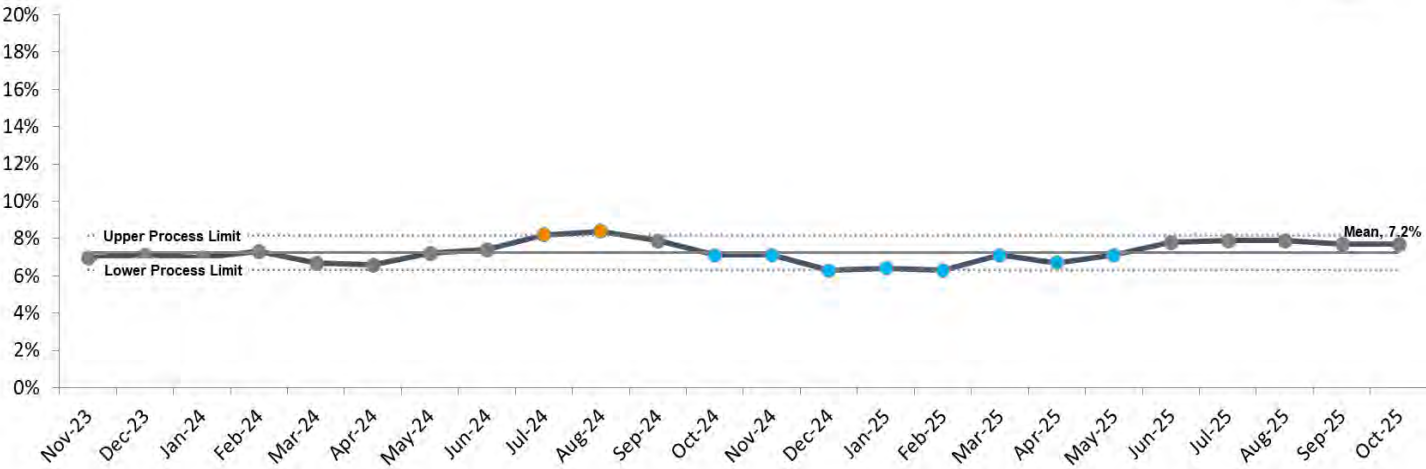
Vacancy Rate

CQC Question: Are We Safe?

Description of metric

The full time equivalent active vacancies at month end from the ledger and expressing them as a percentage of budgeted establishment.

Threshold: None



Analysis

The overall vacancy rate is calculated as the difference between the budgeted establishment (WTE) and the contracted establishment (WTE).

As of September 2025, the budgeted establishment stood at 6,267.9 WTE, increasing to 6,301.2 WTE in October 2025. Over the same period, the contracted establishment rose from 5,784.5 WTE to 5,815.5 WTE, leaving a gap of 485.7 WTE. This equates to a vacancy rate of 7.7%, which remains unchanged from the previous month.

Some movement in the budgeted establishment was anticipated during Q1 and Q2, linked to the finalisation of the 2024/25 year-end position and the setting of 2025/26 pay budgets. However, as posts continue to be held or removed under the Efficiency Programme, there remains a lag in the corresponding budget adjustments. Consequently, establishment figures are expected to fluctuate throughout the remainder of the year. Recruitment activity continues to be managed through the Vacancy Control Panel (VCP) to ensure alignment with workforce and financial plans.

Actions

The medium term planning framework has been launched and work has commenced to ensure we submit a sustainable workforce plan in line with the ambitions NHS10Y plan.

Workforce Planning activity continues across the Trust, with short, medium, and long-term workforce plans being developed to address supply gaps and support transformation programmes. A suite of workforce planning tools, including full-cost modelling, has been developed and piloted within selected services ahead of Trust-wide rollout. To support this, the team has attended directorate meetings to deliver briefings, and workforce planning training is now available for managers to book. However, given the current period of financial constraint and WTE reduction targets, workforce planning remains a complex and dynamic process.

The Vacancy Control Process (VCP) remains in place and aligns with similar approaches used by system partners. Only roles endorsed by the relevant senior manager are submitted to the panel.

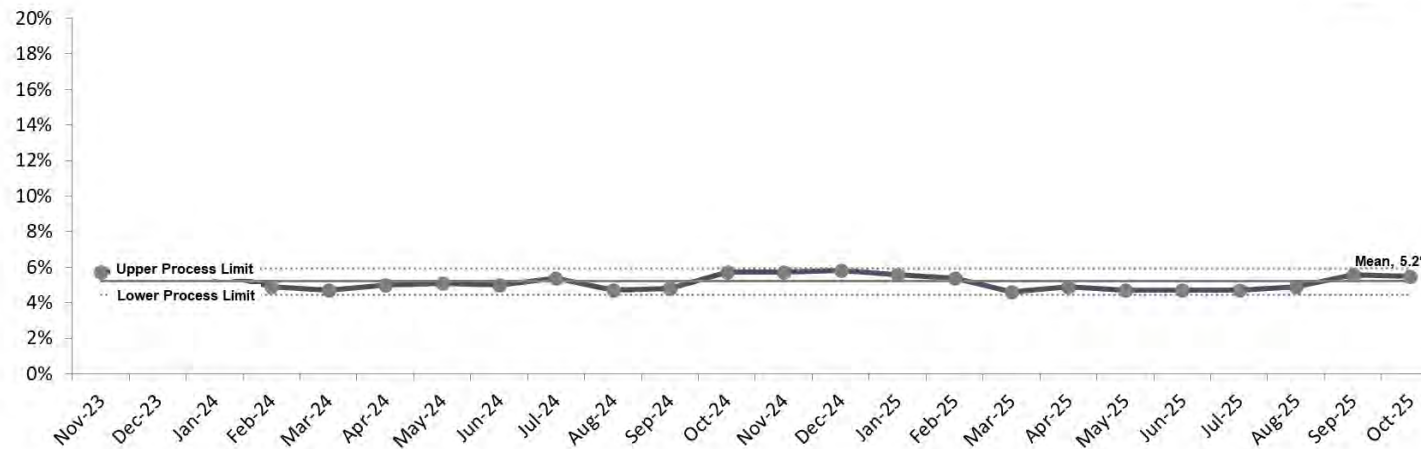
Vacancy Rate (Continued)

CQC Question: Are We Safe?

Analysis (cont.)	Actions (cont.)
The 2025/26 Efficiency Programme is now well underway, with each directorate assigned both a financial and a WTE reduction target. The end of year staff in post figure has been revised downwards and the SIP target is now 6,125 as of M06 this left a gap of 147.5 wte. While recruitment to essential roles continues, further reductions in overall WTE are required to achieve target, with a particular focus on bank usage. Progress is reported regularly to the Executive Team and the Financial Recovery Board. A summary of VCP decisions - including both approvals and declines - is shared weekly with the Executive Team. In addition, the Safer Staffing Group continues to monitor workforce levels across inpatient and community services to ensure safe staffing is maintained. The Resourcing Team continues to support directorates through targeted recruitment campaigns, with a particular emphasis on mental health support workers. Current vacancy rates by directorate: • Children's, Mental Health and LD Services = 8.2% • Integrated Community Services = 4.8% • Medical = 28.6% • Support Services = 8.5% Setchell, Ryan 04/12/2025 09:14:16	Increasingly, decisions to not proceed with recruitment are being made prior to escalation, indicating that the process is embedding well at local levels. In response to high agency usage and retention challenges among Health Care Support Workers (HCSWs), a competency-based recruitment approach is being trialed. In addition, work is underway to develop a centralised recruitment and selection approach for mental health inpatient units, aimed at accelerating recruitment and improving consistency. Targeted efforts to recruit medical staff also continue. Following a successful application for GMC Sponsorship, an international advert for Associate Specialist/Consultant roles was launched in May 2025, attracting a strong field of applicants. Interviews have been completed and conditional offers have been made following a candidate-to-vacancy matching exercise. Onboarding of successful candidates is in progress, and the first postholders are expected to commence in January 2026. A working group is being established within operational services to maximise the efficient deployment of substantive clinical (non-medical) staff. This work aims to ensure that planned efficiencies in bank and agency reductions are achieved across both inpatient and community services.

Sickness Absence Rate (monthly)

CQC Question: Are We Safe?



Description of metric

NHS Oversight Framework

Full Time Equivalent (FTE) Number of Days Sick (including non-working days)/FTE Number of Days Available.

Threshold: None

Analysis

The sickness absence rate for October was 5.5%, representing a slight decrease from 5.6% in September. Although the reduction is small, it is a positive step and moves us closer to the mid-point of the process limits.

Absence rates by service / directorate:

- Children's, Mental Health and LD Services: 5.5%
- Integrated Community Services: 5.9%
- Medical: 5.2%
- Support Services: 4.3%

Key insights from in-month data:

- The most common reasons for absence were anxiety, stress and depression, followed by cold, cough and influenza, and gastrointestinal problems.

Actions

While sickness absence levels remain a concern, they are slightly lower compared with the same period last year. Nevertheless, maintaining focus on this area continues to be a priority. Consistent and effective management of absence across all services is essential to sustain and build on recent progress.

The staff flu vaccination campaign is now underway, and we will continue to actively promote this across all areas of the Trust. Progress is being monitored by the Executive Team and the Senior Leadership Team. At the time of writing this report the overall take up rate is 36%

Reducing sickness absence remains a key workstream within the Workforce Delivery Framework. Our Sickness Absence Strategy aims to shift from a reactive to a proactive approach, underpinned by four core principles: prevention, early intervention, clear and consistent policy, and compassion.

As part of this strategy, we have introduced updated policies for both short

Sickness Absence Rate (monthly) (Continued)

CQC Question: Are We Safe?

Analysis (cont.)	Actions (cont.)
Highest absence levels recorded as a percentage of the workforce were in Additional Clinical Services, followed by Nursing and Midwifery Registered and Medical and Dental.	and long-term sickness absence, supported by a comprehensive communication and engagement plan. This includes virtual briefing sessions, an interactive process flow, and a practical toolkit designed to guide and support both managers and staff. In addition, the new appraisal process now includes a dedicated wellbeing conversation as part of the appraisal cycle. Wellbeing plans are a key tool in helping staff remain well at work, and training and guidance are available to support managers in this area. Manager training is central to this approach. It begins with online pre-course modules covering key procedural content, followed by in-person sessions that emphasise a cultural shift towards proactive and compassionate absence management. These face-to-face sessions focus on improving communication, incorporating tools such as wellness discussions, and fostering supportive team environments. Attendance has been strong, and feedback has been consistently positive. To enable effective local-level management, detailed sickness absence data is shared with managers, including alerts when staff reach key absence triggers. In parallel, the HR Advisory Team review data to identify patterns and hotspots, working alongside managers to implement targeted interventions. Absence data is also embedded in Directorate Management Group (DMG) reports, ensuring service leads have the insight needed to take timely and informed action. We continue to review our policies and processes, seeking feedback to understand what is working well, where challenges remain, and what additional support may be needed to drive sustained and meaningful improvement. It is also important to recognise that sickness absence cases are becoming more complex, often involving multiple, interrelated health issues. These complexities require more tailored, compassionate, and coordinated approaches to ensure staff are appropriately supported and to reduce long-term absence.

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SUSTAINABILITY



Sustainability Metrics (£000s)	In Month	YTD	Current Status/ YTD Threshold	Data Quality
Cash Balance	38,911		● -	High
Capital Expenditure (current status: Green within 15% of planned, Red <>15% of planned)	5,112	20,068	● 44,902	High
Financial efficiency : variance from efficiency plan	1,601	2,053	● 14,954	High
Financial stability : variance from NHSE plan	-601	-601	● -731	High

Finance

CQC Question: Are We Well Led?

Metric	Description	Threshold
Cash Balance	Total of cash held in the bank or as investments.	None
Capital Expenditure	Expenditure on capital assets within the business as usual capital envelope (CDEL).	Within 15% of planned green >15% or <15% red
Financial efficiency: variance from efficiency plan	Cumulative percentage of efficiency savings achieved against plan.	Annual target of £17,500,000 phased evenly throughout the year
Financial stability: variance NHSE plan	Surplus/(deficit) achieved against NHSE plan.	£0.00

Analysis and Actions

Cash metric for this month is £38,911,362 which has increased by £11,108k from last month. This increase is due to the drawing down of £10,154k external funding for the NHP build and £1,810k of deferred income receipts indicating cash received for future services.

The capital expenditure target for 2025/26 is £44,902k including leases capitalised under IFRS16 of £2,544k and LoF funded expenditure. This is a reduction of £6,703k caused by a reduction in forecast NHP expenditure in year of £9,650k, offset in part by £2,184k additional external capital funding agreed for Estates Safety and the £500k Patient Experience Portal and £173k additional LoF funding. The reduction in NHP cost in year is due to securing zero VAT rating with HMRC, and movement into 2026/27. Work is being undertaken to look at additional opportunities to spend the VAT saving in line with the business case objectives. Total capital spend year-to-date is £20,068k, of which £2,666k is internally funded against a YTD plan of £2,507k. Additional to this is IFRS16 related capital spend of £378k YTD against £1,484k YTD plan.

In month savings of £1,551k have resulted in ytd savings of £12,901k which is behind plan (£14,954k) by £2,053k.

An in month surplus of £1,764k has resulted in a ytd surplus of £1,332k which is ahead of plan (£731K) by £601k.

2.4 Research and Development Metrics Q2, 2025-26

The following provides details of the Quality Metrics for the Trust’s Research and Development (R&D) activities.

Metric	In Quarter	Current Status	Additional details																					
Time taken to issue confirmation of capacity and capability	No exceptions	G	All studies received confirmation of capacity and capability within the agreed timeline from site selected date for Q2	Areas/specialities involved in research Research & Development Status per Quarter <table><tr><th>Quarter</th><th>Green</th><th>Amber</th><th>Red</th></tr><tr><td>Q3 (2024-25)</td><td>4</td><td>0</td><td>0</td></tr><tr><td>Q4 (2024-25)</td><td>4</td><td>0</td><td>0</td></tr><tr><td>Q1 (2025-26)</td><td>4</td><td>0</td><td>0</td></tr><tr><td>Q2 (2025-26)</td><td>4</td><td>0</td><td>0</td></tr></table> • Perinatal • Dementia • Eating Disorder • Physiotherapy • Psychosis Pathway • Mental Health • Tissue Viability • Diabetes • Stroke • Vaccine studies • Musculoskeletal	Quarter	Green	Amber	Red	Q3 (2024-25)	4	0	0	Q4 (2024-25)	4	0	0	Q1 (2025-26)	4	0	0	Q2 (2025-26)	4	0	0
Quarter	Green	Amber	Red																					
Q3 (2024-25)	4	0	0																					
Q4 (2024-25)	4	0	0																					
Q1 (2025-26)	4	0	0																					
Q2 (2025-26)	4	0	0																					
Recruitment to target	83	G	Recruitment for Q2 is currently at 130; no target has been agreed for 2025-26.																					
Recruitment of first participant to the study	No exceptions	G	All studies recruited to time for Q2																					
Number of incidents (target < 2)	0	G	There were no incidents in Q2																					
Number of studies in progress	19	-	Currently active in 19 studies: 15 open to recruitment (one is a National Confidential Inquiry study)																					
Number of studies in set-up	4	-	4 portfolio studies currently in set-up																					

Other: R&D staff continue to support the Weymouth Research Hub (WRH), a venture supported by the Research Delivery Network Wessex and Wessex Health Partners and is one of four flagship research Hubs across the Wessex Region. To date, four commercial research studies have been hosted at the WRH. The WRH is now a host site for the Wessex Commercial Research Delivery Centre (CRDC).

Two bids have recently been submitted to Wessex Health Partners (WHP); 1. A Brain Health Clinic research sandpit event and collaborative working group aimed at bringing together patients, carers, clinicians, and researchers to co-create community-driven research. The main goal is to develop studies that address the needs of local and underserved populations, beginning with an initial sandpit event and leading to the establishment of a cross-institutional, Wessex-wide Brain Health Research Group. The second to support BrainFit – a project focused on involving patients and the public in shaping and co-designing personalised care plans. These plans will combine digital tools and community based multimodal health and wellbeing interventions for people with mild cognitive impairment.

Safer Staffing Summary

This information is reported to the monthly Safer Staffing Forum and Quality Governance Group, with escalation to the Quality Governance Committee as required. Detailed staffing data is provided in the monthly Right Staffing Report.

Staffing Challenges

Workforce data and staff feedback highlight that safer staffing levels across the Trust were adversely affected by sickness absence, half-term school holidays, and ongoing vacancies.

The most common causes of sickness were

- Anxiety, stress, and depression
- Cold, Cough, and Influenza

Staffing Incidents

Across all clinical services, 46 staffing-related incidents were formally reported. Anecdotal feedback indicates that actual numbers may be higher due to underreporting.

The quality and comprehensiveness of staffing incident reports varied. However, based on the information available, the following red flags/impacts on patient and staff experience were identified:

Impacts on patient care, experience and associated tasks

- Delays in essential care delivery: including medication administration, clinical reviews, and pressure care
- Delays in serving food and supporting relatives
- Temporary service closures or reductions in service availability
- Reliance on temporary staff unfamiliar with individual patient needs

Impacts on staff experience included

- Inability to take rest breaks and increased workloads due to higher patient acuity and complex dependency needs.
- Absence of senior practitioner on duty
- Redeployment, leaving one RN working on their own
- Reliance on temporary staff during an away day, leaving only one substantive Registered Nurse on shift

Fill Rate Analysis

Hospital Site Details		Ward Name	Specialty 1	Day				Night			
Site code	Hospital Site name			Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nursing associates (%)	Average fill rate - non-registered nursing associates (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nursing associates (%)	Average fill rate - non-registered nursing associates (%)
RDYFY	WESTMINSTER MEMORIAL HOSPITAL	Ashmore/Shaston Ward	321 - REHABILITATION	99.2%	89.5%	-	N/A	100.3%	96.2%	-	-
RDYFC	YEATMAN HOSPITAL	Beech Ward	314 - REHABILITATION	92.5%	97.0%	-	N/A	95.2%	100.0%	-	-
RDYFJ	BRIDPORT COMMUNITY HOSPITAL	Colmers Ward	315 - REHABILITATION	147.2%	71.3%	-	N/A	100.2%	79.6%	-	-
RDY22	ALDERNEY HOSPITAL	Guernsey Ward	316 - REHABILITATION	100.7%	97.8%	-	N/A	100.0%	100.0%	-	-
RDYFE	VICTORIA HOSPITAL W'BORNE	Hanham Ward	317 - REHABILITATION	99.9%	93.2%	N/A	N/A	100.0%	95.2%	-	-
RDY22	ALDERNEY HOSPITAL	Jersey Ward	318 - REHABILITATION	99.4%	97.4%	-	-	100.0%	100.0%	-	-
RDYEG	WESTHAVEN HOSPITAL	Radipole Ward	319 - REHABILITATION	101.1%	89.7%	N/A	N/A	98.5%	91.4%	-	-
RDYFC	YEATMAN HOSPITAL	Rowan Ward	320 - REHABILITATION	96.6%	97.3%	N/A	-	101.6%	81.0%	-	-
RDYFD	SWANAGE COMMUNITY HOSPITAL	Stanley Purser Ward	322 - REHABILITATION	113.9%	81.3%	-	-	103.4%	100.0%	-	-
RDYFF	BLANDFORD COMMUNITY HOSPITAL	Tarrant Ward	323 - REHABILITATION	113.3%	90.6%	N/A	N/A	100.1%	100.0%	-	-
RDYFC	ST ANN'S HOSPITAL	AAU Seaview	710 - ADULT MENTAL ILLNESS	92.5%	110.8%	-	N/A	53.2%	132.8%	-	-
RDY10	ST ANN'S HOSPITAL	Alumhurst Ward	711 - ADULT MENTAL ILLNESS	92.7%	103.5%	-	N/A	85.6%	114.7%	-	-
RDY10	ST ANN'S HOSPITAL	Chine Ward	712 - ADULT MENTAL ILLNESS	85.3%	106.4%	-	N/A	93.5%	132.3%	-	-
RDY10	NIGHTINGALE HOUSE	Florence House	713 - ADULT MENTAL ILLNESS	89.2%	113.0%	-	N/A	107.1%	109.9%	-	-
RDYFX	MAIDEN CASTLE HOUSE	Glendinning Unit	714 - ADULT MENTAL ILLNESS	116.3%	106.8%	-	N/A	109.7%	102.0%	-	-
RDYFT	ST ANN'S HOSPITAL	Harbour Ward	715 - ADULT MENTAL ILLNESS	91.9%	129.0%	-	-	96.8%	206.5%	-	-
RDY10	ST ANN'S HOSPITAL	Haven Ward Female	928 - MENTAL HEALTH REHABILITATION	100.6%	103.5%	-	N/A	96.8%	150.0%	-	-
RDY10	ST ANN'S HOSPITAL	Haven Ward Male	929 - MENTAL HEALTH REHABILITATION	98.1%	105.2%	-	N/A	99.9%	108.6%	-	-
RDY10	ALDERNEY HOSPITAL	Herm Ward	715 - OLD AGE PSYCHIATRY	106.3%	99.0%	N/A	N/A	103.4%	106.0%	-	-
RDY22	KIMMERIDGE COURT	Kimmeridge Court	714 - ADULT MENTAL ILLNESS	68.5%	97.0%	N/A	-	73.6%	145.2%	-	-
RDYEG	FORSTON CLINIC	Melstock House	715 - ADULT MENTAL ILLNESS	120.0%	93.9%	N/A	N/A	176.7%	100.0%	-	-
RDYFX	NIGHTINGALE HOUSE	Nightingale House	716 - ADULT MENTAL ILLNESS	120.2%	79.7%	N/A	N/A	100.0%	101.6%	-	-
RDYFX	PEBBLE LODGE	Pebble Lodge	711 - CHILD AND ADOLESCENT PSYCHIATRY	95.7%	131.9%	N/A	-	101.4%	142.7%	-	-
RDYMR	ALDERNEY HOSPITAL	St Brelades Ward	715 - OLD AGE PSYCHIATRY	87.6%	106.5%	N/A	N/A	100.1%	128.6%	-	-
RDY22	ST ANN'S HOSPITAL	Twynham Ward	712 - FORENSIC PSYCHIATRY	77.7%	95.2%	-	N/A	75.5%	124.2%	-	-
RDY10	FORSTON CLINIC	Waterston AAU	710 - ADULT MENTAL ILLNESS	98.4%	110.0%	-	N/A	100.4%	143.7%	-	-

Overall Position

- Planned versus actual nursing hours (fill rates) for community hospital and mental health inpatient wards show that average Registered Nurse (RN) fill rates remained within agreed parameters for both day and night shifts. Mental Health Support Worker (MHSW) average fill rates were above 120%.
- Fill rates exceeding 120% reflect:
 - Increased care needs requiring additional staff
 - Backfilling of the second RN role with a MHSW
 - Agreed adjustments to demand templates to ensure safer staffing in specific environments (Waterston, Haven Female, Chine).

Community Hospital Wards below 90%

- Colmers: HCSW fill rate fell below 90%; RN fill rate exceeded 100% on day duty due to RNs backfilling HCSW duties.
- Shaston (89%) and Stanley Purser (81%): HCSW fill rates fell below 90% on day duty, primarily due to sickness absence and unfilled temporary staffing requests.
- Rowan: Night fill rates impacted by sickness absence.

2.5 Inpatient Nursing Staffing – National Return for October 2025

- Clinical services report that temporary staffing requests are now sent out two weeks in advance (previously six weeks). This change has reduced availability, as bank workers have moved to other employment. While this would not have prevented the sickness levels, earlier requests may have mitigated some shortfall. The change is in line with the national directive to reduce reliance on temporary staffing and agency use across the NHS.

Mental Health Inpatient Wards below 90%

- Alurhurst, Chine, and Seaview: Frequently rostered only one RN on night duty (instead of the planned two), mainly due to flexible working arrangements, which limit availability for night cover.
- Chine's actual RN hours during the day fell below 90% (85%) As reported last month, the Ward Manager attributes this to performance issues, long-term sickness, and occupational health requirements, all of which have impacted fill rates. The Ward Manager also raises concerns that prioritising two RNs on night shifts is creating a shortfall during the day, which in turn affects supervision, rest breaks, and attendance at patient reviews.
- Haven Female, Haven Male, Kimmeridge, Nightingale, St Brelades, and Twynham staffing shortfalls were attributed to a combination of vacancies, sickness, training, annual and other leave, and unfilled temporary shifts.
- Florence used professional judgement to amend the skill mix in line with reduced bed occupancy.
- Registered Nurse block bookings are currently in place at Kimmeridge, Waterston, Melstock, Haven Male, and Harbour to support continuity of care. These bookings are reviewed regularly through the Vacancy Control Panel to ensure they remain appropriate.

Escalations

- Kimmeridge Court:
 - o The Safest Staffing Protocol remains in place due to vacancies and high reliance on temporary staff.
 - o A successful recruitment drive has filled all RN vacancies; however, new starters will not commence until October.
 - o Block booked agency RN cover is in place to provide consistency.
 - o The ward continues under enhanced surveillance via the Provider Collaborative.
 - o Standing down the Safest Staffing Protocol is anticipated in November, following completion of new starter inductions.
- Harbour remains on the Watchful Waiting list and continues to be monitored by the safer staffing team.

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2.5 Inpatient Nursing Staffing – National Return for October 2025

Hospital Site Details		Ward Name	Specialty 1	CHPPD				
Site code	Hospital Site name			Registered nurses/midwives	Care Staff	Registered nursing associates	Non-registered nursing associates	Overall
RDYFY	WESTMINSTER MEMORIAL HOSPITAL	Ashmore/Shaston Ward	321 - REHABILITATION	3.2	2.7	0.0	0.3	6.3
RDYFC	YEATMAN HOSPITAL	Beech Ward	314 - REHABILITATION	3.8	3.0	0.0	0.0	6.8
RDYFJ	BRIDPORT COMMUNITY HOSPITAL	Colmers Ward	315 - REHABILITATION	2.6	3.0	0.0	0.0	5.6
RDY22	ALDERNEY HOSPITAL	Guernsey Ward	316 - REHABILITATION	2.7	3.0	0.0	0.0	5.8
RDYFE	VICTORIA HOSPITAL W'BORNE	Hanham Ward	317 - REHABILITATION	2.9	3.0	0.2	0.1	6.2
RDY22	ALDERNEY HOSPITAL	Jersey Ward	318 - REHABILITATION	2.5	2.7	0.0	0.0	5.2
RDYEG	WESTHAVEN HOSPITAL	Radipole Ward	319 - REHABILITATION	2.6	2.9	0.1	0.1	5.8
RDYFC	YEATMAN HOSPITAL	Rowan Ward	320 - REHABILITATION	4.3	3.9	0.5	0.0	8.7
RDYFD	SWANAGE COMMUNITIY HOSPITAL	Stanley Purser Ward	322 - REHABILITATION	3.8	2.7	0.0	0.0	6.5
RDYFF	BLANDFORD COMMUNITY HOSPITAL	Tarrant Ward	323 - REHABILITATION	2.7	2.7	0.0	0.1	5.6
RDYFC	ST ANN'S HOSPITAL	AAU Seaview	710 - ADULT MENTAL ILLNESS	4.6	9.2	0.0	0.3	14.0
RDY10	ST ANN'S HOSPITAL	Alumhurst Ward	711 - ADULT MENTAL ILLNESS	2.5	4.0	0.0	0.3	6.8
RDY10	ST ANN'S HOSPITAL	Chine Ward	712 - ADULT MENTAL ILLNESS	4.7	7.2	0.0	0.3	12.3
RDY10	NIGHTINGALE HOUSE	Florence House	713 - ADULT MENTAL ILLNESS	13.1	10.0	0.0	1.9	24.9
RDYFX	MAIDEN CASTLE HOUSE	Glendinning Unit	714 - ADULT MENTAL ILLNESS	4.0	3.7	0.0	1.5	9.2
RDYFT	ST ANN'S HOSPITAL	Harbour Ward	715 - ADULT MENTAL ILLNESS	3.9	6.5	0.0	0.0	10.4
RDY10	ST ANN'S HOSPITAL	Haven Ward Female	928 - MENTAL HEALTH REHABILITATION	7.7	16.9	0.0	0.8	25.4
RDY10	ST ANN'S HOSPITAL	Haven Ward Male	929 - MENTAL HEALTH REHABILITATION	5.2	14.6	0.0	0.6	20.3
RDY10	ALDERNEY HOSPITAL	Herm Ward	715 - OLD AGE PSYCHIATRY	3.5	8.7	0.2	0.2	12.7
RDY22	KIMMERIDGE COURT	Kimmeridge Court	714 - ADULT MENTAL ILLNESS	9.3	11.5	0.7	0.0	21.4
RDYEG	FORSTON CLINIC	Melstock House	715 - ADULT MENTAL ILLNESS	5.5	5.4	0.0	0.4	11.3
RDYFX	NIGHTINGALE HOUSE	Nightingale House	716 - ADULT MENTAL ILLNESS	4.7	6.0	0.5	0.8	11.9
RDYFX	PEBBLE LODGE	Pebble Lodge	711 - CHILD AND ADOLESCENT PSYCHIATRY	8.2	18.6	0.3	0.0	27.1
RDYMR	ALDERNEY HOSPITAL	St Brelades Ward	715 - OLD AGE PSYCHIATRY	3.5	9.9	0.1	0.1	13.6
RDY22	ST ANN'S HOSPITAL	Twynham Ward	712 - FORENSIC PSYCHIATRY	4.5	7.4	0.0	0.5	12.4
RDY10	FORSTON CLINIC	Waterston AAU	710 - ADULT MENTAL ILLNESS	3.3	4.6	0.0	0.2	8.1

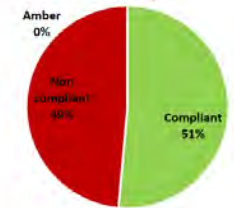
The above table show care hours per patient day (CHPPD). This is calculated by dividing actual staff hours by number of patients on the ward at 23.59.

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Integrated Community Services – Operational Performance Board Summary – October 2025 (7)

Performance/KPI Metric Summary

CHS & IUCS KPI Compliance Monthly



CHS & IUCS System KPI Compliance



47 KPIs included in month end reports
17 non-compliant KPIs of which:

- 2 are system KPIs reported by DHC
- 2 are services still in recovery

Community Hospitals Average Length of Stay



In Oct '25 average LoS at discharge was 33.11 days. If average delays in discharge of 9.31 days had not occurred, average LoS would have been 23.8 days.

Staff Turnover Rate



The 12 month turnover rate for Community Services was 8.75% against a Trust total of 9.08%. This is within target of <10%.

Highlight on a Service

Pain Service – Supra Scapular Nerve Blocks (SSNBs)

Friday 17th October saw Dorset Pain Management Service host their first High Volume Low Complexity Day for procedures. This waiting list initiative project brought together 7 clinicians including Orthopaedic Consultants, MSK ACPs and Consultants in Sports Medicine from DHC, UHD and DCH.

The idea behind the project was that focussing on one simpler procedure would allow for more patients to be treated. With fantastic support from the nursing team at Blandford Hospital in the Portman Unit, 42 patients were treated with Supra Scapular Nerve Blocks (SSNBs) for shoulder pain in comparison to a traditional mixed theatre list of 8 in a day.

Operational and admin support was critical to provide the anticipated efficiencies. This included new procedure note templates specific for SSNBs for faster completion, prepped trays for the injections, specific staff roles to help patient flow quickly, new patient leaflets and new consent forms for specific details around SSNBs.

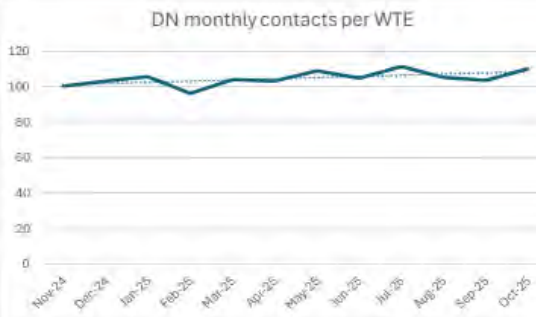
Both staff and patients were hugely positive about the day. Patients were able to receive pain relief for their shoulder pain and were very thankful. Staff were “buzzing” and asking for “more days like this”.

The waiting list initiative not only reduced waiting lists but brought about a significant system approach for treating shoulder pain. From the day, 5 clinicians learnt how to carry out SSNBs. The benefit of networking was substantial and new pathways are already being explored including the newly trained clinicians carrying out SSNBs whilst patients await shoulder surgery resulting in less referrals to the Dorset Pain Management Service and people living in less pain.

Comments received:

- “Excellent day. Lots of intangible gains from getting together with the wider team. Really enjoyed it”- Orthopaedic Consultant
- “Thank you for my injection. I could see that everyone was working so hard”- Patient

Contacts FTE in community nursing



In Oct 25 there was an average of 110 contacts per WTE for District Nursing staff. There has been an increase in contacts per wte over the last year. One of the major factors contributing to this is the continuing rise in insulin administration in the community setting. There has been an increase of 170 visits per day for insulin administration since Oct 24.

Service Director Commentary

We have seen a sustained improvement in reducing the number of patients waiting for a community appointment and there are no patients waiting longer than 52 weeks. We are starting to focus on next years performance standards when we will see 18-week Referral to Treatment (RTT) targets applied to community services for the first time.

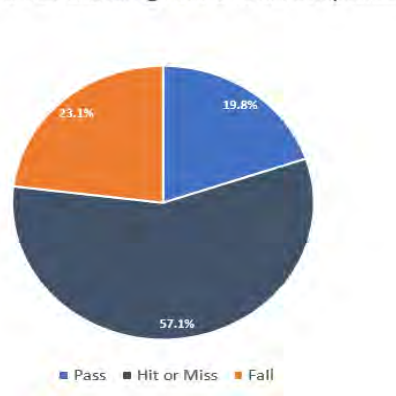
DHC performance against the diagnostic standard has recovered and is performing well against our plan. Significant work continues towards achieving the required new quality accreditation (IQUIPS) requiring considerable clinical resource, this will continue with assessment dates now in diaries in Q4.

The new national IUCS metrics are embedding locally, with benchmarking confirming the Dorset performance in the top quartile for several of the metrics. Moving forward focused work continues to improve clinical call back times, and disposition validation.

CYP, All Age Mental Health & Learning Disability Services – Operational Performance Summary October 2025 (M07)

Overview of Operational Performance/KPI Metric Summary

CYP&F and All Age MH & LD KPI Compliance



There are 182 reportable metrics across All Age MH&LD, CYP and S2W Services. 91 have a measurable target. In October 64.5% of reportable metrics are on target (60/91). Slight decline due to some DQ issues being addressed.

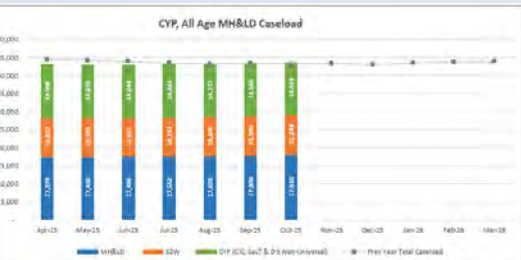
All Age MH&LD: 23/49 (impacted by DQ Issues)
CYP: 27/30
S2W: 10/12

The rest are monitored monthly as agreed Operational priorities by the DMG/ICB. These are a mixture of activity based and non-targeted metrics.

Metrics specific to the NHS Long Term Plan (LTP) are also reported from Future NHSE reporting platform.

Exception summaries and action plans are in place for those off track some of which are part of longer-term transformation /development plans.

Caseload Summary



There are on average 43,207 people (including CYP) caseload each month, this is approx. 5.2% of the Dorset Population (827,116; Diis).

Finance: (Brackets) = favourable variance

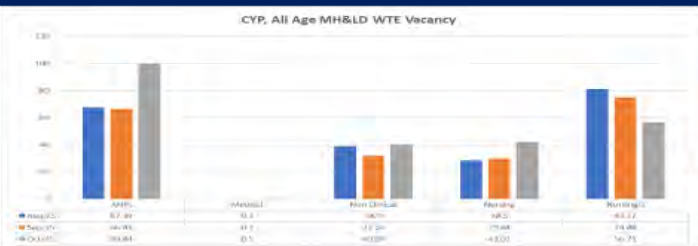
Financial Summary £m				
Annual Budget	YTD Budget	YTD Actual	YTD Variance	FOT Variance
126.1	72.9	74.8	1.9	1.0

The finance summary provides a combined overview of CYP, MH&LD

The YTD variance is attributable to

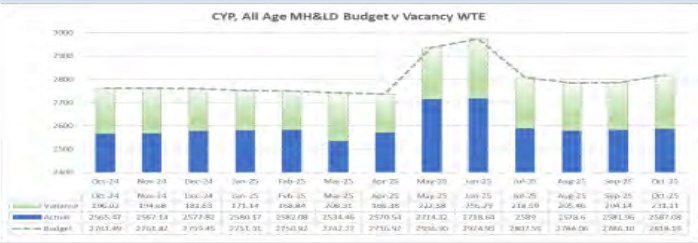
- 1.5 MH Services
- 0.4 CYP Services

Workforce



The vacancy rate is 8.2% (231.11 WTE) based on a contracted 2587.08 WTE.

- CYP 0-19 PHS: 13.35 WTE
- CYP SaLT: -0.88 WTE
- IC: 0.61 WTE
- NHSP: 0 WTE
- CAMHS: 32.43 WTE
- Medical: 0 WTE
- Prim & Psych: 56.64 WTE
- LD & Pro Collab: 87.5 WTE
- Secondary Comm: 59.1 WTE
- High Acuity: 131.7 WTE



Activity Summary

Referrals	24/25 YTD	25/26 YTD	Growth Actual	Growth %
MH&LD	27,412	27,769	357	1%
Steps to Wellbeing	18,913	19,221	308	2%
CYP&F Referrals	2,320	2,736	416	18%
Total	48,645	49,726	1,081	2.2%

Contacts	24/25 YTD	25/26 YTD	Growth Actual	Growth %
MH&LD	156,545	153,867	-2,678	-2%
Steps to Wellbeing	125,682	124,354	-1,328	-1%
CYP&F	99,393	88,657	-10,736	-11%
Total	381,620	366,878	-14,742	-4%
MH Activity not Flowing	56,722	79,676	22,954	40%
Overall total	438,342	446,554	8,212	1.9%

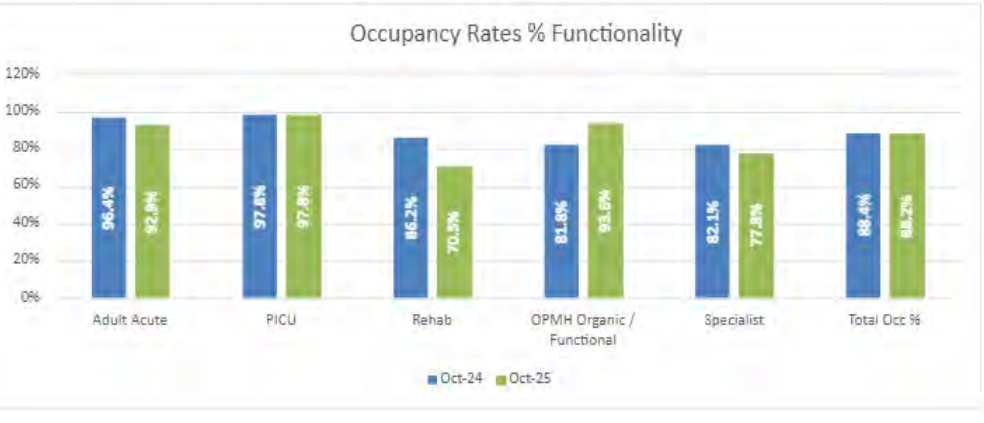
YTD M7 activity is 1.9% (+8,212) growth in contacts compared to M7 24/25.

YTD M7 referrals 2.2% (+1,081) compared to M7 24/25

The services that do not use a viable system as their patient record or clinics with no associated referral that enables the data to be flowed is shown as "Activity not Flowing".

Service Director Commentary

- Services continue to demonstrate resilience and progress against key operational priorities.
- Caseloads remain stable, with an average of 43,207 individuals supported monthly, representing 5.2% of the Dorset population.
- Year-to-date (YTD) activity shows 1.9% growth in contacts and 2.2% growth in referrals compared to the same period last year, reflecting sustained demand and service accessibility.
- Performance against KPIs remains strong, with 64.5% of reportable metrics on target (60/91), although there has been a slight decline due to ongoing data quality improvements.
- CYP services are performing particularly well, achieving 27 out of 30 targets, while adult MH&LD services are addressing areas impacted by data quality issues through agreed action plans.
- Inpatient flow remains challenging, with adult acute occupancy at 92.9% and average length of stay at 96 days, exceeding the operational threshold of 86 days.
- Out-of-area placements are being managed effectively, with block-purchased beds at Southampton Priory fully utilised.
- Inappropriate placements and clinically ready-for-discharge patients (13.1% of adult acute beds) highlight ongoing system pressures and the need for continued collaboration with partners to improve discharge pathways.
- Financial performance shows a favourable variance overall, driven primarily by MH services, with CYP services contributing positively.



Occupancy Rates:

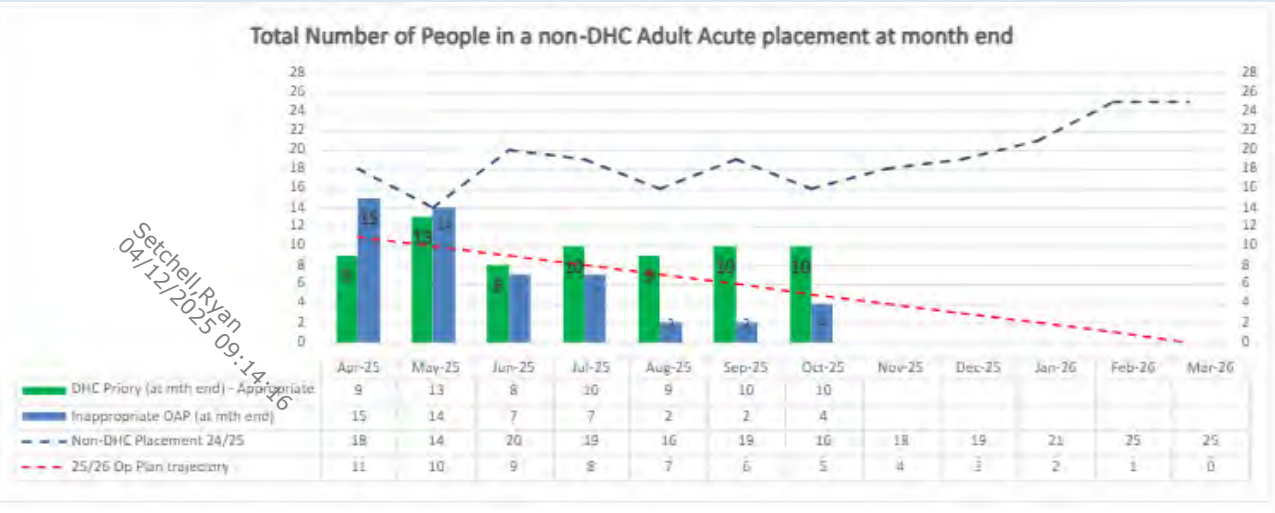
- There were 6293 bed days available in October 25, (excl. Marchwood Priory)
- 5551 were Occupied during the month for an overall Occupancy Rate of 88.2%
- Adult Acute Occ. Rates remain consistently high at 92.9% (Incl. Melstock Discharge Ward, which is now under Adult Acute and impacts on overall occ. rate for adult acute)

Average Time Spent on a Ward:

- This differs to Length of Stay which is based on Hospital Episode (total time from admission to discharge irrespective of internal movement/transfers) compared to the same period in 24/25).
- 25/26 Operational Planning Adult Acute Average LOS (3-month rolling period) was 96 days in Oct against an in-month threshold of 86 days.

Av. Time On Ward (Days)	YTD Mean 24/25	YTD Mean 25/26	Growth (Days)	% Growth	25/26 YTD Median	25/26 YTD Mode
Adult Acute	69	62	-7	-10%	33	14
AAU Seaview	27	22	-5	-18%	15	14
Chine Ward	49	60	11	23%	30	15
Harbour Ward	90	69	-22	-24%	33	16
Melstock House	100	85	-15	-15%	64	17
Waterston Acute Assessment Unit	80	76	-4	-5%	38	14
OPMH Organic/Functional	88	118	32	38%	77	#N/A
Alumhurst Ward	86	118	32	38%	77	60
Herm	147	82	-65	-44%	81	0
St Brelades	190	65	-125	-66%	58	89
PICU	37	40	3	8%	17	#N/A
Psychiatric Intensive Care Unit - F	39	43	4	10%	16	7
Psychiatric Intensive Care Unit - M	36	38	2	5%	19	14
Rehab	217	251	34	16%	173	#N/A
Glendinning Unit	177	264	87	49%	151	10
Nightingale House	257	239	-19	-7%	195	141
Specialist	83	173	84	94%	81	8
Kimmeridge Court	101	147	46	46%	82	8
Pebble Lodge	73	129	57	78%	81	2
Perinatal In-Patient Mother's Ward	49	49	1	1%	38	8
Twynham Ward	135	368	233	173%	474	43
Total	102	116	14	13%	81	14

Out of Area Placements (OAP) No. of Patients Admitted



Supporting Commentary

Out of Area Placements:

- **Appropriate Placements:** As of 31 October, there were ten patients admitted to the Priory. There were seven admissions in month and seven discharges. A total of 314 Occupied Bed Days were utilised.
- **Inappropriate Placements:** As of 31 October, there were four patients admitted to other OAP providers. There were five admissions in month and three discharges for 166 OBDs.
- The 10 block purchased beds at Southampton Priory are being appropriately and fully utilised.
- **CRfD:** In October a total of 47 patients were identified as being Clinically Ready for Discharge (CRfD) for a total of 400 OBDs. This was 13.1% of adult acute beds (104 beds).

Report to	Board of Directors	
Date of Meeting	9 th December 2025	
Report Title	Integrated Board performance report	
Prepared By	Adam Savin, Director of Operational Planning and Performance	
Approved by Accountable Executive	Anita Thomas, Chief Operating Officer	
Previously Considered By	Anita Thomas, Chief Operating Officer Claire Abraham, Deputy Chief Finance Officer Emma Hallett, Deputy Chief People Officer Emma Hoyle, Deputy Director of Nursing	
Action Required	Approval	-
	Assurance	X
	Information	-

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? <i>Delete as required</i>	
Care	Yes	
Colleagues		No
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 Safety and Quality SR4 Capacity and demand	
Financial	Reporting against financial key indicators	
Statutory & Regulatory	Reporting against, constitutional and contractual standards	
Equality, Diversity & Inclusion	N/A	
Co-production & Partnership	N/A	

Executive Summary
The Trusts Integrated performance report pulls together each of the domains within the NHS Oversight Framework and provides tend data, analysis and actions for each of the metrics the trust is measured on, within the framework. All indicators are covered in detail in the respective sub-board committees and therefore, this paper does not attempt to duplicate the committees work or the deep dives, but rather provider an oversight of them combined. The pack of Board papers include the sub-board committee escalation reports, which have been written by each Chair and in conjunction with this report, provides the opportunity for triangulation. Key Highlights: Access to Services: - Cancer care metrics show improvement in the 28-day diagnosis standard (74.5% in October) and progress toward the 62-day treatment trajectory, despite backlog challenges. - Elective care performance remains broadly on plan, with significant gains in reducing 52+ week waiters and maintaining 18-week trajectory. - Urgent and Emergency Care met the 4-hour standard trajectory in October (81.99%), though 12-hour breaches remain a concern, primarily due to bed availability. Effectiveness and Experience: - Flow improvements noted, with reduced delays for discharge-ready patients, supported by initiatives like the Transfer of Care Hub. Process mapping of current discharge arrangements and identification of Quality Improvements is in progress, and in response to patient feedback via the National Inpatient Survey.

- o Patient experience scores remain stable and largely in line with sector benchmarks, with targeted quality improvement plans in place. Quality Improvement work is underway in relation to inequalities and experience of access for inclusion health groups and in accordance with EDS2 priorities.
- o SHMI mortality indicator remains “as expected” at 1.01.
- **Finance and Productivity:**
 - o Combined financial score is 2 (above average), reflecting alignment to plan despite a planned £9.8m deficit.
 - o Year-to-date variance to plan is minimal (0.01%), but delivery of efficiency programmes in Q3/Q4 is critical.
 - o Productivity performance is generally strong, though cost growth in July requires investigation.
- **Patient Safety:**
 - o Staff survey scores for raising concerns remain above average, supported by Freedom to Speak Up initiatives.
 - o Infection rates for C. difficile and MRSA are at multi-year lows, though Klebsiella cases exceed thresholds and are under active review against a very low threshold for 25/26.
- **People and Workforce:**
 - o Staff engagement scores remain above average, supported by initiatives from the People Promise Exemplar Programme.
 - o Sickness absence is stable at 4.4%, below national average, with mental health-related absence as the leading cause.

Recommendation

Members are requested to receive the report for **assurance**.

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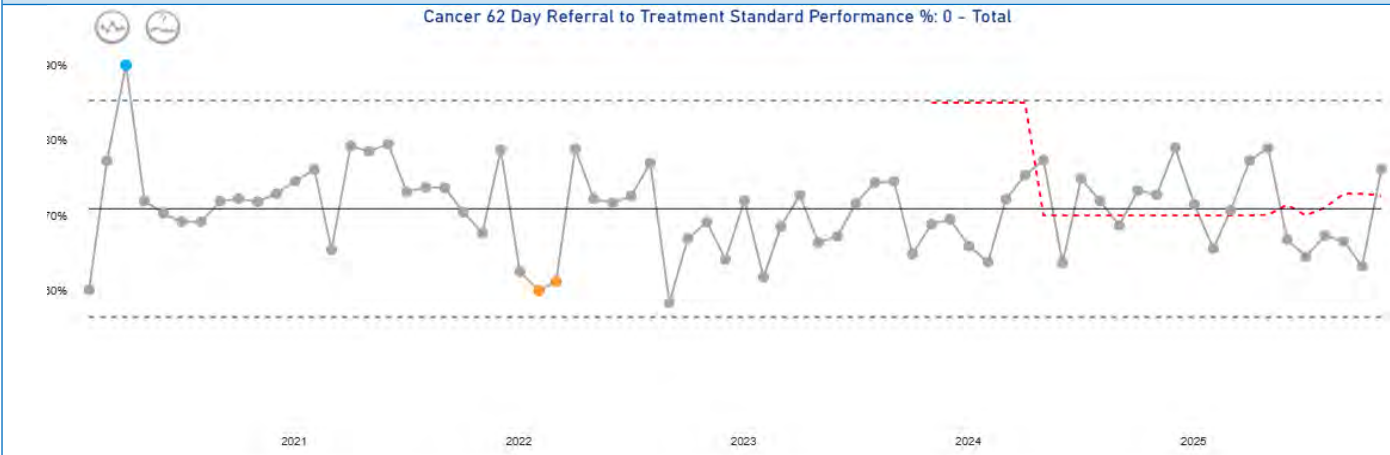
1. Introduction

This paper replaces the previous Balanced Scorecard report for Dorset County Hospital (DCH). It pulls together each of the domains within the NHS Oversight Framework and provides trend data, analysis and actions for each of the metrics the trust is measured on, within the framework.

The first iteration of this paper went to the October Board meeting and contained details on the NHS Oversight Framework 2025 and the first quarter review (the league tables) which was published in September 2025. Quarter 2 results have not been published, so there is no update to the league table. For this reason, to avoid repetition, the league table has been removed from this paper. Where DCH has updated data for the metrics within the NHS Oversight Framework, they have been updated, along with supporting narrative.

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Domain: Access to Services. Sub domain: Cancer care. Measure: Percentage of patients treated for cancer within 62 days of referral.



Description of metric

Percentage of patients treated for cancer within 62 days of referral.

Contractual target 85%, but 2025/26 planning guidance trajectory is 75% by March 2026.

Analysis

Performance of the 62-day combined standard did achieve the trajectory in October. The challenges at the start of the pathway (28-day standard) for much of this year have been impacting on the delivery of the 62-day standard. Improvements of the 28-day standard have meant cancer has been diagnosed earlier in the pathway and thus leading to a quicker treatment date.

Metric	Ops plan 25/26	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
Cancer: 62 RTT (combined)	Plan	70.08%	71.43%	70.00%	71.03%	72.90%	72.88%	72.66%
	actual	78.97%	66.54%	65.22%	67.60%	64.96%	63.60%	75.70%
	variance	8.89%	-4.89%	-4.78%	-3.43%	-7.94%	-9.28%	3.04%

In October, the backlog (62-103 days) increased by 5 to 61, and the backstop (over 104 days) increased by 1 patient to 13. The total waiting list size has decreased by 225 patients in the last two months. November is expected to be above 74%.

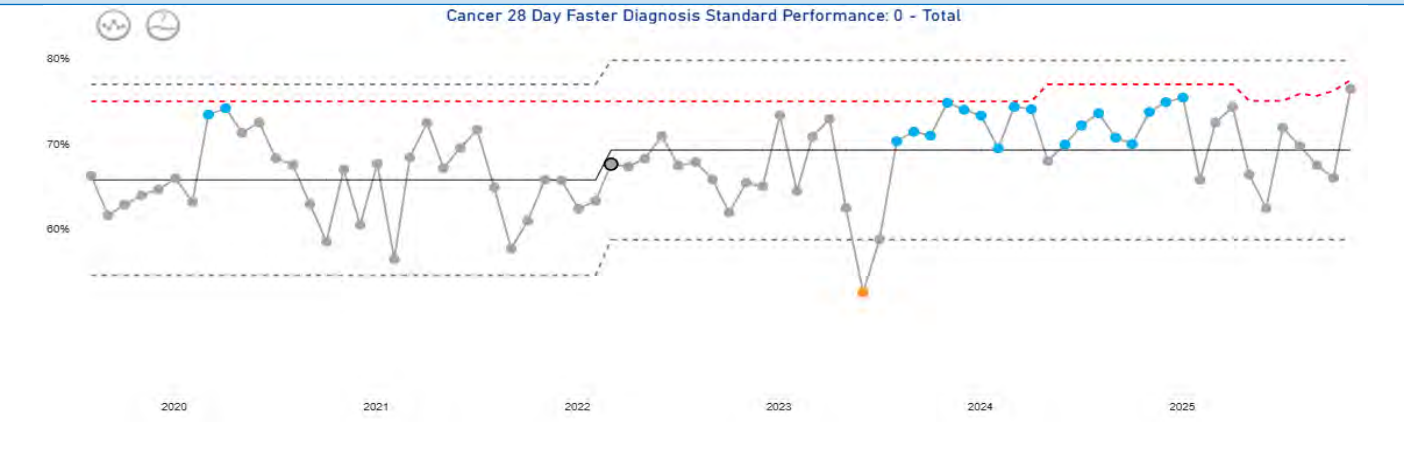
Actions

For patients that breach the 104-day backstop, on a 62-day pathway, a full route cause analysis is completed, which includes a harm review.

Tumor site pathway reviews underway, to identify barriers that are delaying getting to treatment.

Pathway analysis, which was reported last month, has shown that earlier escalation of backlogs at tertiary providers would improve performance. Inter-provider touch points have been put in place, so this is isn't reliant on just reporting/emails.

Domain: Access to Services. Sub domain: Cancer care. Measure: Percentage of urgent referrals to receive a definitive diagnosis within 4 weeks.



Description of metric

Percentage of urgent referrals to receive a definitive diagnosis within 4 weeks (28 day standard).

Contractual target 80%, but 2025/26 planning guidance trajectory is 80% by March 2026, rather than each month of the year.

Analysis

Performance of the 28-day standard improved in the reporting month of October to 74.50%. The 28-day standard has been impacted by an increase in demand of 4.92%. Demand compared to 2024/25, is 17.28% up.

Metric	Ops plan 25/26	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
Cancer: 28 days FDS	Plan	75.07%	75.04%	75.06%	75.89%	76.65%	76.23%	77.51%
	actual	66.58%	62.43%	71.90%	69.80%	67.40%	65.50%	74.50%
	variance	-8.49%	-12.61%	-3.16%	-6.09%	-9.25%	-10.73%	-3.01%

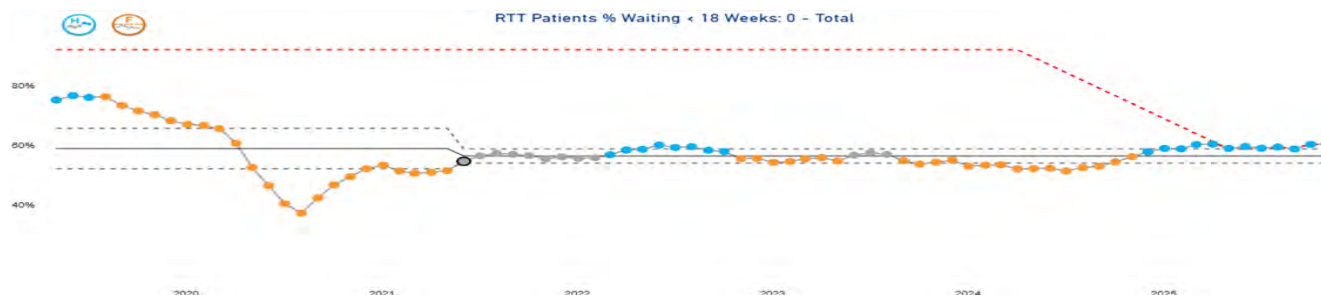
Performance has improved by nearly 10%, driven by a return of key personnel from sick leave. November performance is expected to be above 70%.

Actions

- Insourcing where demand is outstripping capacity at the front of the pathway.
- Reviewed and changed booking process in Endoscopy, to ensure cancer pathways are taking priority. This was implemented in September, with the booking team being centralised with the Admissions team.
- Patient level pathway tracking in place, proactivity unblocking barriers and pulling patients through the pathway.
- Earlier escalation of capacity short fall for first OPA.

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Domain: Access to Services. Sub domain: Elective Care. Measure: Difference between planned and actual 18 week performance and Percentage of cases where a patient is waiting 18 weeks or less for elective treatment



Metric	Ops plan 25/26	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
RTT: %patients waiting <18wks	plan	58.70%	58.70%	58.70%	58.70%	59.00%	59.50%	60.37%
	actual	58.90%	59.59%	58.98%	59.40%	58.69%	60.20%	60.38%
	variance	0.20%	0.89%	0.28%	0.70%	-0.31%	0.70%	0.01%

Description of metric

Difference between planned and actual 18-week performance:

Hit or miss planning trajectory, as per the operating plan.

Percentage of cases where a patient is waiting 18 weeks or less for elective treatment:

Contractual target 92%
Planning guidance target, 63.89% by March 2026

Analysis

DCH slightly missed the target in August but otherwise has hit the trajectory for every month of the year.

Performance against the standard is impacted by demand (referrals) and activity delivered (clock stopping activity). A 4% referral growth factor was applied as part of the operating plan. For 2024/25 total referral demand growth was over 6%. Total referrals year to date, April-October are 4.19% up compared to last year. Demand April-October this year, compared to 2023/24 is 14.03% up and the primary cause of the waiting list growth.

Year to date, the trust has completed 6,906 more first outpatient appointments than planned, as part of a push to hit zero 52+ week waiters (non-admitted). This is the main driver for improved 18 weeks performance at DCH.

November trajectory is expect to be met.

Actions

The trust has been on plan for this metric for every month, apart from August.

Actions taken to ensure future months continue to deliver included:

Focus on validation of pathways over 18 weeks, not just those over 52 weeks.

Ensuring activity is targeted in the correct way, that booking is following clinical order, followed by chronological order.

Where diagnostic tests have been completed, proactively chase clinical review for next steps, supported by the validation team.

Domain: Access to Services. Sub domain: Elective care. Measure: Percentage of patients waiting over 52 weeks for elective treatment

Metric	Ops plan 25/26	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
RTT: 52wk wait	plan	431	410	390	369	348	327	306
	actual	448	439	377	368	365	303	283
	variance	17	29	-13	-1	17	-24	-23
RTT: 52wk cohort % of Waiting List	plan	2.00%	1.90%	1.80%	1.70%	1.60%	1.50%	1.40%
	actual	1.99%	1.94%	1.68%	1.64%	1.64%	1.42%	1.33%
	variance	-0.01%	0.04%	-0.12%	-0.06%	0.04%	-0.08%	-0.07%
RTT: 52wk wait CYP	plan	50	45	40	20	10	0	0
	actual	57	48	44	20	34	24	21
	variance	7	3	4	0	24	24	21

Description of metric

Percentage of patients waiting over 52 weeks for elective treatment

Contractual standard is zero, 52+ week breaches

Planning guidance requests less than 1% of the waiting list waiting over 52+ weeks by March 2026.

Analysis

For October, DCH were 23 patients better than plan. The proportion of the waiting list that is waiting over 52+ weeks, was 0.07% better than plan. This position is expected to be maintained for November.

There was one 65+ week breaches in October due to patient choice.

There is expected to be zero breaches in November.

Actions

Every patient in month, that is over 52 weeks, is reviewed (validated) weekly. This enables proactive pathway management.

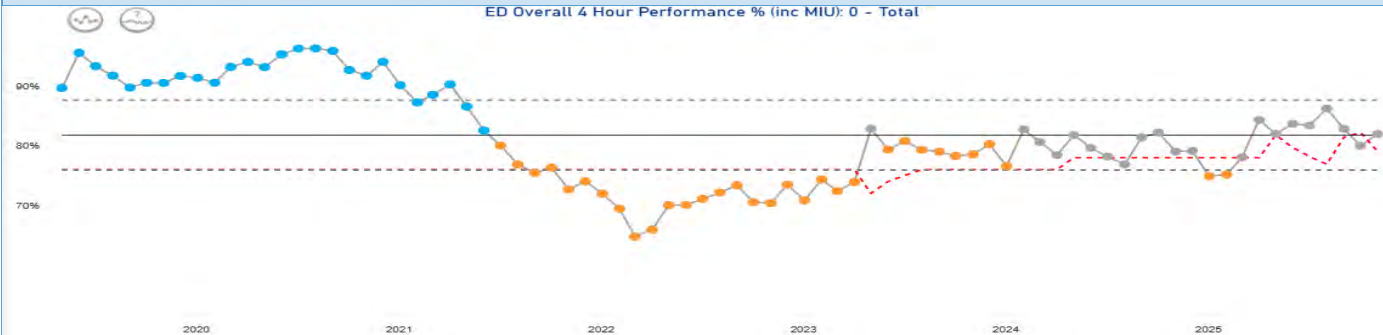
Total cohort is modelled against activity plans and reviewed monthly via the Elective Performance Management Group.

All patients on the waiting list are contacted to confirm they what to remain on the waiting list, once every 12 weeks.

Patients with a confirmed date for surgery are contacted 7 days before to confirm nothing has changed i.e. fitness. This ensures capacity is maximised by avoiding some on-the-day cancellations.

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Domain: Access to Services. Sub domain: UEC. Measure: Percentage of emergency department attendances admitted, transferred or discharged within four hours



Description of metric
Percentage of emergency department attendances admitted, transferred or discharged within four hours.

Contractual target 95%

Planning guidance, 78% monthly

Metric	Ops plan 25/26	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
A&E 4 hour wait %(all)	plan	81.80%	79.64%	78.18%	76.89%	81.43%	82.22%	79.03%
	actual	82.00%	83.7%	83.4%	86.3%	82.8%	79.9%	81.99%
	variance	0.20%	4.05%	5.22%	9.41%	1.37%	-2.34%	2.96%

Analysis

Performance against the 4-hour standard (including UTC's) in September did not meet the trajectory due to the increase demand however, this was recovered in October, with performance 2.96% better than plan at 81.99%. The national planning guidance required a minimum of 78% for 2025/26.

The monthly performance trajectory has been phased to match seasonal variation the full year aggregate delivers 78%.

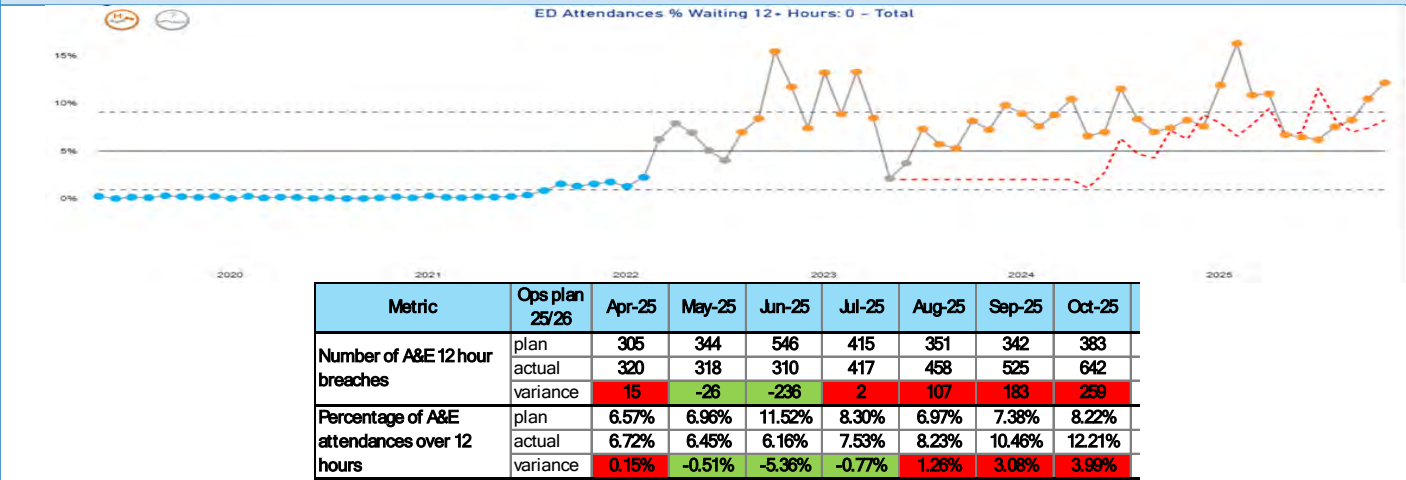
Attendances year to date (April- October) are 8.32% up compared to last year. October had the highest growth factor year to date, with 15.08% more attendance than October 2024. A projected growth rate of 1.8% was applied in the Operating Plan. With 8.32% growth year to date, the Trust has recorded 2,466 more attendances than was set out in the Operating plan.

Actions

4-hour standard is meeting trajectory.

Demand has been escalated to all system partners and brought to the attention of NHSE, as part of the Regional Performance meetings.

Domain: Access to Services. Sub domain: UEC. Measure: Percentage of emergency department attendances spending over 12 hours in the department



Description of metric
Percentage of emergency department attendances spending over 12 hours in the department.

Contractual target- the isn't one for 2025/26

Planning guidance: a higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25

Analysis

Since July, the Trust has had more 12 hour breaches than the trajectory and since August, it has been in excess of the percentage of attendance that went on to be a 12 hour breach.

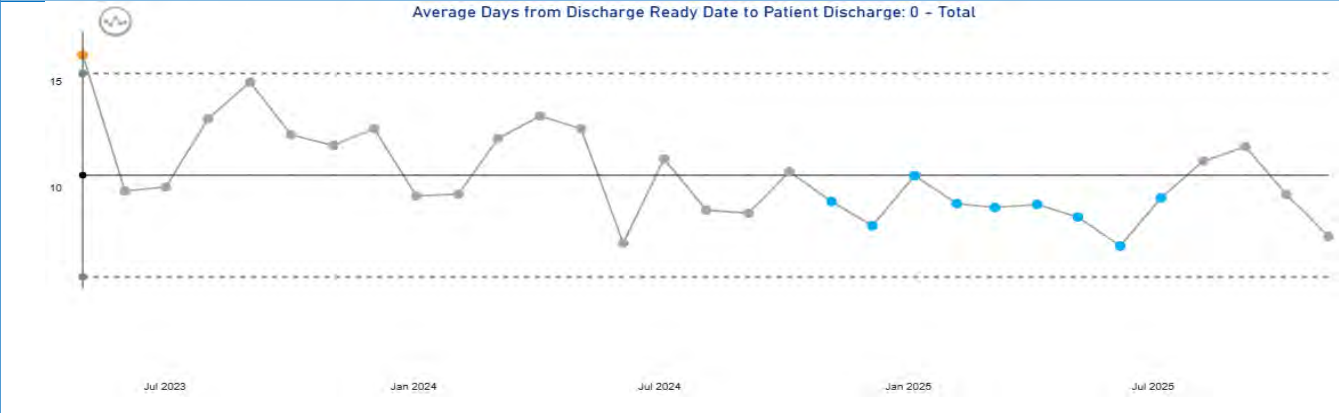
Of the 642 12-hour breaches in October, 518 went on to be admitted. Whilst this indicates a need for bed, data supports that during periods of high pressure in ED, referrals to admit increase.

Actions

- Performance against the headline metric of the 4-hour standard is meeting our provider trajectory and the national minimum requirement of 78%.
- 12-hour breaches are not meeting plan and an area of concern. The largest cause of these breaches is waiting for a bed, however, there are improvements that can be made where patients breach 12 hours but are not admitted.
- The trust will move to managing a cumulative score for the day on the bed reports and discuss more specifically actions we could take to prevent 12/24 hr waits in the 3 times a day bed meeting.

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Domain: Effectiveness and experience. Sub domain: Flow. Measure: Average number of days from discharge ready date to actual discharge date (including zero days)



Description of metric

This measures the extent of delays experienced by patients who are medically ready for discharge but are not able to be discharged from hospital.

The average delay to discharge, from when the patient is ready for discharge to the date of discharge.

Analysis

There has been improvements in this metric, with the number of patients with NRTR reducing in November and an improved flow for p1 (home with care) patients.

LoS was 2.5 above plan in October, an improvement against the last three months. A higher than planned LoS limits the number of times a bed can be turned round and thus, increase the overall bed stock need.

The proportion of patients that are converting to a no criteria to residue status has increased by 2%. Admissions have increased by 8% since last year, with 698 more admissions than the operating plan. The combined effect results in the non-elective LoS being over plan.

Metric	Ops plan 25/26	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
Non-elective average LoS (excl 0 LoS and HAH)	Plan	8.2	7.5	8.3	7.6	7.8	7.7	8.3
	actual	10.22	11.1	10.7	11.1	10.6	10.5	10.8
	variance	2.02	3.6	2.4	3.5	2.8	2.8	2.5

Actions

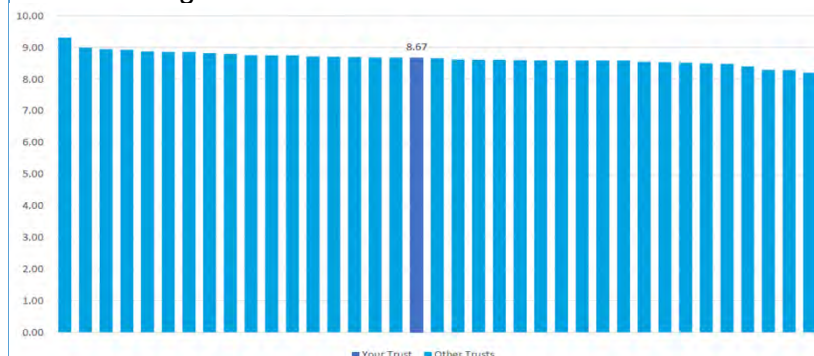
Escalation to all system partners, with Executive involvement for patients with extended length of stay.

FutureCare programme, with admission avoidance schemes and the introduction of the Transfer of Care Hub, which is now fully operational.

Roll out criteria led discharge and standardised board rounds.

Domain: Effectiveness and experience. Sub domain: Patient experience. Measure: CQC inpatient survey satisfaction rate

Overall Rating 8.67



Description of metric

2023 – 2024 Survey

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

Analysis

473 completed questionnaires were returned from the sample of 1105. The final response rate for the Trust was 45%.

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

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

Actions

Quality improvement plans are developed alongside divisional head of nursing, divisional quality and governance leads and other stakeholders relevant to the specific survey. The following focus areas have been identified as part of the quality improvement plan:

Care - improve quality of inpatient care through measures taken to ensure information about how they can get support and raise concerns are well communicated with processes in place to ensure access to basic daily needs.

Discharge - improve communication with patients around discharge, ensuring the patient, family / carer are involved in conversations around discharge and support post discharge

Admission - improve communication around waiting times and admission alongside work going on to reduce waiting lists.

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Domain: Effectiveness and experience. Sub domain: Patient experience. Measure: Summary Hospital Level Mortality Indicator.		
SHMI Value (5 months in arrears)		Description of metric SHMI is calculated by comparing the number of observed (actual) deaths in a rolling 12-month period to the expected deaths (predicted from coding of all admissions).
Analysis SHMI is published by NHS Digital for a 12-month rolling period, and 5 months in arrears. It takes into account all diagnostic groups, in-hospital deaths, and deaths occurring within 30 days of discharge. It is calculated by comparing the number of observed (actual) deaths in a rolling 12-month period to the expected deaths (predicted from coding of all admissions). The latest SHMI publication is for the period Jun 2024-May 2025. The trust's SHMI value is 1.01 which is as expected.	Actions DCH business intelligence team have produced a dashboard which predicts our SHMI aiming to give assurance and the chance to act early if we see a predicted rise in SHMI. DCH's depth of coding is 5.4 for elective admissions and 5.8 for non-elective admissions. Both of these values are stable, but below the national average. The coding team continue with mitigations to achieve year end targets – namely the use of bank/agency coders up to the end of October and coding more from the electronic records (with conditions applied to ensure data quality is not effected). The depth of coding and impact on SHMI will continue to be monitored.	

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Domain: Finance and productivity. Sub domain: Finance. Measure: Combined finance

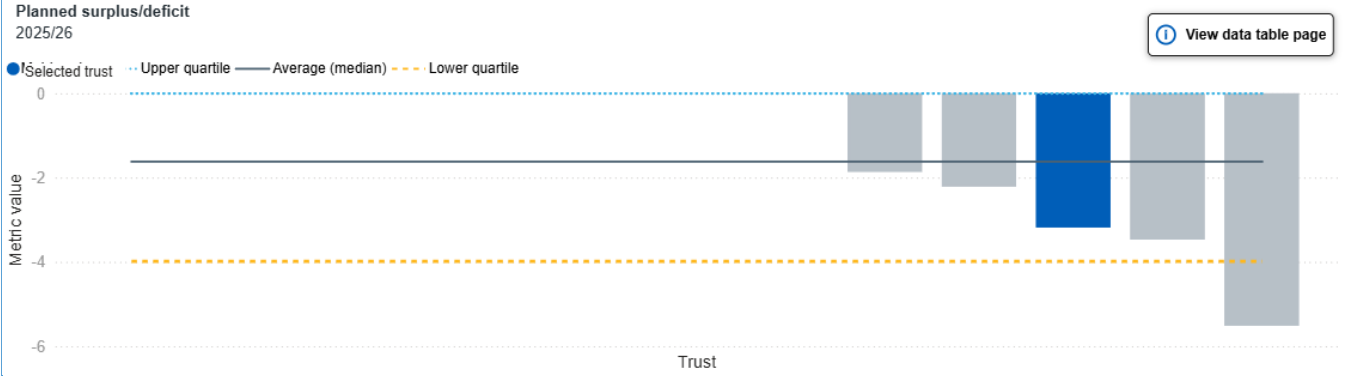
Financial Plan vs Actual 2025/26 Monthly surplus/(deficit) £'000 <table><thead><tr><th></th><th>M1</th><th>M2</th><th>M3</th><th>M4</th><th>M5</th><th>M6</th><th>M7</th><th>M8</th><th>M9</th><th>M10</th><th>M11</th><th>M12</th></tr></thead><tbody><tr><td>Plan</td><td>-2,323</td><td>-3,094</td><td>-2,292</td><td>-3,387</td><td>-3,190</td><td>-2,661</td><td>-671</td><td>-22</td><td>-469</td><td>1,562</td><td>2,585</td><td>4,201</td></tr><tr><td>Actuals</td><td>-2,279</td><td>-3,127</td><td>-2,297</td><td>-3,383</td><td>-3,192</td><td>-2,666</td><td>-497</td><td></td><td></td><td></td><td></td><td></td></tr></tbody></table>														M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Plan	-2,323	-3,094	-2,292	-3,387	-3,190	-2,661	-671	-22	-469	1,562	2,585	4,201	Actuals	-2,279	-3,127	-2,297	-3,383	-3,192	-2,666	-497						Description of metric The combined financial position of the organisation taking into account both planned and actual position metrics (these two individual metrics are detailed in slides below). Resulting in a score between 1 – 4 (1 being high performing, 4 being low performing) Updates on this score will only be provided quarterly, as the metric is only refreshed quarterly
	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12																																								
Plan	-2,323	-3,094	-2,292	-3,387	-3,190	-2,661	-671	-22	-469	1,562	2,585	4,201																																								
Actuals	-2,279	-3,127	-2,297	-3,383	-3,192	-2,666	-497																																													
Analysis The planned deficit score was a 4 and the actual YTD position against plan was a score of 1, these metrics when considered together have given a combined overall finance score of 2 indicating above average. In summary while our planned deficit of £9.8m is not the break-even Trusts are aiming for, at this point in year we are where we planned to be which is positive. The graph above details the Trust’s 2025/26 financial plan to reach £9.8m deficit plus the actuals achieved to month 7. No further data or ranking has been given against this metric.							Actions As this score is a combination of the following two metrics, actions have been listed against their individual metrics.																																													

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Domain: Finance and productivity. Sub domain: Finance. Measure: Planned surplus/deficit

The Trust showing blue against other providers in the South West region.



Description of metric

The overall level of planned surplus/deficit of the organization for the financial year once deficit support funding has been removed.

Metric calculates a score between 1-4 (1 being high performing and 4 being low performing).

This is an annual scoring metric based on the planned deficit, therefore no further updates will be given for this measure.

AnalysisActions

Due to the planned £9.8 deficit the resulting score was a 4 for the Trust, indicating low performance. A score of 4 recognises a performance of -2% or below when compared against other Trust’s surplus/deficit plans, the Trust plans stand at -3.18%. This was between the lower and average quartiles as detailed below:

Lower quartile	Average (median)	Upper quartile
-3.99	-1.62	0.00

The Trust placed 90th out of the 134 Trusts and 11th out of the 13 South West based Trusts, as the graph is showing above.

While this metric cannot be changed for the year as it is only calculated annually, work continues to identify areas of saving opportunity and address the underlying deficit.

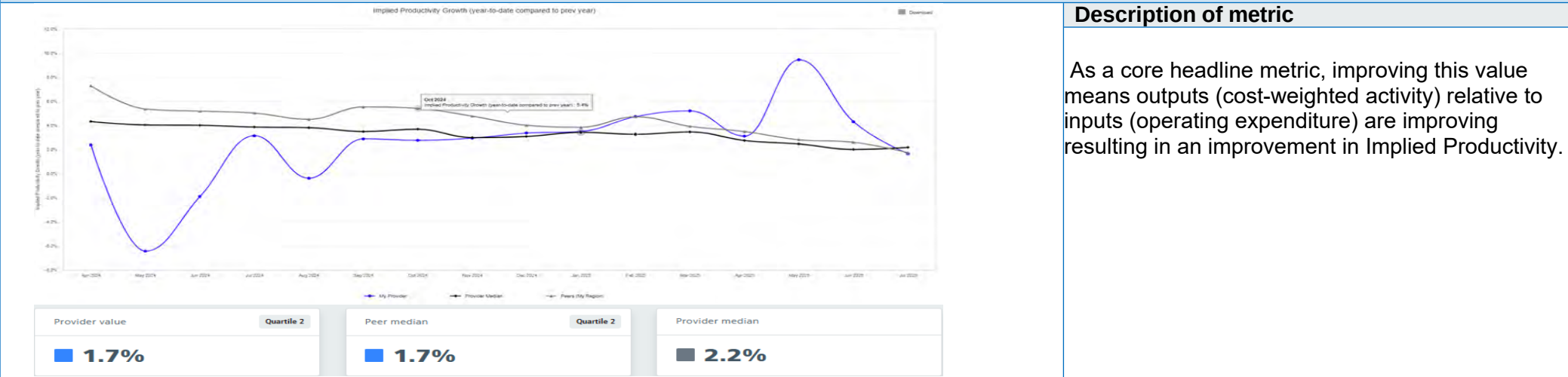
In addition, NHSE has commenced a data gathering exercise to establish if there are under and over funded Trust’s. While this exercise is still in progress and no conclusions can be given at this stage, DCH has previously flagged as possibly underfunded.

Further attention is being given within DCH to address both nationally set target areas and those internally highlighted as an area of opportunity to bring the Trust back into financial balance.

Domain: Finance and productivity. Sub domain: Finance. Measure: Variance year-to-date to financial plan								
Variance year-to-date to financial plan Month 3 2025 Selected trust Upper quartile Average (median) Lower quartile View data table page		Description of metric Percentage of variance of the actual financial position year-to-date when compared to the planned position. Metric calculates a score between 1-4 (1 being high performing and 4 being low performing) based on the % variance against plan. While timing differences and unexpected activity may lead to monthly variation, Trust is required to meet financial plans by the end of the year.						
Analysis Due to the Trust being on plan as at month 3 the resulting score was a 1 for the Trust, indicating high performance. A score of 1 recognises a Trust on plan or doing better, which is considered as anything higher than -0.5%, the Trust has a 0.01% variance to plan at month 3. This was between the average and upper quartiles as detailed below: <table> <tr> <th>Lower quartile</th><th>Average (median)</th><th>Upper quartile</th></tr> <tr> <td>-0.51</td><td>0.00</td><td>0.02</td></tr> </table> The Trust placed 35th out of the 134 Trusts, as indicated in the graph above, and 4th out of the 13 South West based Trusts.	Lower quartile	Average (median)	Upper quartile	-0.51	0.00	0.02	Actions The Trust is aligned to the financial plan as at month 3 but it should be recognised that there is a challenging CIP programme, required for the Trust to reach the planned £9.8m deficit, which is heavily weighted to quarter 3 and 4. Mitigations have been identified to close unidentified efficiency gaps and the Recovery Group is in place to ensure progression and delivery of CIP projects. Further actions to ensure delivery include: - Revisit all system workstreams clarity & pace, including unpalatables - Bring forward schemes consideration at pace/acceleration – E&F in train - WF enhanced controls – essential (bank/rostering/job planning/targeted freeze or delays) - Wider grip & control focus – controllable spend and overspending mitigations essential to remain in budget	
Lower quartile	Average (median)	Upper quartile						
-0.51	0.00	0.02						

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Domain: Finance and productivity. Sub domain: Productivity. Measure: Implied productivity level



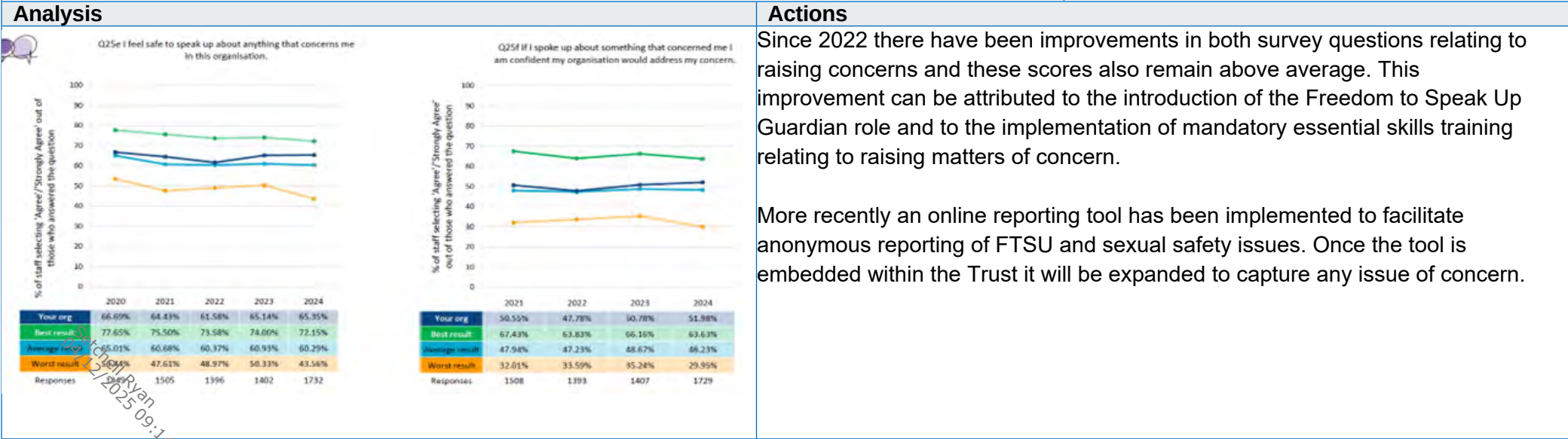
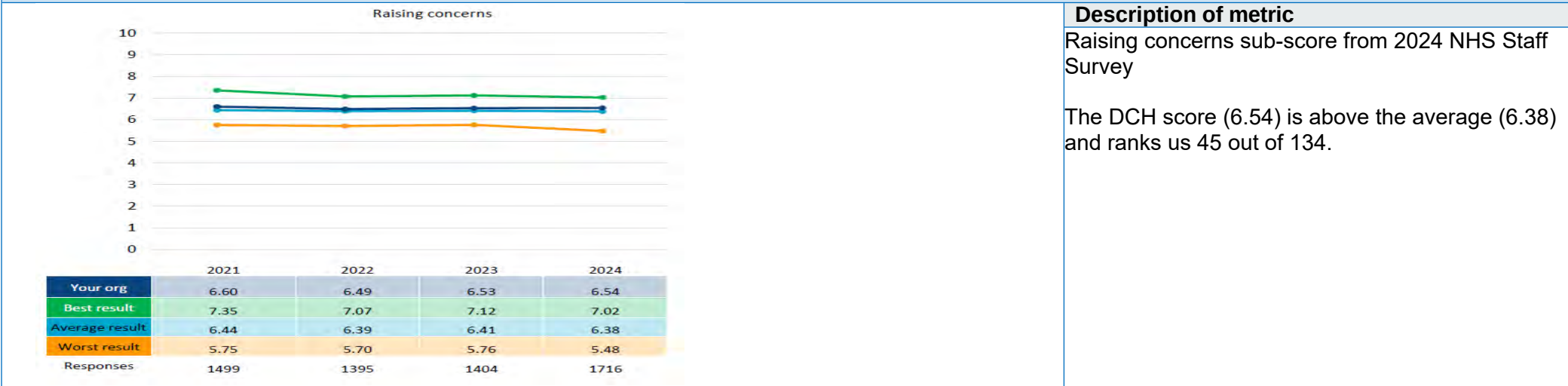
Analysis	Actions
Last date reviewed by FPC was July 2025: DCH is outperforming both the national and regional implied productivity growth metric for most of the financial year, but for July, was slightly below the national median and equal to the regional median. The national target is a 2% improvement on last year. It is important to note that elective activity plans for 2025/26 were lower than 2024/25, at the request of the national planning guidance. As shown in the table below, cost weighted activity growth (CWA) has increased compared to last year from month 2. This is because the trust is delivering more UEC activity, with ED attendances 8% up year to day. The drop in implied productivity in month 4, is driven by a shift in actual cost growth from 3.4% in month 3 to 7.4% in month 4. Despite the growth in front door activity, the trust had 305 occupied beds in	Proactive counting and coding exercise, working with clinical services to identify activity they are doing, which isn't being counted. Benchmarking clinic template design, through the GIRFT outpatients work, with the aim of increasing clinic slots. Early engagement with insourcing and outsourcing providers, to negotiation best possible rates. Delivery of identified CIP, drives improved implied productivity. The finance team are investigating the increase in real term cost growth for month 4.

month 4, compared to 312 in month 3 and 310 in month 2. The finance team are investigating the increase.

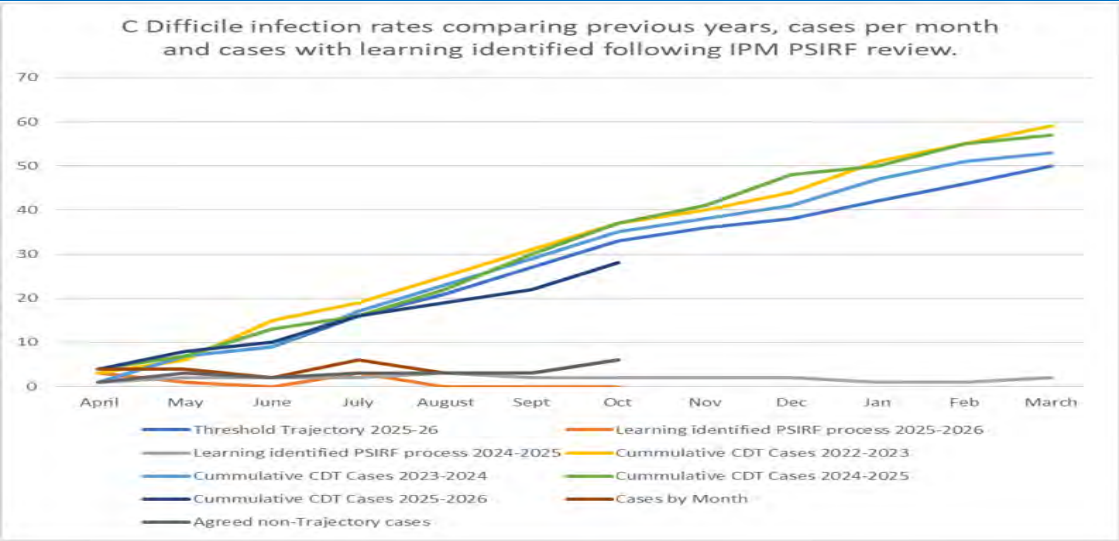
	M01	M02	M03	M04
CWA growth (pathway approach)	0.1%	2.0%	1.1%	1.9%
Real term cost growth	-3.0%	-6.9%	-3.0%	0.2%
Real term cost growth	-3.0%	-6.9%	-3.0%	0.2%
Actual cost growth	3.5%	-0.7%	3.4%	7.6%
Deflators	6.6%	6.7%	6.6%	7.4%
Implied productivity	3.1%	9.5%	4.3%	1.7%

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Domain: Patient safety. Sub domain: Patient safety. Measure: NHS Staff survey - raising concerns sub-score



Domain: Patient safety. Sub domain: Patient safety. Measure: Rate of C-Difficile infections

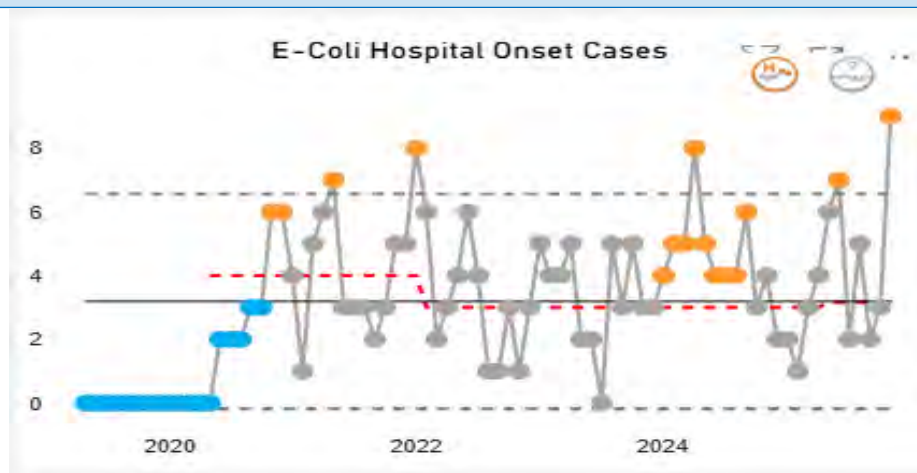


Description of metric
Number of trust apportioned *Clostridioides difficile* (C. diff) cases to be below the national trajectory for 2025/2026. The trust apportioned trajectory figures are 50 for 2025/2026.

Analysis	Actions
Current Reporting as of 31 October 2025 There have been 4 Hospital Onset Healthcare Associated (HOHA), and 5 Community Onset Healthcare Associated (COHA) C. difficile cases reported for September and October 2025. This brings the total of HOHA/COHA cases this year to 28. The graph below compares our figures for the last few years. All the cases have followed the IPC PSIRF (Patient Safety Incident Response Framework) review process. CDI cases for 25-26 have reduced compared to 24-25 case figures for the same time last year. Currently running at a 4-year low.	The IPC Education Framework sets out a vision for the design and delivery of IPC education that supports effective and safe care. The training has a strong Antimicrobial Stewardship (AMS) focus and feedback from the DCH training has been very positive. We are the first Trust in the Integrated Care System, and most of the Southwest, to implement this training using the tiered approach. The Antimicrobial Pharmacy Consultant as performs AMS training to all the new junior Dr's. The Infection Prevention Management team have started performing ward-based face to face scenario-based training.

Domain: Patient safety. Sub domain: Patient safety. Measure: Number of MRSA infections	
Gram Negative Blood Stream Hospital Onset Infections	Description of metric Number of Trust apportioned gram +ve BSI cases to remain low for 2025/2026. There is no trajectory figures set for gram +ve BSIs.
Analysis Current Reporting as of 31 October 2025 There were 1 Hospital Onset Healthcare Associated (HOHA) & 1 COHA (Community Onset Healthcare Associated) cases gram +ve BSI cases in September and October 2025. <i>In total there were the following HOHA/COHA cases in September and October 2025:</i> MRSA 0 Running total for this year 1. MSSA 2 Running total for this year 10. <i>Setchell, Ryan 04/12/2025 09:14:16</i>	Actions The IPM lead specialist nurse has joined the Southwest MSSA collaborative.

Domain: Patient safety. Sub domain: Patient safety. Measure: Rate of E-Coli infections



Description of metric

Number of trust apportioned gram-ve cases to be below the national trajectory for 2025/2026. The trust apportioned trajectory figures are to be 54 as a total for Gram-ve BSI for 2025/2026.

Analysis

Current Reporting as of 31 October 2025

There were 8 Hospital Onset Healthcare Associated (HOHA) & 6 COHA (Community Onset Healthcare Associated) cases gram -ve BSI cases in September and October 2025.

The trajectory levels for 2025/2026:

- *E. coli* 45
- *P. aeruginosa* 3
- *Klebsiella* spp 6

In total there were the following HOHA/COHA cases in September and October 2025:

- *E. coli* 10 Running total for this year 32.
- *P. aeruginosa* 1 Running total for this year 3.
- *Klebsiella* spp 3 Running total for this year 14.

Actions

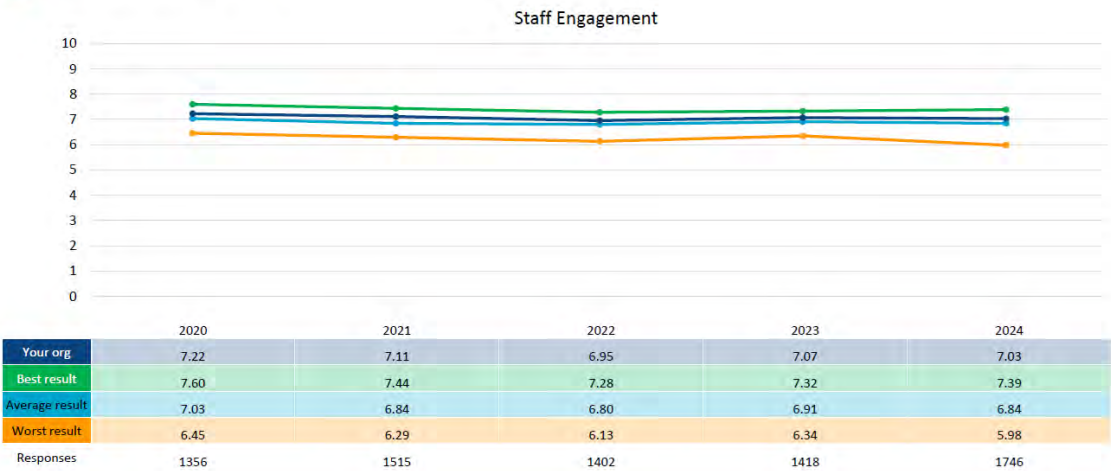
Gram -ve Klebsiella BSI cases are running above threshold level. DCH has a very low threshold figures for Pseudomonas and Klebsiella blood stream infections for 2025-2026. As mitigation for not remaining within these thresholds all Hospital Onset Healthcare Associated (HOHA) are investigated using the IPM PSIRF (Patient Safety Incident Response Framework) review process, and any learning is addressed, and quarterly reports are provided to the Patient Safety and IPM committees.

The IPM team are undertaking a quality improvement project to improve catheter insertion and monitoring documentation and have increased face-to-face teaching over the last few months. This includes ward-based scenario teaching, Doctor induction training and housekeeping training.

Domain: People and workforce. Sub domain: Retention and culture. Measure: NHS staff survey engagement theme sub-score



Theme: Staff Engagement



Description of metric

Engagement theme sub-score from 2024 NHS Staff Survey

The DCH score (7.03) is above the average (6.84) and ranks us 38 out of 134.

Analysis

Despite a small reduction from 2023 to 2024, the staff engagement score for DCH has improved since 2022 and remains above average.

Actions

DCH and DHC jointly participated in the second cohort of the People Promise Exemplar Programme, a 12-month programme focused on improving staff engagement. The programme ended in April 2025 but much of the work undertaken continues to positively impact engagement, including improved induction, management training and flexible working options.

More recent engagement actions have included the launch of a monthly joint briefing by the CEO and the introduction of the Inspire Awards, a quarterly joint recognition scheme. Of particular focus at present is encouraging participation in the 2025 staff survey which runs from 1 October to 28 November.

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Domain: People and workforce. Sub domain: Retention and culture. Measure: Sickness absence rate		
Sickness Rate (%) (1 month in arrears): 0 - Total Long and short term absence - last 12 months		Description of metric Average Sickness Absence Percentage Q4 24-25 The DCH score (4.5%) is below the average (5.2%) and ranks us 26 out of 134.
Analysis Sickness absence in Month 6 increased by 0.3% to 4.6%. The 12-month rolling sickness absence percentage is currently 4.4% Long term absence decreased in month to 2.1%. Short term absence increased to 2.5%. The top reason for absence remains Anxiety/Stress/Depression, accounting for a quarter of all absences every month.	Actions HR support is provided in the ongoing management of absence. A comprehensive health and wellbeing offer is in place for staff, including access to Occupational Health services, a 24/7 Employee Assistance Programme, expediated access to Physiotherapy and onsite counselling provision. Use of the onsite counselling provision remained stable over the past quarter and access to telephone counselling and the Employee Assistance Programme both increased. Over 90 Health and Wellbeing Champions are in place across the organisation, supported by the OD Team. In Month 7 the OD team also undertook activities to promote Menopause Awareness month and World Mental Health Day.	

Report to	Board in Common (DHC)	
Date of Meeting	9 th December 2025	
Report Title	Dorset HealthCare Finance Report for Month 7, October 2025	
Report Author	Michele King – Head of Management Accounts	
Approved by Accountable Executive	Chris Hearn, Joint Chief Finance Officer	
Previously Considered By	Finance & Performance Committee in Common 26/11/25	
Action Required	Approval	No
	Assurance	Yes
	Information	No

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? <i>Delete as required</i>	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR6: Finance	
Financial	Value for money and financial sustainability addressed in the report	
Statutory & Regulatory	Underpins long term financial sustainability and delivery of operational plan	
Equality, Diversity & Inclusion	No implications arising from the report	
Co-production & Partnership	System financial plan delivery	

Executive Summary
Key messages for the seven months ended October 2025 are as follows: - The Trust delivered an adjusted year-to-date surplus of £1.3m at month 7 which equates to a surplus of £0.6m against the plan submitted to NHSE for 2025/26 and breakeven to the H2 trajectory. - With the exception of corporate services, nurse executive and quality and integrated community services, all areas are overspent, with particular challenges around medical agency costs and unachieved savings. - The Trust has delivered savings of £9.3m against a month 7 ytd target of £9.7m. The Trust's full year efficiency target is £38.5m. - The forecast indicates an actual year-end deficit of £2.7m against a planned surplus of £9.77m. This assumes no further savings are found and spend continues at current rates. Actions: - Collectively work together to agree the actions to resolve the financial position at month 7. - Continue to identify recurrent savings.

Recommendation
The DHC Board is requested to receive the report for assurance .

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Trust Financial Performance Report

Month 7 2025/26 – October Summary

1. Summary

At the end of October two out of six KPIs are rated green.

KPI	RAG
Current Month Break Even	Green
Year to Date Variance to Plan.	Green
Forecast Outturn	Red
Year to Date Capital Spend against Plan	Red
Delivery of Savings Programme	Red
Better Payment Policy	Yellow

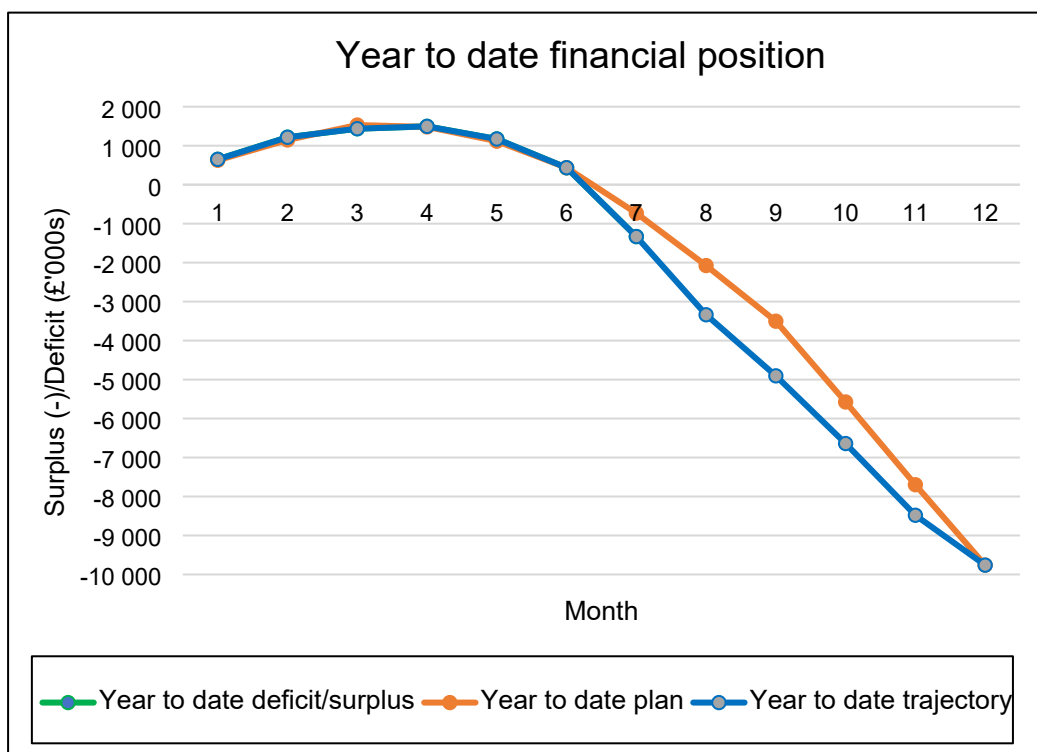
Key messages

- The Trust has three standard measures of financial performance: Income over expenditure, performance against NHSE Plan and, due to phasing of budgets different from NHSE plan, the budget plan.
- In addition to the above, the Trust is also being measured against a regional H2 trajectory.
- The Trust delivered an adjusted year-to-date surplus of £1.3m at month 7 which equates to a surplus of £0.6m against the plan submitted to NHSE for 2025/26 and breakeven to the H2 trajectory.
- With the exception of corporate services, nurse executive and quality and integrated community services, all areas are overspent, with particular challenges around medical agency costs and unachieved savings.
- The Trust has delivered savings of £9.3m against a month 7 ytd target of £9.7m. The Trust's full year efficiency target is £38.5m.
- The forecast indicates an actual year-end deficit of £2.7m against a planned surplus of £9.77m. This assumes no further savings are found and spend continues at current rates. There are mitigations in place that are monitored through the Financial Recovery Board.

2. Year to date performance

2.1 Summary

- The graph below shows that the Trust delivered an adjusted year-to-date surplus of £1.3m at month 7. This equates to a surplus of £0.6m against the plan submitted to NHSE for 2025/26 and is breakeven to the trajectory.
- Appendix 1 includes the full detail of the Trust's financial performance.



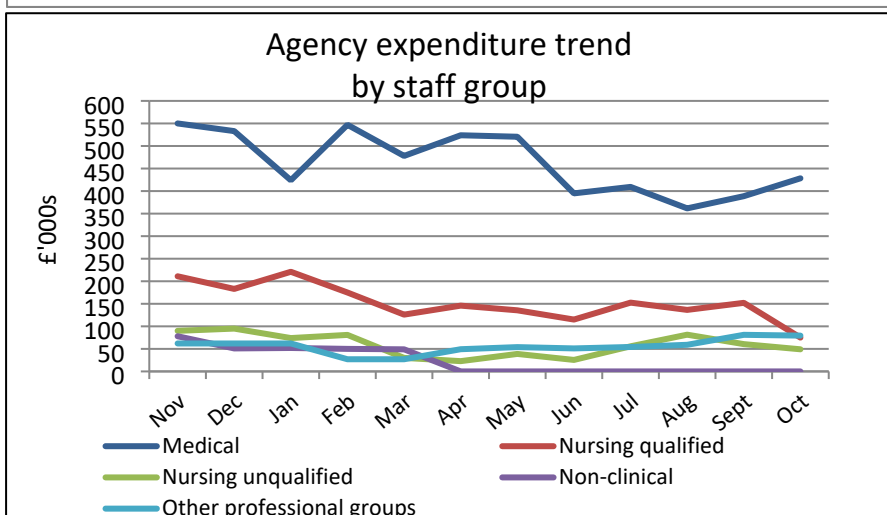
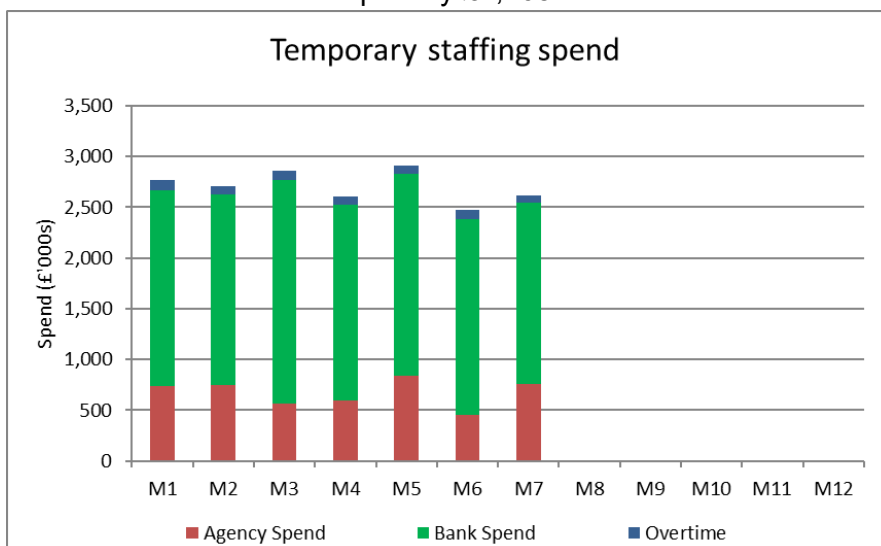
- The key drivers of the Trust's position are set out in the table below.

Drivers of Financial Performance	£'000s
Out of area placements	2,297
Efficiency savings	2,053
Vacancies	(2,321)
Clinical non-pay (drugs, clinical supplies and services)	(1,253)
Income linked to recovery	(1,024)
Interest received	(240)
Finance costs	(113)
Surplus against NHSE plan	(601)

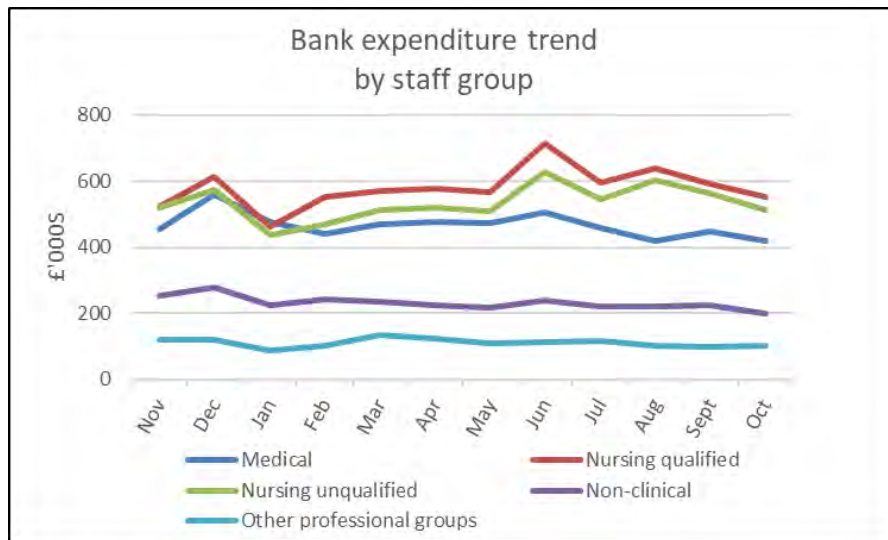
2.2 Temporary staffing

- Temporary staffing costs increased by £145k in month 7.

- Agency costs increased by £309k, from £452k to £761k. This relates to medical agency and is mainly due to a correction of prior month costs following the outcome of the investigation into the calculation methodology. The graph below has been amended retrospectively to reflect the correct costs for June to October.
- October is a 5-week month and adjusting for the difference in weeks results in an increase in agency expenditure of £157k.
- Bank reduced by £143k and overtime reduced by £21k.
- Year to date agency expenditure is £1,310k lower than the same period last year, bank £51k higher and overtime costs £10k higher.
- The largest area of agency spend is currently in the Medical directorate, which is £79k lower year to date, than the same period in 24/25.
- Year to date agency costs are above plan by £78k and are 2.47% of total pay costs.
- YTD bank costs are above plan by £1,268k.

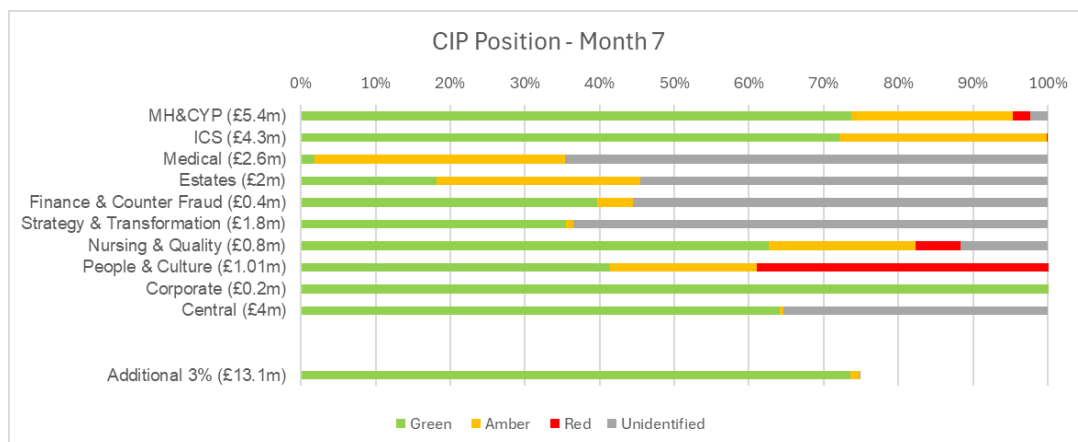


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2.3 Efficiency Programme

- The total target for 2025/26 is £38.5m. This is made up of £22.7m assigned to operational efficiencies and £15.8m transformational efficiencies.
- The graph below shows the position as at the end of October.
- As at month 7, savings of £9.3m have been delivered against a plan of £9.7m, leading to a deficit against plan of £0.4m.



- Of the £38.5m target:
 - £23.8m (62%) of efficiency schemes are fully developed (green).
 - £4.4m (11%) of efficiency schemes are plans in progress (amber).
 - £4.6m (12%) of opportunities are currently being worked on.
 - £5.7m (15%) remains unidentified.
 - £2.0m is the additional CIP stretch target.
- All Dorset organisations have developed recovery plans for the second half of the year.

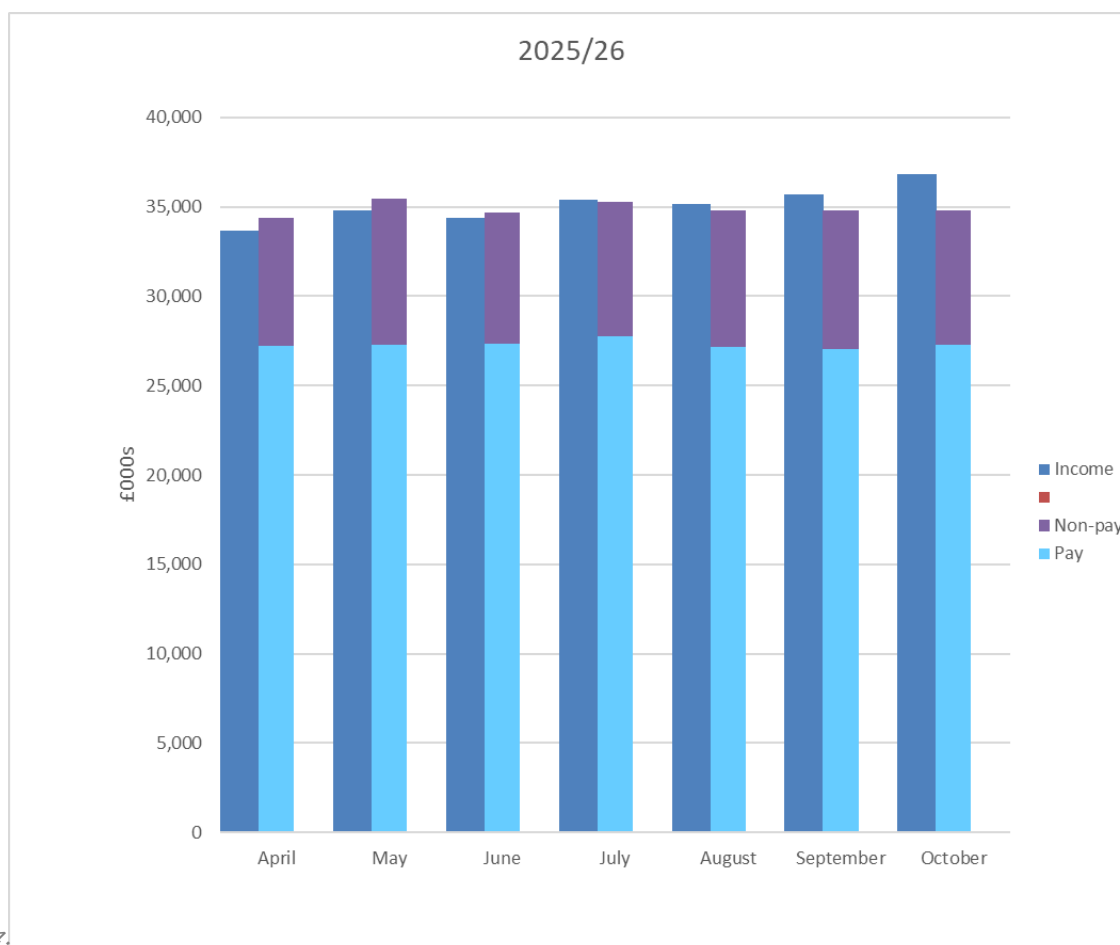
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2.4 Out of area placements

- The mental health bed capacity in Dorset is currently below the modelled requirements, meaning that out of area placements will continue to be necessary until the new St Ann's hospital opens.
- Significant work has been undertaken to reduce the number of inappropriate out of area placements.
- With 4 patients remaining in a non-block booked bed at the end of October, the budget is overspent by £2.3m, reflecting the higher number of placements in months 1-4.
- Beds have been block booked at the Priory in Southampton to compensate for the lack of capacity. Until the end of September 10 beds were block booked. With effect from 1st October and until 31st March 2026, 5 beds are block booked with a further 5 beds at the same rate, but on a spot purchase basis.

3. Performance in month

- During the month of October, the Trust's income exceeded expenditure by £2.0m. This is before technical adjustments and impairments. The run rate is shown in the graph below.

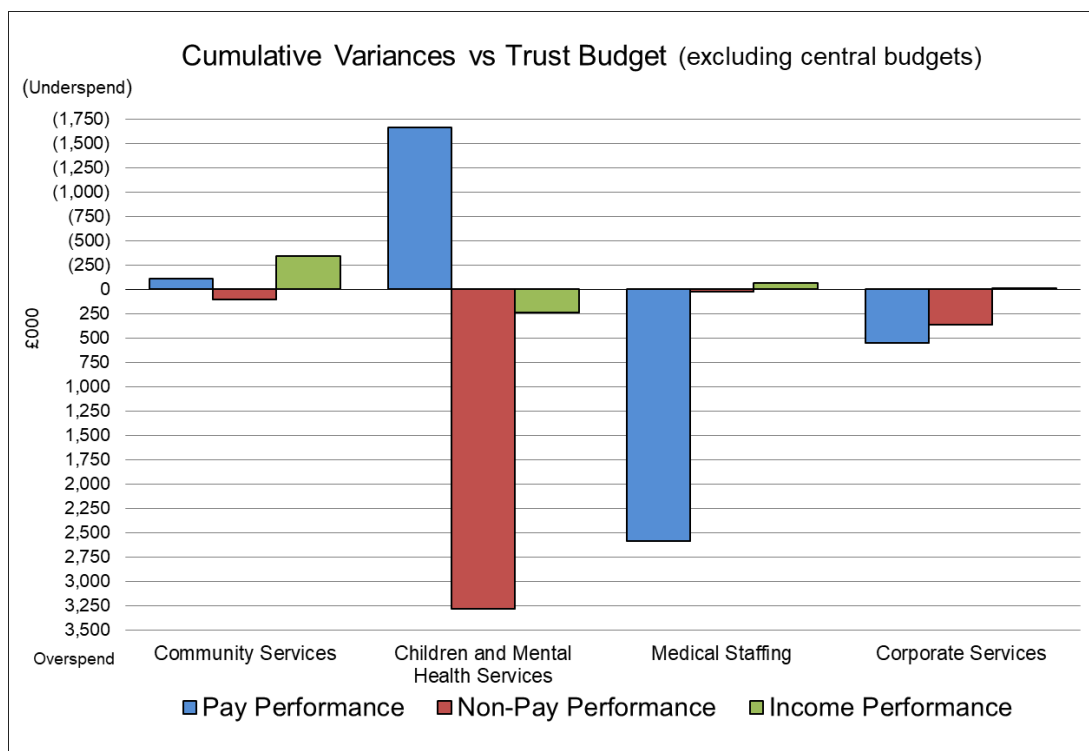


4. Directorate performance

- The table below sets out the financial performance by directorate, with the majority of directorates facing financial challenges.
- Note that the variance to budget is a key internal control measure only and is a key indicator of individual directorate performance. It is not reported as the Trust's deficit externally as the budget phasing does not align with the plan submitted to NHSE.

	Full year budget	Month 7 spend	YTD spend	Variance to budget at Month 7
	£'000s	£'000s	£'000s	£'000s
Trust Wide Income	(349,933)	(30,163)	(200,413)	27
Central budgets	21,465	35	(232)	(449)
Integrated Community Services	109,022	8,690	62,727	(350)
Mental Health & Children's Service	126,050	10,582	74,754	1,865
Medical Staffing	26,032	2,574	17,666	2,541
Nurse Executive and Quality	9,625	728	5,422	(194)
Finance and Strategic Development	41,800	3,564	24,270	314
People & Culture	5,380	407	2,968	322
Strategy, Transformation & Partnerships	14,201	1,242	8,753	489
Corporate Services	3,858	351	2,357	(31)
Total	7,498	(1,989)	(1,728)	4,534
Capital donations/grants/peppercorn lease	(17,260)	397	397	
Adjusted total	(9,762)	(1,592)	(1,332)	

- The table above reflects the net position of each service.



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4.1 Integrated Community Services

	Full year budget	Month 7 spend	Year to date spend	Forecast Outturn	Forecast variance to budget
	£'000s	£'000s	£'000s	£'000s	£'000s
Income	(20,817)	(2,251)	(13,103)	(21,404)	(587)
Pay	107,433	8,879	62,605	107,481	49
Non-pay	22,406	2,063	13,225	22,864	457
Total	109,022	8,690	62,727	108,941	(81)

Drivers of year-to-date performance

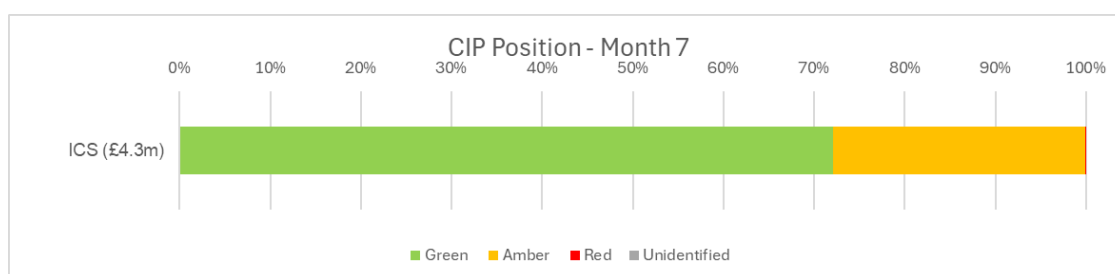
- Unachieved savings of £231k.
- Vacancies in the Pain, Post COVID, Podiatry, Musculoskeletal services and Integrated Community Rehabilitation teams, partly offset by high district nursing and MIU costs due to service demand and Nurse Apprentices working supernumerary and vacancy factor.
- High LVA and MIU income.

Key factors in outturn forecast position

- Assumed unachieved efficiency savings of £1.2m.
- High LVA income and MIU income.
- Vacancies mainly in Integrated Community Rehabilitation teams, Pain, Podiatry, Post COVID, Musculoskeletal services and the wheelchair service partly offset by vacancy factor and MIU demand pressures.
- Low non-pay costs associated with vacancies partly offset by high hearing aid and audiology software licence expenditure.

Performance against efficiency target

- The Integrated Community Services directorate's savings requirement is £4.38m.
- The chart below indicates the level of savings schemes that are fully developed (green) and the confidence in delivery.



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Actions to improve financial sustainability

- Ongoing scrutiny of vacancies.
- Review of all contracts to ensure best value for money and delivering services required.
- Engagement events with clinical teams to see where changes can be made to improve quality and reduce wastage and costs.
- Working with corporate teams to understand service cost base and benchmarking information to identify opportunities to learn from other service models.
- Fortnightly meetings of the management team to review progress towards schemes that improve quality, productivity and cost.

4.2 Mental Health and Children's Services

	Full year budget	Month 7 spend	Year to date spend	Forecast Outturn	Forecast variance to budget
	£'000s	£'000s	£'000s	£'000s	£'000s
Income	(32,852)	(2,702)	(19,314)	(32,164)	688
Pay	142,872	11,621	81,453	139,227	(3,645)
Non-pay	16,031	1,663	12,614	19,996	3,965
Total	126,050	10,582	74,754	127,058	1,008

Drivers of year-to-date performance

- Full year budget reduction actioned in month 5 to more clearly show the cost pressure relating to inappropriate out of area placements.
- Unachieved CIP savings of £651k.
- Vacancies in learning disabilities services, community mental health and rehab teams and primary and psychological services, partly offset by an unfunded RNDA cohort and pay inflation pressure in public health services,
- With 4 patients remaining in a non-block booked bed at the end of October, the budget is overspent by £2.3m, reflecting the higher number of placements in months 1-4.

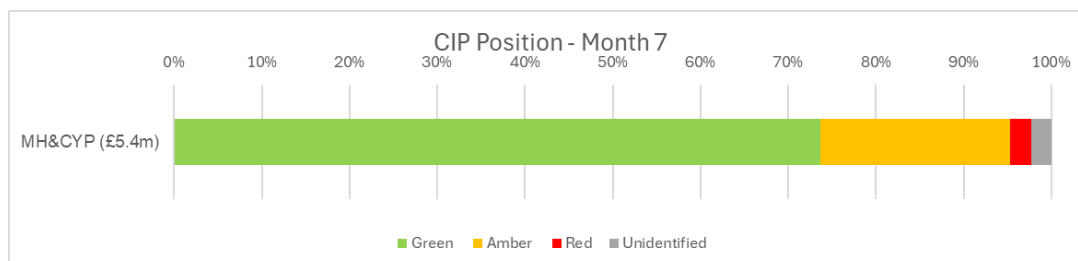
Key factors in outturn forecast position

- Assumed unachieved savings of £1.44m.
- Vacancies partly offset by extra staffing on St Brelades ward and also high bank and agency on other wards together with inflationary cost pressure in public health services.
- Assumption of 10 out of area patients in block booked beds with effect from November, plus 1 ad- hoc bed.

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Performance against efficiency target

- The Children's and Mental Health Services directorate's savings requirement is £5.47m.
- The chart below indicates the level of savings schemes that are fully developed (green) and the confidence in delivery.



Actions to improve financial sustainability

- Working with the system to investigate alternative options to the use of out of area beds.
- Reviewing income received and identifying opportunities to support service cost pressures.

4.3 Medical Staffing

	Full year budget	Month 7 spend	Year to date spend	Forecast Outturn	Forecast variance to budget
	£'000s	£'000s	£'000s	£'000s	£'000s
Income	(2,948)	(328)	(1,846)	(2,998)	(50)
Pay	27,535	2,795	18,641	31,315	3,780
Non-pay	1,444	106	871	1,477	33
Total	26,032	2,574	17,666	29,795	3,763

Drivers of year-to-date performance

- Unachieved CIP savings of £1.47m.
- The cost pressure in Medical staffing is driven by agency costs, which are lower than the same period in 2024/25 by £79k.

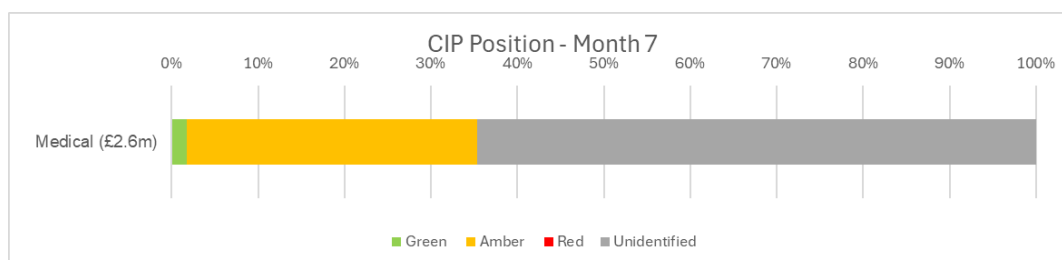
Key factors in outturn forecast position

- Assumed unachieved savings of £2.52m.
- High agency expenditure.

Performance against efficiency target.

- The Medical Staffing savings requirement is £2.56m.

- The chart below indicates the level of savings schemes that are fully developed (green) and the confidence in delivery.



Actions to improve financial sustainability

- The use of agency staff is under review and alternative options are being reviewed to cover or change vacant posts, with a focus on specific high-cost staff.
- International recruitment to vacancies is progressing well with start dates of January and April 2026.

4.4 Nursing Executive and Quality

	Full year budget	Month 7 spend	Year to date spend	Forecast Outturn	Forecast variance to budget
	£'000s	£'000s	£'000s	£'000s	£'000s
Income	(1,530)	(163)	(1,069)	(1,747)	(217)
Pay	9,909	796	5,721	9,682	(227)
Non-pay	1,246	95	770	1,317	72
Total	9,625	728	5,422	9,253	(372)

Drivers of year-to-date performance

- Unachieved CIP savings of £172k.
- Pharmacy, R&D and participation income ahead of target.
- Vacancies in the Mental Health Act team, Pharmacy and Patient Safety.

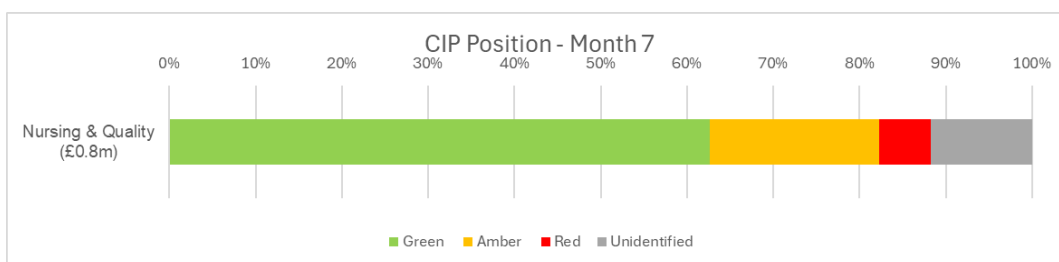
Key factors in outturn forecast position

- Assumed unachieved savings of £307k.
- Pharmacy, R&D and participation income ahead of target.
- Vacancies.

Performance against efficiency target.

- The Nursing Executive and Quality directorate's savings requirement is £0.82m.
- The chart below indicates the level of savings schemes that are fully developed (green) and the confidence in delivery.

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4.5 Finance and Strategic Development

Finance and Strategic Development includes finance, estates and facilities, and counter fraud. The lead provider function for adult eating disorders is also within the directorate.

	Full year budget	Month 7 spend	Year to date spend	Forecast Outturn	Forecast variance to budget
	£'000s	£'000s	£'000s	£'000s	£'000s
Income	(5,615)	(417)	(2,778)	(4,840)	775
Pay	16,243	1,340	9,425	16,295	52
Non-pay	31,172	2,641	17,622	30,861	(311)
Total	41,800	3,564	24,270	42,317	516

Drivers of year-to-date performance

- Unachieved CIP savings of £980k.
- Facilities vacancies.
- Low minor works and utility costs.

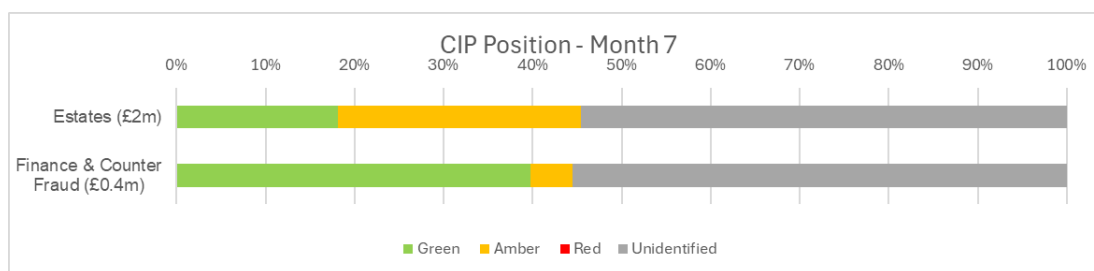
Key factors in outturn forecast position

- Assumed unachieved savings of £1.88m.
- Facilities vacancies.
- Low provisions, cleaning, transport, estates contract and utility costs.

Performance against efficiency target

- The Finance and Strategic Development directorate's savings requirement is £2.41m (Finance and Counter Fraud £0.413m and Estates £1.99m).
- The chart below indicates the level of savings schemes that are fully developed (green) and the confidence in delivery.

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Actions to improve financial sustainability

- A review of leased estate is underway to identify where it may not be required or could be used more efficiently.
- Move of HQ services to No 2 Nuffield early December.
- Review of non-value added work.

4.6 Strategy, Transformation and Partnerships

The Strategy, Transformation and Partnerships directorate includes Information Management and Technology.

	Full year budget	Month 7 spend	Year to date spend	Forecast Outturn	Forecast variance to budget
	£'000s	£'000s	£'000s	£'000s	£'000s
Income	(51)	(16)	(61)	(105)	(53)
Pay	9,801	874	6,048	10,165	364
Non-pay	4,451	384	2,765	4,853	402
Total	14,201	1,242	8,753	14,913	712

Drivers of year-to-date performance

- Unachieved CIP savings of £776k.
- Vacancies.

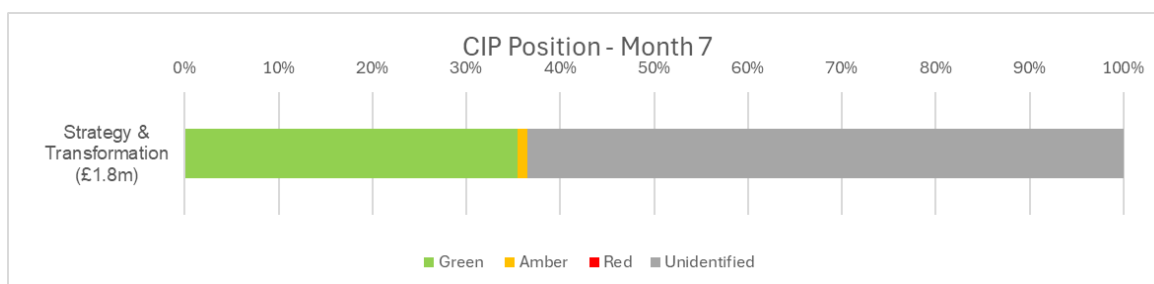
Key factors in outturn position

- Assume unachieved savings of £1.16m.
- Vacancies and costs recharged to capital.

Performance against efficiency target

- The Strategy & Transformation directorate's savings requirement is £1.797m.
- The chart below indicates the level of savings schemes that are fully developed (green) and the confidence in delivery.

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Actions to improve financial sustainability

- Continued development of the One Transformation approach to support the Trust and DCH to deliver change.

4.7 People and Culture

	Full year budget	Month 7 spend	Year to date spend	Forecast Outturn	Forecast variance to budget
	£'000s	£'000s	£'000s	£'000s	£'000s
Income	(7,146)	(633)	(3,975)	(7,117)	28
Pay	9,651	789	5,672	9,996	345
Non-pay	2,874	251	1,271	2,920	45
Total	5,380	407	2,968	5,798	419

Drivers of year-to-date performance

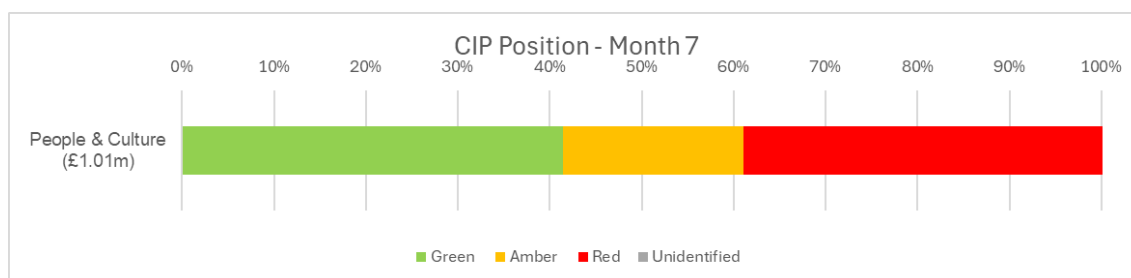
- Unachieved CIP savings of £365k.

Key factors in forecast outturn position

- Assumed unachieved savings of £0.59m.

Performance against efficiency target

- The People and Culture directorate's savings requirement is £1.015m.
- The chart below indicates the level of savings schemes that are fully developed (green) and the confidence in delivery.



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4.8 Corporate Services

	Full year budget	Month 7 spend	Year to date spend	Forecast Outturn	Forecast variance to budget
	£'000s	£'000s	£'000s	£'000s	£'000s
Income	(493)	(40)	(279)	(487)	5
Pay	3,004	233	1,680	2,933	(71)
Non-pay	1,347	158	956	1,368	21
Total	3,858	351	2,357	3,814	(44)

Drivers of year-to-date performance

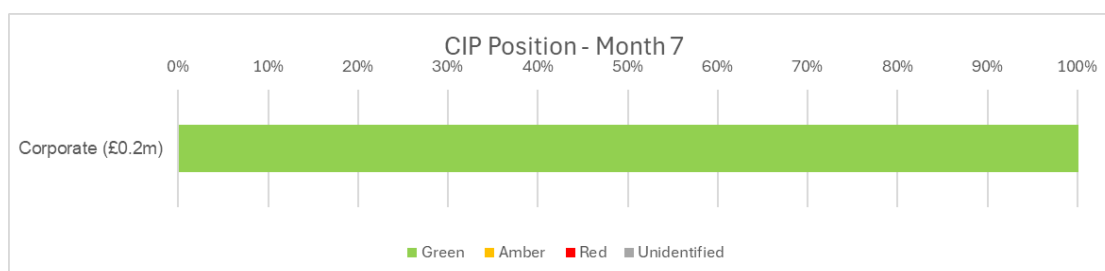
- Vacancies.

Key factors in forecast outturn position

- Over achievement of the CIP savings target by £36k.
- Vacancies.

Performance against efficiency target

- The Corporate Services directorate's savings requirement is £0.166m.
- The chart below indicates the level of savings schemes that are fully developed (green) and the confidence in delivery.



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5. Year-end forecast outturn position

- The table below shows that the current year-end forecast is a potential deficit of £12.5m against the planned £9.77m surplus.

Forecast Outturn	Variance to budget at Month 7	Straight line year-end forecast	Known adjustments to Forecast	Revised forecast variance	Value of actions needed to breakeven
	£'000s	£'000s	£'000s	£'000s	£'000s
Community Services	(350)	(600)	520	(81)	
Mental Health & Childrens Services	1,865	3,197	(2,189)	1,008	(1,008)
Medical Staffing	2,541	4,356	(593)	3,763	(3,763)
Nurse Executive & Quality	(194)	(333)	(39)	(372)	
Finance & Strategic Development	314	539	(23)	516	(516)
People & Culture	322	553	(134)	419	(419)
Strategy, Transformation & Partnerships	489	838	(126)	712	(712)
Corporate Services	(31)	(53)	9	(44)	
Trust Wide Income	27	47	115	161	(161)
Central budgets	(449)	(769)	5,238	4,469	(4,469)
Total	4,534	7,773	2,778	10,552	(11,049)
Capital donations/grants/peppercorn lease				1,942	
Adjusted forecast - Variance to Plan				12,495	

- Current projections assume no further efficiency savings, only the fully developed schemes.
- The forecast has been adjusted for known service changes and one-off costs but highlights that action is required in most areas to mitigate the significant anticipated overspend.
- The central budgets line includes the central, stretched and additional 3% efficiency target, cost pressures, overheads, and capital charges. This funding is not allocated to individual services but contributes to the Trust's overall position.

6. Provider Collaborative Financial Position

6.1 Dorset HealthCare as Provider

Dorset HealthCare provides a number of services through various provider collaboratives. The month 7 financial position is shown below.

Service	Provider Collaborative	Lead	Risk share	YTD expenditure variance to budget £000s	Forecast expenditure variance to budget £000s
Adult secure (low and medium) - For Me PC	Thames Valley and Wessex	Oxford Health	15.44%	(294)	(619)
Children & adolescent mental health services (CAMHS) Tier 4	South West	Devon Partnership	19%	35	59
Perinatal mental health	South West	Devon Partnership	14%	(48)	(69)
Adult eating disorders	Hampshire and Isle of Wight	Dorset HealthCare	100%	(163)	(345)

Drivers of year-to-date performance

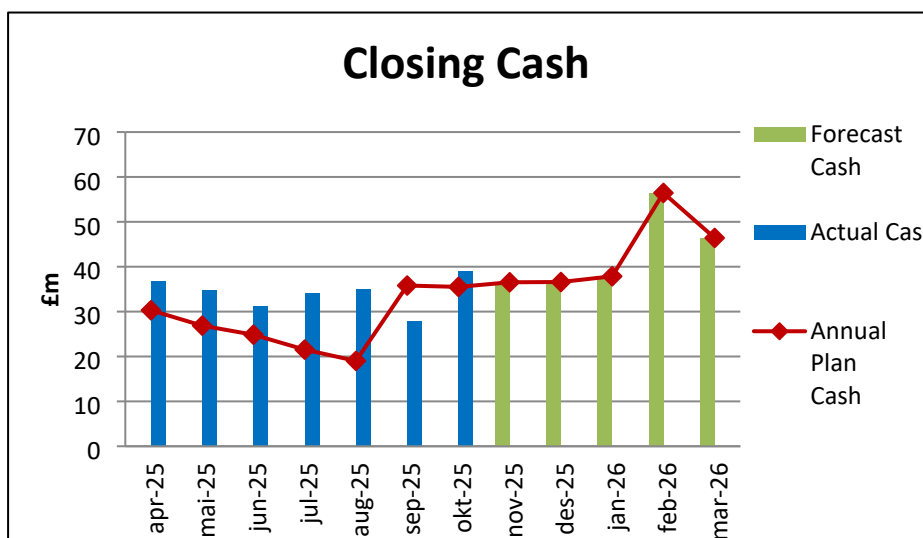
- Adult low secure – vacancies.
- CAMHS Tier 4 – Pebble Lodge high bank spend.
- Perinatal mental health - vacancies
- Adult eating disorders - community team vacancies.

Key factors in the forecast outturn position

- As above.

7. Cashflow and Payments

- The cash balance at M7 was £38.91m, an increase of £11.11m from last month which is due to the receipt of PDC external funding relating to NHP (£10.1m) and an increase in deferred income.
- Cash levels are currently above plan due to NHP funding being received to offset spend to date.
- Overall debtors remain high with £11.86m of LA and NHS debt which is over 90 days old.

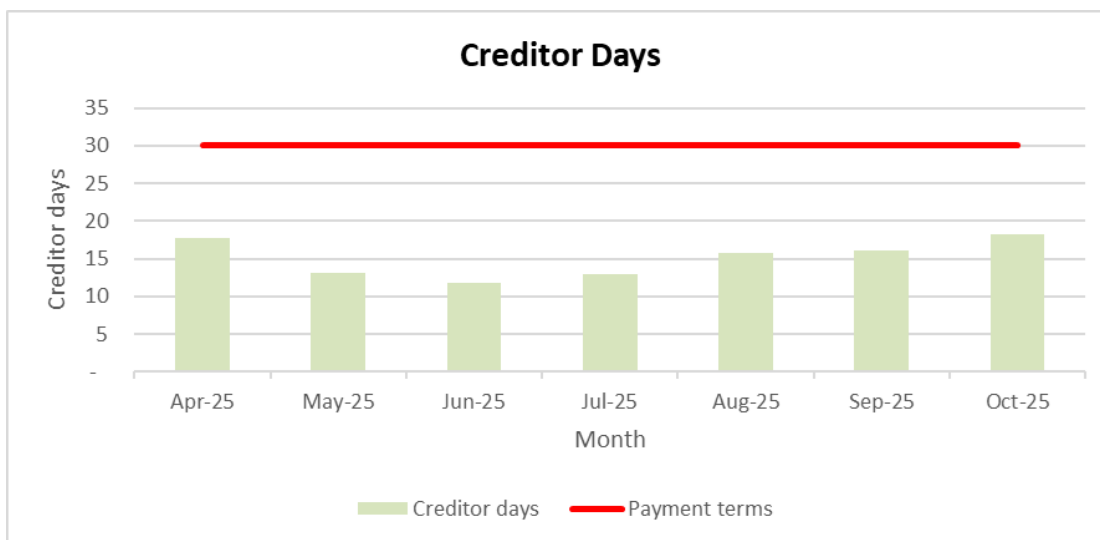


- The YTD Better Payment Practice Code performance is shown below. The target is 95% which has not been achieved this month, due to chasing of old invoices awaiting approval.

YTD							
Month	1	2	3	4	5	6	7
BPPC performance	96.49%	96.22%	95.67%	95.71%	95.30%	95.02%	94.82%

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- Being above the 95% target is reflected in our favourable creditor days. This is the time it takes the Trust to pay its outstanding liabilities.



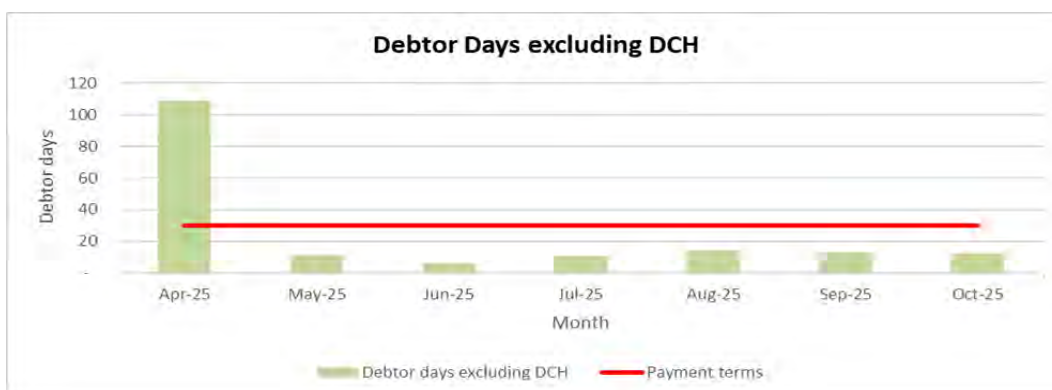
A standard 30-day payment term has been used for comparison.

The cash days graph below shows the number of days that the Trust could sustain its current level of expenditure without any further income.



- The debtors day graph below shows how long it takes the Trust to collect payment from its customers, To give a more accurate picture, the outstanding transactions with Dorset County Hospital have been excluded.
- April was high due to year end debtors including outstanding invoices of £3m with Bournemouth, Christchurch and Poole Council and Dorset of which £1.2m was over 91 days old.

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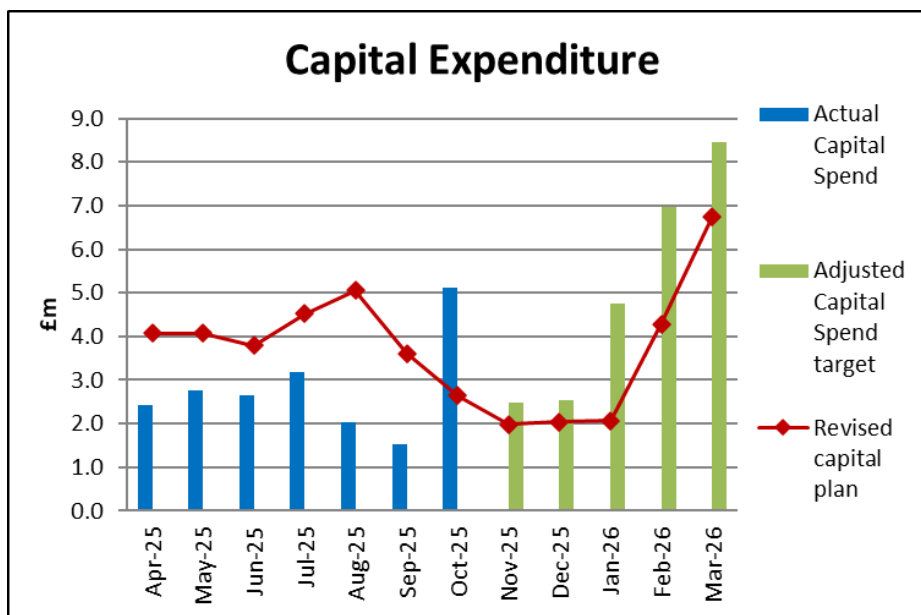
8. Capital programme.

- The capital expenditure target for 2025/26 is £44.90m including leases capitalised under IFRS16 of £2.54m and League of Friends' funded expenditure.
- Forecast spend in year on the continuing New Hospital Programme is £26.79m, a reduction of £9.65m due to an agreement of zero rated VAT with HMRC and slippage into 2026/27. Opportunities for additional expenditure, in line with the original business case, are being explored.
- Total year to date spend is £20.07m against a year to date plan of £27.8m. Internally funded spend is £3.04m against a plan of £3.99m due to the delays in signing property leases.
- Efforts are ongoing to bring capital spend forward in the year and exceed the planned timescale of delivery where possible.
- The delivery of the capital programme is achieved by:
 - o Regular meetings between the capital finance team and key capital budget managers.
 - o Line by line review of larger capital project lines, such as the NHP project, backlog maintenance and IT projects.
 - o The investigation of variances between plan and actual spend.
 - o The accurate accruing to completion at the quarter months.
 - o The identifying of internally funded capital slippage, and the reallocation to additional spends in year brought forward from future years.
 - o Regular monthly meetings of the Capital Investment Meetings (CIM), where progress is reported, and adjustments agreed to the in-year programme to compensate for slippage.
- Key projects within the 2025/26 capital programme include:
 - o St Ann's, CAMHS PICU, and HIP 2 – £26.8m (externally funded)
 - o Backlog maintenance - £4.1m (internally funded)
 - o Solar panels - £0.9m (externally funded)
 - o Critical infrastructure risk - £0.7m (externally funded)

Both NHP new builds are progressing well but issues with the delivery of the MEP (mechanical, electrical and plumbing works) for the CAMHS PICU and a late

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- adjustment in relation the installation of CCTV has pushed the planned completion date back to April 2026. St Ann's Hospital is still due for completion by March 2026 and the further refurbishment works to complete by November 2027.to
- Depreciation totalled £8.22m (plan £8.62m), for month 7, £0.40m below plan. Capitalisation of assets during the year will increase in month depreciation but proposed MEA modelling is likely to decrease 2025/26 depreciation levels.



6. Conclusion

- 2025/26 is a challenging year for the NHS and Trust finances.
- Financial balance will only be achieved by individuals and directorates working hard to achieve a successful outcome and focus on achieving the efficiency target.
- There are a number of risks to financial balance which are being monitored closely across all areas of the Trust.

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Appendix 1 – Trust financial performance

INCOME & EXPENDITURE SUMMARY							
Month 7 2025/26 October	ANNUAL BUDGET	YTD			IN MONTH		
		YTD Budget	YTD Actuals	YTD Variance	Budget	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
INCOME							
Baseline Income	(348,146)	(199,287)	(199,287)	(0)	(30,057)	(30,063)	(6) G
Integrated Community Services	(20,817)	(12,762)	(13,103)	(340)	(2,134)	(2,251)	(116) G
Children, Y.P. & Family Services, All Age Mental Health & L.D. Services	(32,852)	(19,557)	(19,314)	243	(2,756)	(2,702)	54 R
Medical Staffing	(2,948)	(1,777)	(1,846)	(68)	(316)	(328)	(12) G
Nurse Executive & Quality	(1,530)	(900)	(1,069)	(168)	(136)	(163)	(26) G
Finance & Strategic Development	(5,615)	(2,933)	(2,778)	156	(449)	(417)	32 R
People & Culture	(7,146)	(4,006)	(3,975)	30	(664)	(633)	30 R
Strategy, Transformation & Partnerships	(51)	(30)	(61)	(31)	(4)	(16)	(12) G
Corporate	(493)	(285)	(279)	6	(43)	(40)	2 R
Interest Received	(1,788)	(1,153)	(1,126)	27	(127)	(100)	27 R
Central Budgets	(8,917)	(3,083)	(3,083)	0	(95)	(95)	0 G
Total Trust Income	(430,302)	(245,774)	(245,919)	(146)	(36,782)	(36,807)	(25) G
EXPENDITURE							
Integrated Community Services	129,839	75,839	75,830	(10)	11,206	10,941	(265) G
Children, Y.P. & Family Services, All Age Mental Health & L.D. Services	158,902	92,446	94,068	1,622	14,924	13,284	(1,640) R
Medical Staffing	28,980	16,903	19,512	2,609	2,398	2,902	504 R
Nurse Executive & Quality	11,155	6,516	6,490	(26)	935	891	(44) G
Finance & Strategic Development	47,415	26,889	27,048	159	3,996	3,981	(15) R
People & Culture	12,525	6,651	6,943	292	1,049	1,040	(9) R
Strategy, Transformation & Partnerships	14,252	8,294	8,813	520	1,185	1,258	73 R
Corporate	4,351	2,673	2,636	(37)	383	391	8 G
Central Budgets	8,107	0	(449)	(449)	0	(341)	(341) G
Impairments	16,618	0	0	0	0	0	0 G
Total Trust Expenditure	432,144	236,211	240,891	4,680	36,077	34,347	(1,731) R
NET INCOME & EXPENDITURE	1,841	(9,563)	(5,028)	4,534	(704)	(2,460)	(1,756)
PDCD	5,657	3,300	3,300	0	471	471	0 G
RETAINED (SURPLUS)/DEFICIT	7,498	(6,263)	(1,728)	4,534	(233)	(1,989)	(1,756) R
EBITDA			3.9%				
Technical adjustments							
Capital donations/grants/peppercorn lease/PPE	(17,260)		397				
ADJUSTED (SURPLUS)/DEFICIT	(9,762)		(1,332)				

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Report to	Board in Common (DCH Board)	
Date of Meeting	9 th December 2025	
Report Title	DCH Finance Report – Month 7 2025/26	
Prepared By	Claire Abraham, Deputy Chief Finance Officer DCH	
Accountable Executive	Chris Hearn, Chief Finance Officer	
Previously Considered By	Finance and Performance Committee in Common 26/11/25	
Action Required	Approval	No
	Assurance	Yes
	Information	No

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

Executive Summary
Dorset County Hospital NHS Foundation Trust (DCHFT) submitted a £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. The second part of the financial year sees each organisation within the Dorset system having revised H2 (half 2) Trajectories to deliver following NHSE requirement to close the unidentified efficiency gap and treatment of proposed benefit associated with Shared services (SubCo) following notification of national pauses in this area. Key Messages Month seven delivered a deficit of £0.497 million after technical adjustments, being £0.174 million better than the planned deficit and year to date £0.002 million ahead of revised Trajectory at £17.4 million deficit. Updated Trajectory reporting will follow. Within this position, £0.698m 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. October continues to see increased operational pressures with front door activity up against last year and c.2500 more attendances YTD than planned. This is reflected in the increase in pay costs (temporary workforce). Patients with no criteria to reside have also been above plan with increases in length of stay also seen (further detail in the Performance report). Pay expenditure overall is above plan by £2 million, largely driven by bank expenditure offset by agency and noting costs supporting Industrial Action during July of £0.143 million are within this overspend. Further costs linked to supporting Industrial Action can be expected linked to confirmed November activity and will be reported next month once incurred. Corresponding underspends in non pay linked to drugs and stock levels under plan, and timing of income received has enabled the Trust to deliver to plan year to date.

Agency expenditure in October has seen total monthly spend of £0.5 million being slightly worse than plan with an adverse in month variance of £0.035m due to nursing increases. Agency is still however overall £0.5 million better than plan year to date. In month challenges relate to increased emergency activity, vacancies, annual leave cover and increased short term sickness levels.

Ongoing bank usage has been seen in ED, Mary Anning and Ilchester wards, along with SCBU, Kingfisher and Theatres. Clinical coding and Estates and Facilities, in particular catering and security have also seen ongoing usage this month reflecting the increased operational pressures and levels of patients with no criteria to reside.

Enhanced workforce reviews are in the process of being determined to support pressures in temporary staffing, noting this is a key focus and recovery area for the Trust with bank spend is currently £2.7m overspend against plan (including expected phased CIP reductions) year to date.

Break glass Off Framework expenditure is being incurred each month, with £0.1 million incurred in month seven taking the year to date expenditure to £0.072 million, with NHS England expecting nil Off Framework spend since last July 2024.

The Trust wide efficiency target for the year stands at £29.1 million and is circa 8.7% of expenditure budgets in line with peers and national planning expectations.

Year to date, the Trust has delivered £8.8 million against the £8.6 million plan, being 30% of total target delivered. This over achievement includes £1.9 million proportionate share of the £11.6 million planned Shared services (SubCo) benefit, in anticipation of NHSE confirming cash backed or 'allowable miss' treatment.

Previously total schemes identified stood at £24.5 million with £4.5 million of unidentified schemes and further £1.5 million of system transformation schemes deemed at risk. Significant work at pace has taken place to look to close this £6 million gap as part of the H2 Trajectory (presented to Committee last month).

Currently within the efficiency programme, 35% of schemes are classed as high risk at £10.2m, £5m as medium risk being 17% and the remaining £5 million classed as low risk at 17%.

The Trust is being supported across the Federation by an Improvement Director from this month. Efficiency delivery remains a significant challenge and key focus area for the Trust with actions being led by the Chief Executive chaired Financial Recovery Board.

The cash position as at 31 October stands in line with expectations at £16.6 million, and remains ahead of the NHSE submitted plan. Improvement to cash levels are the result of funding received relating to 2024/25 M12 system transactions, a timing benefit for Health Education England income paid in April and timing benefit on capital payments.

Cash does though remain a significant risk and 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 7 spend totaling £1.8 million, which is behind plan by £2.6 million and £8.6 million behind YTD.

Externally funded projects are £6 million ahead of plan year to date due to timing of expenditure in the New Hospital Programme (NHP) construction works. Leased expenditure completes the remainder of the behind plan variance linked to timing of office leases, One Dorset Pathology and lease remeasurements.

Included in the capital plan are bids that the Trust has received from 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.

Key Actions

Whilst the Trust remains ahead of the revised Trajectory at month 7, there are a number of challenging areas which require significant focus and active delivery to ensure the Trust remains on Trajectory throughout the remainder of the year – these being efficiency recovery; delivery to plan as well as pay variance control, in particular bank expenditure. Careful cash monitoring is also still a high priority with active system and NHSE discussions to address longer term mitigations ongoing.

The Trust's Finance Recovery Board chaired by the Chief Executive and supported by the new Improvement Director has clear focus and oversight in these areas.

As part of this recovery is a keen focus on assessing the Trusts grip and control with an exercise adopted across each system organisation to determine areas of good practice and areas which require improvement. This exercise has been used formally by NHSE for a number of systems nationally outside of Dorset, with the Dorset system proactively driving this forward.

Collective interventions are required at all levels and disciplines across the Trust to ensure delivery of plans as the year progresses.

Recommendation

The Board is recommended to receive the month seven financial position for the financial year 2025/26 in line with revised H2 trajectory for assurance.

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Financial Position Update 2025/26

October 2025 - Month 7

Chris Hearn
Chief Financial Officer

 **Healthier lives**  **Empowered citizens**  **Thriving communities**

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Financial Position Update - October 2025

Executive Summary



A summary of progress is presented for the period of October 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 addition, where appropriate, comparisons will be made to updated H2 trajectory plans submitted in October 2025 (presented to Committee last month) to aid confidence in the Systems ability to deliver a breakeven position by the end of the financial year.

In October 2025, Dorset County Hospital NHS Foundation Trust (DCHFT) has delivered a deficit of £0.5 million after technical adjustments, a favourable performance of £0.174 million against submitted plan. Year to date, the Trust is £0.179 million favourable to a planned deficit and £0.002 million favourable to H2 trajectory plan. Within this position, £0.698 million relates to additional costs incurred as a direct result of the closure and support of the Yeovil maternity service, noting this has been offset by assumed income at this stage.

The Trust has achieved £8.8 million YTD of the planned £8.6 million efficiency target at month 7. H2 Trajectory planning was required to address and form plans to deliver the previously unidentified £4.5 million CIP schemes. Whilst efficiency delivery is ahead of original plan, it is in line with updated trajectory planning. Included in month 7 efficiency delivery is an accrual for £1.9m of subsidiary offset income, as conversations continue with NHSE about whether this is cash backed or changes planned year end outturn following NHSE's recent national communications to all organisations regarding stance on subsidiary approvals.

The Trust wide efficiency target for the year stands at £29.1 million and is c.8.7% of expenditure budgets. Of this target, 30% has been delivered YTD putting significant pressure on the remaining 5 months, new Improvement Director and Executive led meetings are driving the efficiency schemes forward with focus being aimed at the initial core delivery of 5%.

Agency expenditure in M7 is £35k worse than planned levels for October 2025 however remains £0.5m better than planned expenditure year to date. Medical agency reduction is a strong focus for the Trust alongside continued work on Nursing agency. Bank expenditure is now a key focus area with bank overspent by £2.7m YTD. Reduction in bank expenditure requires essential focus on enhanced controls across the Trust to manage the overspend in this area. Actions are taking place led by the Trusts Financial Recovery Board, including alignment as appropriate with Dorset HealthCare procedures.

The Trust is progressing with the capital programme for 2025/26 with month 7 YTD spend totalling £12.8 million, which is behind plan by £8.6 million. Externally funded projects are £6.0 million behind plan due to timing of expenditure in the New Hospital Programme (NHP) construction works. Conversations are ongoing with NHSE to rephase the planned spend in line with updated expectations. Internally funded schemes, leased schemes and donated schemes are behind plan by £2.6 million due to delays in the arrangement of an admin office lease and One Dorset Pathology Lot 5 lease. Included in the capital plan are bids that the Trust has successfully made to NHS England for Critical Infrastructure Risks totalling (CIR) £2.7 million and Constitutional Standards bids totalling £0.6 million for Diagnostic projects, £0.9 million for Elective projects and £2.9 million for Urgent & Emergency Care projects. The Trust received approval of the Critical Infrastructure Risks bids from NHS England in June 2025 and subsequent approval for the Constitutional Standard Bids from NHS England in October 2025. The Trust was notified of non-cash backed additional internally funded capital envelope of £1.0 million for Urgent & Elective Care in early July and £0.5 million PDC funding for patient engagement portal. In October the Trust received approval of the additional Critical Infrastructure Risk bids of £2.1 million in October 2025. The Stroke Unit PDC system transfer of £2.3 million from NHS Somerset ICS has been included in the Capital Programme following guidance from NHS England in October 2025.

The cash position as at 31 October was £16.6 million, £0.3 million behind of the adjusted plan forecast. The adjusted plan reflects the 2024/25 £13m Trust year-end surplus position and higher closing cash balance as a result of the surplus position. The variance of £0.3 million is due to a higher payment for payroll including Tax/Ni Superannuation £0.8 million relating to the 2025/26 pay-award, an extra week of Supplier & NHS payments in October £1.2 million and timing of drawdown of PDC capital funding £1.7 million. This is offset by receipt of Health Education England income £3.4 million in October which relates to November to January. Cash remains a significant focus area for the Trust (BAF and risk register linked) with daily monitoring in place for active mitigations where appropriate along with active system & NHSE discussions in this heightened risk area.

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Key Risks

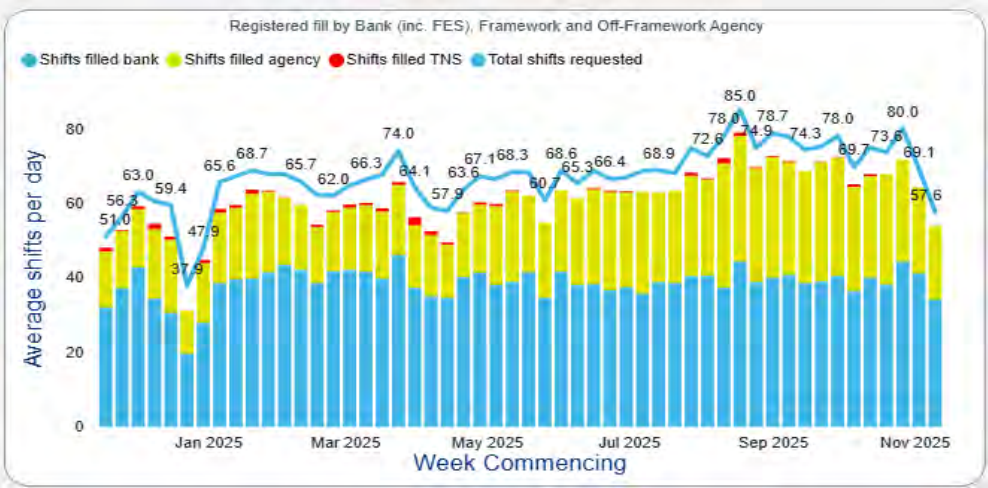


Red Risks:

The Trust has an efficiency delivery requirement of £29.1 million in order to reach the planned full year break even position. Two nationally mandated schemes within this target are a 30% reduction in agency spend and a 10% reduction in Bank Spend. DCH have submitted a plan to meet this agency reduction and have increased the bank target to 20%. This equates to c.£2.4m agency reduction and c.£2.3m bank reduction for the financial year from 2024/25 levels incurred.

Agency expenditure has improved since last year due to a combination of factors including system agency rate reduction and vacancy level decreases. NHSE mandated all off framework agency spends to cease completely from July 2024. The Trust has managed to reduce year on year spend with the exception of safe staffing 'break glass' procedures and mental health escalation requirements. Active plans in place as part of the internal High Cost Agency Reduction group, which was primarily focused on nursing last financial year will now also focus on medical agency and is continuing to help prevent further deterioration of the position against plan. The table below shows registered nursing shift fill by bank, on framework agency and highest cost off framework agency. The Trust is however increasing bank usage whilst decreasing agency usage (maintaining patient and staff safety and quality levels). Agency notice has reduced to 48 hours in order for Bank Staff to access the shifts in the first instance.

Bank expenditure has deteriorated in month 7 due to the impact of supporting operational pressures and continued approach to utilise bank before resorting to agency noting cover for vacancies,sickness, and maternity cover. Further workstreams have been requested to ensure bank is utilised under the appropriate circumstances, rosters are reviewed and managed accordingly, with effective Standing Operating Procedures in place ahead of booking.



Key Risk Status

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

Financial Position Update - October 2025

Key Risks



Red Risks:

Financial Forecast Risk - updated Trajectory H2

There is a risk of delivering the deficit position due to the challenging financial envelopes and significant efficiency plan levels. The Trust is actively deploying targeted support towards achievement with a new Improvement Director across the Federation, led by the CEO as part of the Financial Recovery Board (FRB) and supported by the wider Executive team in order to mitigate the risk to financial balance with stretch targets agreed for efficiencies, productivity, bank and agency to the end of the financial year. In response to the planned deficits delivered during the first half of the year, organisations within the System were asked to complete updated Trajectories to ensure delivery of planned £9.8m deficit. This included plans to deliver the previously unidentified £4.5m of efficiency and a further £1.5m of System efficiency schemes which had not progressed as planned. The Trust's mitigations and updated trajectories have been phased over the remaining months of the year and result in an improved expected monthly performance when compared to original plans.

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 cash levels (BAF and risk register links). 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, the Trust continues to focus on careful cost controls noting efficiency delivery and sound grip & control is essential. The outcome of NHSE discussions surrounding Shared services will influence the cash position.

Risk of Cost Pressures re Yeovil Maternity closure

On 19th May 2025 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, and there are further Somerset residents more local 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.

Additional Capital Funding bids and spend

The Trust submitted capital funding applications totalling £8.5m, drawing from the available Constitutional Standards (CS), Critical Infrastructure Risk (CIR) and Estates Safety (ES) funding streams, all but £2.0m of CS bids have been approved and this outstanding bid is still expected to get approval. To improve the likelihood of delivering these schemes in 2025/26, some work had to be pre-committed at risk prior to bid approval. Now that the bids have been approved, the only remaining risk is the potential for underspending, given the significant value of the schemes and the timing of the late approval. While there is a significant waiting list within the Trust for capital works and purchases, the external bids are ringfenced for specific areas but mitigation plans are under constant consideration and overseen via Capital Planning & Space Utilisation Group (CPSUG).

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Financial Position Update - October 2025

Key Risks

Amber Risk:

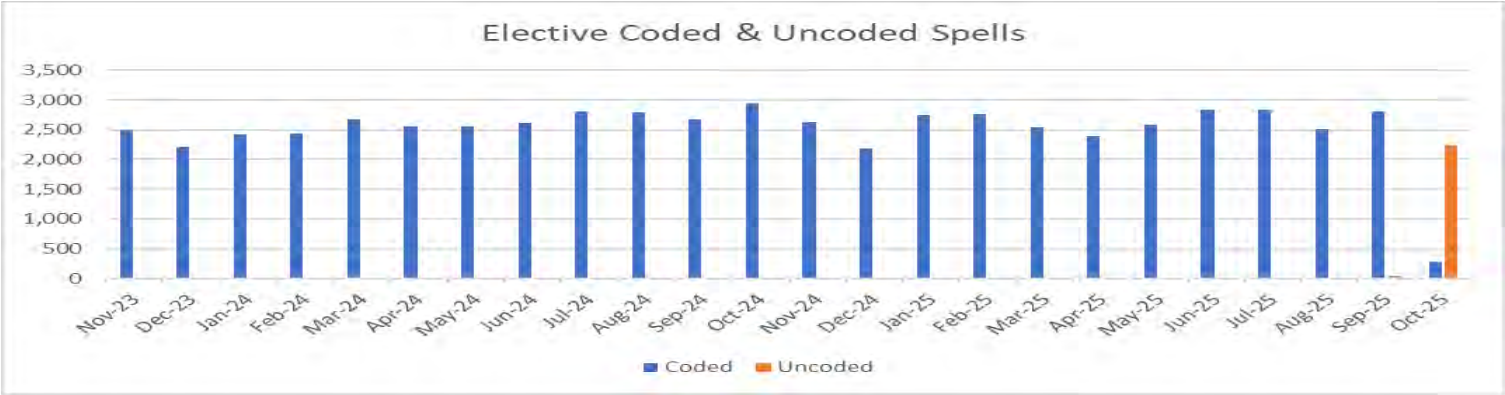
From 2023/24 NHS England introduced the Aligned Payment and Incentive (API) approach to all NHS standard contracts. This approach splits the payment mechanism for the majority of NHS contracts into two envelopes, Fixed and Variable.

The fixed element of the contract will be agreed between NHS providers and commissioners for the provision of specified services, this will be paid on a block basis across the year regardless of activity delivery. The fixed element of the contract will pay for any activity not covered under the variable element. The variable element of the contract will cover most elective activity: Elective Inpatients, Day cases, Outpatient First Attendances, Outpatient Procedures, Chemotherapy delivery and Diagnostics.

An income envelope will be agreed between NHS commissioners and providers to an agreed baseline level of activity, this will then be adjusted for actual performance using the National Tariff. Any underperformance against baseline will be repaid at 100% of the national tariff and any over performance will be received at 100% of the national tariff.

The tariff for each patient is calculated based on their clinical coding assessment. Coding is operated on a flex/freeze model where final coding must be completed by the freeze date to qualify for payment. The freeze date is typically 7 weeks after the end of the month in which the activity occurred, the full timetable is included for information. Any elective activity that remains uncoded after the applicable freeze date represents a loss of income for the Trust.

As at October 2025, the Trust has 2,290 uncoded elective spells & 3,840 uncoded non-elective spells. As demonstrated in the graph below, there is a 2 month lag at the end of each period where coding is completed to meet the applicable freeze dates. Based on coding trends captured over a two year rolling period, no significant coding issues have been incurred.



Month	Flex	Freeze
Apr-25	20 May 25	18 Jun 25
May-25	18 Jun 25	17 Jul 25
Jun-25	17 Jul 25	19 Aug 25
Jul-25	19 Aug 25	17 Sep 25
Aug-25	17 Sep 25	17 Oct 25
Sep-25	17 Oct 25	19 Nov 25
Oct-25	19 Nov 25	16 Dec 25
Nov-25	16 Dec 25	20 Jan 26
Dec-25	20 Jan 26	18 Feb 26
Jan-26	18 Feb 26	18 Mar 26
Feb-26	18 Mar 26	21 Jan 26
Mar-26	21 Apr 26	20 May 26

Key Risk Status

Red - Significant risk of non-delivery. Additional actions need to be identified urgently.

Amber - Medium risk of non-delivery which requires additional management effort to ensure success

Green - Low risk of non-delivery – current actions should deliver.

Financial Position Update - October 2025 Income & Expenditure

Income and Expenditure

In response to the significant deficits delivered during H1, the Providers within the System were asked to complete updated H2 trajectories to see improved performance over the next 5 months and ensure delivery of planned £9.8m deficit. The Trust has identified mitigations and these have been phased over the remaining months of the year, resulting in improved expected monthly performance when compared to submitted plans. The ICB and regional teams will be expecting monthly performance to deliver against these updated trajectories.

The overall revenue position of the Trust in Month 7 is a deficit of £0.497 million after technical adjustments, a favourable performance of £0.174 million against original plan of £0.671 million. Year to date, the Trust is £0.179 favourable (£17.440 million deficit) to the original planned deficit of £17.619 million, and £0.002 million favourable to the H2 trajectory plan.

The Trust has seen ongoing challenges in both emergency attendances and non elective admission in October, with high levels of no criteria to reside patients (see Performance report). Included within the substantive pay overspend (offset by vacancies) is c.£1.294m 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 and options to understand ward establishments and headroom analysis.

Non pay underspends are largely driven by drugs and stock underspends, however this is currently under review noting the ongoing implementation of the new Inventory Management System to ensure accurate recording and reporting is in place.

The Trust has a challenging plan for 2025/26, including current CIP plans of £29.1m (c.8.7% of expenditure budgets). This includes mandated guidance on reducing Agency spend by a further 30%, Bank Spend by a further 10% with the Trust driving a further push to 20%, and with NHSE focused corporate cost savings of c.£3.5m.

Statement of comprehensive income	In Month			YTD		
	Current Plan £'000	Actual £'000	Variance £'000	Current Plan £'000	Actual £'000	Variance £'000
Operating income from patient care activities	23,139	25,044	1,905	162,887	166,428	3,541
Other operating income	4,064	4,564	500	18,621	17,463	(1,158)
Employee expenses:						
- Substantive	(16,950)	(16,903)	47	(117,038)	(116,808)	230
- Bank	(715)	(1,180)	(465)	(5,836)	(8,500)	(2,664)
- Agency	(500)	(536)	(36)	(3,467)	(3,016)	451
Operating expenses excluding employee expenses	(9,265)	(11,130)	(1,865)	(69,725)	(70,265)	(540)
OPERATING SURPLUS/(DEFICIT)	(227)	(142)	85	(14,558)	(14,698)	(141)
FINANCE COSTS						
Finance income	50	96	46	350	854	504
Finance expense	(70)	(67)	3	(443)	(433)	10
PDC dividend expense	(417)	(417)	0	(2,919)	(2,921)	(2)
NET FINANCE COSTS	(437)	(389)	48	(3,012)	(2,500)	512
Other gains/(losses) including disposal of assets	0	0	0	0	2	2
Share of profit/(loss) of associates/joint ventures	0	0	0	0	0	0
Gains/(losses) from transfers by absorption	0	0	0	0	0	0
Movements in fair value of investments, investment property, financial liabilities	0	0	0	0	0	0
Corporation tax expense	(3)	(3)	0	(18)	(19)	(1)
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	(666)	(533)	133	(17,588)	(17,216)	372
Adjusted financial performance						
	Current Plan £'000	Actual £'000	Variance £'000	Current Plan £'000	Actual £'000	Variance £'000
Surplus/(deficit) for the period/year	(666)	(533)	133	(17,588)	(17,216)	372
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	(666)	(533)	133	(17,588)	(17,216)	372
Retain impact of DEL I&E (impairments)/reversals	0	0	0	0	0	0
Remove capital donations/grants/peppercorn lease I&E impact	(5)	36	41	(31)	(224)	(193)
Adjusted financial performance surplus/(deficit) including PSF as per a	(671)	(497)	174	(17,619)	(17,440)	179
Adjusted financial performance surplus/(deficit)	(671)	(497)	174	(17,619)	(17,440)	179
Revised H2 Trajectory	(399)	(497)	(98)	(17,442)	(17,440)	2

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Financial Position Update - October 2025
Trust Wide Performance: Agency

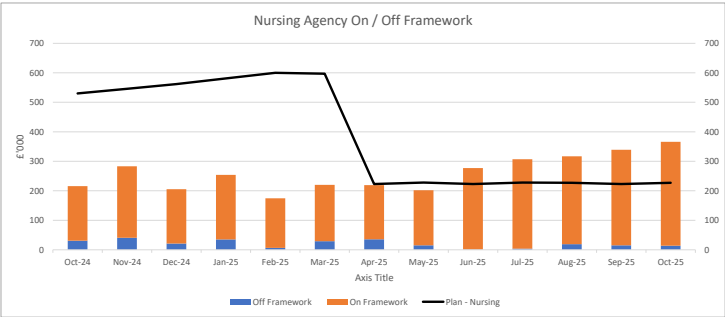
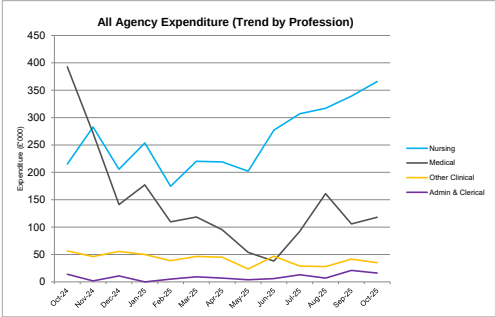
Pay Analysis - Agency

Agency costs in month 7 were £0.535 million against a plan of £0.500 million.

This is an improvement against spend in October last year (£679k) however a deterioration against prior months spend by £27k. Current year plans include a 30% reduction in agency spend from 2024/25 outturn (£6.5 million outturn), requiring a reduction of c.£2.4 million across the year. The Trust is on target to achieve this reduction with £1.2m agency efficiency achievement YTD.

There was an improvement against Medical agency spend compared to last month, with 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 prior months, worsening by £27k linked to continued 1-2-1 staffing requirements for mental health patients and increased activity linked to ED attendances.



Agency Spend by Profession (£'000)	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
Nursing	215	283	206	254	175	220	219	202	277	307	317	339	366
Medical	393	271	141	177	110	118	95	54	38	92	161	106	118
Other Clinical	56	46	56	50	39	46	45	24	47	29	28	42	35
Admin & Clerical	14	2	11	0	5	9	7	4	6	13	7	21	16
Total	679	602	414	481	328	394	366	284	368	441	513	508	535
Plan - Total Agency	833	833	833	833	833	810	464	487	456	548	464	548	500
Variance to Plan	154	231	419	352	505	416	98	203	88	107	(49)	40	(35)

Nursing Agency Category	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
Off Framework	31	41	21	35	7	29	36	15	1	4	19	15	14
On Framework	185	242	184	219	168	191	184	187	276	303	298	324	352
Total	215	283	206	254	175	220	219	202	277	307	317	339	366
Plan - Nursing	530	546	562	581	600	597	223	228	223	228	227	223	227
Variance to Plan - Nursing	315	263	356	327	425	377	4	26	(54)	(79)	(90)	(116)	(139)

YTD Actual	YTD Plan	Variance
2,027	1,577	(450)
664	1,642	978
249	248	(1)
74	0	(74)
3,015	3,467	452

Pay Metrics	In Month Actual	YTD Actual
Agency expenditure as % of total pay	2.9%	2.4%
Off framework expenditure as % of total agency	2.8%	3.0%

Areas Using Nursing Agency including Off Framework YTD (£'000)				
Area	On Framework	Off Framework	Total Nursing Agency	%
Emergency Dept Main Dept	439	4	442	22%
Purbeck Wd	260	2	262	13%
Day Surgery Unit	175	-	175	9%
Moreton Ward - Respiratory	149	1	150	7%
Ichester Integrated Assessment	135	-	135	7%
Lulworth Ward	118	-	118	6%
Surge Area	80	-	80	4%
The Mary Anning Unit	76	1	77	4%
Stroke Unit	76	1	76	4%
Maternity Unit	75	-	75	4%
Fortuneswell Ward	73	-	73	4%
Abbotsbury Ward	66	-	66	3%
Ridgeway Wd	46	-	46	2%
Crcu	39	30	69	3%
Kingfisher Ward	32	13	44	2%
Prince Of Wales	29	-	29	1%
Frailty Sdec	25	-	25	1%
Cardiology Care Ward	17	-	17	1%
Sdec	13	-	13	1%
Discharge Team	2	-	2	0%
Scbu	-	54	54	3%
Emergency Dept Medical Staff	-	-	-	0%
Emergency Dept Nurse Practitioners	-	-	-	0%
Respiratory Medicine	-	-	-	0%
Dch Hosted Gp Posts	-	-	-	0%
Evershot Ward	-	-	-	0%
Total Nursing Agency YTD	1,922	105	2,027	

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Financial Position Update - October 2025
Trust Wide Performance: Bank

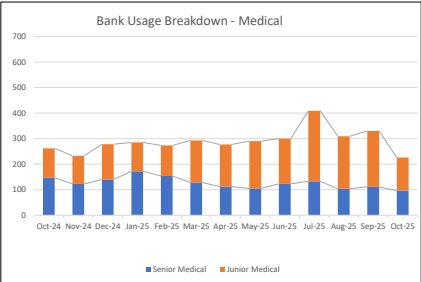
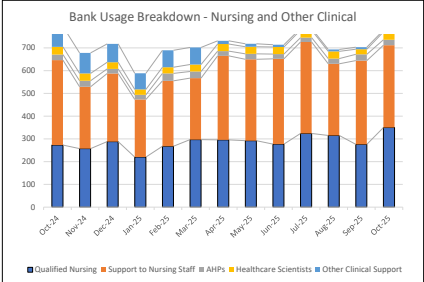
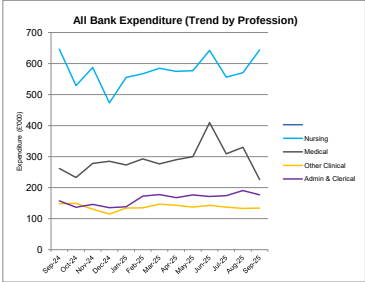
Pay Analysis - Bank

Bank costs in month 7 were £1.181 million against a plan of £0.715 million, similar to the levels seen in prior months, remaining relatively consistent across the past year.

Reduction in bank expenditure is a key focus area nationally, with a minimum of 10% cost reduction expected. As part of 2025/26 planning round, the Trust stretched this target to 20% equating to a cost reduction of c. £2.3m.

Workforce engagement is in place in this area to deliver enhanced booking controls across the Trust, and is being supported by NHSE to provide independent review and appropriate support.

This area requires key focus and will remain a strong area of scrutiny, with the same levels of rigour applied to the agency cost reduction programme developed.



Bank Spend by Profession (£'000)	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
Nursing	646	629	587	473	555	567	585	575	577	642	556	571	644
Medical	262	233	278	285	273	293	277	290	300	410	309	330	226
Other Clinical	148	149	130	115	134	135	147	143	137	143	137	133	134
Admin & Clerical	157	137	146	135	138	173	178	168	176	171	174	191	177
Total	1,213	1,048	1,142	1,009	1,101	1,167	1,186	1,176	1,190	1,366	1,176	1,224	1,181

Bank Category	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
Qualified Nursing	273	258	288	220	268	297	296	292	277	324	315	276	350
Support to Nursing Staff	373	272	300	253	288	270	369	358	375	402	315	368	362
AHPs	25	27	20	20	33	29	21	24	21	19	23	28	24
Healthcare Scientists	34	33	29	24	27	31	31	31	31	33	32	22	34
Other Clinical Support	90	90	81	71	75	75	14	13	10	8	8	9	8
Management / Admin	157	137	146	135	138	173	178	168	176	171	174	191	177
Senior Medical	147	123	140	172	154	128	112	105	123	133	104	111	96
Junior Medical	115	110	138	113	119	165	165	185	177	276	205	219	130
Total	1,213	1,048	1,142	1,009	1,101	1,167	1,186	1,176	1,190	1,366	1,176	1,224	1,181
Plan	826	776	724	669	611	554	830	851	801	917	867	855	715
Variance to Plan	(387)	(272)	(418)	(340)	(490)	(613)	(356)	(325)	(389)	(449)	(309)	(369)	(466)

YTD Actual	YTD Current Plan	Variance
4,150	3,184	(966)
2,141	1,409	(732)
974	789	(185)
1,235	454	(781)
8,500	5,836	(2,664)

Pay Metrics	In Month Actual	YTD Actual
Bank expenditure as % of total pay	6.3%	6.6%

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Financial Position Update - October 2025
Insourcing

Insourcing Narrative
The insourcing budget of £8.3 million is planned to deliver insourcing activity as presented to Committee during the 2025/26 planning round.
Year to date financial performance has delivered £0.07m favourably against year to date plan.
The latest forecast trajectory as at month 7 shows total spend of £8.1m which is in line with plan to deliver 65 week wait activity and Elective Recovery activity. Activity performance will continue to be monitored throughout the year and current forecast underspend may need to be redistributed to underperforming specialties to address performance targets.
The Trust is required to achieve an activity reduction of 27% against elective activity levels achieved in 2024/25 to align to funding envelopes available.

	Actual	Actual	Actual	Actual	Actual	Actual	Actual	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	472	994	700	680	700	700	640	699	4,839	8,258
Spend:														
Breast	13	13	26	15	26	13	13	0	0	13	0	0	119	132
Dermatology	144	126	128	116	145	67	170	118	118	118	118	118	895	1,487
Endoscopy/Gastro	131	107	48	118	105	8	96	107	107	107	107	107	612	1,148
ENT	91	48	11	64	46	191	46	50	50	50	50	50	497	748
General Surgery	6	6	(1)	12	0	12	6	6	6	6	6	6	40	69
Gynaecology	29	29	28	54	55	32	37	48	48	48	48	48	264	505
OMF	147	90	160	65	144	214	85	75	94	75	75	94	905	1,320
Ophthalmology	25	24	76	102	36	46	73	36	36	36	36	236	382	759
Orthopaedics	83	88	99	31	124	23	210	115	5	47	31	16	658	872
Urology	11	11	11	11	11	102	9	11	11	11	11	11	167	225
Theatre Staffing	0	122	57	57	56	9	65	89	89	89	89	89	366	809
Total spend	680	664	643	645	748	716	808	655	565	601	572	775	4,905	8,073
Surplus/(Deficit)	(23)	15	14	34	(276)	278	(109)	24	135	99	68	(76)	(66)	185

 Healthier lives  Empowered citizens  Thriving communities

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Financial Position Update - October 2025
Sustainability & Efficiency



Efficiency & Sustainability Programme Update

The annual efficiency target for the Trust is £29.1 million, made up of the following elements:

- 5% core annual requirement £18.1 million
- 3% central stretch linked to 2024/25 non-recurrent CIP £7.9 million
- 1% System stretch £3.1 million

As a part of the recovery plans, the Trust has submitted an updated H2 Trajectory (reported to Committee last month) which details expected improved monthly performance plus addresses a plan to deliver the previously unidentified £4.5m of CIP and a further £1.5m of System Stretch CIP schemes which had not progressed. As a result while efficiency delivery is ahead of original plans, it is in line with updated trajectory planning. Focus on delivery of the core 5% targets needs to be maintained and will be vital to meet full year plans.

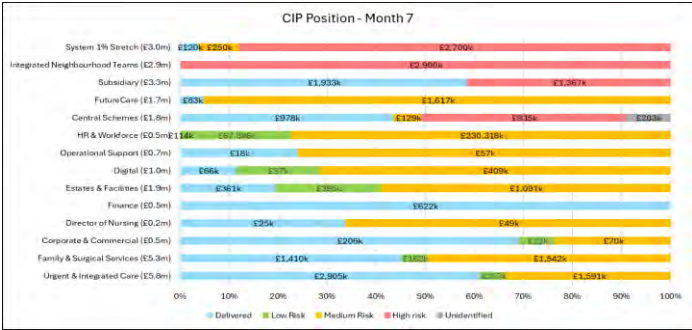
In month delivery of £3.2 million has been achieved, delivered from subsidiary offset income, biosimilar drug savings, agency cost reduction of Off Framework and the remainder largely from finance income (bank interest) and workforce pay savings (vacancies). This is £0.274 million ahead of plan YTD, with YTD delivery being £8.839 million. Included in month 7 delivery is an accrual for £1.9m of subsidiary offset income, as conversations continue with NHSE about whether this is cash backed or changes planned year end outturn following NHSE's change in stance on subsidiary approvals.

At the end of month 7 the Trust has delivered 30% of the £29.1m required CIP with only 5 months remaining, continued focus is needed to deliver full efficiency and Trajectory plans, with support from the new Improvement Director across the Federation.

Further work is ongoing led by the Financial Recovery Board to progress at-risk schemes, complete development and delivery of identified projects to plan.

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	Unidentified (pre H2 trajectory) £'000	Delivered £'000	YTD Plan £'000	Variance to YTD Plan £'000
Core main - 5%							
Urgent & Integrated Care	5,757	-	5,757	1,004	2,905	2,402	503
Family & Surgical Services	5,347	-	5,347	2,233	1,410	1,497	(87)
Corporate & Commercial	277	183	460	162	206	59	147
Director of Nursing	117	117	234	160	25	14	11
Finance	244	244	488	-	622	265	357
Estates & Facilities	942	905	1,847	-	361	971	(610)
Digital	518	471	989	417	66	231	(165)
Operational Support	223	-	223	149	18	24	(6)
HR & Workforce	304	208	512	214	114	128	(14)
NR slippage	-	-	-	-	-	-	-
Central Schemes	-	-	2,246	203	1,098	1,216	(118)
Unidentified	-	-	-	-	-	757	(757)
	13,729	2,128	18,103	4,542	6,825	7,564	(739)
Central NR stretch - 3%							
FutureCare - operational pressures demand increase challenge			1,700	-	83	-	83
Subsidiary offset income			3,300	-	1,933	552	1,381
Integrated Neighbourhood Teams			2,900	-	-	-	-
	-	-	7,900	-	2,016	552	1,464
System Stretch - 1%							
System - WorkStream 4 - RMC			1,300	-	-	215	(215)
System - WorkStream 4 - Revisit unpalatable list			100	-	-	16	(16)
System - WorkStream 4 - Commissioning for sustainability			600	-	-	100	(100)
System - WorkStream 4 - Virtual wards			200	-	-	33	(33)
System - WorkStream 4 - Balance sheet release			370	-	-	-	-
System - WorkStream 4 - system transformation/technical adjustments			500	-	-	83	(83)
	-	-	3,070	-	-	447	(447)
Totals			29,073	4,542	8,841	8,563	278



H2 Trajectory Recovery Gap:	
H2 Trajectory Recovery Summary:	
Service led investments	
Further tightening grip & control measures	
Asset Disposal	
Pay award gap funding	
Planned efficiency delivery	

Financial Position Update - October 2025



Cash

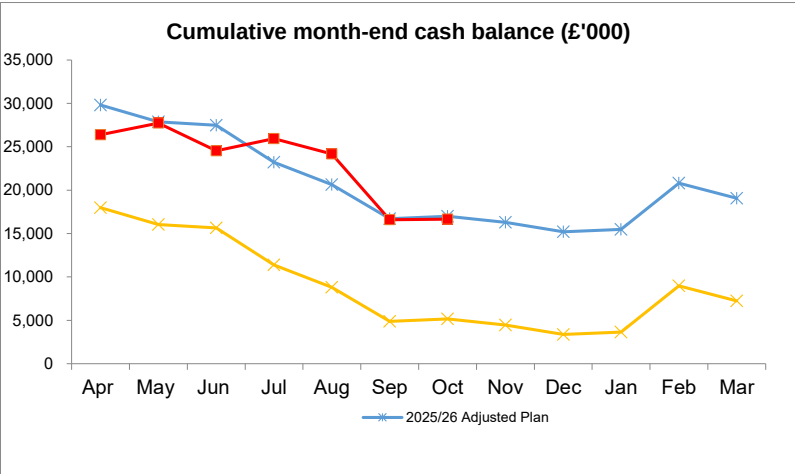
Cash Balance incl Forecast

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 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 £16.6 million at the end of October, which is £0.3 million behind adjusted plan. The Trust benefitted from receiving the Health Education England income in October relating to Months 7 to 10 of which £3.4 million relates to future months, however this is offset by the costs of the 2025/26 payward (including Tax/Nl and Superannuation) £0.8 million, extra week for supplier & NHS payments £1.2 million, and timing of drawdown of PDC capital funding £1.7 million which will catch up.

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. This is reflected in internal BAF and risk register reporting.

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)	0.86
Quick Ratio (As above excluding Inventories from current assets)	0.77
Creditor Days (Average days to pay creditors)	134
Debtor Days (Average days to receive payment for debtor invoices)	29
Inventory Holding Days (Average days inventory is held)	28

Cumulative cash balance	Apr £'000	May £'000	Jun £'000	Jul £'000	Aug £'000	Sep £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000
2025/26 Submitted Plan	17,985	16,046	15,653	11,395	8,809	4,873	5,152	4,450	3,372	3,656	8,967	7,237
2025/26 Adjusted Plan	29,815	27,876	27,483	23,225	20,639	16,703	16,982	16,280	15,202	15,486	20,797	19,067
2025/26 Actual	26,395	27,726	24,550	25,947	24,176	16,592	16,648					

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Financial Position Update - October 2025

Capital



Capital Programme Narrative
Capital expenditure year to date to the end of October was £12.8 million and behind plan by £8.6 million.
Internally Funded schemes and donated schemes are overall ahead of plan at the end of October by £0.7 million.
Digital and Medical Equipment Schemes combined 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 and timing of expenditure.
Externally Funded capital expenditure was £6.0 million behind plan due to timings of expenditure on New Hospital Programme (NHP) construction works.
Donated expenditure is ahead of plan by £0.2 million due to timing of expenditure on Chemotherapy Unit works but this is offset with donated asset income.
Leased expenditure is behind plan £2.5 million due to timing of Admin offices and One Dorset Pathology Lot 5 and lease remeasurements.
Included within the capital plan are bids that the Trust has submitted to NHS England and have now been approved 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 was notified of non-cash backed additional internally funded capital envelope of £1.0 million for Urgent & Elective Care in early July, and funding confirmation in September of £0.5 million towards a patient engagement portal.
In October, the Trust was notified of additional PDC funding of £2.1 million for Estates Safety Fund to address backlog maintenance. Stroke Unit PDC system transfer of £2.3 million from Somerset CS has been included following guidance from NHS England.

CAPITAL	CURRENT MONTH			YEAR TO DATE			FULL YEAR 2025/26			
	Plan	Actual	Variance	Plan	Actual	Variance	Committed Spend	Forecast	Annual Plan	Variance
<i>Estates</i>	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Generator	100	-	100	100	-	100	-	-	800	800
High Acute Stroke Unit (HASU)	100	-	48	148	398	52	757	757	757	-
Other UEC Schemes	-	-	-	-	-	-	-	-	-	-
Estates Schemes	122	32	90	599	869	-	1,069	1,301	1,111	-
<i>Digital Services</i>										
EHR Matched Funding	-	51	-	51	311	-	1,031	1,781	1,781	-
IT Schemes	81	150	-	69	882	1,042	1,619	1,875	1,219	-
<i>Equipment</i>										
Other Equipment	255	162	93	582	447	135	525	2,505	1,557	-
Sub-Total Internally Funded Expenditure	658	346	312	2,613	3,066	-	5,001	8,219	7,225	-
<i>Donated</i>										
Other Donations	-	-	-	-	-	-	-	-	-	-
Chemotherapy Unit Refurbishment	40	-	40	280	478	-	478	480	480	-
Sub-Total Planned Donated Expenditure	40	-	40	280	478	-	478	480	480	-
<i>IFRS 16 Lease Additions</i>										
Admin Offices	-	-	-	1,500	-	1,500	-	1,500	1,500	-
MSCP Lease remeasurement	-	-	-	500	605	-	605	737	500	-
CEF Lease remeasurement	-	-	-	400	92	308	92	263	400	137
One Dorset Pathology	-	-	-	750	-	750	-	750	750	-
Other Leases	700	-	700	700	80	620	80	600	600	-
Accommodation & Vehicle Lease Additions	82	7	75	232	15	217	15	282	382	100
Sub-Total Planned IFRS 16 Expenditure	782	7	775	4,082	792	3,290	792	4,132	4,132	-
Total Internal & Leased Capital Expenditure	1,480	353	1,127	6,975	4,336	2,639	6,271	12,831	11,837	-
<i>Additional funded schemes</i>										
NHP Works	2,500	883	1,617	12,789	7,707	5,082	27,789	27,789	27,789	-
Digital EHR Funding	40		40	280		280		5,482	5,482	-
CIR Funding - Generator	200	40	160	600	69	531	272	1,800	1,800	-
CIR Funding - Renal OP Unit	-		-	-		-	35	600	600	-
CIR Funding - SSD Plant	-		-	302		302	302	302	302	-
Constitutional Standards - Diagnostics	-	8	-	-	179	-	421	550	550	-
Constitutional Standards - Elective	-	64	-	244	64	180	64	869	869	-
Constitutional Standards - UEC	200	459	-	250	459	-	850	2,850	2,850	-
LIMS Reach Programme	-	-	-	-	-	-	-	78	-	-
Critical Cybersecurity Infrastructure Risks	-	-	-	-	-	-	-	20	-	-
Patient Engagement Portal	-	-	-	-	-	-	492	492	-	-
CDC Pathway Optimisation	-	-	-	-	-	-	-	243	-	-
Somerset Stroke	-	-	-	-	-	-	2,245	2,323	-	-
Estates Safety Fund 2526 Phase 2	-	-	-	-	-	-	-	2,086	-	-
Total Externally Funded Capital Expenditure	2,940	1,454	1,486	14,465	8,478	5,987	32,470	45,484	40,242	-
Total Capital Expenditure	4,420	1,807	2,613	21,440	12,814	8,626	38,741	58,315	52,079	-
Expenditure as a % of Plan			41%			60%				112%

People and Culture Committee in Common Assurance Report
for the meeting held on Monday 24 November 2025

Chair	Frances West, NED
Executive Lead	Nicola Plumb, Joint Chief People Officer
Quoracy met?	DHC Y DCH Y, except for 2pm to 2.25pm
Purpose of the report	To provide assurance on the main items discussed and, if necessary, escalate any matter(s) of concern or urgent business.
Recommendation	To receive the report for assurance

Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework	• Board Assurance Framework and Corporate Risk Register discussed by committee, as detailed below • Appointment of joint risk manager in early November; work starting to align reporting and procure a joint risk management system. • Ongoing work to develop and set the right foundations for the joint Anti-Racism and Inclusion Joint Framework

Key issues / matters discussed at the meeting	The committee received, discussed and noted the following reports: Chief People Officer Update noting: • The focus on strengthening staff voice at this time of year, particularly in relation to the staff survey, staff vaccinations, and staff experience given the increasing demand over winter. The work of the Joint Culture and Inclusion Reference Group, including reviewing the anti-racism framework, was noted. • Closure of the formal grievance with Unison relating to the proposed subsidiary company. • Staff across the federation feeling pressure due to winter demands • DHC had been invited to apply to be an Advanced Foundation Trust (AFT); this was a great way to inject energy across the trust. Annual Education Self-Assessment/Overview (DCH/DHC) noting that both trusts met the obligation to report to NHS England. The two trusts shared similar challenges which could be addressed together. Achievements were detailed in the report. The opportunity to share learning and spread improvement methodology between the trusts was noted. GMC Survey Action Plan (DCH/DHC) <u>Dorset HealthCare</u> noting some concerns re core trainers and availability of supervision but work ongoing to improve this. Difficulty recruiting consultants was a contributing factor.

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Dorset County Hospital noting the trust compared favourably with other trusts in the area. Problem areas included burnout, stereotyping of trainees and the need for more trainers but there was high confidence in the reporting mechanisms.

Both action plans were approved by the committee.

Board Assurance Framework (Assigned Risks) (DCH/DHC): SR3 Workforce Capacity continued to be one of the highest scoring risks within the Board Assurance Framework. Details provided regarding the risk appetite statements. Delivery of wholetime equivalent (WTE) reductions continued to be a challenge, particularly at DCH.

Corporate Risk Register (Assigned Risks) (DCH/DHC)

Dorset HealthCare:

- No risks scoring 20+. Six risks scoring 15+. One new risk added re dysphagia staffing scoring 15.
- Four changes in risk score, with one increase and three reductions below threshold for committee.
- Overdue risks continued to be monitored closely

Dorset County Hospital:

- No new risks for the committee. An update on the risk relating to digital workforce was provided to the Strategy, Transformation and Partnership Committee in Common.
- Discussion around risk 1664 re no availability of registered child nurses in children's centre outpatients. DD and EJ to discuss this further outside of the meeting, may need to be referred to Quality Committee in Common in future.

Workforce KPI Dashboard (Joint)

Dorset HealthCare:

- Key data included a reduction in sickness absence, revision of the WTE target with an additional 136 WTE reduction to make, high level of employee relations cases with work ongoing to understand any common themes. Fluctuations in staff turnover in recent months (leavers data was being collected to understand why).
- Staff vaccination stood at just below 40%
- Reduction in appraisal rates following the move to a new platform, which should provide more accurate data.
- Recent approval of a joint apprentice policy

Dorset County Hospital:

- Flu vaccination stood at 53.5%
- WTE figures were challenging; a plan was in place to address headroom challenges, and any changes need to be sustainable

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- Improving mandatory training rates, currently at 89%. Appraisal rates were missing sustained improvements. Positive retention rates but this was impacting WTE delivery. Slight reduction in sickness in month.

Joint Workforce Wellbeing Plan Update (Joint) noting positive progress against actions within both trusts. Plans to move the wellbeing teams to the occupational health team, which aligned with the 10-year plan. Building data insights is a priority for both trusts.

Anti-Racism and Inclusion Joint Framework (Joint). This had been through SLG, JEMT and a Board Development Session and set out how to work to becoming anti-racist organisations. The approach ensured the right foundations were in place before a case was made, including systems, training, guidance etc. Thanks were extended to those who contributed to the anti-racism Board Development Session and the excellent work ongoing in this space was acknowledged.

Guardian of Safe Working Report (DCH/DHC)

Dorset HealthCare noting no safety concerns and a broadly similar position to the last report. The Guardian had been on extended leave for some time and consideration was being given to how to cover this role for longer still.

Dorset County Hospital noting that exception reporting had been extended to locally employed doctors. Exception reporting had moved to healthrota, with more reports made than previously but this was felt to be the result of a change in culture about putting in requests (lower thresholds for reporting additional hours worked, easier reporting process). The high reporting did not indicate more safety concerns; of the 247 exception reports raised in the period there had been only nine immediate safety concerns.

Freedom to Speak up Report (DCH/DHC)

Dorset HealthCare:

- A total of 122 freedom to speak up (FTSU) cases in Q1 and Q2. A focused speak-up group raised 23 patient safety cases due to changes in admission criteria to an inpatient unit.
- Key themes included lack of psychology safety, inappropriate behaviours and some HR issues. Six cases led to formal action
- A positive external review of FTSU arrangements in DHC

Dorset County Hospital:

- A total of 235 contacts in Q1 and Q2, only four were anonymous suggesting staff feel safe to raise concerns.
- FTSU guardian is in regular discussion with executives, the FTSU NED and departments to triangulate information, identifying areas needing additional support.

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- Work continues to raise the profile of FTSU continued, a joint FTSU strategy with DHC was planned for next year as well as a joint matrix to help stratify the severity of concerns.
- Visibility of the FTSU guardian and promotion of the service was felt to account for the high level of reporting.

Maternity Multiprofessional Training Report Q2 (DCH) providing evidence for compliance with the Maternity Incentive Scheme (MIS) including:

- Safety action 6: Compliance with carbon monoxide monitoring, attendance at Saving Babies Lives training update, and Very Brief Advice training (threshold met since the report was written)
- Safety action 8: Expecting to be fully compliant by end of MIS year (30th November)
- The committee approved the extension of the PROMPT training period by six months for rotational anaesthetic staff who joined after July 2025

Protection of Title 'Nurse' (Joint) following change in legislation. Task and finish groups had been set up in both trusts to review all roles in the organisation to ensure they were compliant. The change in legislation was positively received.

Effectiveness of the Responsible Officer Advisory Group (Joint) noting that the group had meet approximately five times, and focused on serious concerns at both trusts, whilst trust specific Responsible Officer groups monitored low level concerns. The group was described as 'establishing' and was working but there was room for improvement. There was value in the discussions and positive medical leadership.

Assurance reports from below sub-groups of the People and Culture Committee in Common

- Joint Culture and Inclusion Reference Group

DCH:

- Local Negotiating Committee

DHC:

- Equality, Diversity, and Inclusion Steering Group
- Trade Union Partnership Forum
- Workforce Wellbeing Group

Consultant Job Planning Benchmarking Internal Audit Report noting the opportunity to ensure parity in job planning and longer-term ambitions to consider team job planning.

10-point plan update (AOB)

Decisions made at the meeting

- Approval of the DCH and DHC GMC Survey Action Plans

	DCH Committee approved the extension of the PROMPT training period by six months for rotational anaesthetic staff who joined after July 2025
Issues / actions referred to other committees / groups	Nil

Quoracy and Attendance						
	28 May 2025	28 Jul 2025	22 Sep 2025	24 Nov 2025	26 Jan 2026	23 Mar 2026
Quorate?	Y	Y	Y	DHC Y DCH Y, except for 2pm to 2.25pm		
Frances West	A	Y	Y	Y		
Suresh Ariaratnam	Y	Y	Y	Y		
Margaret Blankson	Y	Y	Y	A		
Dawn Dawson	Y	Y	A	Y		
Eiri Jones	Y	Y	Y	Y (absent 2-2.25pm)		
Lucy Knight	Y	Y	Y	Y		
Nicola Plumb	A	Y	Y	Y		
Rachel Wharton	A	A	A	Y		

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Report to	Board in Common (DHC Board)	
Date of Meeting	09 December 2025	
Report Title	Freedom to Speak Up Reports – Quarter 1&2 DHC and DCH	
Prepared By	Anne Hiscock - Freedom to Speak Up Guardian; DHC	
Accountable Executive	Nicola Plumb - Chief People Officer	
Previously Considered By	People and Culture Committee in Common, 24/11/2025	
Action Required	Approval	-
	Assurance	X
	Information	-

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below	
Board Assurance Framework	SR2 Culture – The FTSU policy forms part of the controls and assurance through the quarterly and annual reports. The schedule of reporting for 2025 has been mapped to Dorset County Hospital and is now submitted twice yearly (Q1&2 and Q3/4) to the people & culture committee in common along with a high-level monthly report within the KPI dashboard.	
Financial	Potential risk can result where employees take cases to employment tribunal.	
Statutory & Regulatory	The standard NHS contract requires that all trusts and foundation trusts employ a Freedom to Speak up Guardian which is now an established role across the NHS and was a recommendation of the Freedom to Speak Up Review by Sir Robert Francis that was published in 2015. The content of this report is aligned to the guidance set out in the <i>'Freedom to Speak Up: A guide for leaders in the NHS and organisations delivering NHS services'</i> (2022), p33-34.	
Equality, Diversity & Inclusion	The reporting methodology includes staff data relating to the protected characteristics where this is known.	
Co-production & Partnership	The report includes data provided by the learning and development team, the Organisational Development team and the HR team.	

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Executive Summary

This is the quarter 1&2 report on Freedom to Speak Up (FTSU) in Dorset HealthCare (DHC) for 2025.

The Freedom to Speak Up Guardian role has been in place since 2016 as an outcome of the Mid Staffordshire enquiry, led by Sir Robert Francis (2015).

In early 2020 a substantive FTSU Guardian post [3 days per week] was created for the first time in DHC. Prior to this, the role had been an addition to existing portfolios.

Currently we have 3 Associate Guardians at DHC who have undertaken the NGO training and who support the Guardians when capacity allows.

Further ring-fenced funds were secured in the summer 2024 for a Deputy Guardian, 3 days a week and a team administrator 2 days a week. The team administrator commenced her role on the 4th November 2024; the Deputy Guardian joined the team at the end of January 2025.

Now that capacity allows, work has been undertaken to recruit local Champions in order to increase reach across the organisation; we have in the region of 30 Champions currently and will continue to recruit as part of a rolling programme.

Quarterly data returns are sent to the National Guardians Office (NGO) and published on the NGO website, alongside all other NHS Trust returns. Quarter 2 returns have been submitted.

Themes and learning are captured within this report; the FTSU Guardian's share learning with staff and colleagues in a variety of ways in order to promote a positive culture of raising concerns.

The Guardian's attend national and regional events to ensure best practice is brought back and embedded within both DHC and DCH.

The Guardian's receive supervision from a peer Guardian and at DHC receive robust support from the previous DHC Guardian. The Guardian's receive support and supervision additionally from Executive/Non-Executive team members as required.

Quarter 2025	Number of contacts: DHC		Quarter 2025	Number of contacts: DCH
Q1	57		Q1	119
Q2	65		Q2	116

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Dorset HealthCare - Freedom to Speak Up Report

Quarter 1&2 Annual Report

1.0 Introduction

- 1.1 Sir Robert Francis in his Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry (2013) described the experiences of nurses and doctors who raised concerns about the poor care of some patients at Stafford Hospital. As a result, he was asked to conduct a further review into raising concerns in the NHS.
- 1.2 'Freedom to Speak Up – an independent review into creating an open and honest reporting culture in the NHS' was published in 2015. The report identified a need for culture change, improved handling of cases, measures to support good practice, particular measures for vulnerable groups, and extending the legal protection. In particular, he recommended that all Trusts should have a Freedom to Speak Up Guardian to 'act in a genuinely independent capacity' and support staff to raise concerns.
- 1.3 In 2016-17 it became a contractual requirement for all NHS provider Trusts to have a Freedom to Speak Up Guardian. All Trusts in England have made appointments and all Guardians are now in post.

2.0 Main narrative

Assessment of Cases

- 2.1 In quarters 1&2 of 2025/26, **122** contacts were made to the FTSU service as per Trust policy, **34** of which remain open, largely due to them being more recent cases or in the instance of longer established cases, HR process and long-term sickness being a factor.

Table 1

Quarter	Patient Safety/ Quality	Staff Safety/ wellbeing	Bullying and Harassment	Other Inappropriate Behaviours	Anonymous
1	3	57	1	57	2
2	20	65	2	65	2

- 2.3 Bullying and harassment concerns were lower compared to last year's Q1&2 data [4+6] with **99** cases of staff reporting **not feeling psychologically safe** to some degree, which was predominately linked with poor relationships mainly with managers and secondly with colleagues. These cases are reported under the heading of 'other inappropriate behaviours and illustrated in table 3.

- 2.4 Two staff reported sexual safety concerns which were addressed formally and one member of staff reported feeling physically unsafe regarding colleague's behaviours.

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2.5 In quarter one – three **patient safety** concerns were raised. All of these related to staff raising concerns about colleague’s safety to practice. Each one has been addressed by the service managers.

2.6 Of the 20 patient safety issues in Q2, 15 came from a group concern which is being addressed through formal channels and relate to a change in service criteria.

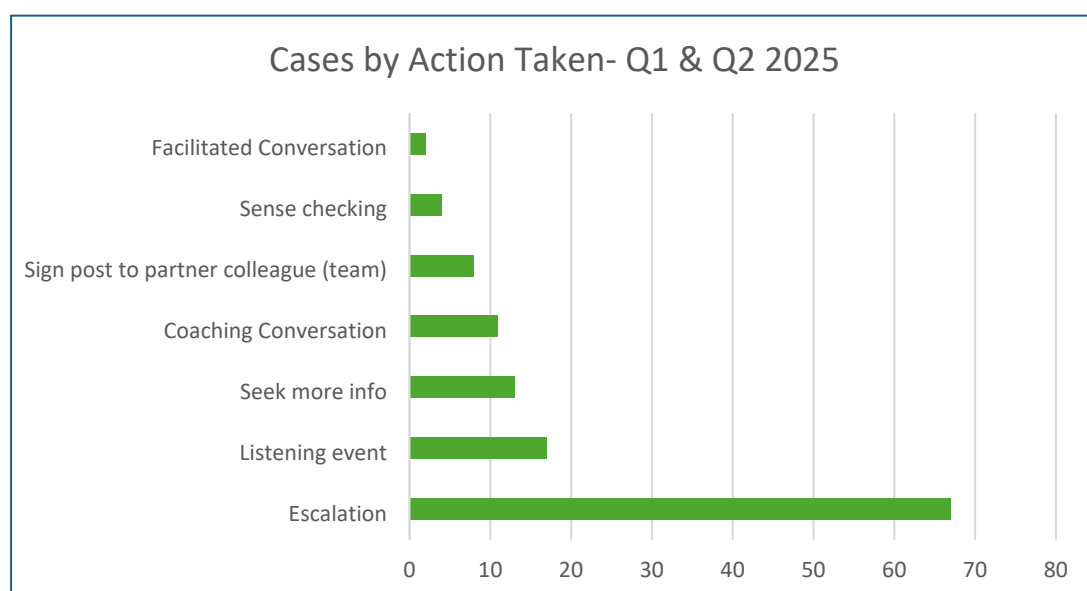
Of the other five cases: one related to a colleague’s safety to practice which was addressed by the manager. One was a drug error that is under review. One was around staff sleeping on night duty which has been reported to service leads. One was around delays in care which was addressed by the service manager and the final one was around the poor relationships between two services currently under review by service leads.

2.7 In many cases, several concerns have more than one element assigned to them, for example where there are relationship issues or concerns around bullying and harassment, staff often feel psychologically unsafe. Where staffing levels have been reported there may be a patient safety concern also.

2.8 Different approaches are adopted by the Guardians in order to facilitate a local informal resolution where possible and appropriate: **eleven** were resolved by having a coaching conversation with the member of staff; **sixty-seven** were escalated and resolved jointly with the line manager; **thirteen** cases were staff ‘sense checking’ and **eight** were sign posted to a partner team; **two** cases were resolved by holding a facilitated conversation.

Quarters one & two position as below:

Table 2



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Other Inappropriate Behaviours Concern Themes

- 2.9 Below is a table outlining themes that historically did not fit into the NGO defined reporting categories which now sit under the 'other inappropriate behaviours' category [122].

Table 3



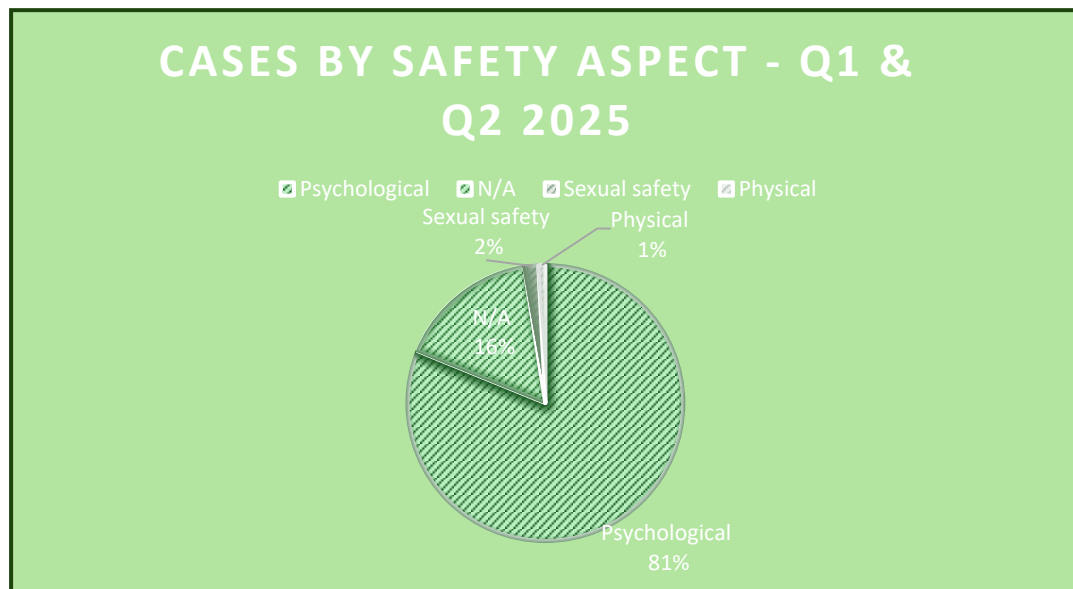
* N/A relates to concerns that came under other categories i.e. patient safety / B&H

- **Relationships:** reflect staff and line manager interactions that could have been managed differently. Some staff reported that they have been treated harshly; feel that they have not been fully supported by their line manager resulting in a breakdown in relationship in some cases. Where this happens, the Guardian offers a facilitated conversation or signposts the member of staff to the Trust's Mediation service.
- **Colleague behaviour:** some relate to bullying behaviours in the workplace – raised voices; behaving in an intimidating manner; accusatory style of communication and inappropriate handling of a work base situation.
- **HR process:** [6] two related to members of staff going through a formal process another other being around the 'Sub Co'. One related to the closure of a service; and a further two cases related to perceived unfair recruitment process.

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2.10 The Q1&2 position for staff safety is illustrated in the table below:

Table 4



2.11 To note, these cases are from the perspective of the staff raising the concern; some may well be the case; others have an element of the case and others are the perspective of the member of staff.

3.0 Analysis of trends

Service

3.1 Staff who raised concerns through quarter 1&2 mainly work in the community services [56] and Mental Health Directorates [45] as these have the largest workforce. Please see table below for a high-level breakdown:

Table 5

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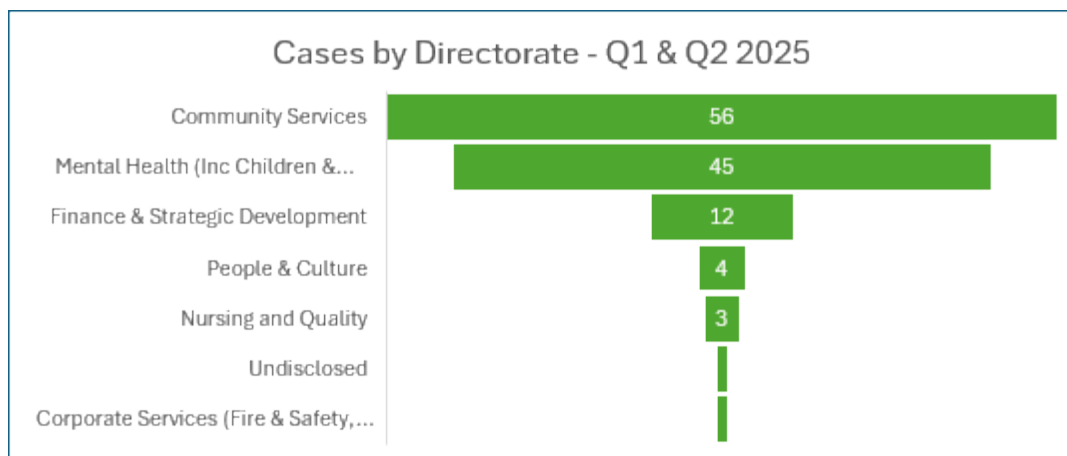
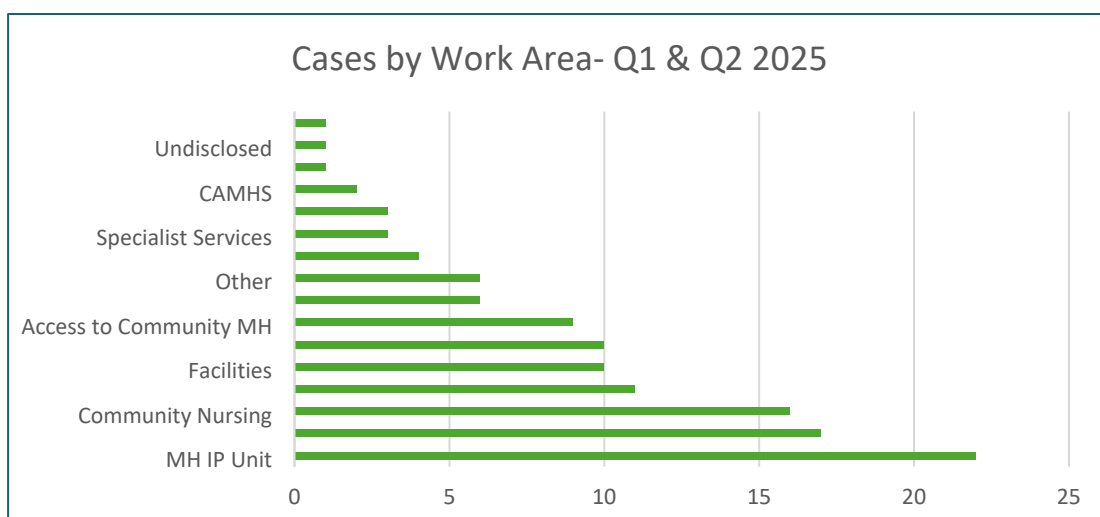


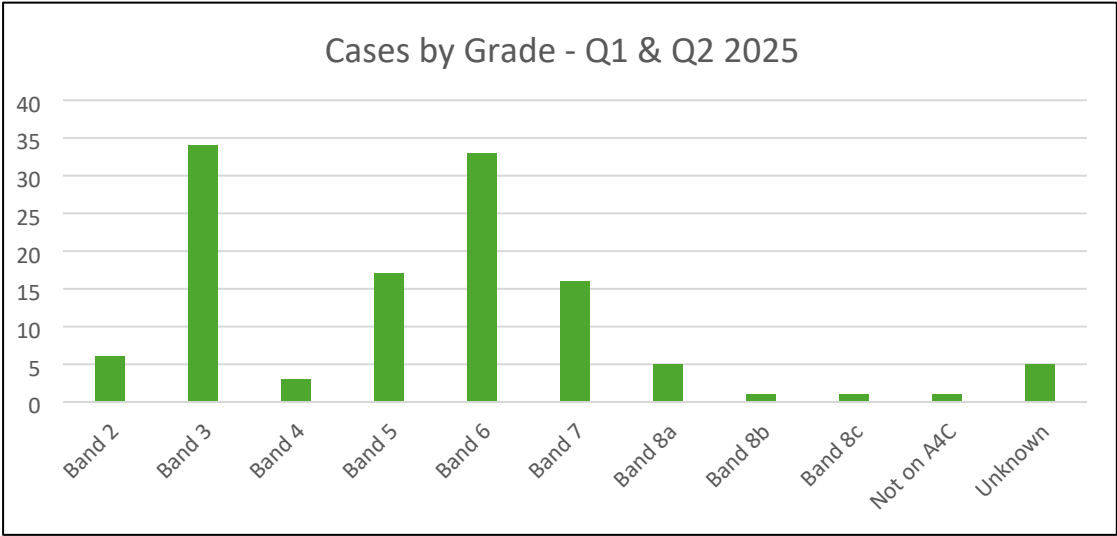
Table 6



- 3.2 Community services was the highest group to report concerns for Q1&2, followed by Mental Health and then Estates [facilities].
- 3.3 Table six provides a little more detail of where staff who have raised concerns are based: with mental health inpatient units being the highest number, followed by community nursing and facilities.
- 3.4 To add a little more context, the following table illustrates pay grades of staff who have raised concerns over Q1&2:

Table 7

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3.5 Bands 3 and 6 are almost neck and neck [33/34] followed by band 5 [17] and band 7 [16].

Red Flag Services

3.6 Continuing on from the 2024/25 annual report, a focused piece of work was carried out late 2024 with one of the access to MH teams with Executive oversight, an action plan was developed and improvements made, the case was subsequently closed down. There was one concern raised since which related to a specific personnel issue which was resolved.

3.7 The in-patient ward referred to in the annual report related to relational issues between medics and senior nurses has also resolved, mediation took place. The nurses moved location, and a new senior nurse was recruited. No further concerns have been raised since the case was closed.

3.8 The concern relating to the closure of a clinical service has also been closed as this was resolved.

3.9 The community service that flagged at the end of 2024 has not been closed down as issues continue. The main themes are around culture & leadership concerns raised by staff. The service leads continue to work on resolving this complex situation.

3.10 Through quarters 1&2 three services flagged:

- One related to an elevated level of concerns raised by staff regarding ways of working and job banding. Listening Events were held and feedback provided to the senior service lead. Resolution was achieved with most aspects; however, with regard to the job banding issues, resolution was not achievable. The case has since been closed - no further concerns have been raised since.
- The second service related to a community service where there were significant relational issues with a patient. A Listening Event was held and feedback

provided to
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the service leads. A meeting took place with the team managers and senior service leads, and a plan was developed to reach an improved way of working. This case has been closed - no further concerns have been raised since.

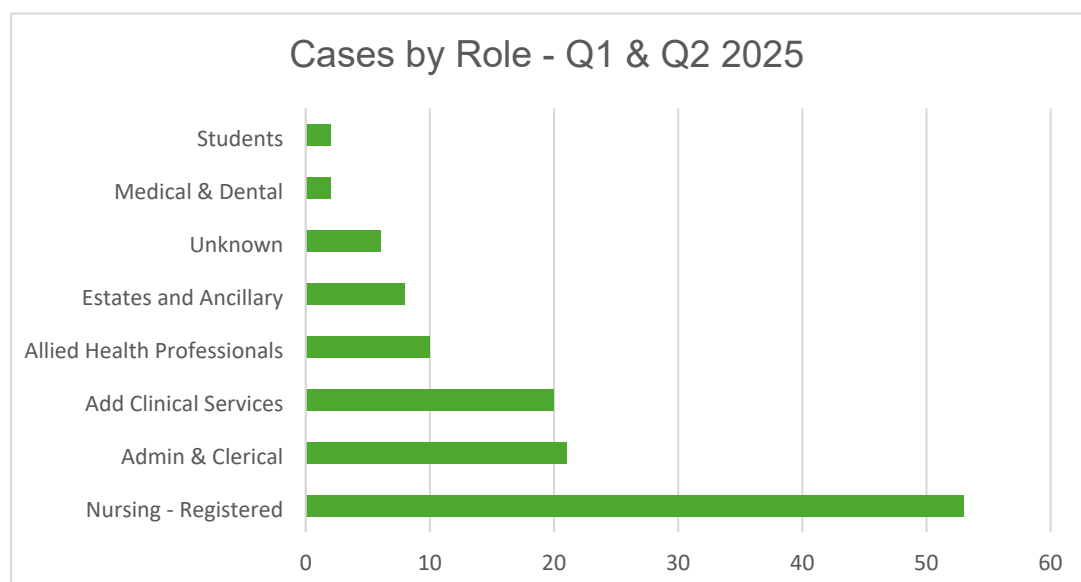
- The third service to flag was an in-patient unit where the admission criteria had been changed which led to staff feeling not listened to and unprepared for the change. A Listening Event was held with the staff and feedback was provided to the service leads/directors and executive directors. This case is following a formal process, hence closed down by the Guardian.

3.11 Should the P&C Committee Chair/Freedom to Speak Up NED require further detail on these cases, they can contact the Guardian for more information. These cases are discussed in more detail at the quarterly senior oversight meetings attended by FTSU NED and Exec Leads and Guardian.

Professional Background

3.12 Roles of staff expressing concerns are listed below:

Table 8



3.13 Registered Nurses [53] are usually the larger staff group to report concerns, which is in alignment with the national picture as this is one of the largest workforce groups, Admin & Clerical came second [21] which is a similar figure to Q4 data; followed by 20 support workers [additional clinical services].

3.14 **Detriment** is a growing concern for the NGO nationally, and this forms part of our quarterly data submission to the National Guardian Office. Out of the **122** contacts for

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this reporting period, **five** people [**4%**] in total reported detriment:

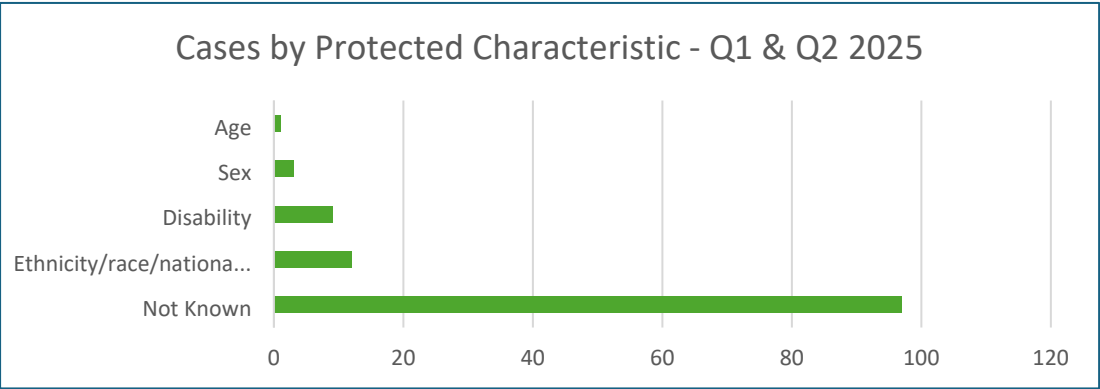
- One person was a witness in an HR investigation and felt intimidated by the colleague at the centre of the investigation.
- Two people (separate services) fed back to service manager some areas they thought could be improved upon within the service and subsequently did not get a job they were waiting/applied for.
- One person raised concerns to their manager and subsequently felt ignored by their manager.
- The fifth person raised a concern with their manager and felt they were treated poorly afterwards.

- 3.15 The detriment reported during this period has been explored through informal fact-finding processes – and have been addressed by the senior manager in each case, with the exception of the fifth case as this was reported anonymously.
- 3.16 Likewise **anonymous** concerns are reportable within the NGO data submission, and as illustrated in table 1, we received **four** anonymous concerns during this reporting period.
- 3.17 Out of the **122** contacts, **twenty-five** members of staff were from a **protected characteristic** group that the Guardian was aware of (**20%**). **Twelve** were from different ethnic backgrounds and **nine** had a disability, the themes were:

- Manager behaviour
- Colleague behaviour
- Line manager behaviour and overbearing case load
- Unfair management of planned sickness (surgery) for disability
- Lack of reasonable adjustments being put in place
- Poor performance cited
- Recruitment

- 3.18 The table below provides a more detailed breakdown:

Table 9



- 3.19 The NGO does not currently require us to collect this data; however, the Guardian feels this is vital data to collect that may potentially inform other internal DHC workstreams, in order to support our corporate and moral stance on discriminatory behaviours in the workplace; furthermore, it is a recommendation from the 'Insightful Provider Board' Guide (November 2024):

<https://www.england.nhs.uk/long-read/the-insightful-provider-board/>

Contacts That Led to Formal Action

- 3.20 Out of all the concerns raised in Q1&2; all bar **six** have been, or are in the process of being, resolved informally through support at meetings, facilitated meetings; coaching; signposting, mediation or speaking to the relevant manager to seek informal mutual resolution. **Six** are being explored more formally – outcomes are not reached on all as yet:
- sexual safety concern – investigated; not enough evidence was found
 - misconduct case and addressed formally
 - grievance regarding manager behaviour (2 separate cases) currently under review
 - sexual safety currently under review
 - group grievance currently under review

4.0 Learning and improvements

- 4.1 In relation to the patient safety concerns as through all quarters, these have been resolved at the time of the concern being raised with the exception of the cases [2] referenced in paragraphs 2.5 & 2.6 where one is going through a formal process and the other is under current review by the senior service leads.
- 4.2 The Guardian has been co-opted onto the 'Joint Culture and Belonging Reference Group Sub-Group' where it is anticipated that rapid action will be taken forward in order to represent staff voices aligned with the joint strategy. One of the first priorities is to develop a quick and easy way for staff to report racial abuse concerns.
- 4.3 The Guardian is also working closely with the EDI & OD leads to review the current arrangements for managers implementing reasonable adjustments for staff with neurodiverse conditions, particularly as this issue is raised with the Guardian on a regular basis.
- 4.4 **Detriment** and lack of psychological safety remains a key feature when staff raise concerns, with **81%** of staff reporting feeling unsafe to raise concerns. In the Q2 Staff Survey, detriment questions were included - further information on this is detailed in section 6 of this report.
- 4.5 The report indicates that most staff raise concerns within their own chain of command – with **18.2%** raising concerns with the Guardian; **24.1%** reported a negative impact when they spoke up, mostly poor behaviours and being perceived as a troublemaker.

- 4.6 The comments received in the free text boxes were troubling – we need to do more to address the issue of detriment.

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4.7 FTSU questions have been added to the (team development) TED tool:

"Members of our team are able to bring up problems and tough issues"

"We are able to raise concerns to our manager"

4.8 Six monthly reports are now being provided by the OD team, which identifies areas that may require additional support. Out of 14 teams 3 were identified as possibly requiring further assistance. Two are yet to be followed up.

4.9 The Guardian worked with HR colleagues to develop and pilot a decision-making tool for disciplinary processes based on the Mersey Care model and RJC principles.

4.10 The Guardians for DCH & DHC developed a joint/single policy document which was ratified and published in May. Plans are in place to do the same with the FTSU strategy in 2026.

4.11 In July this year DHC commissioned an Independent Review to explore the arrangements for FTSU reporting to Board and Board sub-committees. This was in response to a concern that was raised regarding our current approach – in particular to establish if our reporting procedures are complete and comprehensive. The Review findings will be presented to the Board in due course – date to be confirmed.

The outputs from this review will be shared in the next FTSU report, although the recommended actions will be implemented way ahead of the next reporting period.

5.0 Actions Taken to Improve FTSU Culture and Awareness and Guardian Visibility.

5.1 The Guardians continue to visit teams in person/on Teams and deliver face to face sessions to raise FTSU awareness/Listening Events as capacity allows. Teams visited by the Guardians in Q1&2:

Herm ward*	Melstock ward*	Chine ward
MH CRT West	UICS x2*	SALT leads
Twynham ward [x2]	Bournemouth & Christchurch CAMHS	Safeguarding team
Finance lead team	OT network	W&P/Mid-West Locality team Team leads
Pharmacy	Participation team	MH DMG
Quality & Workforce DMG	B&P team x2	

* These teams were visited in response to FTSU concerns being raised; the other visits were at the request of the team as part of raising awareness/CPD.

5.2 The Guardian has a presence on social media and Doris. High level findings from the FTSU Annual Report will be shared via Trust Communication and social media when available and will be added to Doris.

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- 5.3 A joint Newsletter containing this information has also been developed this year – we are on our third publication.
- 5.4 Training is available via e-Hub on the intranet; since it became mandated on 1st April 2024, we are currently **88.74%** compliant, which is a positive trajectory.
- 5.5 The Guardians deliver awareness sessions on the Trust Preceptorship Programme, the Manager Induction Programme and is now delivering face to face sessions on the new Trust Induction Programme that was introduced earlier this year.
- 5.6 The Guardian attends various staff network meetings on a regular basis where it is anticipated that more Champions will be recruited in the new year.
- 5.7 The Guardian monitors how staff knew about FTSU as part of the process; it is of interest to note that **61%** were sign posted by colleagues/word of mouth, followed by **8%** of staff finding the information on Doris and **11.5%** had used the service previously.
- 5.8 The **Board Reflective Tool** continues to be a live/working document and was updated on the 27th March 2025; the compliance has nudged up to **96%**. We have three standards that remain outstanding:
- *We are confident that our managers are learning from speaking up and adapting their environments to ensure a safe speaking-up culture.*
 - *Seek and receive assurance from the relevant executives/senior leaders that speaking up results in learning and improvement.*
 - *Explore how to understand what detriment for speaking up looks and feels like.*
- 5.9 In light of the new resource allocated to Freedom to Speak Up, the Champion model has started to be rolled out this autumn. Network meetings and training programmes have been set up through 2026.
- 5.10 The newly developed Newsletter is instrumental in raising awareness further. This is published on the FTSU page on Doris as well as being published via the regular round up communication notice, and on the staff Facebook group as well as our own growing distribution list.
- 5.11 As with previous years, we raised awareness through Freedom to Speak Up Week [no longer a FTSU month] in October.

6.0 Assessment of The Effectiveness of The Speaking-Up Process

- 6.1 Current research suggests that employee engagement has a positive correlation, with lower patient mortality, lower sickness levels and lower patient complaints.
- 6.2 The National Staff Survey (NPS) and the National Quarterly Pulse Survey (NQPS) provide insights into how well we are meeting the standards outlined in the People Promise (2020/21) and in particular the section 'we each have a voice that counts' of which Freedom to Speak Up forms part. Please see results below:

National Staff Survey [2024]: Staff Feedback

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- 6.3 The Trust scored very positively compared to benchmark equivalents in a number of key indicators in the NHS staff Survey [published March 2025]:

Table 10

Indicator – 2024 NHS staff Survey	DHC	Median for benchmark	Position in relation to benchmark
'We each have a voice that counts' indicator	7.05	6.94	Above
'Raising concerns' sub-score	6.90	6.74	Above
Q20a 'I would feel safe raising concerns about unsafe clinical practice' (% positive)	78.96%	76.27%	Above
Q20b 'I am confident that my organisation would address my concern' (% positive)	64.44%	61.06%	Above
Q25e 'I feel safe to speak up about anything that concerns me in this organisation' (% positive)	71.12%	66.58%	Above
Q25f 'If I spoke up about something that concerned me I am confident my organisation would address my concern' (% positive)	58.17%	54.93%	Above

- 6.4 Benchmarked within the Southwest region, Dorset HealthCare scored the highest - and nationally was on average in the top 40 out of 268 organisations that took part.

National Quarterly Pulse Survey (NQPS): Quarter 1&2

- 6.5 Quarter 1&2 pulse Survey feedback on:

Table 11

Quarter 1	Positively	Neither agree/disagree	Disagreed
<i>"I feel safe to speak up about anything that concerns me in my organisation"</i>	56%	21%	22%
<i>"Has anything happened in Your organisation that you wanted to speak up about in the last 12 months?"</i>	24%	14.7%	61.3%

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Quarter 2	Yes	Prefer not to say	No
<i>“Has anything happened in your organisation that you wanted to speak up about in the last 12 months?”</i>	24%	14.7%	61.3%
<i>“Those who responded ‘Yes’ were asked: Have you spoken up about your concern/s in the last 12 months?”</i>	76.6%	23.4%	N/A
<i>“Those who responded ‘Yes’ were asked: What did you speak up about on the last occasion?”</i>	The top five responses were: • Organisational culture - 31.2% • Staff wellbeing - 24.3% • Leader/manager behaviour – 23.3% • Bullying & harassment - 22.8% • Quality of patient care – 13.2%		
	Yes	No	
<i>“Was there a negative impact for speaking up?”</i>	24.1%	75.9%	
<i>“Those who responded ‘Yes’ were asked: If there was a negative impact, what was it?”</i>	The top five responses were: • Experience poor behaviour – 50% • Perceived as trouble-maker – 43.2% • Mild health problems – 18.2% • Micro-management – 18.2% • Moderate health problems – 13.6%		

6.6 These questions were designed/included into the Survey by NHSE in order to gain a deeper understanding into what detriment looks/feels like. This was in response to widespread reports that NHS staff remain fearful of speaking up, which align to our own findings as previously mentioned.

6.7 It is hoped that the information gathered from the Survey will help organisations to identify and address barriers to speaking up, which is essential for creating a more inclusive, safe, and positive work environment for our staff and ultimately safer high-quality care for our patients.

Worker feedback

6.8 As part of the process for closing down cases, the Guardian sends staff a feedback questionnaire to monitor their experience of speaking up. Please see results below:

Table 12

Quarter 1	Number of responses	Yes	No	Maybe	Don't know

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Would you speak up again	21/60	62% [13]	4% [1]	14% [3]	19% [4]
Quarter 2	Number of responses	Yes	No	Maybe	Don't know
Would you speak up again	12/55	66.5% [8]	25% [3]	8% [1]	[0]

- 6.9 The response rate typically is variable, with 30% for Q1 and just over 20% for Q2. The results can vary significantly depending on what type of concern has been raised within that reporting period.
- 6.10 Another consideration is what the person was hoping to achieve from speaking up, coupled with the manager response as well as their experience of the Guardian. For example, the three people in Q2 who indicated they would not speak up again raised concerns around their job banding.

Peer Review and Audit

- 6.11 As mentioned in the previous Report, peer review and audit have recently been developed by the team (jointly) which will enable the FTSU service to measure successes and make improvements where needed. This, alongside the 'post Speak Up' Survey, will support our continuous improvement cycle.

Table 13

	Yes
Was the referral acknowledged within 5 working days?	100%
Was the colleague thanked?	100%
Did you explain the FTSU process?	100%
Was the issue summarised clearly?	100%
Was the outcome being sought clear?	100%
Were options for action discussed?	100%
Were the suggested options appropriate?	100%
Was the case followed up and fed back?	95%
Was the database completed?	95%
Did a Feedback Survey get sent?	70%

Learning from case reviews

- 6.12 The NGO published the findings of their review into overseas trained workers in May 2025 which mainly offered recommendations to NHSE/NGO to:
- Enhance the NHS international recruitment toolkit
 - Tailoring FTSU arrangements for overseas workers
 - Review the Board reflective tool to include the learning from this review
 - Improve national reporting on overseas workers within the workforce metrics
 - Find the most effective way to deliver cultural intelligence training to workers, managers, and senior leaders and Freedom to Speak Up guardians
 - Organisations to ensure that we have inclusive FTSU arrangements in place

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https://nationalguardian.org.uk/wp-content/uploads/2025/05/NGO-Overseas-trained-workers-report_May-2025.pdf

- 6.13 When case reviews take place, there is an expectation that the Guardian will self-assess /benchmark their own organisation against the findings of the review. This is work in progress and will be presented in the next round of reports.
- 6.14 Currently the NGO are in the process of conducting a speak up review of experiences among temporary workers in the NHS, findings from this will be shared in the next report.

7.0 Actions taken to improve the skills, knowledge and capability of workers to Speak Up.

Training

- 7.1 The NGO developed, in association with Health Education England, online FTSU training which is freely available for anyone who works in healthcare. The training is divided into three modules:
- Speak Up – core training aimed at all NHS staff.
 - Listen Up – aimed at all line managers/Supervisors.
 - Follow Up – aimed at Senior Leaders (8a and above including executive & non-executive Directors).

Table 14

<u>FTSU % Compliance by Directorate as at 30.09.25 - Q2 2025 / 26</u>				
Directorate	Target	Outstanding	Completed	% Compliance
Chief Executive	21	1	20	95.24%
Chief Operating Officer	5215	517	4698	90.09%
Director Of Finance + Strategi	545	126	419	76.88%
Director Of Nursing & Quality	183	28	155	84.70%
Medical Director	11	1	10	90.91%
People And Culture	186	21	165	88.71%
<u>Grand Total</u>	<u>6161</u>	<u>694</u>	<u>5467</u>	<u>88.74%</u>

- 7.2 Compliance compared to the 2024/25-year end position of **83.29%** has increased to **88.74%**, which equates to an overall increase of around **6%**.

8.0 Recommendations

- 8.1 The Committee to note that, with the additional resource, the recruitment of local champions has commenced with a staged rollout plan over the coming year. We have recruited over 30 champions so far.

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- 8.2 The Committee to support strengthening links with senior managers to build trust and confidence in the Guardian role, particularly in light of national concerns raised by the Letby case. Warning letters were sent out by the enquiry team in September, as the final report is due to be completed by the end of November 2025 and published in early 2026.

Likewise, the Lampard Inquiry recommenced hearing evidence from witnesses and bereaved families on 13th October, and the National Neonatal & Maternity Review began this summer; preliminary findings are expected to be published in December.

- 8.3 The Committee to endorse the continued joint working between DHC and DCH Guardians on shared workstreams, including:
- Joint strategy
 - Joint Champion recruitment, training, and network activity
 - Peer review/support
 - Continue to align and work closely on improving service delivery across the federation.

- 8.4 The Committee to note that the remaining three standards from the Board Self Reflective Tool will be completed by year-end (2026) and re-presented to the Board. Currently 96% compliance is recorded .

- 8.5 The Committee to support the inclusion of a detriment-related question in DHC's Staff Pulse Survey [Q4] to respond to ongoing national and local concerns, (also referenced in the Board Reflective Tool and Staff Survey).

9.0 Message from the Guardian

- 9.1 Unsurprisingly, it has been another very busy year so far, with the number of contacts increasing by 47.5% for the same time of year in 2024 [75].
- 9.2 Where possible, resource is shared across the two organisations in that where we are developing an area for DHC, we will also develop it for DCH together with the DCH Guardian e.g. Newsletter/audit/recruitment of Champions/FTSU month - where we can gain economies of scale.
- 9.3 We have made some inroads into introducing a Just & Learning Culture; however, we have much more work to do on this and I would like to explore this further with the Board.
- 9.4 I continue to feel passionate about organisational/team culture and wish to influence how we do things in DHC – striving to be the best organisation to work for and deliver the best care possible. I appreciate the support I receive from the Board and the Senior Leadership team and look forward to continuing to work hard in collaboration with all key stakeholders to achieve this ambition.

Anne Hiscock
Freedom to Speak Up Guardian
November 2025



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Report to	Board in Common (DCH Board)	
Date of Meeting	09 December 2025	
Report Title	Freedom to Speak Up Reports – Quarter 1&2 DHC and DCH	
Prepared By	Lynn Paterson- Freedom to Speak Up Guardian; DCH	
Accountable Executive	Nicola Plumb - Chief People Officer	
Previously Considered By	People and Culture Committee in Common, 24/11/2025	
Action Required	Approval	-
	Assurance	X
	Information	-

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below	
Board Assurance Framework	SR2 Culture – The FTSU policy forms part of the controls and assurance through the quarterly and annual reports. The schedule of reporting for 2025 is now aligned with Dorset Healthcare and is now submitted twice yearly (Q1&2 and Q3/4) to the people & culture committee in common along with a high-level monthly report within the KPI dashboard.	
Financial	Potential risk can result where employees take cases to employment tribunal.	
Statutory & Regulatory	The standard NHS contract requires that all trusts and foundation trusts employ a Freedom to Speak up Guardian which is now an established role across the NHS and was a recommendation of the Freedom to Speak Up Review by Sir Robert Francis that was published in 2015. The content of this report is aligned to the guidance set out in the <i>'Freedom to Speak Up: A guide for leaders in the NHS and organisations delivering NHS services'</i> (2022), p33-34.	
Equality, Diversity & Inclusion	The reporting methodology includes staff data relating to the protected characteristics where this is known.	
Co-production & Partnership	The report includes data provided by the learning and development team, the Organisational Development team and the HR team.	

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Executive Summary

This is the quarter 1&2 report on Freedom to Speak Up (FTSU) in Dorset County Hospital (DCH) for 2025.

The Freedom to Speak Up Guardian role has been in place since 2016 as an outcome of the Mid Staffordshire enquiry, led by Sir Robert Francis (2015).

Now that capacity allows, work has been undertaken to recruit local Champions in order to increase reach across the organisation; we have in the region of 30 Champions currently and will continue to recruit as part of a rolling programme.

The Guardian at DCH has now been in post for almost 3 years and has been working full-time in the role since July 2024 with over 60 Champions in post.

Quarterly data returns are sent to the National Guardians Office (NGO) and published on the NGO website, alongside all other NHS Trust returns. Quarter 2 returns have been submitted.

Themes and learning are captured within this report; the FTSU Guardian’s share learning with staff and colleagues in a variety of ways in order to promote a positive culture of raising concerns.

The Guardian’s attend national and regional events to ensure best practice is brought back and embedded within both DHC and DCH.

The Guardian’s receive supervision from a peer Guardian. The Guardian’s receive support and supervision additionally from Executive/Non-Executive team members as required.

Quarter 2025	Number of contacts: DHC		Quarter 2025	Number of contacts: DCH
Q1	57		Q1	119
Q2	65		Q2	116

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Dorset County Hospital - Freedom to Speak Up Report

Quarter 1 & 2 Report

1.0 Introduction

- 1.1 Sir Robert Francis in his Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry (2013) described the experiences of nurses and doctors who raised concerns about the poor care of some patients at Stafford Hospital. As a result, he was asked to conduct a further review into raising concerns in the NHS.
- 1.2 'Freedom to Speak Up – an independent review into creating an open and honest reporting culture in the NHS' was published in 2015. The report identified a need for culture change, improved handling of cases, measures to support good practice, particular measures for vulnerable groups, and extending the legal protection. In particular, he recommended that all Trusts should have a Freedom to Speak Up Guardian to 'act in a genuinely independent capacity' and support staff to raise concerns.
- 1.3 In 2016-17 it became a contractual requirement for all NHS provider Trusts to have a Freedom to Speak Up Guardian. All Trusts in England have made appointments and all Guardians are now in post.

2.0 Main Narrative

Assessment of Cases

- 2.1 In Q1 & 2 of 2025, **235** contacts were made to the FTSU service, a very similar picture to the previous reporting period of 243, of which 0 remain open. There remains an increase in staff seeking advice/guidance which are quicker cases to resolve and close.

Table 1

Reporting period	Contacts	Patient Safety & Quality	Staff Safety & Wellbeing	Bullying & Harassment	Other Inappropriate Behaviours	Anon
Q1	119	14	89	12	90	3
Q2	116	21	86	10	68	1
Total	235	35	175	22	158	4

- 2.2 There continues to be a distinct correlation between wellbeing and other inappropriate behaviours (OIB). The predominant themes within OIB are poor communication and lack of feedback which aligns with the responses from the Q2 Pulse Survey. Other leading themes are colleague behaviour/incivility, manager behaviour/futility reporting to managers and lack of support from manager. Similar themes are reported locally via the Dorset and Somerset Network Guardians. Managers need to provide clarity for their staff and close the communication gap which can further create an environment of instability and insecurity in the continuing economic climate.

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- 2.3 In many cases, concerns are attributed to more than one element of perceived risk, for example, a colleague worried about staffing levels might assign both patient safety and worker safety/wellbeing to the concern. To note, all cases are assigned from the perspective of the colleague raising the concern.
- 2.4 Different approaches are adopted by the Guardian and are discussed with the individual to facilitate a local informal resolution where possible and appropriate. Just over 100 of cases during Q1 & Q2 were for advice/guidance, 78 needed escalation, 30 were listen and log only, 8 required a feedback session, 6 for sense checking and 4 for signposting to partner services. This gives reassurance that the FTSU service is being utilised appropriately.
- 2.5 60% of contacts were met with face to face, a further 23% corresponded via email. Around 5% were met with via Teams, a further 8% contacted by telephone with letter via the FTSU post box being the least utilised contact to the Guardian.
- 2.6 Any colleague raising a patient safety concern is strongly advised to complete a Datix and guided to anonymous Datix reporting where appropriate. There has been a significant decrease in contacts reporting patient safety concerns from 56 in Q3 & Q4 down to 35 in Q1 & Q2.
- 2.7 Anonymous concerns have fallen and only accounted for <2% of contacts made, less than the previous 2 quarters. Colleagues are encouraged to raise a concern by any means they feel most comfortable.
- 2.8 The Guardian submits data online via the NGO portal quarterly. This data includes number of contacts, professional group, number of anonymous concerns, number of colleagues who suffered detriment and categories eg. patient safety, worker safety/wellbeing.
- 2.9 Benchmarking against a similar size Trust who employ approximately 3,600 staff, our case numbers of 119 for Q1 are over double the 44 cases they reported. At this time, their Q2 numbers have not been submitted so a comparison cannot be made. This is likely due to those Guardians additionally working for other Trusts, not solely for one organisation.

3.0 Analysis of Trends

Service

- 3.1 There were similar number of concerns raised from both Division A and Division B. Work is ongoing on a new database to further breakdown services as currently only the 2 Divisions, People, and Corporate Services are recognised.
- 3.2 The following table illustrate pay grades of staff (including bank staff) who have raised concerns in Q1 & Q2:

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Table 2

Pay Grade	Headcount	No of Contacts	Approx. % of Headcount	% of Total Contacts
Bands 1 – 4	2011	90	5%	38%
Bands 5 – 7	1962	109	6%	46.5%
Bands 8A and above	222	11	5%	5%
Non AFC	762	13	2%	5.5%
Not known		12	N/A	5%
Total	4957	235	N/A	100%

- 3.3 Targeted listening events are held if the Guardian is receiving several concerns within a service, or at the request of the local manager due to lack of engagement from staff or when an area is reporting concerns anonymously, which could indicate staff are feeling psychologically unsafe in their work environment. The risk management team assist the Guardian to flag areas reporting anonymously via Datix.
- 3.4 During Q1 & Q2 listening events have taken place for teams in Pathology, Pre-Assessment Unit, Acute Hospital at Home, Phlebotomy and Ward Clerks. Staff concerns from these events are collated into themes and anonymised. Action plans are drawn up with the managers and shared with teams to address the themes raised.
- 3.5 Robust triangulation of data continues to help identify areas that may need additional support. Weekly Patient Safety huddles are attended by the Guardian and relevant stakeholders, in addition to regular meetings with the Safeguarding Lead. The Guardian meets separately every month with the Director of Nursing, Chief People Officer, NED for FTSU, Human Resources, EDIB Lead and the Heads of Nursing to discuss and escalate matters as necessary. Monthly local intelligence meetings between HR, Workforce Business Partners, Education, Recruitment and the OD Team continue and prove incredibly useful in flagging areas requiring support.

Flagging Services

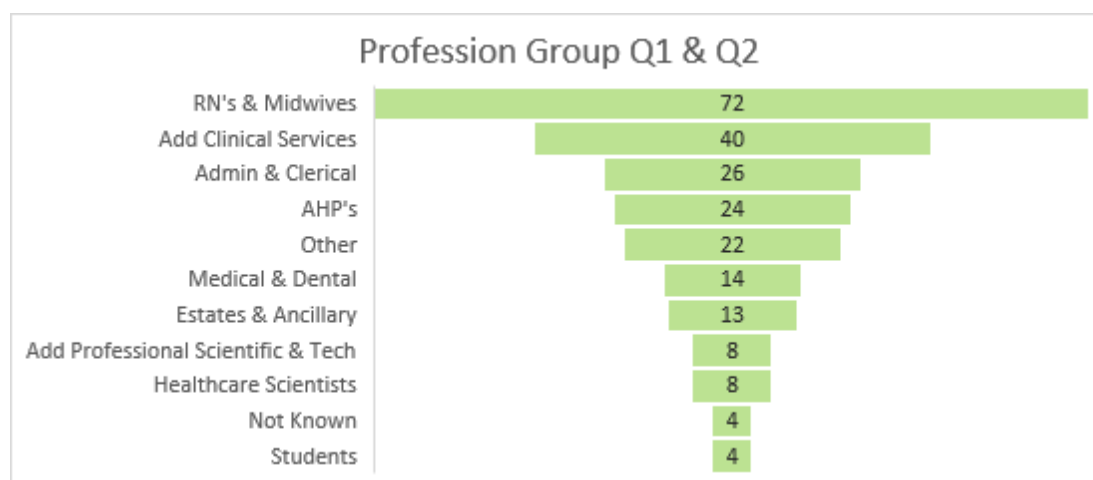
- 3.6 One service flagged following a listening event and the action plan was then shared with the Manager of the Department, Service Manager, HR, Divisional Manager and Workforce Business Partner to prompt support in the department.
- 3.7 A number of concerns came from a department due to changes in job remit. This has been escalated to the Clinical Leader, HR Manager and Director of Nursing.
- 3.8 Several concerns were raised within a department around culture, which appear to be historical but have not been resolved. This has been escalated to both the Service Manager and Matron and support will be provided by myself and the OD Team.

Professional Background

- 3.9 Roles of staff expressing concerns are listed in Table 3 below.

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Table 3



3.10 Registered Nurses remain the group with the highest number of concerns reported, accounting for over 30% of cases. This mirrors the national picture as Nurses/Midwives are the largest workforce group. Additional Clinical Services roles accounted for 17% of the cases which is a change from Admin & Clerical who have previously been the 2nd highest group. Concerns have been raised from every professional group and work can be targeted to those groups with the lower number of contacts, such as attendance at the Student Forums.

3.11 Detriment is nationally a growing concern for the NGO who require Guardians to report 'where detriment is indicated'. Prior to seeking clarity from peers, the Guardian used to ask colleagues if they felt there could be repercussions as a result of speaking up. This no longer occurs, and if detriment is reported, it will be documented subsequent to speaking up. The NGO has recognised disparities amongst Guardians to reporting detriment and recently published further guidance.

[Detriment-guidance.pdf](#)

3.12 From the 235 contacts, 35 members of staff were from a protected characteristic group that the guardian was aware of (15%). The NGO does not require us to collect this data and we do not ask directly, however it is a recommendation from the 'Insightful Provider Board' guide (Nov 2024) and could inform other workstreams.

<https://www.england.nhs.uk/long-read/the-insightful-provider-board/>

Contacts that Led to Formal Action

3.13 From the concerns raised in Q1 & Q2, all have been resolved informally through supportive discussions, facilitated meetings, referring onto coaching/mediation or speaking to the relevant manager to seek a resolution.

4.0 Learning and Improvements

4.1 In collaboration with the DHC Guardian a joint single policy document for Freedom to Speak Up has been developed and was ratified and published in May.

4.2 Several improvement initiatives have been undertaken by the Guardian in collaboration with

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the DHC Guardian:

- A newsletter has been developed and published quarterly. This has enabled joint sharing and learning from FTSU activity with staff.
- A FTSU audit tool is being utilised to enable the service to measure standards of speak up practice against KPI's as part of a peer review arrangement across DCH/DHC.
- Data collation has been reviewed to capture the KPI information for audit including time to respond to contacts; time to close cases; failure demand rates; was the contact thanked etc. The database itself will need further work to capture this information.
- Report templates between the two organisations have been reviewed/aligned and agreed for consistency moving towards a joint report.

4.3 The Guardian has been co-opted onto the 'Joint Culture and Belonging Reference Group Sub-Group' where it is anticipated that rapid action will be taken forward in order to represent staff voices.

4.4 Plans are in place to develop a joint strategy in 2026.

4.5 Feedback from a listening event has gone on to be included in a development plan for one department, where the team should be able to see tangible progress on the concerns they raised.

5.0 Actions Taken to Improve FTSU Culture & Awareness and Guardian Visibility.

5.1 The Guardian continues to visit teams in person and deliver face to face sessions to raise awareness and hold listening events as capacity allows. The Guardian attends Ward Leaders meetings regularly.

5.2 A new initiative called 'Third Thursdays' has been established in collaboration with the Chaplaincy service offering regular engagement opportunities for colleagues in the Chapel and the Guardian also holds a drop-in sessions between 7-8pm to connect with night duty colleagues. Additionally, the Guardian attends various staff network meetings and staff forums to capture the professional groups that are unrepresented including student forums.

5.3 Regular clinical Wednesday walkarounds continue, often with either Network Chairs or Practice Educator for HCSW's.

5.4 The Guardian delivers awareness sessions on the Trust Preceptorship programme; Student Nurse Induction, Non foundation Drs Induction and has now taken ownership of the regular Trust Induction slot previously facilitated by OD.

5.5 The Guardian routinely supports OD to deliver Dignity & Respect in the Workplace workshop which has a focus on civility and following discussion with the Education Centre, is now leading its introduction into the Preceptorship programme and new FY1 Induction programme. This supports the FTSU agenda as it incorporates incivility and the impact of colleague behaviour.

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- 5.6 FTSU training is available via ESR on the intranet and was mandated on the 1st September 2024. Since then, there has been a significant increase in uptake with 3695 colleagues now completed training, accounting for 83% of staff compliance, an increase of 15% since the last report which is a very encouraging.
- 5.7 The Guardian monitors how staff knew about FTSU; it is of interest to note that the majority were through word of mouth from colleagues, followed by staff communications/bulletins.
- 5.8 The Board Reflective tool is a mandated improvement tool designed to help identify strengths in the leadership team and the organisation – and any gaps that need work. It should be used alongside Freedom to speak up: [A guide for leaders in the NHS and organisations delivering NHS services](#), which provides full information about the areas addressed in the statements, as well as recommendations for further reading. It is now in draft with the intention to submit at the next Committee meeting for consideration.
- 5.9 Champion recruitment continues with now over 60 in post, an increase of 20%. Further recruitment will take place with a view to establishing a Champion in areas currently not represented and the Associate Guardian role has been explored to align with the DHC model.
- 5.10 The newly developed newsletter has been instrumental in raising awareness further. This is published on the FTSU page as well as utilising the usual communication channels and staff Facebook group.
- 5.11 As with previous years we look forward to boosting awareness through FTSU month in October.

6.0 Assessment of the Effectiveness of the Speaking-Up Process

- 6.1 Current research suggests that employee engagement has a positive correlation with lower patient mortality, lower sickness levels and lower patient complaints.
- 6.2 The National Staff Survey (NSS) and the National Quarterly Pulse Survey (NQPS) provide insights into how well we are meeting the standards outlined in the People Promise (2020/21). The section 'we each have a voice that counts' is pertinent to the speaking up culture.
- 6.3 In relation to the Q2 of the NQPS, 'We each have a voice that counts' scored almost 5% above the national average.

Worker Feedback

- 6.4 As part of the process for closing cases, the Guardian sends colleagues a feedback questionnaire - 100% of staff who responded said it was easy to make initial contact with the Guardian, the initial response was very helpful and they would recommend speaking to the Guardian. 95% said they would speak up again, 5% don't know if they would.

Peer Review and Audit

- 6.5 As mentioned in paragraph 4.2, peer review and audit have recently been developed jointly which will enable the service to measure successes and make improvements where needed. This, alongside the colleague feedback questionnaire, will support our continuous improvement cycle. This information will be presented in future reports.

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Learning from Case Reviews

- 6.6 The NGO have recently published a review into the experiences of 'trained overseas workers.' When case reviews take place there is an expectation that the Guardian will self-assess/benchmark their own organisation against the findings of the review. This review affected various workstreams so is likely to be a collaborative process.

7.0 Actions Taken to Improve the Skills, Knowledge and Capability of Workers to Speak Up.

Training

- 7.1 The NGO developed in association with Health Education England online FTSU training, which is available to anyone who works in healthcare. The training is divided into three modules:
- Speak Up – core training aimed at all NHS staff.
 - Listen Up – aimed at all Line Managers/Supervisors.
 - Follow Up – aimed at Senior Leaders (8a and above including executive & non-executive Directors).

- 7.2 Our current compliance is reported in paragraph 5.5 and is a substantial improvement on the previous year.

8.0 Recommendations

- 8.1 **Committee to note** that the Guardian will continue targeted work to improve visibility and psychological safety across the organisation, and support ongoing learning from speaking up cases.

- 8.2 **Committee to note** the proposed joint working areas with DHC on FTSU, including a joint strategy next year, recruitment/training of Champions, quarterly newsletters to highlight themes and learning and coordinated communications for FTSU month.

- 8.3 **Committee to note** a targeted approach to Champion recruitment in under-represented areas to strengthen FTSU coverage.

- 8.4 **Committee to note** that the Board Self Reflective Tool is in draft for submission at the next Committee meeting.

9.0 Message from the Guardian

- 9.1 There has been lots of activity this year with the number of contacts remaining high so it encouraging that many of our colleagues are speaking up.

- 9.2 Collaboration with DHC has enabled many of the improvements outlined in this report and have contributed to efficiencies within the service.

- 9.3 I feel privileged to work for the NHS and am passionate about influencing cultural change, promoting civility within the workplace and supporting colleagues to raise concerns. The endorsement from the Committee is highly valued and I look forward to the year ahead, listening, collaborating and empowering colleagues to respectfully challenge where necessary to promote civility.

Lynn Paterson
Freedom to Speak Up Guardian
November 2025



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Report to	Board in Common (DHC Board)	
Date of Meeting	9 December 2025	
Report Title	GMC Survey results and action plan	
Prepared By	Ian Rodin, Director of Medical Education	
Approved by Accountable Executive	Lucy Knight, Chief Medical Officer	
Previously Considered By	Medical Education Team meeting NHSE (Wessex Deanery) People and Culture Committee in Common 24/11/2025	
Action Required	Approval	N
	Assurance	Y
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? <i>Delete as required</i>	
Care	Yes	
Colleagues	Yes	
Communities		No
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR2 Culture SR3 Workforce Capacity SR4 Capacity and Demand The survey is an indication of the quality of the medical education programmes we are contracted to provide and the morale and wellbeing of our resident doctors	
Financial	NHSE contributions to resident doctors' salaries support service delivery, though there is no prospect of these being withdrawn	
Statutory & Regulatory	No implication	
Equality, Diversity & Inclusion	No implication	
Co-production & Partnership	No implication	

Executive Summary
The 2024 GMC training survey suggests residents on our core psychiatry training programme have become progressively less satisfied over the last four years, and those on our general psychiatry higher training programme are less satisfied this year. Our other higher training programmes in psychiatry are too small to be included in the survey. There are no causes for concern regarding our GP training placements. Our consultant trainers gave similar responses to those in other Trusts and programmes. Poor provision of educational supervision to new starters in psychiatry training in 2023 and limited delivery of the Associate DME role may have contributed to the changes shown in the 2024 survey. Our action plan will address these concerns, bring residents and medical education leaders together more often, and improve the strategic and operational support provided by the medical education management team.

Recommendation
Members are requested to receive the report for assurance

GMC Survey results and action plan

1. Executive Summary

- 1.1. The 2025 GMC training survey has given us feedback from resident doctors on our psychiatry core training and foundation programmes. There was a high response rate from residents on these three programmes.
- 1.2. Our higher training programmes and GP placements are smaller in number and not enough returns were made regarding these programmes for them to be included in the data provided to us.
- 1.3. Results for the core psychiatry programme were similar to last year, with scores in the lower quartile for five of the fifteen domains, including overall experience, none in the bottom 10%, and the remainder within the interquartile range.
- 1.4. Educational supervision of core residents was the only domain with scores in the bottom 10% in 2024 and was targeted for improvement, through recruitment, training and peer support of educational supervisors. Scores in this domain improved substantially this year, though were still in the lower quartile.
- 1.5. Clinical supervision of core residents was also in the lower quartile this year and we know has been affected by consultant vacancies and workload. Good supervision is likely to improve outcomes in other domains. We aim to build on improvements in educational supervision in the last year and extend this to clinical supervision.
- 1.6. Results for the foundation programmes were in the interquartile range or higher, except for the adequate experience domain. We will speak to our foundation doctors about this aspect of their placements and address their concerns.
- 1.7. Our consultant trainers gave similar responses to those in other Trusts and programmes, but there is scope for improvement of their experience as educators

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2. Introduction

- 2.1. The GMC carries out a national training survey each year, which all doctors in training, and trainers, are requested to complete.
- 2.2. Resident doctors in Dorset HealthCare from the following training programmes are invited to complete the survey:
 - Core psychiatry training (CT1-3) – 18 posts (increased to 21 since the survey)
 - Higher training programmes (ST4-6) in
 - o Genitourinary medicine – 1 post
 - o CAMHS – 3 posts
 - o Psychiatry of learning disability – 1 post
 - o General psychiatry – 7 posts
 - o Old age psychiatry – 3 posts
 - o Learning disability – 1 post
 - GP training placements in DHC – 4 posts in psychiatry, 2 in frailty hubs
 - Foundation Year 2 doctors, nearly all of whom working for Dorset HealthCare do so in psychiatry placements – 7 posts.
 - Foundation Year 1 doctors, all of whom working for Dorset HealthCare do so in psychiatry placements – 7 posts
- 2.3. Data are collated by training programme and only included in the results if three or more doctors on a local training programme have completed the survey.
- 2.4. Results are presented as absolute scores, categorised relative to all responses across all programmes, as follows:

- Green – top 10%
- Light green – in top quartile, not an outlier
- Neutral – within interquartile range
- Pink – in lower quartile, not an outlier
- Red – lower 10%

3. Main narrative

- 3.1. We received no results for our higher training programmes, because fewer than three resident doctors on each completed the survey. This is unusual for our general psychiatry higher training programme, on which there are seven posts, but not for the other higher training programmes, which are smaller.
- 3.2. We have four GP training posts in psychiatry, two in community hospitals. There were not enough returns for us to receive data from these resident doctors this year.
- 3.3. The response rates for the psychiatry core training programme were 67%, foundation year 2 100% and foundation year 1 75%. The results for these programmes were as follows:

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	Core psychiatry training (n=6-10)	Psychiatry F2 (n=6-10)	Psychiatry F1 (n=3-5)
Overall satisfaction	74	69	63
Clinical supervision	87	85	76
Clinical supervision out of hours	87	85	75
Reporting systems	61	63	80
Workload	65	63	83
Teamwork	68	68	78
Handover	56	65	-
Supportive environment	64	78	80
Induction	74	83	79
Adequate experience	76	63	53
Educational governance	71 (63)	67	88
Educational supervision	81	86	90
Feedback	81	83	70
Local teaching	83	-	-
Regional teaching	75	-	-
Study leave	76	73	-
Rota design	72	63	63
Facilities	71	72	n<3

- 3.4. The results for core psychiatry training are similar to 2024, when three domains were in the pink zone (induction, feedback and study leave) and one in the red (educational supervision). We targeted educational supervision as an area for improvement, through recruitment, training and peer support, and the score increased from 59 in 2024 to 81 this year.
- 3.5. The returns from foundation year 2 doctors were similar to 2024, when the workload domain was also in the green zone and others in the interquartile range. We did not have data from foundation year 1 doctors last year.
- 3.6. Trainer responses were all with the interquartile range, similar to 2024, as follows:

Supportive environment	73
Educational governance	59
Professional development	64
Appraisal	63
Support for training	60
Time to train	55
Rota issues	62
Handover	n<3
Resources to train	75

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4. Conclusion

- 4.1. Feedback from core residents in psychiatry provided through the GMC survey was similar to last year, with results a little worse than the national average. The one area of major concern from last year, educational supervision, has improved, following measures to improve recruitment, training and peer support.
- 4.2. The results suggest that clinical and educational supervision of core residents in psychiatry require further improvement, in line with internal quality monitoring. Good supervision is likely to improve outcomes in other domains. We aim to build on improvements in educational supervision in the last year, by including clinical supervision in our peer support processes and using end-of-placement feedback to help clinical supervisors develop as educators.
- 4.3. Feedback from foundation doctors was a little better than the national average. The only area of concern was the adequacy of experience provided. We will speak to our foundation doctors about this aspect of their placements and address their concerns.
- 4.4. Our consultant trainers gave similar responses to those in other Trusts and programmes, but there is scope to improve their experience as educators. Appointment of an Associate DME and enhancement of medical education management this year, alongside the training and peer support we provide for supervisors, will help us identify and address areas for improvement.

5. Recommendations

- 5.1. The Board is recommended to:
 - Receive the report for **assurance**

Name and Title of Author: Ian Rodin, Director of Medical Education

Date 18/11/2025

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Report to	Board in Common (DCH Board)	
Date of Meeting	09 December 2025	
Report Title	2025 GMC National Training Survey	
Prepared By	Dr Paul Murray – Director of Medical Education	
Approved by Accountable Executive	Rachel Wharton – Chief Medical Officer	
Previously Considered By	People and Culture Committee in Common (25/11/25)	
Action Required	Approval	N
	Assurance	Y
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? <i>Delete as required</i>	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR3: Workforce Capacity The Trust aspires to provide high quality educational opportunities to all trainees. In the case of medical trainees, they are an important factor in both current and future workforce plans	
Financial	Poor survey outcomes may mean that training places and associated funding is withdrawn.	
Statutory & Regulatory	As above.	
Equality, Diversity & Inclusion	As above.	
Co-production & Partnership	NA	

Executive Summary
The purpose of this presentation is to provide the People and Culture Committee in Common with an overview of the most recent GMC National Training Survey results. The survey is undertaken in March to May each year. This report outlines the areas of excellence and those areas that were low outliers. Both the DCH trainee (51%) and trainer (77%) response rates exceeded the Wessex and National average. Scores declined in 12 of the 18 overall elements of the survey but no elements scored in the lower quartile. There were several individual areas of excellence, including areas in Trauma and Orthopaedics, Paediatrics, Respiratory and Renal Medicine. Areas identified as red (low outliers) were clinical supervision in Stroke Medicine, handover in Diabetes and Endocrinology, rota design in Urology, rota design and handover in Obstetrics and Gynaecology and reporting systems and teamwork in Geriatrics. This is fewer lower outliers than in the previous survey. Actions plans were requested by the Deanery for Urology and O&G and these are in place. Overall, DCH continues to score well in relation to the facilities and training provided to trainees when compared to other local Trusts. In relation to burnout, although the DCH trainees report less than the national average, it has been identified that additional support should be provided to Emergency Medicine, where the risk of burnout is highest.

Recommendation
Members are requested to: • Receive the presentation for assurance

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2025 GMC National Training Survey – DCHFT Results

Dr Paul Murray, Director of Medical Education

Scores explained

Green are scores in the top quartile nationally and are significant

Light green, top quartile but don't reach significance

Red scores are lower quartile outliers and reach significance

Pink are lower quartile but do not reach significance.

2025 Response Rates

	Dorset County	Wessex	National
Trainee	77.08%	66.18%	69.41%
Trainer	50.81%	44.30%	33.17%

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Trainee Survey 2025

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Summary from Overall Report

50,637

doctors in training completed the survey in 2025.

Supervision



87%

rated the quality of their clinical supervision as good or very good.

Burnout

Rota gaps

26%

said training is affected because rota gaps aren't dealt with appropriately.



Leadership skills



63%

said their posts gave them opportunities to develop their leadership skills.



61%

considered to be at moderate or high risk of burnout.

Satisfaction



84%

said the quality of their experience was good or very good.

Discriminatory behaviours



28%

experience micro-aggressions, negative comments, or oppressive body language from colleagues.



39%

don't feel confident about reporting discrimination where they work without fear of adverse consequences.

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Overall DCHFT Results 2025



Dorset County Hospital
NHS Foundation Trust

	2022	2023	2024	2025	
Overall Satisfaction	73.31	78.45	79.31	77.59	↓
Clinical Supervision	88.3	89.24	90.16	88.35	↓
Clinical Supervision out of hours	83.42	84.99	85.82	83.07	↓
Reporting Systems	71.38	75.14	73.54	71.29	↓
Workload	47.14	48.87	50.21	50.91	↑
Teamwork	75.31	74.76	80.12	75.9	↓
Handover	65.56	72.45	70.64	70.86	↑
Supportive Environment	75.56	77.47	78.42	74.15	↓
Induction	74.75	81.74	80.09	80.66	↑
Adequate Experience	71.25	76.58	78.71	77.57	↓
Educational Governance	69.58	72.51	73.58	71.28	↓
Educational Supervision	83.28	84.91	89.79	86.1	↓
Feedback	64.96	70.66	77.11	80.23	↑
Local Teaching	63.24	67.3	60.65	66.79	↑
Regional Teaching	65.55	61.34	61.44	55.93	↓
Study Leave	55.78	60.11	70.1	70.78	↑
Rota Design	47.4	58.28	54.15	53.23	↓
Facilities	75.06	75.31	75.47	74.16	↓

How Does DCHFT Compare?



Dorset County Hospital
NHS Foundation Trust

	DCHFT	HHFT	IoW	Portsmouth	Salisbury	Southampton	UHD
Overall Satisfaction	77.59	73.94	72.12	76.34	80.04	79.13	77.14
Clinical Supervision	88.35	86.12	84.34	88.74	90.9	91.56	87
Clinical Supervision out of hours	83.07	84.14	81.53	86.29	87.92	89.89	85.34
Reporting Systems	71.29	68.22	70.34	72.71	77.16	73.63	73.48
Workload	50.91	44.56	50.06	42.12	48.47	46.86	46.65
Teamwork	75.9	71.52	68.49	72.9	78.45	75.97	75.08
Handover	70.86	71.41	74.35	68.45	73.26	70.56	69.97
Supportive Environment	74.15	71.13	69.09	72.59	77.66	74.53	74.85
Induction	80.66	73.98	82.42	81.56	82.38	82.33	79.16
Adequate Experience	77.57	74.69	69.32	75.74	81.64	78.7	77.37
Educational Governance	71.28	67.31	73.48	71.48	76.48	72.54	72.58
Educational Supervision	86.1	84.82	89.2	88.12	89.01	87.09	87.14
Feedback	80.23	72.96	85.38	76.89	78.83	76.04	75.08
Local Teaching	66.79	62.35	52.92	64.49	66.72	68.35	62.15
Regional Teaching	55.93	63.18	83.33	62.5	62.14	63.98	62.15
Study Leave	70.78	65.53	73.75	68.29	74.15	74.57	73.76
Rota Design	53.23	53.88	53.7	55.53	61.65	61.38	56.4
Facilities	74.16	62.41	56.67	66.89	69.73	64.82	63.08

2025 Excellence (Green Outliers)

- Facilities in T+O
- Supportive environment in surgery specialty training
- Regional teaching in CST
- Facilities in O+G (all posts)
- Facilities in Paeds (all posts)
- Facilities in Stroke Medicine (all posts)
- Facilities in surgical F2
- Handover in Respiratory Medicine
- Study Leave in Renal Medicine (all posts)
- Induction and Adequate Experience in Paeds (GP Posts)

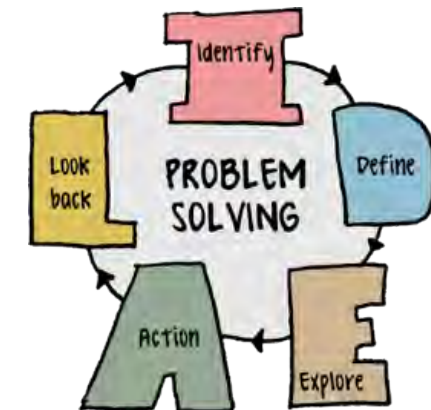
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2025 Low Outliers – Red scores

- Clinical supervision in **Stroke Medicine**
- Handover in **D&E (medicine)**
- Rota design in **Urology**
- Rota Design and Handover in **O+G specialty**, rota design for **ALL O+G posts**
- Reporting Systems and Teamwork in **Geriatrics**

- Fewer “Reds” than 12 months ago
- **Deanery only required action plans for Urology and O+G**



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O+G (all posts)



Dorset County Hospital
NHS Foundation Trust

		2022	2023	2024	2025
Obstetrics and gynaecology	Overall Satisfaction	49.38	58.33	75	60
	Clinical Supervision	84.38	85	90.54	88
	Clinical Supervision out of hours	84.38	87.5	85.71	91.25
	Reporting Systems	77.86	68	77.14	79
	Workload	64.58	48.61	41.07	51.25
	Teamwork	82.29	68.06	88.1	65
	Handover	54.17	57.29	66.97	57.5
	Supportive Environment	75.63	71.67	85.71	65
	Induction	70.63	80	80.71	81
	Adequate Experience	50	56.25	73.21	55
	Educational Governance	68.75	58.33	76.19	61.67
	Educational Supervision	71.09	72.92	85.71	77.5
	Feedback	43.33	63.54	67.5	77
	Local Teaching	48.75	32.33	66.39	52.67
	Regional Teaching	66.67	65.83	76.39	43.33
	Study Leave	58.33	63.33	76.79	60
	Rota Design	37.5	37.5	51.79	32.5
	Facilities	79	67.5	67.86	86.5

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O+G Specialty Training



Dorset County Hospital
NHS Foundation Trust

		2022	2023	2024	2025
Obstetrics and gynaecology	Overall Satisfaction	40	60	85	50
	Clinical Supervision	93.75	91.67	93.33	86.67
	Clinical Supervision out of hours	92.19	87.5	91.67	89.58
	Reporting Systems	88.33		90	75
	Workload	72.92	58.33	43.75	58.33
	Teamwork	89.59	86.11	91.67	61.11
	Handover	52.61	58.33	75.7	39.58
	Supportive Environment	86.25	83.33	93.33	63.33
	Induction	75	75	95	75
	Adequate Experience	28.13	50	79.17	37.5
	Educational Governance	68.75	66.67	91.67	52.78
	Educational Supervision	71.88	64.58	87.5	81.25
	Feedback	63.89	62.5	87.5	78.33
	Local Teaching	43.75	24.44	66.67	54.44
	Regional Teaching	75	75	83.33	52.78
	Study Leave	81.25	63.89	91.67	45.83
	Rota Design	35.94	35.42	58.33	29.17
	Facilities	88.33		73.75	79.17

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- Appointment of new LED registrars to bolster that tier
- Additional funding for further registrars to support Yeovil demand
- New 1 in 8 rota to improve rest times and increased learning
- Tier 1 rota moving to on call gynae and labour ward duties to reduce workload and improve rest from December 2025

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Urology – all posts



Dorset County Hospital
NHS Foundation Trust

		2022	2023	2024	2025
Urology	Overall Satisfaction	73.33		77.5	86.67
	Clinical Supervision	91.67		86.25	91.67
	Clinical Supervision out of hours	89.58		85.42	76.39
	Reporting Systems			71.67	71.67
	Workload	33.33		58.86	50
	Teamwork	66.67		77.09	58.33
	Handover				
	Supportive Environment	71.67		83.75	78.33
	Induction	80		75.63	83.33
	Adequate Experience	83.33		75	83.33
	Educational Governance	63.89		66.67	63.89
	Educational Supervision	89.58		85.94	81.25
	Feedback	58.34		88.89	
	Local Teaching				
	Regional Teaching				
	Study Leave				
	Rota Design	39.58		54.69	22.92
	Facilities				

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- Recognition of issues of shared urology/surgical on call rota
- Aim to move to dedicated urology on call to preserve learning experiences. Aim to commence **by February 2026**
- Extra ST3+ registrar post secured (Deanery tariff-funded) with funding commenced August 2025

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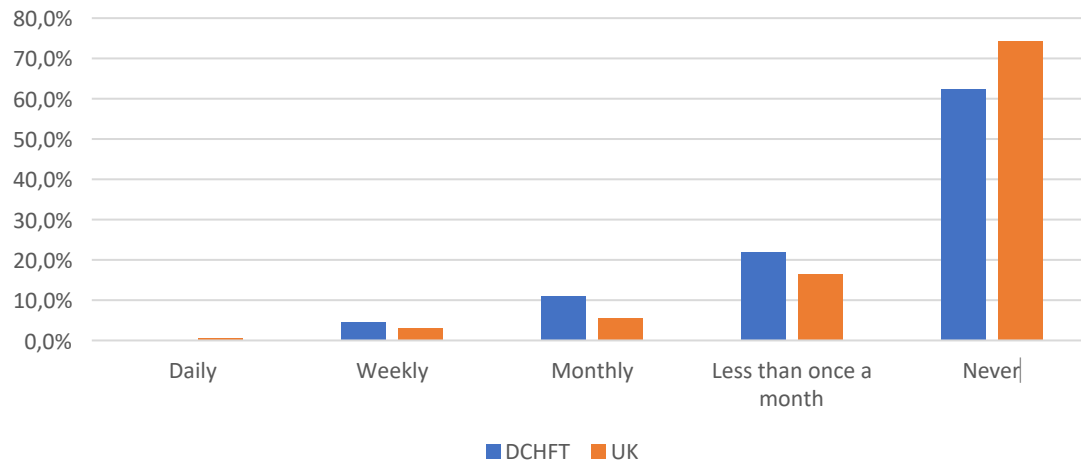
Comments

- Lots of positive comments in challenging circumstances, Greens outweigh reds
- Definite reduction in overall Red outliers

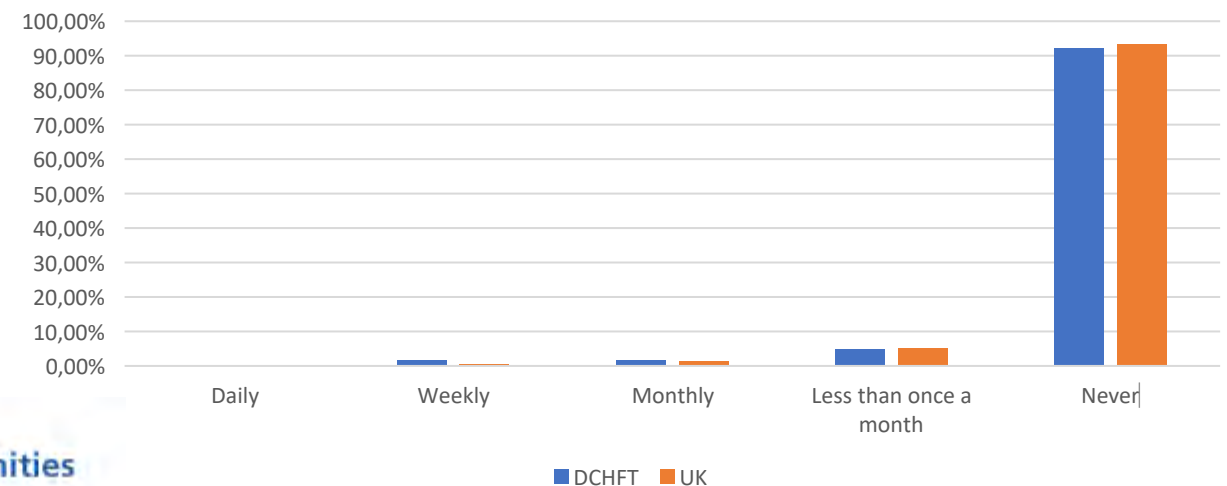
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Discrimination questions (1)

GENHQ236 - In your current post how often, if at all do you hear insults, stereotyping or jokes in your presence on the grounds of age, race (colour, nationality, ethnic or national origin), sex, gender reassignment, disability, sexual orientation, religi



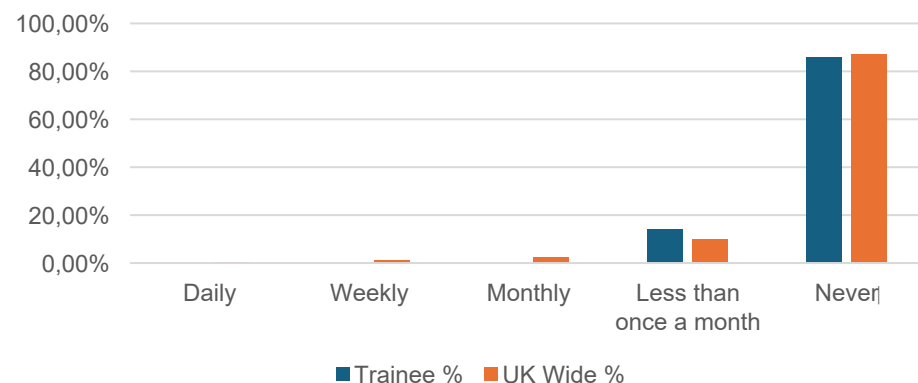
GENHQ241 - In your current post how often, if at all do you experience unwelcome sexual comments or advances causing you embarrassment, distress or offence?



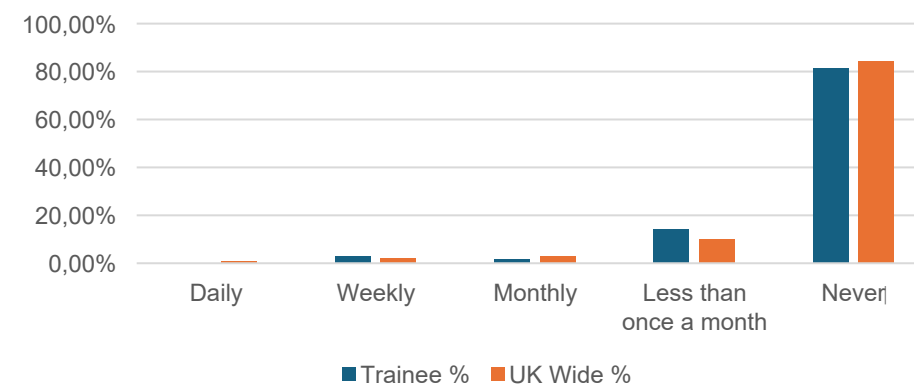
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Discrimination questions (2)

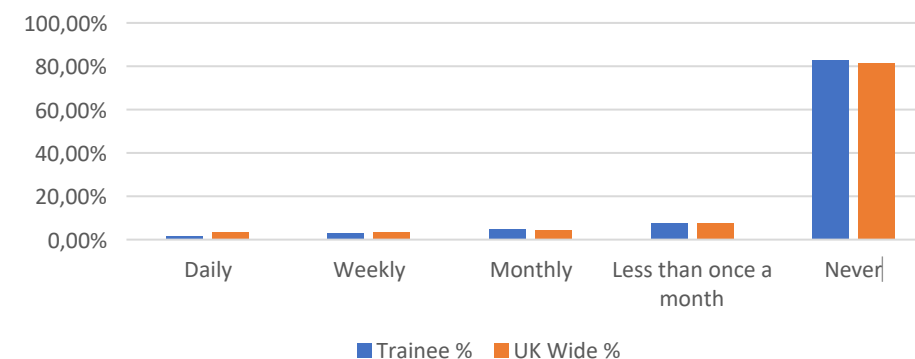
GENHQ239 - In your current post how often, if at all are you intentionally humiliated in front of others?



GENHQ240 - In your current post how often, if at all are you ignored or excluded from conversations, groups or meetings?



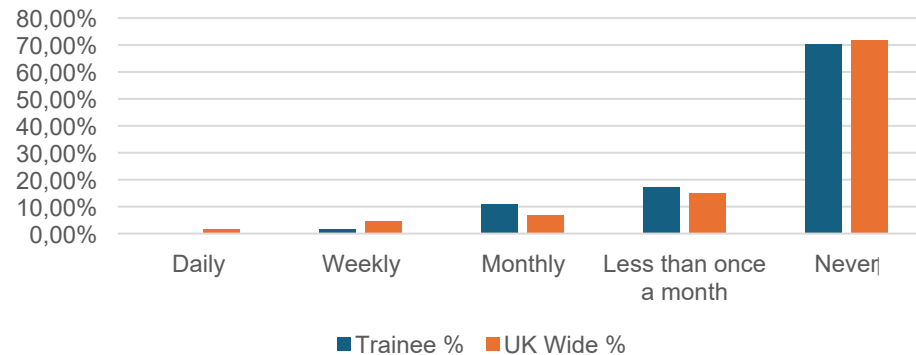
GENHQ245 - In your current post how often, if at all are you not given the same training opportunities as your peers at the same stage of training (e.g. opportunity to observe an unusual case)?



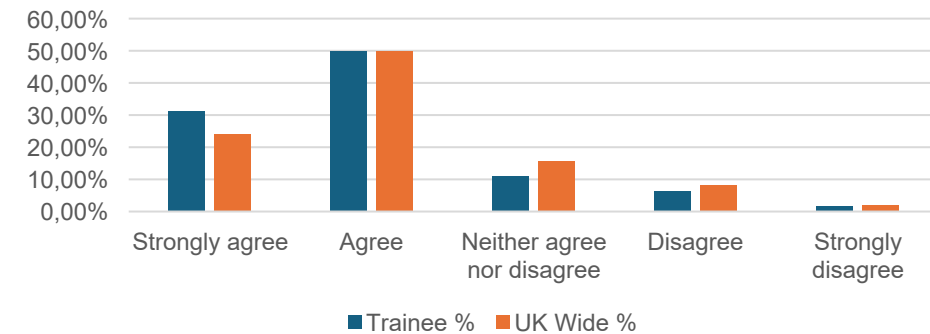
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Discrimination questions (3)

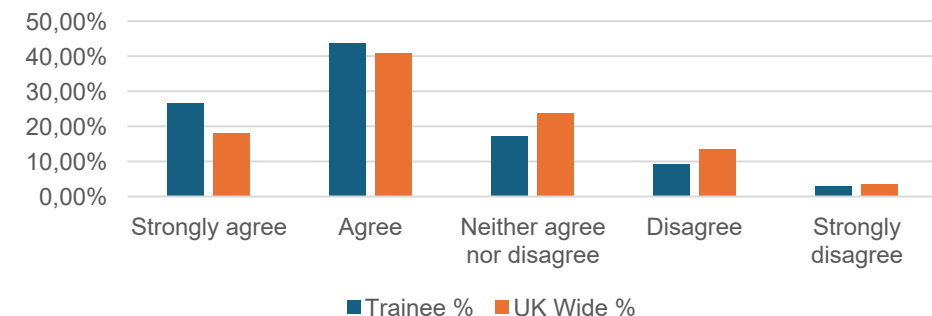
GENHQ246 - In your current post how often, if at all do you experience micro-aggressions, negative comments or oppressive body language from colleagues?



GENHQ247 -
I am confident that I know how, or could find out how, to report discrimination where I work.



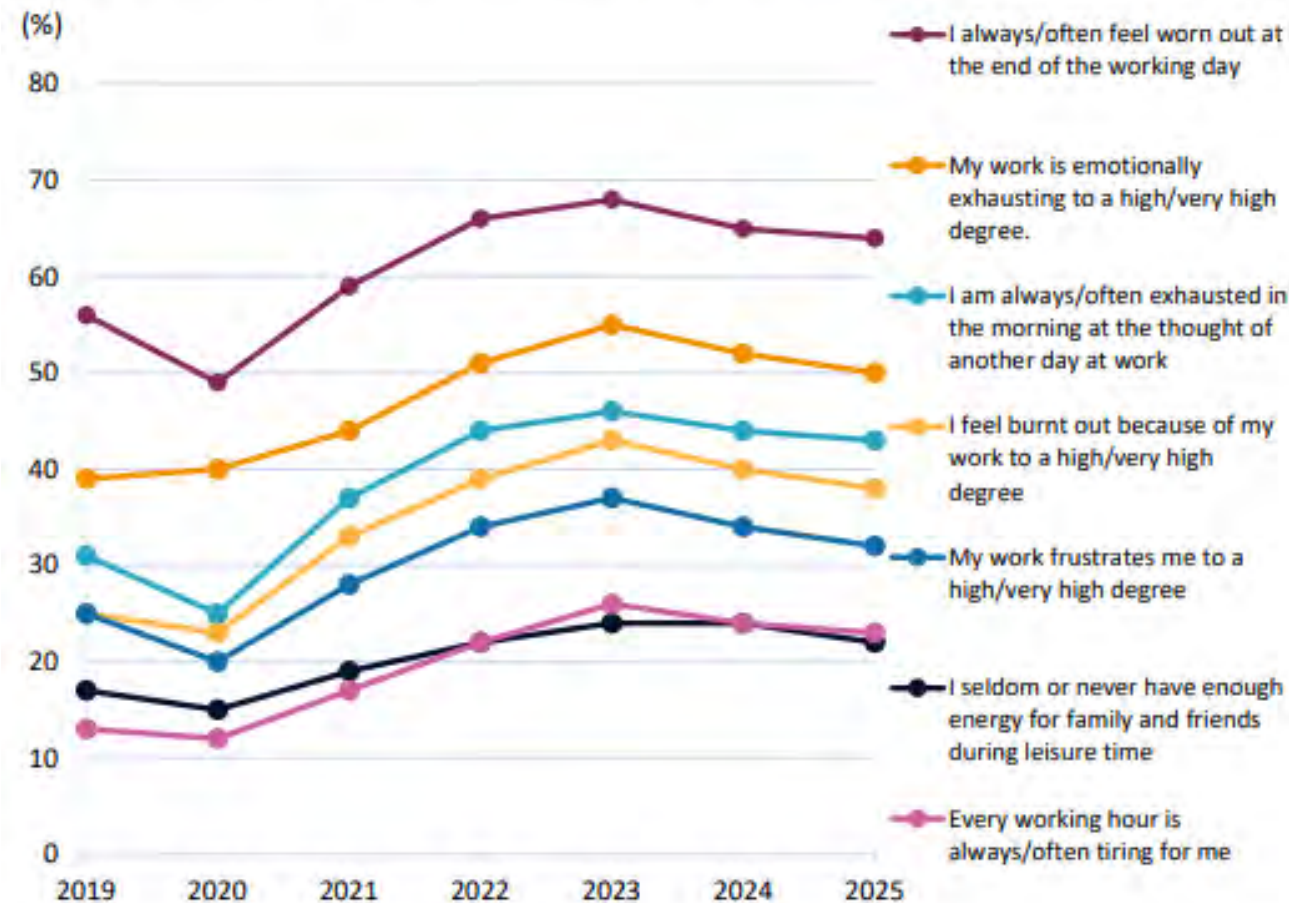
GENHQ249 -
In this post, I feel confident to challenge discrimination and unprofessional behaviours amongst my colleagues and healthcare professionals.



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Overall report on Burnout

Figure 5: Trainees – Negative responses to individual burnout questions, 2019–2025



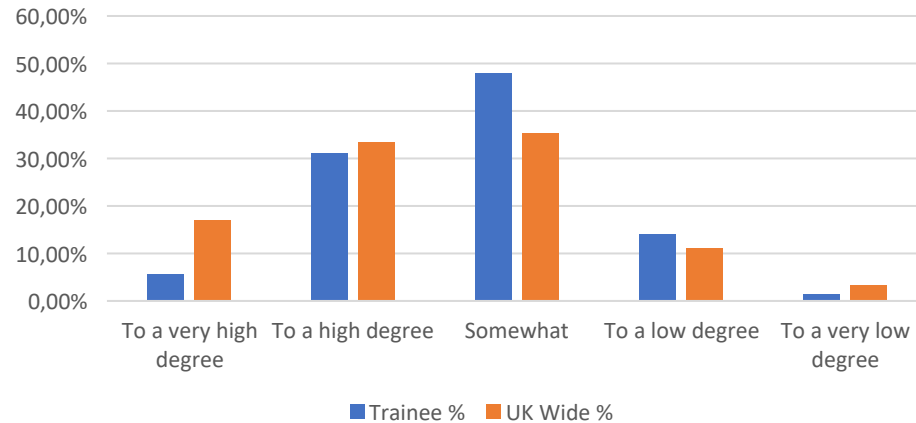
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Burnout –DCH Trainees 2025 (1)

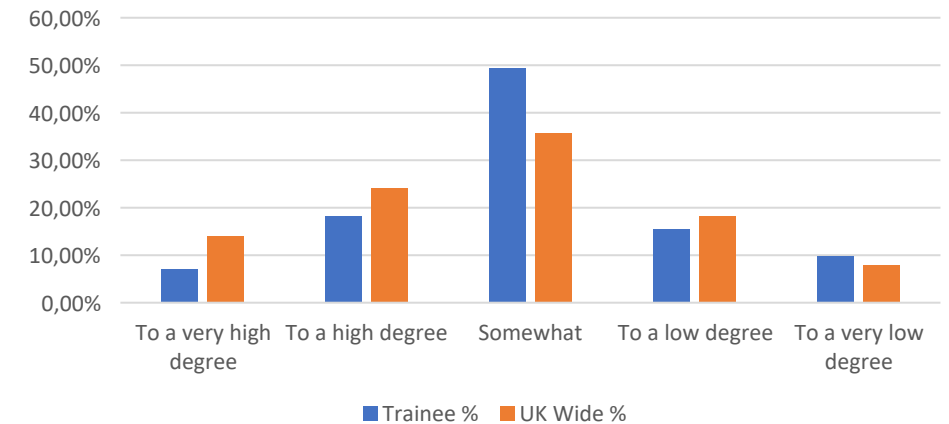


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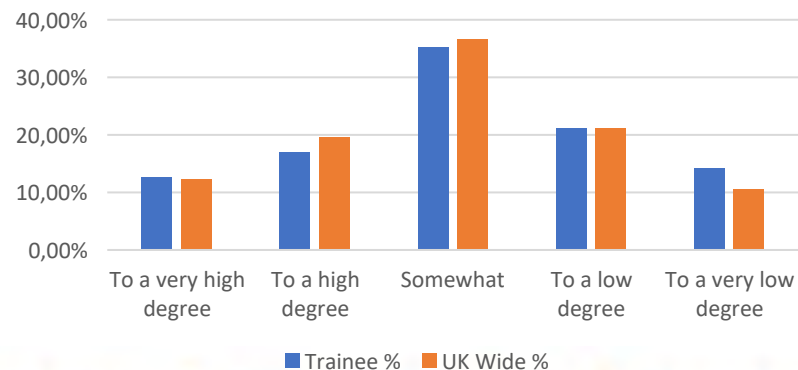
GENHQ198 - Is your work emotionally exhausting?



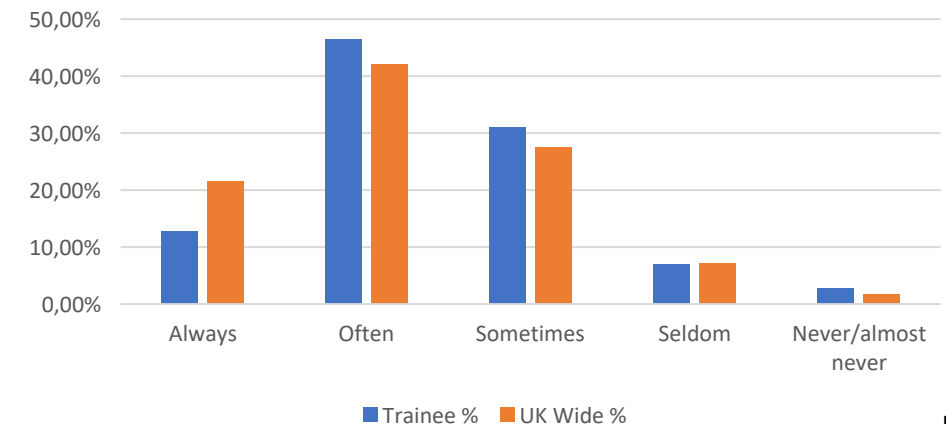
GENHQ199 - Do you feel burnt out because of your work?



GENHQ200 - Does your work frustrate you?



GENHQ201 - Do you feel worn out at the end of the working day?



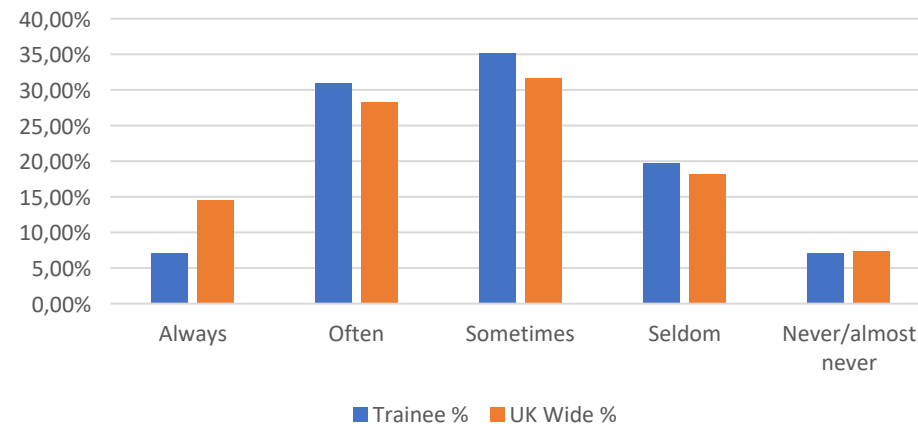
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Burnout – DCH Trainees 2025 (2)

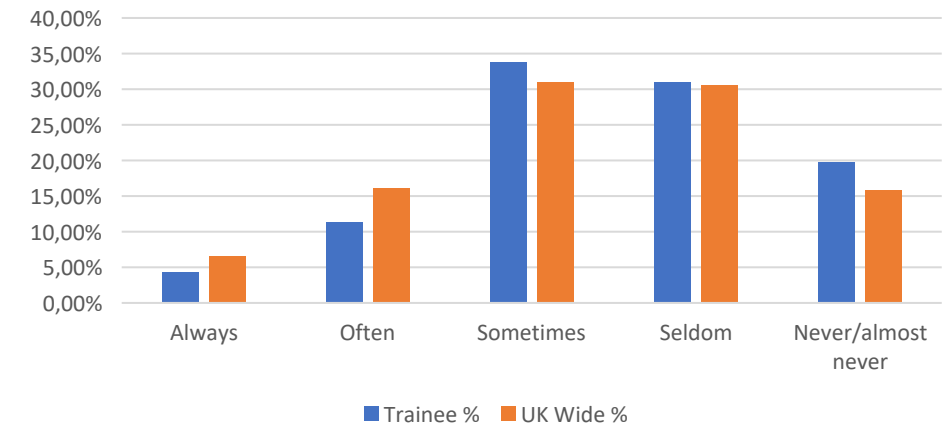


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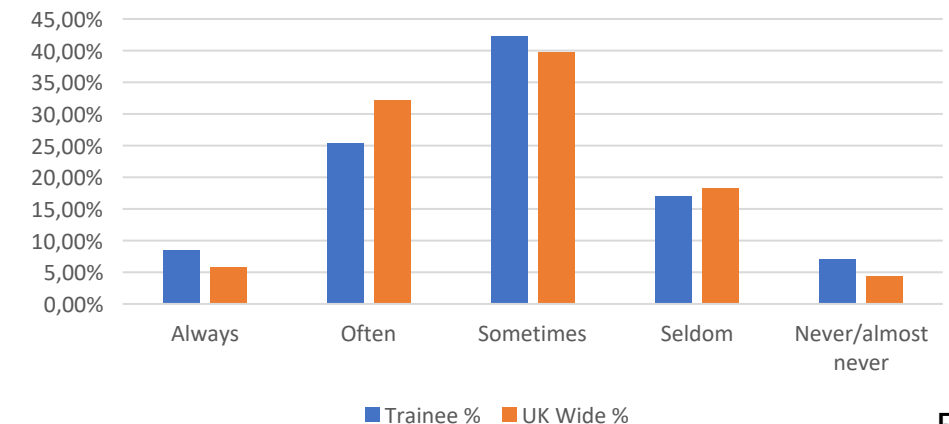
GENHQ202 - Are you exhausted in the morning at the thought of another day at work?



GENHQ203 - Do you feel that every working hour is tiring for you?



GENHQ204 - Do you have enough energy for family and friends during leisure time?



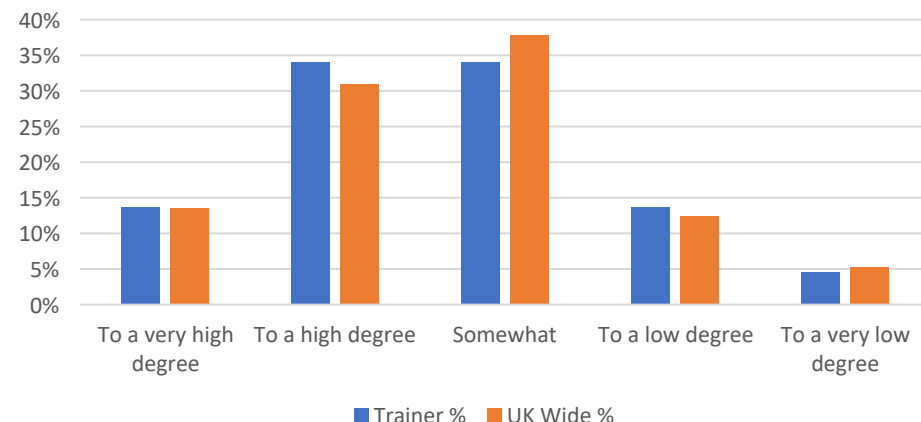
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Burnout - DCH Trainers 2025 (1)

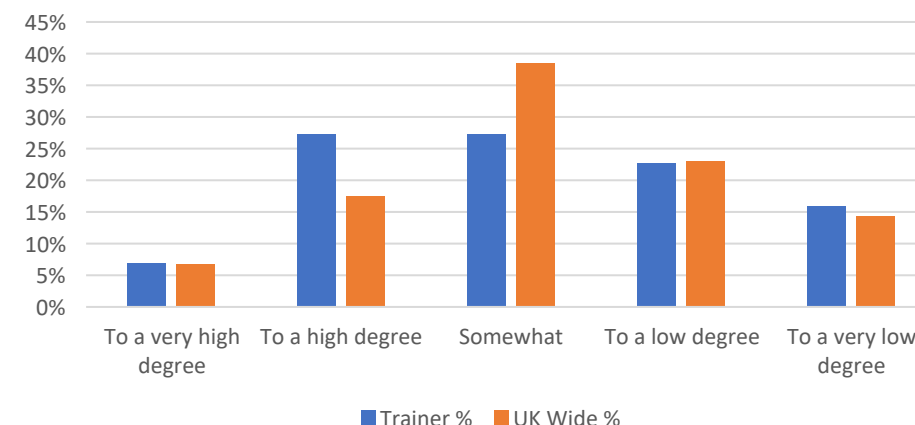


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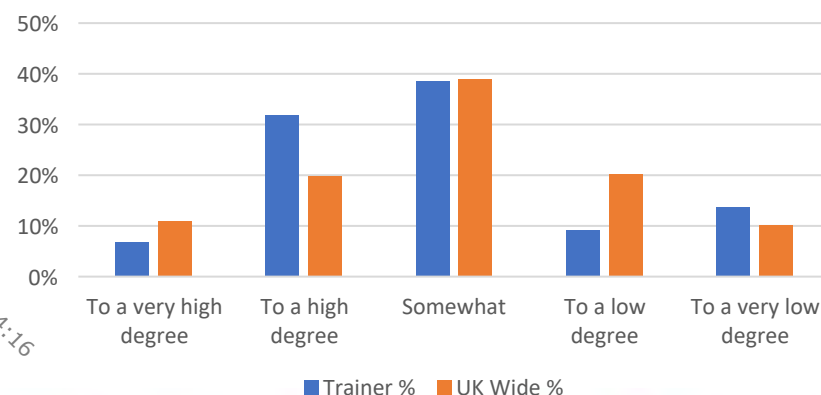
TGENQ102 - Is your work emotionally exhausting?



TGENQ103 - Do you feel burnt out because of your work?



TGENQ104 - Does your work frustrate you?



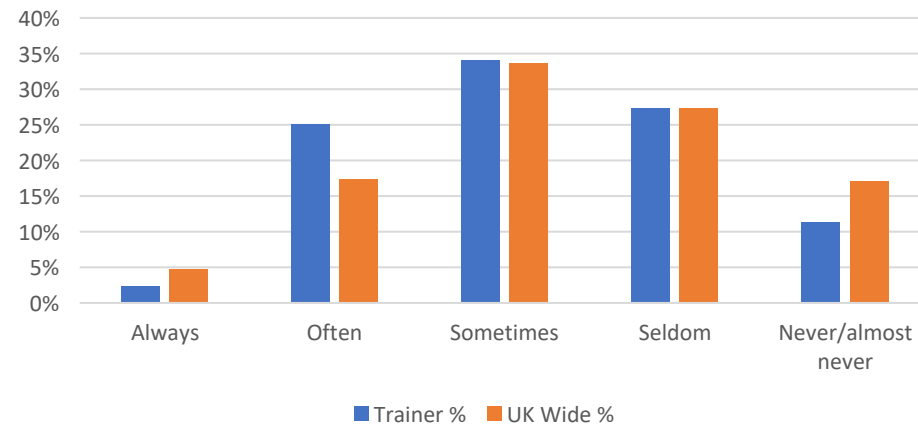
TGENQ105 - Do you feel worn out at the end of the working day?



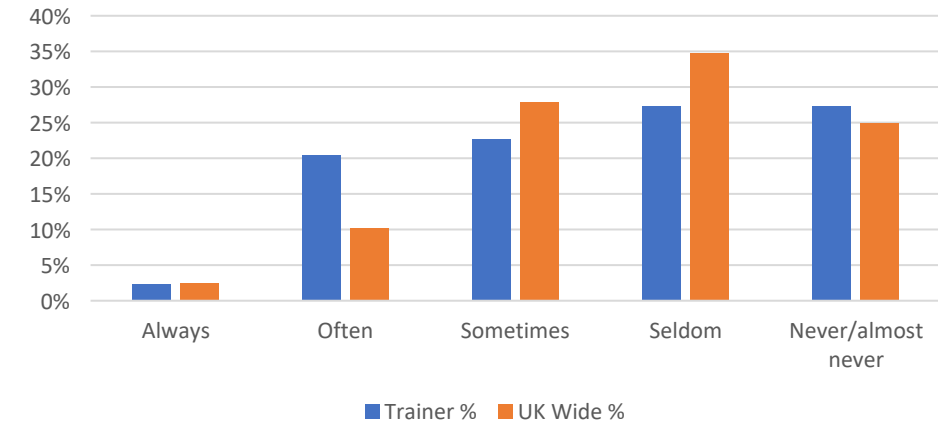
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Burnout – DCH Trainers 2025 (2)

TGENQ106 - Are you exhausted in the morning at the thought of another day at work?



TGENQ107 - Do you feel that every working hour is tiring for you?



TGENQ108 - Do you have enough energy for family and friends during leisure time?



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Discrimination and Burnout - Comments



Dorset County Hospital
NHS Foundation Trust

- Continued high risk of burnout nationally, some specialties more than others – **Emergency Medicine** appears high risk for both trainees and trainers
- **DCH trainees** appears slightly less fatigued or at risk of burnout as compared to national numbers (continued trend)
- **DCH trainers** – increasing trend towards fatigue as compared to 2024 results and UK wide %
- **DCH trainees** are being exposed to insults, stereotyping or jokes relating to protected characteristics more frequently than the UK wide %. However, more report confidence in reporting discrimination and unprofessional behaviours

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Trainer Survey results

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Summary from Overall Report

Key findings: trainers

21,289

trainers completed the survey in 2025.

Burnout



47%
considered to
be at moderate
or high risk
of burnout.

Training and support



90% of trainers enjoy their role.



70%
rated support they
receive from their
employer/local
education team as
good or very good.

Satisfaction



30%
said their work
frustrates them
to a high or
very high degree.

Rota gaps

29%

of secondary care
trainers said their
trainees' education
and training is
adversely affected
because rota gaps aren't
dealt with appropriately.



Time to train



29%
of secondary care
trainers and



18%
of GP trainers
said they weren't
always able
to use their
allocated training
time, specifically
for that purpose.

DCHFT Trainer Results 2025



Dorset County Hospital
NHS Foundation Trust

		2023	2024	2025
Dorset County Hospital NHS Foundation Trust	Supportive Environment	73.05	72.2	74.4
	Educational Governance	70.45	64.49	66.26
	Professional Development	75.31	72.67	72.69
	Appraisal	56.65	53.54	58.73
	Support for Training	73.94	73.38	71.36
	Time to Train	60.11	59.39	60.25
	Rota Issues	48.91	49.24	55.56
	Handover	56.25	57.2	58.87
	Resources to Train	73.4	67.16	59.13

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DCHFT results v Wessex



Dorset County Hospital
NHS Foundation Trust

DCHFT	HHFT	IOW	Portsmouth	Salisbury	Southampton	UHD
74.4	68.55	65	65.76	68.47	71.2	69.27
66.26	62.64	53.33	58.81	64.01	61.71	63.72
72.69	74.65	67.71	71.9	73.37	72.64	75
58.73	56.96	57.92	54.82	52.7	60.05	60.59
71.36	72.35	65.83	68.55	73.77	69.58	72.83
60.25	51.31	57.64	49.91	59.38	48.78	53.04
55.56	52.89	37.5	45.93	55.59	50.29	45.68
58.87	69.55	63.89	62.72	69.58	62.04	64.15
59.13	64.31	69.17	65.49	69.32	64.58	65.28

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Strategy Transformation and Partnerships Committee Assurance Report
for the meeting held on Monday 24 November 2025

Chair	David Clayton-Smith, Chair
Executive Lead	Dawn Dawson Nicola Plumb Chris Hearn (Beverley Bryant)
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	• Low-cost high impact research into motorcycle injury prevention in collaboration with innovation partners. • Strategy Delivery Dashboard to go live at the end of November with a partial set of agreed metrics. • Joint transformation Improvement Board has been relaunched with an initial focus on resetting the transformation and improvement priorities • Re-collaboration of resources to ensure right capacity is in the right place to meet the revised Transformation and Improvement priorities. • Digital Roadmap and Strategy endorsed. • Socialisation of Healthset (EHR) benefits has commenced.

Key issues / matters discussed at the meeting	The committee received, discussed and noted the following reports: Executive Leads Update • Presentation received on the Advanced Foundation Trust (AFT) background, assessment and submission process with a tight 6-week timetable for application noted. • The first draft of the staff survey results is expected in December once the survey response window closes at the end of November. • The medium-term planning round is underway, and the draft submission will be agreed in December with the final submission in February 2026. Much of the plan crosses over with the work required for the AFT submission Strategy in Action – Wessex Motorcycle Injury Prevention Network A presentation was received on the research and action work underway at DCH to prevent motorcycle injury (funded by the Wessex Health Partnership), highlighting its national significance, collaborative approach and data driven interventions. The DCH teams are at the forefront of the research and real tangible results are being realised resulting in less injury and death. Strategy Delivery Dashboard – Final Metric Specification

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The strategy delivery dashboard is planned go live at the end of November 2025. The status of the metric development was summarised using a red, amber and green categorisation. Green metrics will be published at launch, whilst amber and red metrics will continue to be worked on. It was recognised there is more work to do but the Dashboard will begin to give insights into strategy delivery.

Joint Strategy Five Enabling Plans: Update on Progress

The 5 enabling plans have developed at different paces, reflecting the differing operating circumstances for each. The Clinical & Quality, People, and Infrastructure plans have been launched. The Finance plan is in development reflecting the wider financial planning changes for the second half of the financial year. The Digital plan scope was enlarged and brings together the Federation and UHD. The combined plan is due for approval in March 2026. It is expected that each Enabling Plan will report into their relevant sub-committee to report progress.

Updated Transformation & Improvement Approach & Priorities

The Joint transformation Improvement Board has been re-established and have met to determine the current approach and priorities. There have been transformation resource constraints to delivery and a need to optimise resources and build capacity and capability within the team and wider organisation. The 4 proposed priority areas are the INT / Neighbourhood Health Programme, Mental Health Inpatient Flow, DCH unplanned care flow and Joint Improvement Programme.

Wessex Health Innovation & Wessex Health Partners Updates

The role and work of the Health Innovation Wessex was summarised along with an introduction to the de-implementation model of safe removal (or reduction) of low-value practices that are not proved to be effective. The Committee noted the relevance of the model in prioritisation and resource optimisation.

Technology Roadmap

Assurance was provided on the approach being taken to manage technical debt and IT risks at DCH and DHC, and the alignment of risk registers and holistic risk management approach across all Dorset Providers. This was supported and endorsed by the Committee.

Digital Strategy

The Dorset Digital Strategy was summarised, highlighting its collaborative development across the ICS, providers and primary care, with a focus on integration, interoperability and reducing administrative burden. The strategy explains what is planned and why. The next step will be articulating 'how' early next calendar year with work on an operating model. The strategy was well received and approved by the committee to go forward for Board consideration and approval.

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HealthSet Statement of Benefits

Now that the preferred supplier of the Electronic Health Record platform has been approved, a summary of the benefits was provided in advance of production of the full business case in January 2026 to give committee members and stakeholders the opportunity to comment. This is the first step in formally communicating the benefits to encourage engagement and ownership. The statement was well received and supported by committee members

Corporate Risk Register Assigned Risks

- DCH – There are 2 risks rated 20+, one of which has been mitigated since the production of the report relating to PACS image management (Risk 2200). 18 risks are rated (15-19) and 3 risks have been closed since last quarter.
- DHC – There are 2 risks scoring 15+ relating to asset management and closure of the Business Objects reporting facility. There have been 4 changes in risk score, 3 of these risks now score below the Committee's threshold for review. 6 risks are overdue for review.
- A joint Risk Manager has been appointed and the Risk Strategy is currently being updated.

Board Assurance Framework Assigned Risks

Committee members received the report for assurance. There are no changes in the scores at DCH or DHC. There are overdue actions for two of the four risks areas relating to:

- SR8 – Transformation and Improvement –full implementation of the Joint Improvement Framework (DCH and DHC).
- SR9 Digital – establishing a Dorset wide Digital Leadership Group. All appointments have been made and the final post-holder will be in post from January 2026.

Memo of understanding between DCH and DHC

Amendments to the memo of understanding were agreed and approved by the Committee.

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

- Information Governance Group Meeting
- Joint Transformation and Improvement Board Meeting

Decisions made at the meeting

- ToR Approved.
- Memo of Understanding between DHC and DCH Approved.



- Joint Transformation and Improvement Board Meeting Terms of Reference Approved.
- Dorset Digital Strategy Approved

Issues / actions referred to other committees / groups

- None

Quoracy and Attendance					
	28/05/2025	28/07/2025	22/09/2025	24/11/2025	
Quorate?	Y	Y	Y	Y	
David Clayton-Smith	Y	Y	Y	Y	
Frances West	Y	Y	Y	Y	
Dave Underwood	Y	Y	Y	Y	
Andreas HAIMBOCK-TICHY	Y	Y	N	N	
Claire Lehman	Y	Y	Y	N	
Nick Johnson	Y	Apols	N/A	N/A	
Chris Hearn	Y	Y	Y	Y	
Dawn Dawson	Y	Y	N	Y	
Nicola Plumb	N	Y until 11	Y	Y	

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Report to	Board in Common, Part 1	
Date of Meeting	9 December 2025	
Report Title	Dorset Digital Strategy	
Prepared By	Beverley Bryant – Chief Digital Officer	
Approved by Accountable Executive	Beverley Bryant – Chief Digital Officer	
Previously Considered By	JEMT – 18 November 2025 Strategy, Transformation and Partnership Committee in Common – 24 November 2025	
Action Required	Approval	Yes
	Assurance	No
	Information	No

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? <i>Delete as required</i>	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR9 - Digital Infrastructure	
Financial	Will be addressed through strategy implementation	
Statutory & Regulatory	No Implication	
Equality, Diversity & Inclusion	Developed through collaborative approach as described in strategy	
Co-production & Partnership	Developed through collaborative approach as described in strategy	

Executive Summary

The Dorset Digital Strategy is a comprehensive plan aiming to transform Dorset's health and care system through digital innovation by 2030. It emphasises creating a seamless, integrated digital ecosystem that empowers staff, improves patient experiences, and leverages emerging technologies to deliver equitable, efficient, and person-centred care across all health and social care settings.

Background

The Dorset Digital Strategy has been developed through a highly collaborative, iterative co-creation process, co-designed and co-owned by digital, clinical, and operational leaders across Our Dorset's health and care system. Every stage, from mobilisation to completion, has been shaped through engagement, evidence, and shared ownership. This approach ensures the strategy is both ambitious and grounded in real-world delivery.

Throughout, progress was guided by system-wide engagement and alignment with the Our Dorset vision. The result is a collectively owned, evidence-based strategy endorsed by digital leadership and system partners, ensuring shared commitment to meaningful digital transformation across Dorset.

The Dorset Digital Strategy focuses on the 'why' and the 'what'. Once approved by the Boards in December 2025, the next phase will be developing the roadmap for the Dorset Digital Strategy. This work will begin with a planning workshop on 22 January 2026.

Recommendation

Members are requested to:

- **Approve** the Our Dorset Digital Strategy.

Our Dorset Digital Strategy

2025–2030

Improving Health & Care
Through Digital Technology



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Chapter One - Purpose & Strategic Intent

Becoming a Digital Pioneer

The **Our Dorset Digital Strategy** is a comprehensive plan aiming to transform Dorset's health and care system through digital innovation by 2030. It emphasises creating a seamless, integrated digital ecosystem that empowers staff, improves patient experiences, and leverages emerging technologies like AI to deliver equitable, efficient, and person-centred care across all health and social care settings.

Strategic Vision and Context

Dorset aspires to be recognised as a digital pioneer within the NHS by 2030, where people, data, and technology work harmoniously to deliver outstanding care. The strategy addresses Dorset's diverse population of over 810,000, highlighting existing health inequalities and the need for digital tools to overcome challenges such as rural access and ageing demographics. Digital technology is positioned as essential for a resilient health and care system, not merely an optional enhancement. The strategy promotes a unified digital approach across all partners and providers, focusing on interoperability, shared priorities, and sustainable investment. AI and automation are central to this vision, supporting clinicians and enhancing care without replacing human capability.

Strategy Development, Objectives and Themes

This strategy has been co-created with our people, not delivered to them. Over the past months, we brought together digital, clinical, and operational leaders from every part of the Dorset system to develop a shared digital ambition that genuinely reflects how care is delivered across settings. Through workshops, design sessions, and continuous engagement, we have built a common purpose rooted in local priorities, lived experience, and the expertise of those who know our services best. (See [Appendix A](#) for a summary of this co-creation process.)

The strategy sets out four strategic objectives and four themes that together provide the foundations to transform care for citizens and staff. These objectives define what we must achieve to make digital a true enabler of better outcomes, while the themes describe how we will deliver change consistently and safely across the system. These form our digital blueprint for Dorset – built on collaboration, standardisation and shared capability to support every care setting ([Appendix B](#)).

To guarantee this strategy converts ambition into measurable progress, we have defined system-wide Key Performance Indicators that will track the benefits delivered over time ([Appendix C](#)). This ensures transparency, accountability, and pace — giving confidence that Dorset is not only imagining a better digital future but is equipped to deliver it.

Chapter Two – Enabling Care Across Settings

This chapter focuses on integrating digital systems across Dorset's varied health and social care settings to enable seamless, joined-up care. It identifies current challenges such as patchy digital maturity, inconsistent data sharing, multiple logins, and reliance on paper processes. The strategy commits to removing legacy systems, adopting modern interoperability standards, expanding electronic patient records, and embedding digital solutions into care pathways. Collaborative governance and strategic alignment are deemed essential to unify digital initiatives and data governance, ensuring privacy and ethical use. Transformation programmes like Integrated Neighbourhood Teams (INTs), a unified Electronic Health Record (HealthSet), and Future Care are key enablers for integrated, person-centred, and preventative care.

[Chapter Three – Workforce & Culture](#)

This section highlights the critical role of a digitally capable and confident workforce in achieving the digital strategy's ambitions. It addresses challenges such as mixed staff confidence in digital skills, recruitment and retention difficulties, and dispersed leadership. It aims to cultivate digital skills at all levels, professionalise the digital workforce, and embed inclusive, accessible training. Leadership collaboration between digital, operational, and clinical teams is key to ensuring sustained, person-centred digital transformation. It also seeks to raise digital confidence across the wider health and care workforce, tackling digital exclusion and fostering a positive culture around innovation.

[Chapter Four – Digitally Enabling and Empowering Citizens](#)

This chapter addresses the imperative to improve digital engagement and access for Dorset's citizens. Despite technological advances in other sectors, parts of the NHS remain analogue, leading to fragmented patient experiences and limited digital service adoption. It focuses on providing a unified, user-friendly digital experience through tools like the NHS App, enhancing patient access to appointments, records, and health information. The chapter further prioritises equitable digital inclusion by offering flexible alternatives and support to those with limited digital literacy or connectivity. Our aim is to empower individuals to manage their health proactively.

[Chapter Five – Modern Infrastructure Foundations](#)

This segment underscores the importance of a resilient, secure, and scalable digital infrastructure as the backbone of modern healthcare. Challenges include aged infrastructure, legacy systems, inconsistent user experience, and cyber risks. Dorset plans to establish shared infrastructure governance, standardise procurement, adopt cloud solutions, and align infrastructure with clinical priorities to improve interoperability and user experience. It commits to improving system reliability, connectivity, and support services, while embedding robust cybersecurity frameworks, business continuity plans, and green IT initiatives to reduce environmental impact.

[Chapter Six – Data, Analytics & Insights](#)

Data is a critical asset for enabling evidence-based decision-making, proactive care, and population health management. It emphasises enhancing data sharing and governance, developing robust data architecture leveraging cloud technologies, and advancing analytics capabilities for performance monitoring, predictive modelling, and prevention. Existing platforms like the Dorset Care Record (DCR) and Dorset Intelligence & Insight Service (DiIS) are foundational, with plans to align with national initiatives such as the Federated Data Platform (FDP). It also promotes innovation in analytics, including the use of unstructured data and AI-enabled tools, alongside active engagement with patients and communities for co-designed data solutions.

[Chapter Seven – Alignment with Other Strategies](#)

The digital strategy aligns with a broad range of national, regional, and local policies, frameworks, and plans, including NHS England's 10-Year Plan, Department of Health and Social Care priorities, and local integrated care strategies. It maps its chapters to the NHS's "What Good Looks Like" framework, ensuring coherence with established success measures such as leadership, safety, workforce support, citizen empowerment, care improvement, population health, and foundational infrastructure.

Ensuring
coherence
with
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success
measures
such as
leadership,
safety,
workforce
support,
citizen
empowerment,
care
improvement,
population
health,
and
foundational
infrastructure.

Digital Strategy Scope

In the past, digital plans in Dorset have been made separately by each organisation, focusing on their own needs. This has led to different systems, varied patient experiences, and made it harder to plan and work together across the county.

Now, Dorset is moving towards sharing resources and building a fully joined-up health and care system. To do this, we need one clear digital strategy that works across all services, supports the flow of patient information, and focuses on shared priorities across care settings rather than organisational boundaries.

This strategy is not about technology for its own sake. It is about harnessing digital and data to meet Dorset's challenges head-on and secure a healthier future for every community we serve.

Core Strategy Focus: Acute (Dorset County Hospital & University Hospitals Dorset) Community, Mental Health, Learning Disabilities (Dorset HealthCare), Integrated Care Board (NHS Dorset), and Primary Care (GP Practices).

Strategy Interlock with Integrated Areas of Working: Partners, such as Pharmacy, Optometry, Dental, Local Authorities (Adult & Child Social Care), Voluntary and Community Sector, Emergency Services (Ambulance, Fire, Police), County, and Regional Partners.

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Chapter Two – Enabling Care Across Settings

Why This Matters

The NHS 10-Year Plan, published in July 2025, sets a bold ambition: to reinvent the NHS as a sustainable, patient-controlled, digitally advanced system focused on prevention. In Dorset, this vision must encompass a wide spectrum of care, from primary and secondary services to social care, diagnostics, prison healthcare, and voluntary groups.

Insights from the Digital Strategy Questionnaire revealed that only 8 out of 421 respondents felt digital systems supported joined-up care “extremely well.” Most described disconnected experiences, especially among patients with long-term conditions as 56% of Dorset’s population have one or more.

This fragmentation stems from uneven digital maturity and poor interoperability across sites, leading to incomplete records, duplicated effort, and clinical risk.

What Dorset Aims to Achieve

		
Integrated Digital Systems Across Health and Care Settings	Collaborative Governance and Strategic Alignment	Future-Focused Programmes and Technologies
“Every clinician and patient in Dorset will have secure access to the right point-of-care information at the right time, via systems that talk to each other across all care settings. Paper is eliminated, except where a patient has explicitly opted for paper correspondence, connectivity is reliable and all correspondence across care settings is handled electronically.”	“Digital decisions in Dorset will be made once, wisely, and together. All organisations will work to a single strategy, with shared governance that prioritises long-term value, safety, and resilience over short-term fixes. Every partner feels ownership of the digital future.”	“Dorset will lead the way in adopting innovative evidence-based digital programmes that improve lives today and prepare for tomorrow. From integrated neighbourhood teams to AI-powered diagnostics and a single patient record, technology will enable proactive, preventative, and personalised care.”

1. Integrated Digital Systems Across Health and Care Settings

Why: Fragmented systems and inconsistent data sharing create gaps in care and increase risk.

Many NHS organisations, including those in Dorset, continue to rely on outdated, disconnected digital systems, hindering progress toward joined-up, patient-centred care. This challenge is compounded by the need for a flexible, digitally enabled workforce (as outlined in Chapter 3), supported by foundational investments like single sign-on and interoperability services (Chapter 5).

Fragmentation stems from suppliers’ limited coordination around shared standards and the tendency to implement digital infrastructure at an organisational rather than system-wide level. The 2025 Data (Use and Access) Act now mandates common standards across health and care, aiming to ensure systems can interface seamlessly.

Despite this, staff still face daily frustrations: multiple logins, inconsistent platforms, and repetitive training across sites. These inefficiencies not only slow adoption but increase cyber risk and compromise care quality.

Dorset's strategy focuses on aligning standards, simplifying user experience, and centralising patient records to improve transitions and outcomes. Crucially, digital tools must be embedded as core to how services operate, not optional add-ons. Adoption, training, and ongoing support are as vital as the technology itself in enabling care across diverse settings.

Dorset's NHS sites vary widely in digital maturity, creating inconsistent experiences across the region. Hundreds of clinical systems are in use, many of which don't interoperate, making joined-up care difficult.

Digital tools are often treated as optional, leading to a patchwork of paper and digital processes with little standardisation. Staff face siloed data, multiple logins, and inconsistent user interfaces, which slows adoption and increases frustration.

This complexity also raises cyber risks, especially where standards haven't been adopted. Without a unified approach, digital progress remains uneven, and care delivery suffers.

What We Will Do:

- **We will move towards a connected, interoperable digital health ecosystem** with a major emphasis on integrating Primary, Secondary and Social Care.
- **We will ensure all systems can communicate and share data effectively** by using FHIR API standards.
- **We will expand and centralise our Electronic Patient Records** to include more care settings and data to support areas of service and pathway improvement across the county.
- **We will eliminate the use of paper** in the administration of patient care.

2. Collaborative Governance and Strategic Alignment

Why: Effective digital transformation requires shared responsibility, clear objectives, and robust data governance.

Each Dorset NHS organisation has historically worked in isolation to create strategies and selected their own digital solutions, and whilst this was intended to foster innovation and responsiveness, it has led to a patchy and inefficient set of digital systems. This has resulted in limited interoperability, increased costs and difficulties in achieving consistent patient outcomes.

Career opportunities for digital staff are limited to their own organisation and clinical and operational staff working pan-Dorset require multiple devices and logins.

Within our organisations involvement of clinical and operational leaders in digital decision making have been patchy and inconsistent. Digitally enabled transformation is everybody's job and considering the process and people aspect is as important as the technologies.

What We Will Do:

- **We will move as one 'Dorset System'** establishing cross-organisational governance to deliver digital strategy and share responsibility.
- **We will promote shared ownership and co-creation** of digital initiatives that emphasise standardised processes with clinical and operational buy in.

- **We will develop data sharing agreements** that protect privacy while enabling safe, ethical digital adoption.
- **We will ensure technology keeps pace with ambitions** for collaboration and standardised working.

3. Future-Focused Programmes and Technologies

Why: National reform demands a reimagined NHS: digital, decentralised, and preventative.

Science and technology are central to this reinvention. The NHS of the future will offer instant access, predict and prevent illness, empower frontline staff, and operate with the values of the NHS supported by a broader network of digital innovation.

The Dorset's Digital Strategy must respond directly to clinical and operational priorities. Technology should not exist in isolation, it must enable service alignment, standardised processes, and consistent ways of working across the system. Major transformation programmes are already underway to deliver the NHS 10-Year Plan, including:

- Integrated Neighbourhood Teams (INTs)
- Unified Electronic Health Record (HealthSet)

These initiatives must work in tandem: INTs driving person-centred care, and the EHR providing the digital backbone. However, challenges remain around flexibility, inclusivity, and pace of change. Addressing these will require strong interoperability, cultural alignment, and full engagement from all Dorset providers and partners.

Success also depends on the enabling roles of HR, people and culture, communications, and marketing teams, ensuring the transformation is inclusive, understood, and embedded across the system.

Integrated Neighbourhood Teams (INTs):

Integrated Neighbourhood Teams (INTs) bring together everyone who cares for, or supports, a community. They include team members drawn from Nursing, Medical, Allied Health Professionals with Social Care, wider Local Authority Teams and the Voluntary and Community Sector.

INTs will have common purpose, vision and shared objectives, quality outcomes and access measures with a single unified leadership team. Data and technology will provide an information thread supporting collaboration and enabling INTs to deliver proactive, preventative, and personalised care closer to home, improving health outcomes and system efficiency.

In summary INTs will:

- Bring together all professionals supporting a community (nursing, medical, allied health, social care, local authority, voluntary sector).
- Use data and technology to support proactive, preventative, and personalised care closer to home, and better support collaboration across organisational boundaries.
- Operate with unified leadership, shared objectives, and common access measures.

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Unified Electronic Health Record (HealthSet)

Converging onto a single Electronic Health Record (EHR) system across Dorset and Somerset is a once-in-a-generation opportunity to transform care delivery. By uniting Dorset County Hospital, University Hospitals Dorset, Somerset NHS Foundation Trust, and Dorset HealthCare, we will improve patient experience through shared care pathways and service innovations.

This collaboration enables us to maximise digital investment, achieving economies of scale in implementation, hosting, and long-term maintenance.

Implementing a new modern EHR solution across Dorset and Somerset will:

- Align pathways between acute organisations and from acute to community and mental health, with consideration of how to integrate and standardise pathways with primary care, social care, and the voluntary community.
- Enable new pathways of care and service delivery innovations.
- Drive a focus on population health.
- Deliver parity of physical and mental health for our patients.
- Maximise the investment in digital solutions and achieve economies of scale.

This programme is a cornerstone of our regional digital strategies and a critical enabler of system-wide transformation.

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Chapter Three – Workforce & Culture

Why This Matters

Health and care are expected to look very different in 10 years, influenced by population aging, changing workforce expectations and rapid digital advancement. This chapter outlines how Our Dorset will cultivate a digitally capable and confident workforce, recognising that effective digital transformation is fundamentally about people, not the technology.

Our staff are our greatest asset, and their ability to confidently use digital tools is crucial if we are to achieve our digital ambitions. In an increasingly technology-driven health and care environment our workforce must be equipped with the right digital knowledge, skills, leadership, and culture to meet the challenges of an ever-changing healthcare landscape.

The Digital Strategy Questionnaire insights demonstrated that staff confidence is mixed when it comes to using digital technology. Of the 421 responses to the questionnaire, only 82 staff reported being extremely confident using digital tools and 43 were not confident at all, with most falling in between. There was a strong preference for self-paced learning and in-situ training in the workplace, supported by peer-to-peer learning, with a clear demand for accessible, flexible training approaches focused on career pathways and embedding digital capability into everyday learning culture.

Our vision for a digitally enabled workforce is one where staff are confident and supported in using technology to fulfil their role.

What Dorset Aims to Achieve

Our people are central to Dorset's digital future. To prepare the health and care workforce, we aim to:

- Build digital skills and capability from frontline to board level
- Professionalise the digital workforce and grow a sustainable talent pipeline through education, retention, and mobility
- Standardise training and improve digital and data literacy
- Drive safe innovation aligned with regulatory standards and best practice

To deliver these ambitions, we will focus on three priority areas:

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Leadership and Collaboration	Digital Workforce Development	Wider Health and Care Workforce Development
"Digital leadership will be embedded at every level, from board to frontline, with clinical, operational, and digital leaders working together through shared governance to drive transformation across Dorset."	"Dorset will nurture a professional, sustainable Digital, Data and Technology workforce with clear career pathways, accredited training, and opportunities for development, ensuring we attract and retain top talent."	"All staff feel confident and supported in using digital tools, with equitable access to training and minimum digital skill standards, creating a culture where technology enables safe, inclusive, and high-quality care."

1. Leadership and Collaboration

Why: Effective leadership of digitally enabled change is crucial for guiding the NHS and social care sectors through significant reforms, ensuring long-term sustainability, and unlocking widespread benefits.

When digital, clinical and operational teams are involved together in shaping and leading digital change, the outcomes are more relevant, sustainable, and impactful.

A shared governance can go some way to ensuring success but in Dorset, we are digging deeper into how roles within governance can contribute to making sure that their planned digital transformation is delivered everywhere and forever.

- **Digital Leadership** - makes sure that the chosen technologies are fit for purpose. They should own the contract and relationship with any suppliers and drive value-for-money ongoing in supplier contracts. They drive towards a changed outcome, providing the programme management rigour and discipline through to a safe transition and close-down of the legacy digital systems and contracts.
- **Operational Leadership** - prepare for and understand the impact of a switch to digital and prepare their teams to be ready for it. They drive for standardised operating procedures (SOPs), ensure staff are trained and supported and drive uptake and adoption of the digital tools, removing paper.
- **Clinical Leadership** - help ensure that digital systems improve patient safety, reduce clinical errors, and support equitable access to care. They champion the safe adoption of innovation, empowering staff to use digital tools confidently and responsibly.

Digital transformation is everybody's job and adopting a team approach to it, not just during the transition but ongoing through optimisation and transformation, is key to achieve digital systems and tools that are person-centred, ethical, safe, effective, efficient, timely, and equitable.

There are national and local shortages of Digital, Data and Technology (DDaT) professionals, limiting capacity for delivery and innovation. Unclear career pathways and training frameworks make it difficult to attract, develop, and retain talent. Clinical digital leaders are often under-supported, reducing their ability to influence change and connect clinical and digital priorities.

What We Will Do:

- **We will embed digital leadership at all levels** ensuring that senior leaders are digitally aware and that digital leadership is present at board level.
- **We will foster shared and inclusive governance** to promote joint decision-making and co-ownership of digital initiatives ensuring all voices are heard in digital transformation.
- **We will invest in development of clinical digital leadership** to make digital core to our delivery of care in all settings.

2. Digital Workforce Development

Why: Digital, Data and Technology (DDaT) workforce development is paramount if we are to embed digital and data across our organisations. Digital professionals protect us from cyber-attacks, keep our systems up to date, manage data migrations, ensure interoperability, procure and build applications.

Our ambition for digital staff is to make Dorset an attractive destination for people to live and work. We will grow a strong, capable and skilled DDaT workforce which has the ability and agility to meet the future needs of the health and care sector, whilst having the dedicated time to continuously develop and assist patients with technology.

Chief Clinical Information Officers (CCIOs) play a key role between medical and digital teams, advocating for the benefits of digital to the clinical workforce and pushing digital potentials to improve usability for clinicians.

We will develop an Dorset-wide digital clinical leadership pipeline and position CCIOs and Chief Nursing Information Officers (CNIOs) to feel empowered to advocate for patients and carers helping contextualise digital safety risks associated with pathways, processes, tools and data, whilst sharing best practice.

What We Will Do:

To reimagine our approaches to recruitment and retention:

- **We will partner with education and industry to build a talent pipeline** from trainees to apprentice and graduates to attract the best people to Dorset.
- **We will improve retention through career mobility** by enhancing growth and providing flexible development opportunities for staff.
- **We will create a supportive, fulfilling environment** where digital professionals feel valued and invested in through accredited career pathways and continuous learning opportunities.
- **We will embed digital risk management** and transformation principles into DDaT roles to encourage safe, sustainable change.

To champion and embed digital clinical leadership:

- **We will invest in clinical digital leadership across all our services** giving our existing clinicians a formal role in our digital team.
- **We will develop a clinical leadership pipeline** with opportunities for clinicians to receive formal and informal training and support to move into those roles.
- **We will ensure clinical digital leadership are embedded** within the future target operating model for digital services across Dorset.

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3. Wider Health and Care Workforce Development

Why: Digital transformation must include all staff, not just digital professionals. Confidence and competence in using technology are essential for everyone, and we must acknowledge that resistance and negativity toward digital transformation can arise from insufficient investment to support staff with digital skills development.

The development of the wider non-digital health and care workforce is a critical component of the ongoing digital transformation within the NHS and social care sectors. The overarching goal is to empower all staff with the necessary digital skills to thrive in an increasingly technology driven environment, ensuring high-quality, personalised, and efficient patient care.

A relentless focus on digital skills and leadership at all levels is necessary to make transformation durable. Leaders must prioritise and facilitate workforce upskilling by ensuring staff have the time, funding, and accessible equipment needed for training. They need to foster a learning culture and ensure that staff have the right skills and confidence to apply new technologies successfully. This includes addressing issues of digital literacy, fear of digital systems, and unequal access to technology and training among staff.

Digital is often seen as an "add-on" rather than central, and there can be a polarised perception where it's either a panacea or a villain, hindering realistic adoption. Too often, digital tools are treated as 'optional' rather than an integral part of how services operate.

Low digital confidence and fear of technology remain common across the workforce. Access to IT training and tools is unequal, with many staff beyond digital professionals lacking the support they need. Digital is often perceived as optional or disruptive, rather than integral to improving care and efficiency.

What We Will Do:

Our ambition for the wider health and care workforce is to:

Create a digitally confident and highly skilled health and care workforce in Dorset that is deeply integrated into a culture of continuous innovation and improvement, empowered by collaboration.

To cultivate digital confidence:

- **We will offer foundational skill support** to enhance confidence and competence with investment in digital educators and developing a network of peer digital champions.
- **We will provide tailored, ongoing digital training** and peer support to meet individual's needs and baseline skills ensuring it is ongoing and continuous reducing fear as technology evolves
- **We will work in collaboration with our workforce colleagues to agree minimum digital skills standards for all job roles** which new starters are supported to achieve as part of their induction period and where existing staff are provided with dedicated time to maintain their digital skills development.

To make access fair and equitable:

- **We will provide equitable access to training** by providing a single point of access for learning and consistent funding policies enabling ease and equity of access at a time and place of the learner's choosing.
- **We will tackle digital exclusion through multi-channel offers** ensuring traditional means of learning remain aligned to their needs and for those who cannot or prefer not to access digital tools for education purposes.

- **We will foster a positive, inclusive culture** around digital innovation transformation and optimisation underpinned by psychological safety, enabling staff to adopt new technologies without inherent barriers and celebrating successes.
- **We will make efforts to ensure that our diverse workforce is supported by an inclusive and accessible digital offer** which breaks down barriers and meets people where they are.

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Chapter Four – Digitally Enabling & Empowering Citizens

Why This Matters

Despite rapid global advances in technology, the NHS remains a “20th century technological laggard,” as described in the NHS 10-Year Plan. While people routinely use mobile apps, wearables, and online platforms in daily life, the NHS has yet to match this level of digital convenience.

Patients reasonably expect to book appointments, view test results, and access medical records online. These services have been available in General Practice for nearly a decade, but in secondary care, many still rely on letters or long call queues for basic information.

The Digital Strategy Questionnaire insights that patients face barriers including limited digital literacy, poor connectivity, and concerns over trust. Our staff believe that enabling patient access to records and secure digital communication are the most valuable interventions for improving patient care. Therefore, we must prioritise empowerment through simplicity, accessibility, and trust-building initiatives, with a focus on increasing adoption of the NHS App and similar platforms.

Where digital tools exist, they’re often limited to a few specialties. A patient’s journey may begin digitally, booking a GP appointment or receiving a test result notification, but quickly reverts to paper and manual processes, leaving them without visibility or timely updates.

This highlights the urgent need for consistent, system-wide digital transformation.

What Dorset Aims to Achieve

Improving Experience, Access and Choice

"Every citizen in Dorset will have access to the NHS APP enabling a simple, trusted digital front door to health and care services, offering consistent quality, seamless access, and genuine choice in how they engage with their care."

Equitable Offer for All

"Nobody in Dorset will be excluded from digital health and care. Services, support and training will be accessible to all – regardless of skills, confidence, or connectivity – so that everything citizen benefits equally."

1. Improving Experience, Access and Choice

Why: People and patients face uneven access to health information and inconsistent digital services. A unified, user-friendly experience is essential.

Access to health and care information for an individual is currently too convoluted, making it accessible to the most determined and digitally savvy. There is a plethora of apps available, and it is difficult for the

average person to know which ones are safe or appropriate to support their specific health and care needs.

This toolkit is focused on tools with enabling functionalities such as Patient Engagement Portals (PEPs) and the NHS App helping people and patients view and manage appointments, order repeat prescriptions, receive messages and notifications and access their health record.

Online services across the system remain uneven, with inconsistent user experiences and confusing navigation. Integration between platforms is poor, limiting personalisation and continuity of care. Accessibility and inclusivity are also limited, leaving some users unable to fully engage with digital tools.

What We Will Do:

- **We will promote and implement new technologies** to support people to self-manage their conditions e.g. Hybrid Closed-Loop Systems.
- **We will increase the number of digitally enabled citizens** through increased accessibility and a consistent offer whilst providing them with the skills and support needed for digital inclusion and improving digital literacy.
- **We will increase the utilisation and understanding of how the NHS App will enhance user experience and choice** through convenient access to services, personalised health information and give patients the ability to access their data and make informed decisions about their care. It can provide choice based on patient satisfaction, waiting times and healthcare outcomes enabling access to the best care.
- **We will increase our adoption of trustworthy AI** to give patients access to trusted health information, helping patients articulate their health needs and preferences confidently whilst providing information on any conditions they may currently have.
- **We will transform towards a single user experience** focused on integration to the NHS APP.

2. Equitable Offer for All

Why: Digital tools must be accessible to everyone, regardless of skills, connectivity, or confidence.

We will develop our tools and services to ensure no one is left behind and that information is accessible to all in line with the Accessible Information Standard (AIS). We will tailor our services base on individual preferences for communication, capability, accessibility and need.

We are aware of the risks of digital exclusion. While digital tools can enhance care, they should not be a barrier to care. Therefore, all digital pathways and services will be designed with flexible alternatives when digital is not suitable. Digital champions and community navigators will be on hand to support patient choice utilising digital pathways where suitable

Digital literacy and access support vary widely across the system, leaving some staff and patients without the skills or help they need. The availability of digital services is inconsistent across organisations, care settings, and service types. Many tools also lack inclusive design, making them harder to use for diverse populations.

What We Will Do:

- **We will offer information that is easy to access and use**, with clear, simple messaging (about what help is available close to home determined by their health need and disability).
- **We will increase workforce knowledge and skills around digital literacy and inclusion** with a view to consistent care offerings – messaging and signposting to appropriate services.

- **We will embed a Digital Champion programme (or equivalent) across Dorset** to increase the support available so as not to leave anyone behind.
- **We will increase our understanding of digital exclusion metrics** refining our approach with system colleagues including voluntary, community and social enterprise (VCSE) and social care.

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Chapter Five – Modern Infrastructure Foundations

Why This Matters

A modern digital infrastructure is the catalyst for transformation and innovation in healthcare. It enables the deployment of advanced technologies, including AI and automation, supports seamless data integration, and ensures the security and reliability of digital health services. It also underpins the digital enablement of corporate services, helping streamline operations such as HR, finance, and procurement. By prioritising infrastructure development, Our Dorset can lead the way in creating a future-ready health and care system that is both innovative and resilient.

Insights from the Digital Strategy Questionnaire highlight system reliability as a recurring issue. Over 110 of 421 respondents disagreed or strongly disagreed that systems are reliable, and 58% reported that outages had affected their work. While confidence in security is strong, performance is not yet at the level required for ‘silent running’, where everything works smoothly behind the scenes. The strategy must commit to modernising infrastructure, ensuring fast, resilient, and integrated foundations.

In addition, Dorset is committed to implementing green IT infrastructure. This includes adopting energy-efficient technologies and practices that reduce the environmental impact of digital systems. By prioritising sustainability, Dorset can minimise its carbon footprint while maintaining high standards of performance and reliability. Green IT not only supports environmental goals but also contributes to cost savings and operational efficiency.

What Dorset Aims to Achieve

			
Infrastructure as an Enabler	Alignment with Clinical Priorities	User Experience and Service Reliability	Security, Continuity and Support
"Infrastructure in Dorset will be recognised as a critical enabler of safe, effective and efficient care – invested in strategically to support transformation, clinical outcomes, and staff wellbeing."	"Digital infrastructure will be designed around clinical priorities and system goals, ensuring every investment directly supports better care, improved safety, and greater productivity."	"Staff and citizens will experience simple, seamless, and always-available digital services. Infrastructure will be intuitive, reliable, and designed to reduce frustration and duplication."	"Resilient security, business continuity and consistent support will be embedded across all organisations, building public trust and ensuring uninterrupted care in both everyday and exceptional circumstances."

1. Infrastructure as an Enabler

Why: The infrastructure is the foundation for any modern digital strategy and underpins both operational stability and strategic innovation.

Each organisation has historically procured its own digital solutions, creating complex demands layered over siloed infrastructure. Independent strategies and practices have embedded a wide range of technologies and configurations, making standardisation difficult and increasing the need for diverse skills and fragmented procurement. Compatibility between legacy and new systems is increasingly challenging, especially where contracts are extended and support becomes costly or unavailable.

Common platforms, including those for corporate services such as HR, finance, and procurement, will help resolve these issues by reducing duplication, enabling shared support models, simplifying integration, and creating a consistent, scalable foundation for digital transformation across the system.

What We Will Do:

- **We will establish a common, connected digital infrastructure** across all Dorset provider organisations, reducing duplication and technical debt.
- **We will ensure any infrastructure technologies are discussed and agreed via a single (cross organisational) governance** structure and overarching leadership to ensure alignment and harmonisation moving forward
- **We will standardise hardware and software procurement** to streamline maintenance, updates, reduce costs and support across the organisation while improving user experience.
- **We will, where appropriate, adopt cloud-based solutions** for data storage and applications, enhancing scalability, backup, and disaster recovery capabilities and embed an ability to innovate faster.
- **We will implement common platforms** to support our corporate services across HR, Finance, Procurement and Estates and Facilities.

2. Alignment with Clinical Priorities

Why: To ensure that the infrastructure directly supports better patient outcomes through operational efficiency, and strategic transformation across our healthcare systems.

Staff across different organisations often lack access to shared systems, leading to delays and duplicated effort. Legacy IT and outdated technologies hinder integration, with technical debt preventing a single, up-to-date view of patient care. Regulatory and compliance requirements, while essential for safety, can slow infrastructure changes if not well planned. Inadequate data sharing means patients must repeat information and clinicians lack a complete picture. To adopt efficiency tools and AI safely, staff need confidence that these technologies are secure, regulated, and clinically sound.

What We Will Do:

- **We will develop a unified digital architecture to ensures interoperability across Dorset**, so information can move seamlessly with the patient.
- **We will prioritise clinical-led digital transformation** ensuring infrastructure decisions are driven by the needs of clinicians and patients, not just IT cycles, ensuring digital directly supports better outcomes.
- **We will modernise core infrastructure to enable single sign-on** to reduce wasted time, improve efficiency, and enhance safety by ensuring clinicians always have rapid, secure access to the tools they need regardless of where they are working.
- **We will promote digital inclusion principles to ensure infrastructure works for all patients**, including those facing digital barriers, to support equitable access to care.
- **We will promote the safe use of AI and efficiency tools** aligned with clinical workflows by embedding governance and safety processes, so Dorset can benefit from innovation without compromising trust or patient safety.
- **We will implement green IT infrastructure** adopting energy-efficient technologies and practices that reduce the environmental impact of digital systems and prioritising sustainability, whilst reducing our carbon footprint.

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3. User Experience and Service Reliability

Why: A smooth, intuitive user experience reduces time spent navigating systems or seeking help. Reliable services mean fewer disruptions, allowing users to focus on their core tasks. Users are more confident in systems that are consistently available and easy to use. Positive experiences lead to higher satisfaction scores and better adoption of new technologies. When users trust the systems, they're more open to adopting new tools and workflows. This allows information technology teams to focus on strategic initiatives rather than firefighting.

Staff and patients often face inconsistent digital experiences that don't support new ways of working, with tools sometimes acting as barriers rather than enablers. Minimising downtime is critical, as planned or unplanned outages disrupt care, strain clinical workflows, and erode trust in digital systems.

Connectivity varies across organisations and care settings, making it difficult for staff to access the systems and data they need, impacting both productivity and care quality. Inconsistent mobile coverage further limits the effectiveness of integrated neighbourhood teams, forcing community staff to rely on workarounds and reducing their ability to deliver timely, joined-up care.

What We Will Do:

- **We will take a person and clinical-centred design approach to create** infrastructure services for staff and patients to ensure technology supports workflows rather than complicates them, improving adoption and outcomes.
- **We will establish experience-based KPIs to** measure staff and patient satisfaction with digital services to help us continually refine and deliver tools that meet expectations in practice.
- **We will enable consistent long-term investment to remove technical debt** by addressing legacy digital systems systematically, which will free up resources to invest in innovative solutions and avoid repeating cycles of short-term fixes.
- **We will deliver a seamless, consistent customer experience with reliable connectivity across every health and care setting** to allow staff to access information and tools wherever they are, ensuring patients receive joined-up care without digital barriers.
- **We will strengthen service desk and support models** to deliver a responsive, Dorset wide support offers to ensure staff have rapid assistance, helping to maintain confidence and minimise downtime.

4. Security, Continuity, and Support

Why: Essential for resilience, trust, and maintaining operational stability, staying on top of cyber threats protects data, assets, and reputation.

The growing threat landscape and complexity of digital systems make it difficult to gain full visibility and prioritise security improvements. Suppliers vary in cyber maturity and standards adoption, placing additional strain on IT teams' time and resources.

A fragmented cyber workforce with differing skills and experience leads to inconsistent security responses and risk tolerance across organisations. Legacy infrastructure, unmanaged operational technology, shadow IT, and end-of-life devices further increase vulnerability.

Staff confidence in cyber practices is low, with wide variation in awareness and education, highlighting the need for consistent training and a system-wide approach to cyber resilience.

What We Will Do:

- **We will share and standardise cybersecurity frameworks** and remediation plans and establish a dynamic approach to the management of cyber risk.
- **We will establish a shared cybersecurity operating model and technology.** By unifying our cyber approach across organisations, we improve resilience, reduce duplication, and protect against system-wide vulnerabilities.
- **We will commit to upgrading legacy systems to minimise vulnerability.** This reduces security risks and ensures all staff are working with modern, safe, and efficient tools that can integrate with future technologies.
- **We will develop and regularly test robust business continuity and disaster recovery plans.** Practicing recovery ensures Dorset can maintain critical services during any outage or attack, protecting patient care and safety.
- **Ensure our tooling, capabilities and analysis provide a mature and multi-layered security posture** that can meet evolving threats, ensure our staff are risk aware and know where to go for help, advice and guidance.
- **Promote security and privacy by design** in the building and procurement of new digital solutions (digital demand process).

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Chapter Six – Data, Analytics & Insights

Why This Matters

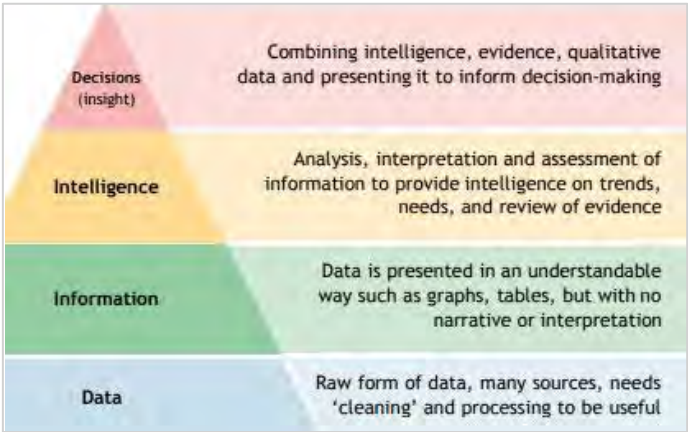
Our data must be available to us in the Right place at the Right time:

Data is one of the NHS’s most valuable assets. When used effectively, it enables evidence-based decision-making, proactive care, and service design tailored to population needs. Dorset must become a data-driven system, embedding analytics into every aspect of health and care to improve outcomes, reduce inequalities, and support transformation.

The term "Data & Analytics" is becoming the preferred terminology within the NHS and will be used interchangeably with "business intelligence" throughout this chapter. This change emphasises that analytics is evolving into a more technical discipline, focusing not only on data collection, storage, and modelling but also on the output and reporting.

The data to insights triangle below, describes how analytical teams take raw data and turn it into intelligence which supports insightful decision making.

Data Insights Triangle



Neighbourhood model of care & population health management (PHM):

Data and analytics are fundamental in our increasingly digital world for understanding the behaviours of our communities and individuals, as well as for designing the services needed to support them.

Population Health Management (PHM) is key for ICSs like Dorset, enabling a shift from a reactive to a proactive, person-centred care. By using joined-up data and techniques like segmentation and risk stratification, we gain insights to prioritise at-risk groups for prevention, tackle health inequalities, and deliver tailored, integrated care. Effective data and analytics underpin informed decision-making and service design for our communities. The Dorset Intelligence & Insight Service (DiiS) has been driving population health in Dorset over several years and this chapter describes the developments required to embed the neighbourhood model of care across Dorset.

The following diagram shows how the PHM cycle supports the three shifts within the NHS 10 Year Plan from population needs assessments through to effective evaluation and improved outcomes. Strategic commissioning will help us approach population health more effectively, working with partners, such as hospitals and the voluntary sector. Sharing pseudonymised and anonymised data will improve

understanding of the local population and help us tailor services to meet their needs. The cycle describes how all partners within Dorset including Public Health and Local Authorities work collaboratively to deliver sustainable and cost-effective change using evidence-based interventions.

What Dorset Aims to Achieve

				
Data Sharing and Governance	Robust Data Architecture and Integration	Analytics for Performance and Modelling	Analytics for Prevention and Population Health	Innovation and Future Capabilities
"Dorset will have a trusted, transparent data-sharing environment where information flows securely and seamlessly across health, care, and community settings – improving care, planning and public confidence."	"A modern, scalable data architecture will ensure consistent standards, seamless integration, and rapid access to information, enabling clinicians, managers, and researchers to make better decisions faster."	"Real-time insights and predictive modelling will empower teams to anticipate demand, target interventions, and continuously improve services – making Dorset a leader in proactive, data-driven care."	"Dorset will develop advanced risk tools to identify high risk patients, we will continue towards advanced statistical modelling, demand and capacity forecasting, machine learning, and predictive analytics whilst building staff confidence in data."	"Dorset will harness AI, secure research environments, and citizen-led innovation to unlock new insights, test cutting-edge solutions, and build future-ready services that are ethical, inclusive and impactful."

1. Data Sharing and Governance

Why: Linked, high-quality data enables proactive care, strategic commissioning, and personalised services.

Dorset has a lot of data, and this will keep growing, for those in our population who are currently patients and to prevent those who are yet to be. It's important for Dorset to continue building our data-sharing culture. By linking data from primary care, hospitals, community services, mental health, local authorities, and the voluntary sector, we can improve patient and personalised care.

So far, we have made progress by establishing important clinical systems. We have created the Dorset Care Record (DCR), and the population health management system called the Dorset Intelligence & Insight Service (DiiS). These tools help us adopt digital solutions to manage patients in the community better, supporting the goal of providing care outside of hospitals.

Across Dorset information governance group works with our integrated care system to embed a culture of safe, proactive and consistent data sharing. Alongside this group, our public engagement groups such as the Digital Patient Engagement Group (DPEG), enable a transparent discussion on the purposes for data collection, the use of this data and the outcomes that result having done so. It is essential we keep sharing and accessing data from Dorset systems to support key programmes like Integrated Neighbourhood Teams (INTs) and Future Care.

What We Will Do:

We will work to eliminate data silos, strengthening data sharing across all sectors, including voluntary and social care, which will support patient journeys and service redesign, ensuring we use data safely and appropriately.

- **We will involve analysts in clinical teams or create dedicated analytical teams** to enhance data quality and improve service efficiency.

- **We will continue working with data security and protection teams across Dorset to improve our data sharing processes** and new capabilities. This will create a consistent and secure workforce, allowing us to communicate effectively about data sharing ensuring transparency on how we use and protect personal data.

2. Robust Data Architecture and Integration

Why: Scalable architecture enables timely access to linked data for care, planning, and research.

Developing a robust and scalable data architecture across Dorset and beyond is essential for enabling timely sharing of linked data sets for various purposes.

Continually advancing the integration of more data into the DiiS platform will enable a deeper understanding of population behaviours and trends, providing clinical and MDT teams with the intelligence needed to develop timely interventions and treatments both within and outside care settings.

The national data platform, the Federated Data Platform (FDP), offers the opportunity to align nationally for benchmarking and onboard rather than redevelop tools built on standardised datasets. By linking data nationally and enabling local teams, the FDP can be developed by local analytical teams to meet their needs, such as understanding acute service modelling.

What We Will Do:

- **We will develop a robust and scalable data architecture across the ICS** leveraging cloud technologies to enable timely sharing of standardised data sets between providers, partners, and with our regional and national parties.
- **We will continue to align with the Federated Data Platform (FDP) to benchmark nationally**, avoid duplicating development of analytical tools, and empower local analytical teams to address specific needs such as acute service modelling.
- **We will increase support for operational programmes and services, including the Electronic Health Record (EHR) programme**, ensuring business and clinical needs are met through consistent data standards such as OMOP and SNOMED and improved data quality.

3. Analytics for Performance and Modelling

Why: Performance analytics support operational efficiency, early intervention, and service redesign.

Business intelligence teams across Dorset are skilled in analysing shared data and building intuitive dashboards. By sharing architecture and expertise, we can tailor insights to organisational, clinical, patient, and population needs.

Linked datasets and data-sharing systems will enable timely access to the information needed for operations, planning, and patient engagement. Enhancing performance reporting and access to near real-time data will drive productivity and service improvement, supported by BI teams.

Improving data quality is essential for routine performance management and initiatives like 'Getting it Right First Time' and will support the transition to a unified EHR. Strengthening performance, contract management, and productivity will help providers go beyond compliance using shared insights to better understand patient behaviours and optimise clinical resources.

What We Will Do:

- **We will enhance real-time performance reporting and predictive modelling** to drive and deliver productivity and service improvements.

- **We will embed data-driven decision-making in operational, business, and leadership activities across all parts of Dorset**, enhancing everything from seasonal planning to targeted interventions (e.g., Falls Risk).
- **By automating more of the compliance driven data needs, we will increase focus onto information that directly supports clinical care**, transformation, and productivity, ensuring that data resources are used to deliver genuine service improvements.

4. Analytics for Prevention and Population Health

Why: Enhanced data and insight capabilities enable self-service reporting, predictive risk tools, and data-driven transformation.

The demand for more data and reporting comes from various sources, including national, regional, ICB, and local organisational levels. By enhancing the quality of analytics and delivering them more seamlessly, we can support each organisation in improving its data confidence and create a more self-service data offering. This will help reduce some demand and provide a better working experience for data teams allowing us therefore to grow and upskill our teams to meet the challenges of the future.

Through the partnership with Public Health and Local Authority analytical teams, we are best placed to support the analysis for INTs and enable place-based care. Building on the relationships already in place both operationally and across the data and analytics teams, we can work with transformation teams to embed a culture of data driven change. Underpinning this is the need for a strong focus on data quality to ensure that data driven change is informed in the most timely and accurate way possible.

What We Will Do:

- **We will sustain and advance the Diis platform for population health and established data-sharing processes**, enabling a deeper understanding of population behaviours and supporting timely clinical interventions.
- **We will further develop risk stratification tools to identify high-risk patients** to inform preventative interventions, enabling clinicians to intervene earlier in patient journeys, thus reducing reliance on hospital services and supporting proactive care models.
- **We will continue to evolve from basic dashboards towards advanced statistical modelling, demand and capacity forecasting, machine learning, and predictive analytics**, to better support decision-making.
- **We will build staff confidence in using data**, allowing time for training, and utilise automated tools to significantly improve data quality, system design, and access to important care insights.

5. Innovation and Future Capabilities

Why: Future-ready systems must support AI, unstructured data, and citizen-led innovation.

Developments in data science and AI capabilities offer a greater degree of self-service than ever before. We need to be able to describe future capabilities (e.g., risk profiling, machine learning) in a way that inspires without alienating. We must continue to define and coach to instil confidence in the adoption of these emerging technologies.

While data quality and coding remain essential and must be invested in, we must also increase the focus on future possibilities, like using unstructured data, large language models and data science, without overwhelming people still grappling with basic data confidence.

National and regional research platforms, such as the Secure Data Environments for research (SDEs), offer the opportunity to share anonymised data for research projects. Governed by the Data Access

Committees (DAC), these can be academically or clinically led and can generate an income depending on the project focus and share insights back into clinical practice or population services.

What We Will Do:

- **We will build on and expand our analytical platforms** to create a single point of entry for data insights – providing timely, high-quality data to all staff, regardless of organisation or care setting, and enabling users to search and interrogate information that supports decision-making independence and improved outcomes.
- **We will increase our active engagement with patients, citizens, and user groups.** Co-designing intuitive digital tools that embed user-centred delivery, improve basic care pathways, and ensure people can confidently interact with their own data and care plans.
- **We will expose new insights from both structured and unstructured data sources.** Unlocking the value of clinical notes, imaging, and other untapped information through advanced analytics and AI, making data accessible for real-time querying by clinicians and users.

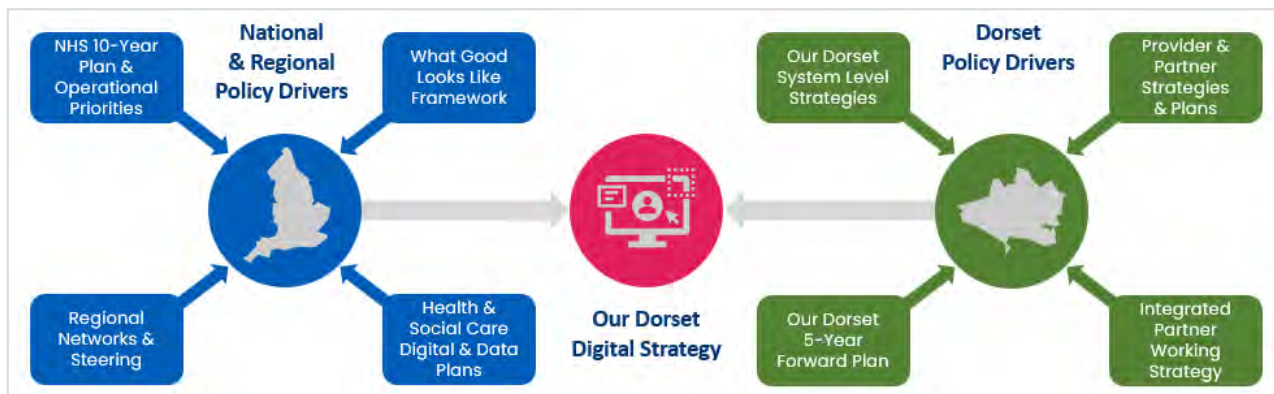
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Chapter Seven – Alignment with Other Strategies

Introduction

An essential part of the Dorset Digital Strategy development is understanding the broader strategic context and embedding this into the chapters. This involved translating the following strategies, plans, and guidelines into digital capabilities that Dorset needs to consider as part of its digital investments and transformation efforts.

The Dorset Digital Strategy strategic alignment



The National & Regional Policy Drivers

Department of Health & Social Care and NHS England

- Department of Health & Social Care – [Health & Social Care Integration](#) and [Data Saves Lives](#)
- NHS England - [2025/26 Priorities and Operational Planning for England](#)
- NHS England - [10-Year Plan for England](#)

Regional Networks and Steering

- [Health Innovation Wessex](#) (NHS Dorset’s supporting Health Innovation Network)
- [Health Innovation Southwest](#)
- NHS England Southeast 3 – Wessex Imaging Network (Internal Facing)

The Dorset Policy Drivers

Our Dorset System Level Strategies

- NHS Dorset - [5-Year Joint Forward Plan](#)
- NHS Dorset - Strategic Commissioning Intentions 2026-2031 (Internal)
- Our Dorset - [Integrated Care Partnership Strategy](#)
- Our Dorset - Infrastructure (Estates) Strategy (Internal)
- Our Dorset - Clinical Digital Strategy (Internal)
- Our Dorset - Clinical Strategy 2023-2028 (Internal)

Provider and Partner Strategies & Plans

- Bournemouth, Christchurch & Poole Council - [Adult Social Care Strategy](#)
- Dorset Council - [Adult Social Care Strategy](#)
- Dorset County & Dorset HealthCare - [Federated Strategy](#)
- University Hospitals Dorset - Digital Transformation Strategy (Internal)
- University Hospitals Dorset - [Operational Plan 2024-2025](#)
- Dorset GP Alliance - [Creating Sustainable General Practice in Dorset](#)
- Southwest Ambulance Service Trust - [Strategy \(Partner Working Section\)](#)

National Health Service (NHS) & Department of Health & Social Care What Good Looks Like (WGLL)

The What Good Looks Like (WGLL) framework originated within the NHS to provide leaders, teams, and system partners with clear guidance about what “good” looks like for digital transformation across health and care settings. The framework focuses on seven success measures, which are consistent across both healthcare and adult social care settings:

- Well Led
- Smart Foundations
- Safe Practice
- Support Workforce
- Empower People
- Improve Care
- Healthy Populations

These measures were designed collaboratively by NHS England, the Department of Health and Social Care (DHSC), Local Government Association, and partners from both sectors, reflecting the drive for more joined-up, digitally mature, person-centred care.

Building on the WGLL, the NHS Digital Maturity Assessment (DMA) is a diagnostic tool used by NHS providers and integrated care systems to understand the current state of their digital services, identify strengths and gaps, and shape priorities for digital investment and improvement. The NHS Digital Maturity Assessment is explicitly structured around the seven success measures set by the WGLL framework.

The Dorset Digital Strategy Chapters can be directly mapped to the WGLL and DMA as shown below:

How the Digital Strategy Chapters map to the WGLL and DMA

WGLL Success Measure	Digital Maturity Assessment	Digital Strategy Chapter
Well Led	Assessed via leadership and strategy	Workforce & Culture
Safe Practice	Reviewed via clinical safety	
Support Workforce	Evaluated through digital literacy/training	
Empower People	Measured via citizen engagement and service accessibility	Digitally Enabling & Empowering Citizens
Improve Care	Examined through quality and digital care pathways	Enabling Care Across Settings
Healthy Populations	Analysed via the use of data for population health	Data, Analytics & Insights
Smart Foundation	Covered via infrastructure and security	Modern Infrastructure Foundations

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Appendices

Appendix A

How We Created This Strategy

The Dorset Digital Strategy has been developed through a highly collaborative and iterative co-creation process, co-designed and co-owned by digital, clinical, and operational leaders from across Dorset’s health and care system.

The process has ensured that every stage, from mobilisation to roadmap, has been shaped through engagement, evidence, and shared ownership. This approach brings together leaders, clinicians, and operational teams to create a strategy that is both ambitious and grounded in real-world delivery.

The work followed five structured and progressive phases:

- **Phase 1: Mobilisation.** Established scope, governance, and engagement plans through initial leadership alignment and one-to-one interviews.
- **Phase 2: Discovery & Baseline.** Reviewed existing strategies and maturity, identifying strengths, gaps, and shared priorities.
- **Phase 3: Co-Design.** Facilitated a series of five workshops with digital, clinical, and operational leaders to develop, refine, and align the strategic themes and chapters. A staff questionnaire was also conducted.
- **Phase 4: Strategy Drafting.** Splitting into multi-disciplinary chapter teams with cross organisational representation. Drafts were produced and reviewed during workshops and individual feedback loops.
- **Phase 5: Roadmap & KPI Framework.** Translated the strategy into an actionable delivery plan, defining measurable outcomes and key performance indicators for each chapter.

Throughout, progress was guided by continual feedback system-wide engagement, and alignment with the Dorset vision. The result is a strategy that is collectively owned, evidence-based, and fully endorsed by the digital leadership and system partners, ensuring a shared commitment to deliver meaningful digital transformation across Dorset.

The phases of the Dorset Digital Strategy development



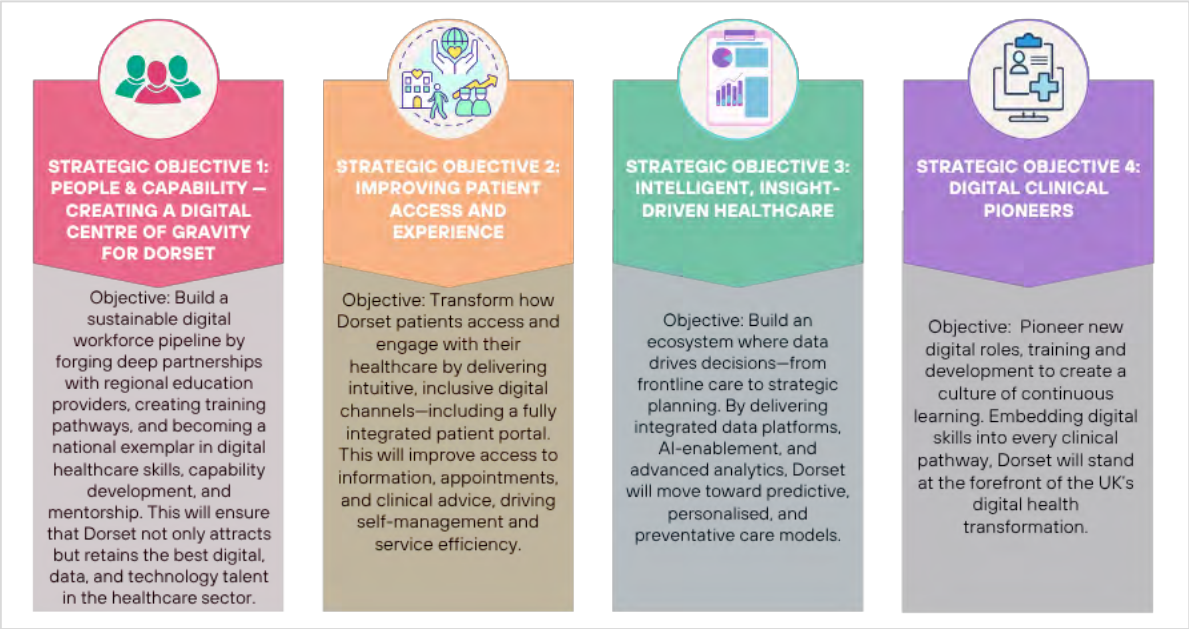
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Appendix B

Our Strategic Objectives

Through engagement across Dorset’s health and care system, four strategic objectives define our journey to 2030:

The four strategic objectives for the Dorset Digital Strategy



Digital Strategy Themes

These themes are the big ideas that shape our digital plans. They give clear direction and help everyone in Dorset work in a joined-up way to deliver the strategy.

The four strategic themes for the Dorset Digital Strategy



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Digital Strategy Principles

These principles serve as a guide to ensure our digital plans are ethical, practical, and help us make the right decisions as we improve and deliver new digital services.

The three strategic principles to guide the Dorset Digital Strategy



Digital Strategy Chapters

Each chapter focuses on a key priority or area of work. This structure will help us plan, deliver, and communicate more effectively across Dorset's health and care system.

The seven chapter headings for the Dorset Digital Strategy



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Appendix C- Consolidated KPI Table

Chapter 2 – Enabling Care Across Settings

Chapter	WGLL Theme	Strategy Outcome Theme	Strategy Chapter Outcome	Strategy Chapter Outcome KPI(s)
Enabling Care Across Settings	Improve Care	Integrated Digital Systems Across Settings	Every clinician and patient in Dorset will have secure access to the right point-of-care information at the right time, via systems that talk to each other across all care settings. Paper is eliminated, except where a patient has explicitly opted for paper correspondence, connectivity is reliable and all correspondence across care settings is handled electronically.	1. Clinicians managing patient noting and correspondence digitally. 2. Paper limited to patient correspondence where preferred. 3. Uptime/reliability of connectivity in all clinical locations. 4. Referrals and discharge summaries between secondary and primary care handled digitally with a high level of data quality.
		Collaborative Governance and Strategic Alignment	Digital decisions in Dorset will be made once, wisely, and together. All organisations will work to a single strategy, with shared governance that prioritises long-term value, safety, and resilience over short-term fixes. Every partner feels ownership of the digital future.	5. Shadow IT and stranded IT contracts eliminated. 6. Annual stakeholder satisfaction scores regarding collaborative governance and decision-making.
		Future-Focused Programmes and Technologies	Dorset will lead the way in adopting innovative evidence-based digital programmes that improve lives today and prepare for tomorrow. From integrated neighbourhood teams to AI-powered diagnostics and a single patient record, technology will enable proactive, preventative, and personalised care.	7. Successful HealthSet implementation. 8. Delivery of a framework to allow AI and other clinically led digital innovations to persist via APIs into the HealthSet system. 9. Neighbourhood Teams fully digitally enabled.

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Chapter 3 – Workforce & Culture

Chapter	WGLL Theme	Strategy Outcome Theme	Strategy Chapter Outcome	Strategy Chapter Outcome KPI(s)
Workforce & Culture	Well Led Safe Practice Support People	Leadership and Collaboration	Digital leadership will be embedded at every level, from board to frontline, with clinical, operational, and digital leaders working together through shared governance to drive transformation across Dorset.	10. Qualified digital leadership representation at Board-level and across all departments. (100%) 11. Digital leadership training standard established with a process and cohorts to build capability underway.
		Digital Workforce Development	Dorset will nurture a professional, sustainable Digital, Data and Technology workforce with clear career pathways, accredited training, and opportunities for development, ensuring we attract and retain top talent.	12. Number of digital/data professionals enrolled in accredited training schemes annually. 13. Retention rate for digital talent year-on-year. 14. Proportion of staff with advanced digital skills certification.
		Wider Health and Care Workforce Development	All staff feel confident and supported in using digital tools, with equitable access to training and minimum digital skill standards, creating a culture where technology enables safe, inclusive, and high-quality care.	15. Proportion of staff meeting minimum digital skill standards. 16. Number of staff participating in ongoing digital training. 17. Staff confidence scores for using digital tools (annual workforce survey).

Chapter 4 – Digitally Enabling and Empowering Citizens

Chapter	WGLL Theme	Strategy Outcome Theme	Strategy Chapter Outcome	Strategy Chapter Outcome KPI(s)
Digitally Enabling and Empowering Citizens	Empower Citizens	Improving Experience, Access and Choice	Every citizen in Dorset will enjoy a simple, trusted digital front door to health and care services, offering consistent quality, seamless access, and genuine choice in how they engage with their care.	18. Proportion of population accessing services via digital front door. 19. Mean time to digital service access for citizens versus analogue methods. 20. Patient satisfaction with range and quality of digital access options. 21. Proportion of patients managing conditions using digital technologies.
		Equitable Offer for All	Nobody in Dorset will be excluded from digital health and care. Services, support and training will be accessible to all – regardless of skills, confidence, or connectivity – so that every citizen benefits equally.	22. Percentage of population with access to digital health services across all demographics. 23. Number of digital support interventions delivered in deprived or low-connectivity areas. 24. Reduction rate in digital exclusion indicators – e.g., upskilling and device distribution.

Chapter 5 – Modern Infrastructure Foundations

Chapter	WGLL Theme	Strategy Outcome Theme	Strategy Chapter Outcome	Strategy Chapter Outcome KPI(s)
Modern Infrastructure Foundations	Smart Foundations	Infrastructure as an Enabler	Infrastructure in Dorset will be recognised as a critical enabler of safe, effective and efficient care – invested in strategically to support transformation, clinical outcomes, and staff wellbeing.	25. Percentage completion of planned infrastructure upgrades versus target milestones. 26. Number of infrastructure-related incidents resolved within SLA (target >95%). 27. Staff-reported reliability and satisfaction scores with digital infrastructure.
		Alignment with Clinical Priorities	Digital infrastructure will be designed around clinical priorities and system goals, ensuring every investment directly supports better care, improved safety, and greater productivity.	28. Clinical safety improvement rates attributable to digital investments. 29. Clinical team satisfaction with infrastructure support.
		User Experience and Service Reliability	Staff and citizens will experience simple, seamless, and always-available digital services. Infrastructure will be intuitive, reliable, and designed to reduce frustration and duplication.	30. Average incident response time for digital service interruptions. 31. Percentage uptime/availability of core digital services (target >99.9%).
		Security, Continuity and Support	Resilient security, business continuity and consistent support will be embedded across all health and care settings, building public trust and ensuring uninterrupted care in both every day and exceptional circumstances.	32. Number of cybersecurity incidents detected and positively responded to per year. 33. Mean time to restore critical digital services after incident (target <2 hours). 34. Data Security and Protection Toolkit – Standards Met across all organisations.

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Chapter 6 – Data, Analytics & Insights

Chapter	WGLL Theme	Strategy Outcome Theme	Strategy Chapter Outcome	Strategy Chapter Outcome KPI(s)
Data, Analytics & Insights	Healthy Populations	Data Sharing and Governance	Dorset will have a trusted, transparent data-sharing environment where information flows securely and seamlessly across health, care, and community settings – improving care, planning and public confidence.	35. Number of successful cross-organisation data exchanges per month. 36. External audit findings on data governance robustness.
		Robust Data Architecture and Integration	A modern, scalable data architecture will ensure consistent standards, seamless integration, and rapid access to information, enabling clinicians, managers, and researchers to make better decisions faster.	37. Number of data platforms meeting interoperability standards (e.g., FHIR). 38. Time to on-board new datasets (mean days). 39. Frequency of data integration failures (target: <0.5%).
		Analytics for Performance and Modelling	Real-time insights and predictive modelling will empower teams to anticipate demand, target interventions, and continuously improve services – making Dorset a leader in proactive, data-driven care.	40. Percentage of services using real-time insights for operational decision-making. 41. Staff satisfaction with access to actionable data insights.
		Analytics for Prevention and Population Health	Dorset will develop advance risk tools to identify high risk patients, we will continue towards advanced statistical modelling, demand and capacity forecasting, machine learning, and predictive analytics whilst building staff confidence in data.	42. Number of active risk stratification/predictive prevention initiatives. 43. Uptake of advanced statistical models across departments. 44. Change in key population health indicators attributed to data-driven interventions.
		Innovation and Future Capabilities	Dorset will harness AI, secure research environments, and citizen-led innovation to unlock new insights, test cutting-edge solutions, and build future-ready services that are ethical, inclusive and impactful.	45. Number of AI research or citizen-led digital innovation projects in progress. 46. Percentage of digital services reviewed for ethical and inclusive design annually.

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Appendix D

Case Studies

Below gives one example of a patient with multiple morbidities and how a streamlined care system, underpinned with the right technology at the right time can influence, empower and positively impact a patient journey:

Patient Story

Ella's Background and Conditions Summary



Female | 16 years old



Lives with parents in Dorset



Scottish



Supportive family environment



- Generalised anxiety disorder with low mood symptoms
- Insomnia
- Iron deficiency anaemia (mild)
- Psychosocial stressors
- Reduced concentration and fatigue



Ella

Ella is a 16-year-old student living with both anxiety and iron deficiency, which together affect her sleep, concentration, and performance at school. Exam pressures and friendship difficulties add to her stress.

After visiting her GP, Ella is prescribed iron supplements and a low-dose anti-anxiety medication. To help her manage these treatments, she uses an NHS-approved digital medication diary, which provides reminders, tracks her symptoms, and shares progress with her care team in real time.

She also accesses NHS Talking Therapies online, allowing her to complete self-guided modules and virtual check-ins that fit around her school timetable. Her school receives secure digital updates on her wellbeing through the local NHS education portal, enabling pastoral staff to adjust deadlines and provide timely support.

By integrating digital tools across physical and mental health care, Ella's GP, counsellor, and school staff have a joined-up view of her progress. This helps them coordinate support, reduce duplication of appointments, and adapt her care plan quickly. As a result, Ella begins to sleep better, feels more confident managing her anxiety, and is better able to balance her health with her education.

Male | 47 years old

Social housing

Afro-Caribbean heritage

No family are in the area but good community to lean on.



- COPD
- Smoker 20+years
- Current vaper
- Anxiety



Dave

Dave has recently returned to work after a period of unemployment. He was a heavy smoker from an early age but quite about 5yrs ago following his COPD diagnosis. However, due to his recent episode of unemployment he commenced vaping as an alternative to smoking to alleviate his anxiety.

The vaping has triggered his COPD and Dave was hospitalised with a chest infection and exacerbation to his breathing difficulties. Dave is discharged with virtual support. He has been prescribed an inhaler and COPD rescue pack for future flare ups.

Dave receives support from the COPD community nursing team who will perform a virtual visit to follow up on his condition and prescribe remote management tools as part of his package of care

Weekly virtual appointments for outpatient care are scheduled at times that are convenient for Dave. He uses his NHS App to view his appointments and care plan and get notifications or messages from his care team. Dave is asked to submit observations and answer clinical questionnaires on a scheduled basis and explained how his care team will review and monitor these which are clarified in a digital leaflet hosted by the care organisations webpages.

A digital care coordinator shows Dave how to take his vital signs and how it is directly fed into the record from integrated smart monitoring devices.

Using prescriptive algorithms, abnormal observations are automatically flagged to the teams for response with a clear standard operating pathway.

Digital confidence level



Virtual check ins



Citizen / Patient portal



Remote monitoring with integrated smart devices

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Michael Dorset Resident



By 2029, I will be able to...

- Easily access support by completing the digital activities that matter to me.
- Follow consistent signposting to find information about the local digital support offer and the various places I can do to receive help.
- Access good quality Wi-Fi in my GP surgery so that I can receive help with accessing online health services and support.
- Get the care I need either from my home or a place of my choice, without the need for travel.
- Easily find information about services available to support me in my community neighbourhood.

Sarah Clinical



By 2029, I will be able to...

- Easily refer people to support with accessing healthcare-related apps so that they can engage with our online services, or alternatively, refer them to partners in voluntary groups e.g. Citizens Advice, if their need is better served by them.
- Have a strong understanding of the digital support needs in the community I serve and the tools with which to target and serve those needs.
- Understand the digital literacy ability of all of our patients with long term conditions, the potential to support them with digital tools, and have a clear view of those who need more help.
- Provide a healthcare service that I am proud to have co-designed with accessibility in mind.

Ian Volunteer



By 2029, I will be able to...

- Easily refer people to support with accessing healthcare-related apps so that they can engage with online services.
- Work in partnership with other voluntary sector organisations, using our combined resources to support our communities.
- Guide people to available local digital support e.g. device loaning, connectivity and free Wi-Fi.
- Access training on how to support the public; receive specific training and guidance on specific apps e.g. the NHS App.

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Report to	Board of Directors	
Date of Meeting	9 December 2025	
Report Title	DHC – Advanced Foundation Trust Application and Assessment	
Prepared By	Jenny Horrabin Joint Director of Corporate Affairs Dawn Dawson, Joint Chief Nursing Officer	
Approved by Accountable Executive	Matthew Bryant, Joint Chief Executive Officer	
Previously Considered By	N/A	
Action Required	Approval	N
	Assurance	N
	Information	Y

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? <i>Delete as required</i>	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	No specific BAF risks	
Financial	No specific implications arising from the process – there are implications if approved.	
Statutory & Regulatory	No specific implications arising from the process – there are implications if approved.	
Equality, Diversity & Inclusion	No specific implications arising from the report – but content in individual domains	
Co-production & Partnership	Partners, staff and service users will be engaged throughout the process	

Executive Summary
On 12 November 2025, NHS England (NHSE) published a draft Advanced Foundation Trust programme guide for applicants which is out for consultation until 11 January 2026. Advanced Foundation Trust (AFT) is the name for what the 10-year health plan (10YHP) referred to as a ‘new FT’. AFTs will benefit from three ‘core freedoms’: • Strategic and operational autonomy • A capability-based regulatory approach • Financial flexibilities In addition, only AFTs will be able to apply for IHO contract holder status, and AFTs will ‘benefit from a greater leadership role locally and nationally’, which might include sharing best practice and innovation, and supporting other providers’ improvement work. Dorset HealthCare (DHC) have been announced of one of eight ‘wave one’ trusts eligible to apply for AFT status. We are currently working to the process set out in the consultation documents, with the application due to be submitted by the end of December 2025 and an assessment process to the end of March 2026.

Recommendation
Note that DHC is part of the ‘Wave 1’ AFT applicants and Note the process to be followed for board approval of the application

Advanced Foundation Trust Application and Assessment

1. Background: Overview of the Advanced Foundation Trust programme

- 1.1. On 12 November 2025, NHS England (NHSE) published a draft Advanced Foundation Trust programme guide for applicants which is out for consultation until 11 January 2026. Advanced Foundation Trust (AFT) is the name for what the 10-year health plan (10YHP) referred to as a 'new FT'.
- 1.2. As set out in the 10YHP, the aim of the AFT programme is to redistribute power to the frontline, using a rules-based approach to re-empowering provider boards. Aspirant AFTs will be expected to focus on their core purpose, ensure quality of care is not compromised, and if approved, use their greater autonomy to improve population health and tackle health inequalities, as well as playing a proactive role in delivering the three shifts. Organisations that prioritise their own status or organisation will not pass the AFT test. The 10YHP's aspiration that all NHS providers will be AFTs by 2035 is reiterated
- 1.3. AFTs will benefit from three 'core freedoms':
 - Strategic and operational autonomy: characterised by 'a different relationship with the centre and regions' which frees up provider management and leadership bandwidth, including a more strategic approach to annual planning.
 - A capability-based regulatory approach: AFTs will be given more time to address performance issues where they arise. Boards will have clarity about what is expected of them, including the triggers for capability concerns. AFT status can be removed where standards and provider capability drop. AFTs will go through reassessment every five years.
 - Financial flexibilities: capital flexibility, able to retain and reinvest aggregate revenue surplus, excluding deficit support funding, accumulated since 2024/25, in capital projects. Capital autonomy, with business case approval not required for up to £100m capital department expenditure limit (CDEL) spend. Revenue flexibility, limited to non-recurrent spending to support implementation costs linked to capital investment and transformation, of RDEL surpluses accumulated since 2024/25, subject to having enough cash reserves.
- 1.5. In addition, only AFTs will be able to apply for IHO contract holder status, and AFTs will 'benefit from a greater leadership role locally and nationally', which might include sharing best practice and innovation, and supporting other providers' improvement work.
- 1.6. Dorset HealthCare (DHC) have been announced of one of eight 'wave one' trusts eligible to apply for AFT status. We are currently working to the process set out in the consultation documents, with the application due to be submitted by the end of December 2025 and an assessment process to the end of March 2026.

2. Eligibility and Assessment Criteria

2.1 The eligibility criteria to apply for AFT status is set out below:

- NHS Oversight Framework (NOF) segments one or two, for two consecutive quarters. DHC were NOF segment 2 in the last quarter, and the next quarterly outcome is expected to be published in December 25.
- Care Quality Commission (CQC) rated 'good' or 'outstanding' with no site/service 'inadequate', with contemporary assurance sought from CQC to mitigate issues

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around timeliness of assessments. The last well led of review of the Trust took place in 2019 and DHC was rated as outstanding in this domain.

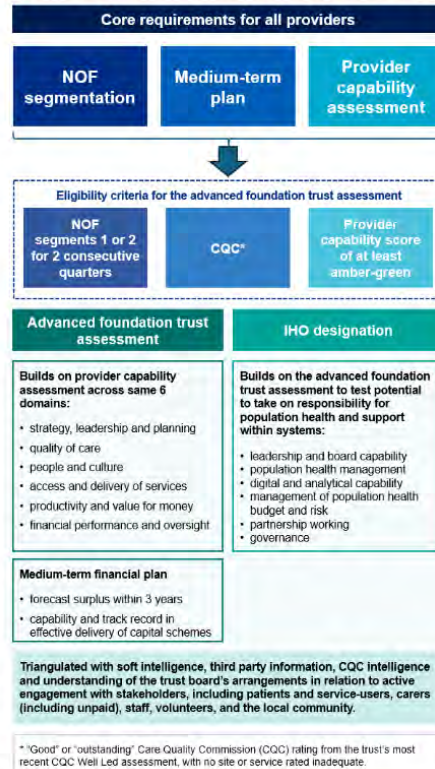
- Provider capability of at least amber-green. We submitted our Provider Capability Assessment (PCA) in October 2025 and the outcome of this is expected in the next year.
- Support of local Integrated Care Boards (ICBs) and NHSE region. We have been liaising with colleagues in partner organisations, and this will continue throughout the assessment process.

2.2 Applicants for advanced foundation trust status will be assessed against the three fundamental questions set out below, underpinned by more detailed assessment criteria structured around the six domains set out in [The Insightful Provider Board guidance](#) and the [Assessing Provider Capability guidance](#).

- Is the trust well led, collaborating with system partners to improve population health and tackle inequalities, and responsive to local communities?
- Does the trust provide high-quality services with robust quality governance in place?
- Is the trust financially sustainable with a focus on productivity improvement? This includes a medium-term financial plan demonstrating a high likelihood of an adjusted surplus position in year one, and a sustainable surplus by year three.

The approach is set out in the diagram below, with further details found in the guidance for applicants [NHS England » Advanced Foundation Trust Programme – guide for applicants](#)

Assurance approach for advanced foundation trusts assessment and IHO designation



3. Our approach

3.1 Building on our approach to the Provider Capability Assessment we have designed a robust process to build our application and to the work through the assessment process.

- Assigned clear executive leadership for the application and assessment process and established a project team to co-ordinate the application and assessment process.
- Briefed our Senior Leaders and engaged them in the application process.
- Established an AFT Development Group to maintain oversight throughout the application and assessment process.
- Developed a communications and engagement plan to ensure we engage in an effective and inclusive way with partners, staff and patient on our vision for the Trust as an AFT.
- Each domain has been aligned to a Committee of the Board and we will adopt a 'Confirm and Challenge' approach with Leads and Committee Chairs during w/c 15 December 2025. This will enable assurance to be provided by Committee Chairs to the Board to support approval.
- Board approval at an extra-ordinary Board meeting to be scheduled 22 December 2025.

Domain	Committee
Strategy, leadership and planning	Strategy Transformation and Partnerships Committee
Quality of care	Quality Committee
People and culture	People and Culture Committee
Access and delivery of services	Finance and Performance Committee
Productivity and value for money	Finance and Performance Committee
Financial performance and oversight	Finance and Performance Committee

4. Recommendation

Members are requested to:

- Note that DHC is part of the 'Wave 1' AFT applicants
- Note the process to be followed for board approval of the application

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Audit Committee Assurance Report
for the meeting held on 28 November 2025

Chair	Steve Peacock, Non-Executive Director
Executive Lead	Chris Hearn, Joint Chief Finance Officer
Quoracy met?	Yes
Purpose of the report	To assure the Board on the main items discussed by the Committee and, if necessary, escalate any matter(s) of concern or urgent business which the Committee is unable to conclude.
Recommendation	To receive the report for assurance

Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework	• The BAF was commended by Committee members for its progress and content. • Gradual increase on the risk levels within the BAF and potential for overlapping risks and suggested review of target risk scores. • Positive feedback on Risk Appetite Statement . • Outcome of Patient Falls audit referred for further review and discussion in Quality Committee. • Internal Audit benchmarking report has highlighted potential gaps in current audit pipeline plans. • Conflict of interest compliance rates require further focus but are increasingly rapidly.

Key issues / matters discussed at the meeting	The committee received, discussed and noted the following reports: Board Assurance Framework The highest scoring risks continue to be Workforce Capacity, Finance and Digital Infrastructure. The publication of the Digital Strategy has helped address outstanding actions against digital and cyber risks. Risk score for Culture (Sr2) and Collaboration (SR7) have increased to 12. Assurance was provided that actions are not closed until there is full evidence of completion. Work continues to assign key metrics to each risk through Q3 which is planned for completion for the 26/27 financial year. In-depth discussion relating to gradual increasing levels of risk, the setting of realistic target scores according to achievable mitigations and overlapping of risks. The BAF was commended by committee members for its progress and content. Corporate Risk Register • A new joint Head of Risk has been appointed. • Once approved the Risk Appetite framework will feed into the production of the Risk Management Strategy in the new year. • Procurement of a Dorset-wide single Risk Management IT platform will improve reporting. • All Board sub-committees have reviewed their assigned risks. • There are 16 overdue risks which continue to be escalated to the relevant risk owners with additional training on responsibilities.

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Risk Appetite Statement Review

The Committee approved the content of the Risk appetite statement which had been developed through a Board Workshop and will be incorporated into the Joint Risk Management Strategy for publication in January 2026. There was universal positive feedback from committee members on the content and progress made with helpful suggestions on next steps to bring it to life for the organisation.

Scheme of Delegation

The Scheme of Delegation has been updated to align with Dorset County Hospital and was approved by the Committee subject to some minor changes and points for clarification. The Committee noted the importance of communicating the changes and refreshing budget holder training to ensure all managers understand their delegated responsibilities.

Internal Audit Progress Report, Follow Up Report, and Annual Report 2024-25 Benchmarking

- The proposal to postpone the audit on responding to concerns around medical staff to 2026/27 and replace with a Business Continuity Plan audit requires further consideration in light of the benchmarking report which lists potential high-risk areas for audit focus.
- The outcome of the Patient Falls audit was summarised with a moderate rating for both design and effectiveness. Agreement to share, review and discuss within the Quality Governance Committee.
- One Cultural Maturity, two KFS (Budgetary Controls) and two Joint Strategy audit actions have now been closed. One Digital Maturity audit action is reported as overdue with a revised target date.
- The Annual Benchmarking Report was received by the committee for assurance with no areas of concern highlighted, noting in particular the audit areas which fall outside of the current plan, for consideration to be included in the pipeline plan

Extension of Internal and External Audit Contract

The Committee noted the contractual provision allowing for a 24-month extension and approved the extension of the collaborative contract with Dorset NHS organisations until 31 March 2028. A recommendation will be provided to the Council of Governors on the Trust's preferred course of action, in relation to the External Auditors, and the rationale for it.

Counter Fraud Q2 Progress Report

- Q2 focus has been on:
 - Investigating allegations of fraud.
 - Progressing Project WISE in collaboration with partners.
 - Reviewing and revising policies and procedures.
 - The annual targeted staff survey of fraud awareness
- 6 Investigation remain open, 4 of which relate to imposter fraud.
- 6 new reports of suspected fraud were received in Q2 with one resulting in an open investigation
- The committee accepted the report for assurance and commended the counter fraud work and report for its depth.

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Anti-Fraud, Bribery and Corruption Policy IN-071

The revisions to the policy were highlighted and content summarised to the committee which was accepted for assurance. Detailed discussion around the Fraud Risk Assessment document and the importance of incorporating into the risk register and socialising those aspects of the policy and responsibilities that senior managers need to be aware of. Cross-referral agreed to the People & Culture Committee.

Security (LSMS) Report

The report was received and noted by the Committee and will be brought back to the next meeting for a full update and conversation delivered by the Trust LSMS lead.

Managing Conflicts of Interest Compliance

The report was summarised for assurance. Percentage compliance reported has increased to 57% since the publication of the report (from 41%). Focussed work continues to improve compliance which is expected to increase rapidly.

Treasury Management Policy

This policy has been reviewed in line with Dorset County Hospital's Treasury Management policy and additional detail has been added to the purpose and scope section. Approved by the Committee.

Governance Structures

Each committee has received their respective elements in September 2025. Assurance was provided to the Audit Committee of the governance arrangements in place and the allocation of statutory and regulatory roles.

Decisions made at the meeting

- Risk Appetite Statement - Approved
- Scheme of Delegation - Approved
- Treasury Management Policy - Approved
- Extension of Internal and External Audit Contract - Approved

Issues / actions referred to other committees / groups

- Patient Falls Internal Audit report referred to the Quality Committee
- Orientation of the Anti-Fraud, Bribery and Corruption Policy referred to People & Culture Committee
- Extension of External Audit Contract for recommendation to the Council of Governors

Quoracy and Attendance

	30/05/2025	01/08/2025	28/11/2025			
Quorate?	Y	Y	Y			
Steve Peacock	Y	Y	Y			
Frances West	N	N	Y			
Dave Underwood	Y	Y	Y			

Audit Committee Assurance Report for the meeting held on 01 December 2025

Chair
Executive Lead
Quoracy met?
Purpose of the report
Recommendation

Stuart Parsons
Chris Hearn, Chief Finance Officer
Yes
To provide assurance on the main items discussed and, if necessary, escalate any matter(s) of concern or urgent business.
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.
- Clinical audits behind schedule on some mandatory audits.

Key issues / matters discussed at the meeting

The committee received, discussed and noted the following reports:

Board Assurance Framework, noting that:

- All strategic risks had been reviewed at committees over the last week
- The highest scoring risks were SR3 Workforce, SR5 Estates, SR6 Finance, an dSR9 Digital Infrastructure, all scoring 15 or more.
- There had been two changes to score since the last review; SR2 Culture and SR7 Collaboration, both due to the level and pace of change in the NHS at present.
- Overdue actions were largely due to appropriate reasons
- There were significant challenges to achieving whole-time equivalent (WTE) reductions, but work was ongoing in this space. Financial Recovery Board had recently approved to convert some temporary staffing to substantive to right-size teams.

Corporate Risk Register, noting:

- All risks had been reviewed at committees over the last week
- A joint head of risk had been appointed. Priority work included standardising a joint risk management strategy.
- A joint risk report would be developed for committees from April 2026.
- The need and plans for targeted risk management training to ensure consistency in risk scoring. Discussion about very high scoring risks and whether these were scored appropriately.
- New local risk management system expected in 2026; this would support with accurate risk reporting.

Risk Appetite Statement Annual Review describing the process to develop the risk appetite statement. The same approach had been followed with DHC and the option for different statements between the two

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trusts. However, the proposed statements are the same for both DCH and DHC. The risk appetite statement was recommended to Board for approval.

Internal Audit progress and benchmarking reports, noting:

- Moderate assurance on design and operational effectiveness of controls for the Key Financial Systems (Capital Programme) audit. There were three medium levels findings all of which were accepted by management.
- An independent review of the Maternity Incentive Scheme (MIS) compliance for information. There was evidence of good practice and some areas where additional evidence may be needed, although some of these had been completed since the report was written. The extent of the administrative burden of MIS was highlighted, with thanks extended to maternity and supporting teams for their work on MIS.
- Follow up report, noting progress of actions for previous audit reports.
- Benchmarking report showed that the trust was in line with others in BDO's client base, and highlighted areas that may be considered for audits in 2026/27.

Counter Fraud Reports, noting:

- Receipt of the now signed 2024/25 Counter Fraud Annual Report 2024/25
- Three new reports of fraud in quarter two. The significant increase in counter fraud work was highlighted, with discussion around the reasons for this.
- Q2 progress report. 3 new reports of fraud. Significant increase in counter fraud work. 86% of the total number of referrals received in 2024/25 had been received to date in 2025/26.
- Discussion around the underlying causes of fraud with a future report on this requested.

Security LSMS Report providing updates on improvements in the organisation and governance of security risk management, the improved structure of the security operational team, improved intelligence gathering through BI. The committee further discussed conflict resolution training compliance.

Governance Structure outlining the structure of committees and board across the trust. A suggestion that Clinical Effectiveness Committee is linked to Audit Committee, with particular reference to oversight of the clinical audit function.

Treasury Management Policy which had been updated to align with the DHC policy; changes mainly related to ensuring consistent wording across the two trusts. The policy was approved.

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	Extension of Internal and External Audit Contracts: Recommendation to approve the proposal to extend the contracts for a further two years. Board and Council of Governors to approve the contracts for internal and external auditors respectively. Clinical Effectiveness Committee update noting - The ability to add guidance and treatment plans to an app for staff to refer to. - Discussion around the 2025/26 clinical audit programme which was known to be behind plan on some mandatory audits, and discussion about whether this should have been raised as a significant matter in the report. - Positively, SHMI was at 1.0056. Thanks extended to coding team for improving depth of coding contributing to improved SHMI score.
Decisions made at the meeting	- Recommendation for Board to approve the Risk Appetite Statement - Recommendation for Board to approve the extension of Internal Audit Contract, and recommendation for the Council of Governors to approve the extension of the External Audit Contract - Approval of the Treasury Management Policy
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	Y		
Stuart Parsons	Y	Y	Y	Y		
Stephen Tilton	Y	A	Y	Y		
Dave Underwood	Y	Y	Y	Y		

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Mental Health Legislation Committee in Common (MHLCiC) Assurance Report
for the meeting held on Wednesday 3 December 2025

Chair	Andreas Haimböck-Tichy, NED
Executive Lead	Lucy Knight, DHC Chief Medical Officer
Quoracy met?	Yes
Purpose of the report	To assure the Board on the main items discussed by the Committee and, if necessary, escalate any matter(s) of concern or urgent business which the Committee is unable to conclude.
Recommendation	To receive the report for assurance

Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework	• Positive reduction in the use of the Mental Health Act across the 3 acute hospital sites in Dorset • Success story of the implementation of 2 Mental Health Response Vehicles across Dorset • Executive membership of the Mental Health Legislation Committee in Common is increased from two to three to now include the Joint Director of Corporate Affairs with updated Terms of Reference • Mental Health Act panel member re-approval recommended to the Board

Key issues / matters discussed at the meeting	Corporate Risk Register Assigned Risks There are 2 DHC risks and 1 DCH risk assigned to the committee. All are now scoring below the threshold for committee review and will be removed from further reports. No new risks have been identified and no matters for escalation were raised. DHC and DCH Mental Health Legislation Assurance Dashboards A summary of the dashboards for Q2 was provided with assurance given on mitigating action for areas highlighted as a concern (using 'Alert, Advise, Assurance categories). A reduction was noted in the use of the Mental Health Act across the 3 acute hospital sites in Dorset primarily attributed to the interpretation of the legislation. Mental Health Response Vehicle - Service Provision and Shared Learning The committee received a presentation on the positive work and impact of the two Dorset Mental Health Response Vehicles which operate across the East and West of the county in partnership with SWAST. A 95% 'see and treat' rate was reported for individuals requiring emergency mental health support in the community, which will be reducing demand on acute hospital services. The committee commended the service and presentation. Strategic Mental Health Legislation Multi-Agency Group Update

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	The report was received for assurance with no significant escalations to the committee. The high number of out of area section 136 cases were noted by the committee. Mental Health Act Panel Member Re-approval Following positive formal reviews there are 7 Mental Health Act panel members who require re-appointment for a further period of two years. The committee approved and recommended the re-appointment to the Board. Policies (relevant to the work of the committee) A summary of the policy position relating to the Mental Health Legislation Committee was provided for information. There are currently 3 policies past their review date with a plan in place to address.
Decisions made at the meeting	• Addition of an Executive to the membership of the committee – Approved • Mental Health Act Panel Members – Re-approved
Issues / actions referred to other committees / groups	

Quoracy and Attendance				
	24/04/2025	31/07/2025	27/11/2025	29/01/2026
Quorate?	Y	DHC Y DCH	DHC Y DCH Y	
Andreas Haimböck-Tichy (DHC)	Y	Y	Y	
Dawn Dawson (or deputy)	N	Y	N	
Lucy Knight (DHC)	Y	N	Y	
Rachel Wharton (DCH)	N/A	N	N	
Margaret Blankson (DCH)	Y	N	Y	
Steve Peacock (DHC)	Y	Y	Y	
Suresh Ariaratnam (DHC)	N	Y	N	
Stuart Parsons (DCH)	N/A	N	Y	
Jenny Horrabin	N/A	N/A	Y	

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Report to	Board in Common (DHC Board)	
Date of Meeting	9 December 2025	
Report Title	DHC - Scheme of Delegation	
Prepared By	Mandy Ford, Joint Deputy Director of Corporate Affairs	
Approved by Accountable Executive	Jenny Horrabin, Joint Executive Director of Corporate Affairs	
Previously Considered By	DHC Audit Committee 28/11/2025	
Action Required	Approval	Y
	Assurance	N
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? <i>Delete as required</i>	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR6 Finance	
Financial	Relevant to delegated authority	
Statutory & Regulatory	As above	
Equality, Diversity & Inclusion	As above	
Co-production & Partnership	As above	

Executive Summary
Dorset HealthCare (DHC) Scheme of Delegation was reviewed in October 2022 and was due for Review in May 2025. As part of working within a Federation we have sought to align the Scheme of Delegation across both Trusts. Dorset County Hospital (DCH) has quite a detailed document, whereas the current DHC one was shorter and did not cover all of the expected elements. In reviewing this document and trying to align, we compared both Schemes of Delegation documents to University Hospitals Dorset, Torbay and South Devon NHS Foundation Trust and Liverpool University Hospitals NHS Foundation Trust. Both the existing and new Scheme of Delegation were reviewed by the Audit Committee, with only the new Scheme of Delegation attached for approval by the Board. The recommendation made to the Audit Committee was that Dorset Healthcare adopts the Scheme of Delegation within this paper, which is based on the DCH document, but has been strengthened with Sections 1-9, to link in with the 'Code of Governance for NHS Provider Trusts 2022', and Schedule 7 of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022. This document must be read in conjunction with and subject to the Constitution, the Standing Orders and Standing Financial Instructions adopted by each Trust. The DCH Scheme of Delegation will be updated at the next scheduled review (alongside the Standing Financial Instructions for both Trusts). The paper was discussed at DHC Audit Committee on 28 November 2025, and any comments received have been incorporated into the document.

Recommendation
Members are requested to: Approve the Scheme of Delegation for DHC

Scheme of Delegation

1. Executive Summary

- 1.1. The Scheme of Delegation within the NHS outlines the delegation of authority and decision-making powers to various levels of governance within the Trust.
- 1.2. It ensures clear accountability, proper use of public money, and compliance with national rules, guidance and Legislation.
- 1.3. The scheme includes various financial delegations, such as expenditure approval, business case approval, procurement, contract signing and other non-financial delegations to senior staff and to Board and Sub Board Committee levels ensuring that decisions are being made at the appropriate levels, by the appropriate staff.
- 1.4. The recommendation to the Committee is that Dorset Healthcare adopts the Scheme of Delegation within this paper, which is based on the DCH document, but has been strengthened with Sections 1-9, to link in with the 'Code of Governance for NHS Provider Trusts 2022', and Schedule 7 of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022.

2. Introduction

- 2.1. Code of Governance for NHS Provider Trusts 2022 requires the Board of Directors of NHS Foundation Trusts to have a "schedule of matters specifically reserved for its decisions" (B.2.17) ensuring that management arrangements are in place to enable the clear delegation of its other responsibilities.
- 2.2. Within the Licence Conditions issued by the Regulator, the Trust is required to demonstrate the existence of comprehensive governance arrangements which may be delegated in accordance with Schedule 7 of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022. These arrangements are to be read in conjunction with and subject to the Constitution, the Standing Orders and Standing Financial Instructions adopted by the Trust.

3. Purpose of the Scheme of Delegation.

- 3.1 The purpose of this document is to provide details of the powers reserved to the Board of Directors, and those delegated to the appropriate level for the detailed application of Trust policies and procedures. However, the Board of Directors remains accountable for all of its functions, including those which have been delegated, and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.
- 3.2 Dorset HealthCare (DHC) Scheme of Delegation was reviewed in October 2022 and was due for Review in May 2025. As part of working within a Federation we have sought to align the Scheme of Delegation across both Trusts. Dorset

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County Hospital (DCH) has quite a detailed document, whereas the current DHC one was shorter and did not cover all of the expected elements. In reviewing this document and trying to align, we compared both Schemes of Delegation documents to University Hospitals Dorset, Torbay and South Devon NHS Foundation Trust and Liverpool University Hospitals NHS Foundation Trust. Both the existing and new Scheme of Delegation were reviewed by the Audit Committee, with only the new Scheme of Delegation attached for approval by the Board.

- 3.3 The attached document sets out the powers reserved to the Board, the powers delegated to committees of the Board and to specific officers of the Trust. The document sets out the delegation derived from the code of conduct and accountability and from the Standing Orders for the Board of Directors. The document does not duplicate the extensive delegated powers and responsibilities set out within the Standing Financial Instructions. Therefore, the Scheme of Delegation must be read in conjunction with the Standing Financial Instructions.
- 3.4 All powers of the Trust which have not been retained as reserved by the Board of Directors or delegated to a committee or sub-committee of the Board of Directors shall be exercised on behalf of the Board of Directors by the Chief Executive Officer.
- 3.5 The scheme of delegation identifies those functions, which the Chief Executive Officer shall perform personally and those which are delegated to other Directors and Officers. All powers delegated by the Chief Executive Officer can be re-assumed by him/her should the need arise.

4. Recommendations

- 4.1. The Board is recommended to:
 - a. **Approve** the Scheme of Delegation

Name and Title of Author: Mandy Ford, Joint Deputy Director of Corporate Affairs

Date: 28.11.2025

5. Appendices

- 5.1. Appendix 1: Proposed Scheme of Delegation

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SCHEME OF DELEGATION AND RESERVATION OF POWERS TO THE BOARD

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November 2025
Corporate Governance.
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Version	Approval	Date	Ratified	Date
V1	Audit Committee	28.11.2025	Trust Board	09.12.2025

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1. Introduction

- 1.1 *Code of Governance for NHS Provider Trusts 2022* requires the Board of Directors of NHS Foundation Trusts to have a "schedule of matters specifically reserved for its decisions" (B.2.17) ensuring that management arrangements are in place to enable the clear delegation of its other responsibilities.
- 1.2 Within the Licence Conditions issued by the Regulator, the Trust is required to demonstrate the existence of comprehensive governance arrangements which may be delegated in accordance with Schedule 7 of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022. These arrangements are to be read in conjunction with and subject to the Constitution, the Standing Orders and Standing Financial Instructions adopted by the Trust.
- 1.3 It should be emphasised that the financial delegations in themselves give no power to act. The power to act up to the limits prescribed, derives from approved annual plans and budgets and, where applicable, authorised capital and revenue business cases.
- 1.4 Each corporate function is constrained by its agreed annual plan, which governs staffing, facilities and financial resources. Corporate functions may not exceed agreed budgets or deviate from approved plans without prior agreement of the Chief Executive Officer.
- 1.5 All projects are bound by these schemes of delegation even where funded partly or wholly from charitable or third-party funds. Approval for business cases, and subsequent approval to commit expenditure must be in strict accordance with the detailed scheme of delegation, in addition to the requirement for approval to release funds which are set out in the Trust's charitable fund procedures.
- 1.6 Standing Orders (SOs), Standing Financial Instructions (SFIs) and Accountable Officer Memorandum set out in some detail the financial responsibilities of the Joint Chief Executive, the Joint Chief Financial Officer and other Directors.
- 1.7 The Scheme of Delegation covers matters delegated by the Board to the Joint Chief Executive and Directors, and certain other specific matters referred to in SFIs. It also details where approval is required by the Board or Board Sub-Committee
- 1.8 This document covers only matters delegated by the Trust to its Senior Officers. Each Director is responsible for delegations within their function and should produce their own scheme of delegation, which should be distributed to all relevant staff, including the finance department.
- 1.9 Director schemes of delegation may not exceed the limits set out in this framework, but they may restrict delegation further. All such schemes of delegation should include the requirement that all officers with delegated authority must make formally documented arrangements to cover their delegations in circumstances where they are absent for more than 48 hours.
- 1.10 Those with delegated limits are responsible for ensuring that Standing Orders and Standing Financial Instructions are followed and that commitments are only made

using the Trust formal processes which requires that goods and services must be ordered utilising the Trust Purchasing processes as issued from time to time by the Chief Financial Officer or Head of Procurement & Logistics and that the formal tendering process, where applicable, has been followed in accordance with Standing Orders and Standing Financial Instructions.

- 1.11 All delegated authority, except where otherwise indicated, applies only to the Divisions or cost centre for which the delegated authority has been given as described on the Delegated Authority Form.
- 1.12 Delegated authority may be exercised only on amounts up to budget limits and no higher and carries no discretionary freedom to overspend against budgets.
- 1.13 The Reservation of Powers and Scheme of Delegation should be read in conjunction with the Trust's Standing Orders and Standing Financial Instructions.**

2. Purpose

- 2.1 The purpose of this document is to provide details of the powers reserved to the Board of Directors, and those delegated to the appropriate level for the detailed application of Trust policies and procedures. However, the Board of Directors remains accountable for all of its functions, including those which have been delegated, and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.
- 2.2 This document, sets out the powers reserved to the Board, the powers delegated to committees of the Board and to specific officers of the Trust. The document sets out the delegation derived from the code of conduct and accountability and from the Standing Orders for the Board of Directors. The document does not duplicate the extensive delegated powers and responsibilities set out within the Standing Financial Instructions. Therefore, the Scheme of Delegation must be read in conjunction with the Standing Financial Instructions.
- 2.3 All powers of the Trust which have not been retained as reserved by the Board of Directors or delegated to a committee or sub-committee of the Board of Directors shall be exercised on behalf of the Board of Directors by the Chief Executive Officer.
- 2.4 The scheme of delegation identifies those functions, which the Chief Executive Officer shall perform personally and those which are delegated to other Directors and Officers. All powers delegated by the Chief Executive Officer can be re-assumed by him/her should the need arise.
- 2.5 Where the Trust Board or one of its Committees has reached a decision under its terms of reference, the subsequent documentation committing the Trust to that decision will be signed in line with the Standing Orders

3. Caution over the use of delegated powers

- 3.1 Powers are delegated to Directors and Officers on the understanding they will not exercise delegated powers in a manner which in their judgement is likely to be a cause for public concern.

4. Delegation to Committees

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- 4.1 The Board may determine that certain of its powers shall be exercised by committees. The composition and terms of reference of such committees shall be that determined by the Board from time to time taking into account where necessary the requirements of NHS England and or the Charity Commissioners (including the need to appoint an Audit Committee and a Remuneration Committee). The Board shall determine the reporting requirements in respect of these committees. In accordance with SO 7.5 committees may not delegate executive powers to sub-committees unless expressly authorised by the Board. This is contained within Sections 11.

5. Directors' ability to delegate their own delegated powers.

- 5.1 The Scheme of Delegation shows only the 'top level' of delegation within the Trust. The Scheme of Delegation is to be used in conjunction with the system of budgetary control and other established procedures within the Trust. A Director's delegated power may be delegated to designated deputies. This is detailed within Appendix 1.

6. Absence of Directors (or Deputy) or Officer to whom powers have been delegated.

- 6.1 To assist the Chief Executive in their duties, and in accordance with the principle of holding individual Officers accountable for specific duties, they will delegate such functions as they consider appropriate, and in turn adjust such delegations as they deem necessary.
- 6.2 In the absence of a Director or Deputy/Officer to whom powers have been delegated, those powers shall be exercised by that Director or Officer's superior unless alternative arrangements have been identified in the Scheme of Delegation or approved by the Director/Officer's superior.
- 6.3 In circumstances where the Chief Executive Officer has not nominated an Officer to act in his/her absence, the Board of Directors shall nominate an Officer to exercise the powers delegated to the Chief Executive Officer in his/her absence.

7. Definitions

- 7.1 **Budget manager** means a member of staff with clear delegated authority from a director or level 2 manager to manage income and/or expenditure budgets. Delegated authority only applies to a budget manager's specific area of the Trust for which they are responsible for the budget.
- 7.2 The **Chief Executive Officer** is the Accounting Officer of the Trust (Paragraph 16(1) of Schedule 7 to the 2006 Act) and is responsible and accountable for discharging the functions specified in the NHS Foundation Trust Accounting Officer Memorandum.
- 7.2.1 As Accounting Officer, the Chief Executive Officer is accountable for the funds entrusted to the Trust. The Chief Executive Officer has overall responsibility for the Trust's activities, is responsible to the Board of Directors for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control. The Chief Executive Officer should also ensure that he/she complies with the NHS foundation trust accounting officer memorandum.
- 7.2.2 The Chief Executive will establish appropriate management arrangements to ensure that senior Officers pursue the Trust's policies in a corporate manner. All powers delegated by the Chief Executive can be re-assumed by them should the need arise.

- 7.3 **Director** means a formally appointed voting or non-voting director of the Trust Board and unless otherwise specified does not include other personnel who carry the word 'Director' or 'Chief' as part of their title.
- 7.4 **Executive leadership team** means the formally appointed voting and non-voting executive directors of the Trust Board.
- 7.5 **Level 2 managers are:**
- Deputies to members of the executive leadership team
 - Heads of functions directly reporting to members of the executive leadership team
- 7.6 Unless specified otherwise, all amounts set out in this document exclude Value Added Tax (VAT).

8. Roles and Responsibilities

8.1 Council of Governors Roles and Responsibilities

- Appoint and, if appropriate, remove the Chair
- Appoint and, if appropriate, remove the other NEDs
- Decide the remuneration and allowances and the other terms and conditions of office of the Chair and the other NEDs
- Approve the appointment of the Chief Executive
- Appoint and, if appropriate, remove the Trust's external auditors
- Receive the Trust's annual accounts, any report of the auditor on them, and the annual report
- Give views on the Trust's forward plans
- Approve (or not) any increase by 5% or more the proportion of the Trust's total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England
- Hold the NEDs to account, individually and collectively, for the performance of the Board
- Approve (or not) any proposal for merger, acquisition, separation or dissolution
- Approve (or not) any significant transaction (as defined in the Trust's Constitution)
- To represent the interests of FT members and the public as a whole
- Approve (jointly with the Board of Directors) any amendments to the Trust's Constitution.

9. Scheme of Reservation and Delegation

- 9.1 **The following decisions are reserved to the Board, i.e. these decisions may only be made by the Board under the arrangements outlined with the Standing Orders.**

REF	DECISION MAKER	DECISIONS RESERVED TO THE BOARD
A	General Enabling Provision	
	The Board	1. The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.
B	Regulations and Control	
		1. Approve the Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business.
		2. Suspend Standing Orders

REF	DECISION MAKER	DECISIONS RESERVED TO THE BOARD
		3. Approve variations or amendments to the Standing Orders
		4. Approve a scheme of delegation of powers from the Board to the Chief Executive and other Committees
		5. Require and receive the declaration of Board members' interest which may conflict with those of the Trust and, taking account of any waiver which the Secretary of State for Health may have made in any case, determining the extent to which that member may remain involved with the matter under consideration.
	The Board	6. Require and receive the declaration of officers' interest that may conflict with those of the Trust. 7. Approve arrangements for dealing with complaints. 8. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto. For clarity this would comprise details of the structure of the Board of Directors and its committees, 9. Receive reports from Committees, including those that the Trust is required by the Secretary of State or Regulator to establish and to action appropriately. 10. Confirm the recommendations of the Trust's committees where the committees do not have executive power.
		11. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust. 12. Establish terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board. 13. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailee for patients' property. 14. Authorise the use of the seal. 15. Discipline members of the Board or employees who are in breach if statutory requirements or the Standing Orders. 16. Approve any urgent decisions taken by the Chair of the Trust and the Chief Executive for ratification by the Trust in public session.
C Appointments/ Dismissal		
	The Board	1. Appoint the Vice Chair of the Board. 2. Appoint and dismiss other committees (and individual members) that are directly accountable to the Board. 3. Appoint, appraise, discipline and dismiss other members 4. Confirm appointment of members of any committee of the Trust as representatives on outside bodies 5. Approve proposals of the Remuneration Committee regarding directors and senior employees and those of the CEO for staff not covered by the Remuneration Committee. (see Section 11)
D Strategy, Operational Plan and Budgets		
		1. Define and approve the vision, strategic aims, forward plans and objectives of the Trust. 2. Identify the key strategic risks, evaluate them and ensure adequate responses are in place and are monitored. 3. Approve plans and budgets in respect of the application of available financial resources to support the agreed Annual Plan. 4. Approval of the capital programme and determine within which the CEO may approve variations to the programme.

REF	DECISION MAKER	DECISIONS RESERVED TO THE BOARD
	The Board	5. Approve proposals for ensuring quality and developing clinical governance for services provided by the Trust, having regard to any guidance issued by the Secretary of State and/or Regulator. 6. Approve the Trust's policies and procedures for the management of risk. 7. Approve Outline and Final Business Cases for the Capital Investment if this represents a variation from the Plan. 8. Advise of the introduction or discontinuance of any significant activity or operation. An activity or operation shall be regarded as significant if it has a gross annual income or expenditure (that is before any set off) in excess of £250,000. 9. Ratify proposals for acquisition, disposal or change of use of land and/or buildings. 10. Approve PFI proposals 11. Approve the opening of bank accounts 12. Approve Executive proposals on individual contracts (other than NHS contract) of a capital or revenue nature amounting to, or likely to amount to over £500,000 per annum. 13. Approve Executive proposals on individual cases for the write off of losses, or making of special payments above the limits of delegation to the Joint Chief Executive and Joint Chief Financial Officer (for losses and special payments) previously approved by the Board. 14. Approve individual compensation payments made outside of any legal /statutory or mandatory requirements after treasury approval received. 15. Approve proposals for action on litigation against or on behalf of the Trust. 16. Approve revenue investments greater than £500,000
E	Policy Determination	
	The Board	1. The approval of Trust corporate management policies where they do not fall within the current Policy Approval processes, or within the Committee structures for assurance.
F	Audit	
	Council of Governors	1. Approve the appointment (and where necessary dismissal) of External Auditors and advise Regulator on the appointment (and where necessary change/removal) of External Auditors including arrangements for the separate audit of funds held on trust, and to receive reports of the Audit Committee meetings and take appropriate action.
	The Board	2. Receive the annual management letter received from the External Auditor and agreement of the Executive's proposed action, taking account of the advice, where appropriate, of the Audit Committee.
G	Annual Reports and Accounts	
	The Board	1. Receipt and approval of the Trust's Annual Report and Annual Accounts.
H	Monitoring	
	The Board	1. Receipt of such reports as the Board sees fit from the Executive in respect of its exercise of powers delegated.

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10. Decisions/Duties Delegated by the Board to Committee.

The following decisions and duties have been delegated by the Board to the Committees , and Sub Committees as detailed below.

COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
Audit Committee	The Committee will: 1. Advise the Board on internal and external audit services 2. The Committee shall review the establishment and maintenance if an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives. 3. Review schedules of losses and compensations and agree write offs 4. Review the annual financial statements prior to submission to the Board.
Remuneration Committee	The Committee will: 1. The Committee is responsible for identifying and appointing candidates to fill all executive director positions on the board of directors (the Board) of Dorset HealthCare University NHS Foundation Trust (DHC or the Trust) and for determining their remuneration and other conditions of service. This will include Associate or non-voting executive director positions, where the individual regularly attends meetings of the Board. 2. Make recommendations to the Board on the remuneration and terms of service if senior employees to ensure that they are fairly rewarded for their individual contribution to the Trust having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff. 3. Ensure proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate to advise on and oversee appropriate contractual arrangements for such staff. 4. Report in writing to the Board the basis for its recommendations.
People and Culture Committee	The Committee will advise the Board, for full details refer to the Terms of Reference on the Trust's website.
Finance and Performance Committee	The Committee will advise the Board, for full details refer to the Terms of Reference on the Trust's website.
Strategy, Transformation and Partnership Committee	The Committee will advise the Board, for full details refer to the Terms of Reference on the Trust's website.
Quality Committee	The Committee will advise the Board, for full details refer to the Terms of Reference on the Trust's website.
Mental Health Legislation Assurance Committee	The Committee will advise the Board, for full details refer to the Terms of Reference on the Trust's website.

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11. Scheme of delegation derived from the Accountable Officer Memorandum.

The following duties are delegated by the Board to the Chairman and Executive Officers.

REF	DELEGATED TO	DUTIES DELEGATED
AOM 3	Joint Chief Executive	Accountable through NHS Accounting Officer to Parliament for stewardship of Trust resources.
AOM 3	Joint Chief Executive and Joint Chief Finance Officer	Ensure the accounts of the Trust are prepared under principles and in a format directed by the Regulator / Secretary of State. Accounts must disclose a true and fair view of the Trust's income and expenditure and its state of affairs.
AOM 3		Sign the accounts on behalf of the Board.
AOM 3	Joint Chief Executive	Sign a statement in the accounts outlining responsibilities as the Accountable Officer.
AOM 3		Sign a statement in the accounts outlining responsibilities in respect of Internal Control.
AOM 10	Joint Chief Executive	Endure effective management systems that safeguard public funds and assist the Trust Chairman to implement requirements of Corporate Governance including ensuring managers: • Have a clear view of their objectives and the means to assess achievements in relation to those objectives. • Be assigned well defined responsibilities for making best use of resources. • Have the information, training and access to the expert advice they need to exercise their responsibilities effectively.
SO 2.1	Joint Chair	Implement requirements of corporate governance.
AOM 8	Joint Chief Executive	Achieve value for money from the resources available to the Trust and avoid waste and extravagance in the organisation's activities. Follow through the implementation of any recommendations affecting good practice as set out in reports from such bodies as the Audit Commission and the National Audit Office (NAO). Use to best effect the funds available for providing healthcare, developing services and promoting health to meet the needs of the local population.
AOM 8	Joint Chief Executive	
AOM 7	Joint Chief Financial Officer	Operational responsibility for effective and sound financial management and information.
AOM 7	Joint Chief Executive	Primary duty to see that the JCFO discharges the function above.
AOM 3	Joint Chief Executive	Ensuring that expenditure by the Trust complies with Parliamentary requirements.
	Joint Chief Executive	The Codes of Conduct and Accountability incorporated in the Corporate Governance Framework issued to NHS Board by the Secretary of State are fundamental in exercising your responsibilities for regularity and probity. As a Board member you have explicitly subscribed to the Codes; you should promote their observance by staff.
AOM 12	Joint Chief Executive and Joint Chief Financial Officer	Chief Executive, supported by Joint Chief Financial Officer, to ensure appropriate advice is given to the Board on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness.
AOM 13	Joint Chief Executive	If Joint Chief Executive considers the Board or Joint Chair is doing something that might infringe probity or regularity, he/she should set

REF	DELEGATED TO	DUTIES DELEGATED
		this out in writing to the Joint Chair and the Board. If the matter is unresolved, he/she should ask the Audit Committee to inquire and if necessary the Regulator.
AOM 13	Joint Chief Executive	If the Board is contemplating a course of action that raises an issue not of formal propriety or regularity but affects the Joint Chief Executive's responsibility for value for money, the Joint Chief Executive should draw the relevant factors to the attention of the Board. If the outcome is that you are overruled it is normally sufficient to ensure that your advice and the overruling of it are clearly apparent from the papers. Exceptionally, the Joint Chief Executive should inform the Regulator. In such cases, and in those described in paragraph 24, the Joint Chief Executive should as a member of the Board vote against the course of action rather than merely abstain from voting.

12. Scheme of Delegation derived from the Codes of Conduct and Accountability.

The following duties and decision are either reserved to the Board or delegated to the stated Committees, Non-Executive Members or Executive Officers.

DELEGATED TO	AUTHORITIES / DUTIES DELEGATED.
Board	Ensure proper and widely publicised procedures for voicing complaints, concerns about maladministration, breaches of Code of Conduct, and other ethical concerns
All Board Members	Subscribe to Code of Conduct
Board	Board members share corporate responsibility for all decisions of the Board.
Chair and Non-Executive Directors.	Chair and Non-Executive Directors are responsible for monitoring the executive management of the organisation and are responsible to the Board of Governors for the discharge of those responsibilities.
Board	The Board has six key functions for which it is held accountable by the Regulator of Health on behalf of the Secretary of State: 1. to ensure effective financial stewardship through value for money, financial control and financial planning and strategy. 2. to ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation; 3. to appoint, appraise and remunerate senior executives. 4. to ratify the strategic direction of the organisation within the overall policies and priorities of the Government and the NHS, define its annual and longer-term objectives and agree plans to achieve them. 5. to oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary. 6. to ensure that the Executive leads an effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs.
Setchell, Ryan 04/12/2025 09:14:16	It is the Board's duty to: 1. act within statutory financial and other constraints. 2. be clear what decisions and information are appropriate to the Board and draw up Standing Orders, a Schedule of Decisions Reserved to the Board and Standing Financial Instructions to reflect these. 3. ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives for the main programmes of action and for performance against programmes to be monitored and senior

DELEGATED TO	AUTHORITIES / DUTIES DELEGATED.
Board	executives held to account. - establish performance and quality measures that maintain the effective use of resources and provide value for money. - specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board can fully undertake its responsibilities. - establish Audit and Remuneration Committees on the basis of formally agreed terms of reference which set out the membership of the committee, the limit to their powers, and the arrangements for reporting back to the Board.
Chair	It is the Chair's role to: - provide leadership to the Board. - enable all Board members to make a full contribution to the Board's affairs and ensure that the Board acts as a team. - ensure that key and appropriate issues are discussed by the Board in a timely manner. - ensure the Board has adequate support and is provided efficiently with all the necessary data on which to base informed decisions. - lead non-executive Board members through a formally - appointed Remuneration Committee of the main Board on the appointment, appraisal and remuneration of the Chief Executive and (with the latter) other executive Board members. - appoint non-executive Board members to an Audit Committee of the main Board. - advise the Council of Governors and NHS England on the performance of non-executive Board members.
Chief Executive	The Chief Executive is accountable to the Chairman and non-executive members of the Board for ensuring that its decisions are implemented, that the organisation works effectively, in accordance with Government policy and public service values and for the maintenance of proper financial stewardship. The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Board. The other duties of the Chief Executive as Accountable Officer are laid out in the Accountable Officer Memorandum.
Non-Executive Directors	Non-Executive Board members are appointed by or on behalf of the Council of Governors to bring independent judgement to bear on issues of strategy, performance, key appointments and accountability.
Chair and the Board Members	Declaration of conflict of interests.
Board	NHS FT Boards must comply with legislation and guidance issued by the NHS England, respect agreements entered into by themselves or on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money.

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Appendix 1: Delegated Authority

The individual, who has the delegated matter delegated to them, retains responsibility for this matter. The individual who has operational responsibility delegated to them is responsible for undertaking the actual delivery of the matter.

DELEGATED MATTER		DELEGATED TO	OPERATIONAL RESPONSIBILITY
1. Standing Orders / Standing Financial Instructions / Constitution			
	a) Final authority in interpretation of Standing Orders	Joint Chair	Joint Chair
	b) Notifying Directors and employees of their responsibilities within the Standing Orders and Standing Financial Instructions and ensuring that they understand the responsibilities.	Joint Chief Executive	Directors / Heads of Department
	c) Responsibility for security of the Foundation Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming with Standing Orders, Financial instructions and financial procedures	Joint Chief Executive	All Directors and Employees
	d) Suspension of Standing Orders	Board of Directors	Board of Directors
	e) Review suspension of Standing Orders	Audit Committee	Audit Committee
	f) Variation or amendment to Standing Orders	Board of Directors	Board of Directors
	g) Emergency powers relating to the authorities retained by the Board of Directors	Joint Chief Executive with two Non- Executives	Joint Chief Executive with two Non- Executives
	h) Disclosure of non-compliance with Standing Orders to the Joint Chief Executive (report to the Board of Directors)	All	All
	i) Disclosure of non-compliance with SFIs to the Chief Financial Officer (report to the Audit Committee)	All	All
	j) Advice on interpretation or application of SFIs	Joint Chief Financial Officer	Joint Chief Financial Officer / Director of Corporate Affairs
2. Meetings			
	a) Calling meetings of the Foundation Trust	Joint Chair	Joint Chair
	b) Chair all Foundation Board of Directors and Council of Governors meetings and associated responsibilities.	Joint Chair	Joint Chair
3. Financial Planning / Budgetary Responsibility			
	a) setting		
	• Submit budgets to the Board of Directors	Joint Chief Financial Officer	Joint Chief Financial Officer
	• Submit to the Board of Directors financial estimates and forecasts	Joint Chief Financial Officer	Joint Chief Financial Officer
	b) Monitoring		
	Delegate budget to budget holders	Joint Chief Executive	Joint Chief Financial Officer

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DELEGATED MATTER		DELEGATED TO	OPERATIONAL RESPONSIBILITY
- Monitor performance against budget - Preparation of a business case for investment over £50,000 - Identify and implement cost improvements and income generation activities in line with the Service development Strategy. - Submit monitoring returns - Preparation of annual accounts - Preparation of annual report - Authorisation of Virement It is not possible for any officer to vire from non-recurring headings to recurring budgets or from capital to revenue/revenue to capital. Virement between different budget holders requires the agreement of both parties. - Provision of budget holder guidance instructions and ensuring adequate training is delivered on an ongoing basis to budget holders		Joint Chief Finance Officer	Budget holders with support from Finance Manager
		Joint Chief Executive	Project Sponsors and Leads supported by Programme Office
		Joint Chief Finance Officer	Deputy Chief Finance Officer
		Joint Chief Finance Officer	Deputy Chief Finance Officer
		Joint Chief Executive	Joint Chief Finance Officer
		Joint Chief Executive	Refer to Appendix 2 Delegated limits
		Joint Chief Finance Officer	Deputy Chief Finance Officer
4. Bank / OPG Accounts (excluding Charitable Fund Accounts)			
- Operation: - Managing banking arrangements and operation of bank accounts (Board of Directors approves arrangements) - Opening bank accounts - Authorisation of transfers between Foundation Trust bank accounts - Authorisation of: - Investment of surplus funds in accordance with the Foundation Trust's Operating Cash Management Policy. - Approval and Monitoring of Operating Cash Management Policy - Petty Cash		Joint Chief Finance Officer	Deputy Chief Finance Officer
		Joint Chief Finance Officer	Joint Chief Finance Officer
		Joint Chief Finance Officer	To be completed in accordance with bank mandate/internal procedures
		Joint Chief Finance Officer	To be completed in accordance with bank mandate/internal procedures
		Board of Directors	Joint Chief Financial Officer
		Joint Chief Finance Officer	Refer to Appendix 2 Delegated limits
5. External borrowing			
- Advise the Board of Directors of the requirements to repay / draw down Public Dividend Capital - Application for draw down of Public Dividend Capital, overdrafts and other forms of external borrowing.		Joint Chief Finance Officer	Deputy Chief Finance Officer
		Joint Chief Finance Officer	In accordance with relevant mandate

DELEGATED MATTER		DELEGATED TO	OPERATIONAL RESPONSIBILITY
	c) Authorisation of drawing of working capital financing facilities up to principal sum of £10,000,000 at any one time	Joint Chief Finance Officer	In accordance with relevant mandate
	d) Preparation of procedural instructions	Joint Chief Finance Officer	Deputy Chief Finance Officer
6. Non Pay Expenditure			
	a) Obtain the best value for money when requisitioning goods.	Joint Chief Finance Officer	Head of Procurement and Logistics
	b) Financial limits for Budgetary Expenditure (including invoice authorisation without purchase orders)	Joint Chief Executive	Refer to Appendix 2 Delegated limits
	c) Non-Pay Expenditure for which no specific budget has been set up, and which is not subject to funding under delegated powers of virement.	Joint Chief Executive	Joint Chief Finance Officer
	d) Payment of accounts in accordance with terms and conditions of purchase.	Joint Chief Finance Officer	Deputy Chief Finance Officer
7. Supplies, Systems and Receipt of Goods			
	a) Responsibility for purchasing systems, stock control systems and ensuring procedures are in place for the control over stores and receipt of goods, issues and returns	Joint Chief Finance Officer	Deputy Chief Finance Officer / Head of Procurement & Logistics
	b) Responsibility for control of Pharmaceutical stocks	Chief Operating Officer	Chief Pharmacist
	c) Stocktaking arrangements	Joint Chief Finance Officer	Deputy Chief Finance Officer
	d) Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items.	Joint Chief Finance Officer	Deputy Chief Finance Officer / Head of Procurement & Logistics
8. Capital Investment			
	a) Requirement setting: Ensure that there is a robust requirement setting process for capital investment	Joint Chief Executive	Joint Chief Finance Officer
	b) Programme: - Ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on business plans - Preparation of Capital Investment Programme - Preparation of a business case expenditure over £50,000 - Financial monitoring and reporting on all capital scheme expenditure including variations to contract	Joint Chief Executive Joint Chief Executive Joint Chief Finance Officer Joint Chief Finance Officer Joint Chief Executive	Joint Chief Finance Officer Joint Chief Finance Officer Capital Planning & Space Utilisation Group All Directors Refer to Appendix 2 Delegated Limits

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DELEGATED MATTER		DELEGATED TO	OPERATIONAL RESPONSIBILITY
	• Authorisation of capital requisitions	Joint Chief Executive	Capital Planning & Space Utilisation Group
	• Responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost.	Joint Chief Executive	Joint Chief Finance Officer
	• Ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences.	Joint Chief Executive	Joint Chief Finance Officer
	• Issue procedures to support capital investment	Joint Chief Finance Officer	Deputy Chief Finance Officer
	c) Private finance: • Demonstrate that the use of private finance represents best value for money and transfers risk to the private sector. Proposal to use PFI must be specifically agreed by the Board of Directors	Joint Chief Executive	Joint Chief Finance Officer
	d) Leases: • Granting and termination of leases with annual rent <= £50k	Joint Chief Finance Officer	Joint Chief Finance Officer
	• Granting and termination of leases with annual rent < £100k • Granting and termination of leases with annual rent >= £100k	Joint Chief Executive Board of Directors	Joint Chief Finance Officer Joint Chief Executive
9. Quotation, Tendering and Contract Procedures			
	a) Services: • Best value for money is demonstrated for all services provided under contract or in-house	Joint Chief Executive	Joint Chief Financial Officer, supported by Head of Procurement & Logistics.
	• Nominate officers to oversee and manage the technical and, or qualitative and, or operational aspects of contract on behalf of the Foundation Trust.	Joint Chief Executive	As nominated by Joint Chief Executive.
	• Oversee the commercial aspects of the contract on behalf of the Foundation Trust, including contract management and amendments and pricing.	Joint Chief Finance Officer	Head of Procurement & Logistics
	b) Quotations	Joint Chief Executive	Refer to Appendix 2 Delegated Limits
	c) Competitive Tenders • Authorisation limits	Joint Chief Executive	Refer to Appendix 2 Delegated Limits
	• Receipt and custody of tenders prior to opening.	Joint Chief Executive	Joint Chief Executive
	• Opening of tenders	Joint Chief Executive	Two Senior Officers, one of whom should be a senior manager, not from the originating department or the officer receiving the tenders.

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DELEGATED MATTER		DELEGATED TO	OPERATIONAL RESPONSIBILITY
			Consisting of a Board member or Deputy/Associate Director.
	Decide if late tenders should be considered	Joint Chief Executive	Joint Chief Finance Officer
	d) Waiving the requirement to request quotes or tenders – subject to SOs	Joint Chief Executive	Refer to Appendix 2 Delegated Limits
	e) Where the lowest tender or quotation is not accepted the details are to be permanently documented using a quotation or tender acceptance form	Joint Chief Executive	Joint Chief Finance Officer
	f) Reporting of waivers for tenders and quotations to the Audit Committee	Joint Chief Finance Officer	Joint Chief Finance Officer
10. Fixed Assets			
	a) Maintenance of asset register	Joint Chief Finance Officer	Deputy Chief Finance Officer
	b) Approve procedures for reconciling balances on fixed asset accounts in ledgers against balances on fixed asset register	Joint Chief Finance Officer	Deputy Chief Finance Officer
	c) Calculate and pay capital charges in accordance with the requirements of the Independent Regulator	Joint Chief Finance Officer	Deputy Chief Finance Officer
	d) Responsibility for security of Foundation Trust assets including notifying discrepancies to the Joint Chief Finance Officer and reporting losses in accordance with Foundation Trust procedures.	Joint Chief Executive	All Staff
11. Personnel and Pay			
	a) Nominate officers to enter into contracts of employment regarding staff, agency staff or consultancy service contracts	Joint Chief Executive	Refer to Appendix 3 Establishment & Pay Control
	b) Authority to fill funded post on the establishment with permanent staff.	Joint Chief People Officer	Refer to Appendix 3 Establishment & Pay Control
	c) The granting of additional increments to staff within budget (other than automatic increments) as per Agenda for Change and Medical staff terms and conditions	Joint Chief People Officer	Refer to Appendix 3 Establishment & Pay Control
	d) All requests for upgrading/regrading major skill mix changes shall be dealt with in accordance with Foundation Trust Procedures and Agenda for Change and Medical Staff terms and conditions	Joint Chief People Officer	Refer to Appendix 3 Establishment & Pay Control
	e) Establishments - Additional staff to the agreed establishment with specifically allocated finance - Additional staff to the agreed establishment without specifically allocated finance	Joint Chief People Officer	Refer to Appendix 3 Establishment & Pay Control
		Joint Chief People Officer	Refer to Appendix 3 Establishment & Pay Control
	f) Pay - Authority to complete standing data forms effecting pay, new starters, variations and leavers - Authority to authorise overtime - Authority to authorise travel & subsistence expenses	Joint Chief People Officer	Refer to Appendix 3 Establishment & Pay Control
	g) Leave (To be applied in accordance with Agenda for Change and Medical Staff terms and conditions of service) Approval of annual leave	Joint Chief People Officer	Refer to Appendix 3 Establishment & Pay Control

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DELEGATED MATTER		DELEGATED TO	OPERATIONAL RESPONSIBILITY
	- Annual leave – approval of carry forward up to a maximum of 5 days as per Agenda for Change and Medical Staff terms and conditions of service - Annual leave – approval of carry forward of 6-10 days (to occur in exceptional circumstances) - Annual leave - approval of carry forward in excess of 10 days.		Refer to Appendix 3 Establishment & Pay Control
	h) Family and Special Leave as per Foundation Trust policy covering: - Bereavement Leave - Special leave for Family and Domestic Reasons - Adoption Leave - Paternity Leave - Parental Leave - Maternity Leave i) Special Leave as per Foundation Trust policy covering: - Jury Service - Armed Services - Short term Unpaid Leave - Employment Break Leave - Medical Staff Leave of Absence – paid and unpaid - Time off in lieu j) Sick Leave on half pay as per Attendance Management Policy - Phased return to work part-time on full pay to assist recovery - Extension of sick leave on full or half pay k) Study Leave - Medical staff study and professional leave - Career grade - Non-Career grade - All other study leave as per policy l) Removal Expenses (Authorisation of payment of removal expenses incurred by officers taking up new appointments as per policy) m) Grievance Procedure (All grievances cases must be dealt with strictly in accordance with the Grievance Policy) n) Authorised Car & Mobile Phone Users - Publicise policy for authorised car user and mobile phone user - Requests for new posts to be authorised as car users - Requests for new posts to be authorised as mobile telephone users	Joint Chief Executive Joint Chief Executive Joint Chief Executive Chief Medical Officer Post Graduate Tutor Joint Chief People Officer Joint Chief People Officer Joint Chief People Officer Joint Chief Finance Officer Joint Chief Finance Officer Joint Chief Finance Officer	Refer to Appendix 3 Establishment & Pay Control Refer to Appendix 3 Establishment & Pay Control Refer to Appendix 3 Establishment & Pay Control As policy Clinical Director within Divisions Line Managers Refer to Appendix 3 Establishment & Pay Control Department in conjunction with Deputy Chief People Officer Deputy Head of Estates and Facilities All Directors, Heads of Department All Directors, Heads of Department

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DELEGATED MATTER		DELEGATED TO	OPERATIONAL RESPONSIBILITY
	o) Renewal of Fixed term Contracts	Joint Chief People Officer	Refer to Appendix 3 Establishment & Pay Control
	p) Staff Retirement Policy • Authorisation of extensions of contract beyond normal retirement age • Authorisation of return to work in part time capacity under the flexible retirement scheme • Redundancy • Ill Health Retirement	Joint Chief People Officer Joint Chief People Officer Joint Chief Executive Joint Chief People Officer	Directors Directors Joint Chief People Officer Directors, Head of Department in association with Deputy Chief People Officer
	q) Disciplinary Procedure (excluding Executive Directors) as per Disciplinary Policy and Medical Staffing Policy	Joint Chief People Officer	To be applied in accordance with the Foundation Trust's Disciplinary Procedure
	r) Ensure all employees are issued with a Contract of employment in a form approved by the Board of Directors and which complies with employment legislation.	Joint Chief People Officer	Deputy Chief People Officer.
12. Engagement of Staff Not on the Establishment			
	a) Non-Medical Consultancy Staff • Where aggregate commitment in any one year (or total commitment) is less than £20,000 and is within directorate budget • Where aggregate commitment in any one year is more than £20,000	Joint Chief Executive	Directors
	b) Booking of Bank Staff • Nursing • Medical	Joint Chief Executive Joint Chief Nursing Officer Chief Medical Officer	Joint Chief Finance Officer Matron, Budget Holder Clinical Directors within Divisions
	c) Booking of Agency Staff • Nursing • Medical	Joint Chief Nursing Officer Chief Medical Officer	Matron General Manager
13. Funds held on Trust			
	a) Management: • Funds held on trust are managed appropriately	Joint Chief Finance Officer	Nominated Fund Holder
	b) Maintenance of authorised signatory list of nominated fund holders.	Joint Chief Finance Officer	Deputy Chief Finance Officer
	c) Expenditure Limit		Refer to Appendix 2 Delegated Limits
	• Fundraising Appeals • Preparation and monitoring of Budget • Reporting progress and performance against budget • Operation of Bank Accounts	Joint Chief Finance Officer	Fund Raising Manager with advice from the Deputy Chief Finance Officer

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DELEGATED MATTER		DELEGATED TO	OPERATIONAL RESPONSIBILITY
	d) Managing banking arrangements and operation of bank accounts e) Opening bank accounts f) Investments - Nominated deposit taker - Placing Transactions g) Registration of Funds with Charities Commission h) Approval of the annual charitable funds' accounts	Joint Chief Finance Officer in conjunction with trustees Joint Chief Finance Officer Joint Chief Finance Officer Board of Trustees Joint Chief Finance Officer Joint Chief Finance Officer Board of Directors acting on behalf of the Corporate Trustee	Deputy Chief Finance Officer Joint Chief Finance Officer Refer to Appendix 2 Delegated Limits Joint Chief Finance Officer Deputy Chief Finance Officer. Deputy Chief Finance Officer TBC
14. Patient Service Agreements			
	a) Negotiation of: - Main Commissioning Contracts for Community and Mental Health services - Contracts b) Quantifying and monitoring Non-contract activity c) Reporting actual and forecast income including payments by results d) Costing Foundation Trust Agency Purchase Contract and Non Commercial Contracts e) Ad hoc costing relating to changes in activity, developments, business cases and bids for funding	Joint Chief Executive Joint Chief Finance Officer Joint Chief Finance Officer Joint Chief Finance Officer Joint Chief Finance Officer Joint Chief Finance Officer	Joint Chief Finance Officer Directors Deputy Chief Finance Officer Deputy Chief Finance Officer Deputy Chief Finance Officer Deputy Chief Finance Officer / Head of Management Accounts
15. Setting of Fees and Charges			
	a) Overseas Visitors, Income Generation and other patient related services.	Joint Chief Finance Officer	Deputy Chief Finance Officer
	b) Private Patients	Joint Chief Finance Officer	Deputy Chief Finance Officer
	c) Non patient care income	Joint Chief Finance Officer	Directors / Heads of Department
	d) Informing the Joint Chief Finance Officer of monies due to the Foundation Trust	Joint Chief Finance Officer	All staff
	e) Recovery of debt	Joint Chief Finance Officer	Deputy Chief Finance Officer
	f) Security of cash and other negotiable instruments	Joint Chief Finance Officer	Deputy Chief Finance Officer
16. Disposal and Condemnations			

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DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
Items obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively	Joint Chief Finance Officer	Refer to Appendix 2 Delegated Limits
17. Losses, Write-off and Compensation		
a) Prepare procedures for recording and accounting for losses and special payments including preparation of a fraud response plan and informing the Counter Fraud and Security Management Service of frauds	Joint Chief Executive	Deputy Chief Finance Officer
b) Financial Limits	Joint Chief Executive	For Financial Limits refer to Appendix 2
Ex-gratia Payments:		
a) Financial Limits	Joint Chief Finance Officer	For Financial Limits refer to Appendix 2
b) Other, except cases of maladministration where there was no financial loss by claimant £50,000	Joint Chief Finance Officer	Joint Chief Finance Officer
18. Reporting of Incidents to the Police		
a) Where a criminal offence is suspected		
• Criminal offence of a violent nature	Joint Chief People Officer	Senior Manager On-call, Directors, Director of Operational Planning and Performance
• Arson or theft		
• other		
b) Where a fraud is involved (Counter Fraud and Security Management Service and External Audit)	Joint Chief Finance Officer	Local Counter Fraud Officer
19. Financial Procedures		
a) Maintenance & Update on Foundation Trust Financial Procedures	Joint Chief Finance Officer	Deputy Chief Finance Officer
b) Accountable for Financial Control	Joint Chief Executive / Joint Chief Finance Officer	All budget holders with support from Finance Manager
c) Responsibilities		
• Implement Foundation Trust's financial policies and co-ordinate corrective action.		
• Maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared and documented	Joint Chief Finance Officer	Deputy Chief Finance Officer
• Ensuring that sufficient records are maintained to explain Foundation Trust's transactions and financial position.		
• Providing financial advice to members of the Board of Directors and staff.		
• Maintaining such accounts, certificates etc to meet statutory requirements.		

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DELEGATED MATTER		DELEGATED TO	OPERATIONAL RESPONSIBILITY
	d) Financial Systems - Responsible for the accuracy and security of computerised financial data. - Ensure that contracts for computer services clearly define responsibilities for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage. - Ensure that new and upgraded systems are developed in a controlled manner and tested.	Joint Chief Finance Officer	Deputy Chief Finance Officer
20. Audit Arrangements			
	a) Ensure an adequate internal audit service, for which he / she is accountable, is provided (and involve the Audit Committee in the selection process when / if an internal audit service provider is changed.) b) Review, appraise and report in accordance with Government Internal Audit Manual (GIAM) and best practice. c) Provide an independent and objective view on internal control and probity. d) Ensure cost-effective external audit. e) Implement recommendations	Board of Directors Audit Committee Audit Committee Audit Committee Joint Chief Executive	Joint Chief Finance Officer Internal Audit Internal Audit / External Audit Joint Chief Finance Officer Relevant Officers
21. Legal Proceedings			
	a) Engagement of Foundation Trust's Solicitors b) Approve and sign all documents which will be necessary in legal proceedings c) Sign on behalf of the Foundation Trust any agreement or document not requested to be executed as a deed	Joint Chief Executive Joint Chief Executive Joint Chief Executive	Joint Chief Finance Officer Appropriate Delegated Officer Appropriate Delegated Officer
22. Clinical Audit			
	Clinical Audit	Chief Nursing Officer	Clinical Directors / Clinical Managers/ Department Heads / Clinical Governance Department
23. Commercial Sponsorship			
	a) Agreement to proposal	Joint Chief Executive	Joint Chief Finance Officer
24. Patients' Property (in conjunction with financial advice)			
	Ensuring patients and guardians are informed about patients' monies and property procedures on admission Prepare detailed written instructions for the administration of patients' property Informing staff of their duties in respect of patients' property Issuing property valued >£5,000 only on production of a probate letter of administration	Joint Chief Executive Joint Chief Nursing Officer Joint Chief Nursing Officer Joint Chief Finance Officer	Joint Chief Nursing Officer Deputy Chief Nursing officer / Director of Nursing Deputy Chief Finance Officer Deputy Chief Finance Officer

DELEGATED MATTER		DELEGATED TO	OPERATIONAL RESPONSIBILITY
	Deceased Patients Property	Joint Chief Nursing Officer	Deputy Chief Nursing Officer / Director of Nursing
25. Patients and Relatives Complaints			
	a) Overall responsibility for ensuring that all complaints are dealt with effectively	Joint Chief Executive	Joint Chief Nursing Officer
	b) Responsibility for ensuring complaints relating to a Directorate are investigated thoroughly.	Joint Chief Nursing Officer	Respective Director
26. Seal			
	The keeping of a register of seal and safekeeping of the seal	Joint Chief Executive	Joint Director of Corporate Affairs
27. Hospitality			
	Keeping of hospitality register	Joint Chief Executive	Joint Director of Corporate Affairs
	Applies to both individual and collective hospitality receipt items in excess of £100.00 per item received	Joint Chief Executive	All staff declaration required in Foundation Trust's Hospitality Register
28. Declaration of Interest (SFI 20)			
	a) Declare relevant and material interest	Joint Chief Executive	Board of Directors, Joint Executive Management Team, Consultants, Head of Department
	b) Maintaining a register	Joint Chief Executive	Joint Director of Corporate Affairs
29. Data Protection Act			
	a) Review of Foundation Trust's compliance	Joint Chief Executive	Joint Chief Finance Officer
30. Records			
	Review Foundation Trust's compliance with the Retention of Records Act	Joint Chief Executive	Executive Directors
	Retention of records held under Records Management Code of Practice for Health and Social Care	Joint Chief Executive	Executive Directors / Head of Department
	Ensuring the form and adequacy of the financial records of all departments	Joint Chief Finance Officer	Deputy Chief Finance Officer
31. Confidential Information			
	Review of the Foundation Trust's compliance with the Caldicott report on protecting patients' confidentiality in the NHS.	Joint Chief Executive	Chief Medical Officer

DELEGATED MATTER		DELEGATED TO	OPERATIONAL RESPONSIBILITY
	Freedom Of Information Act Compliance Code	Joint Chief Executive	Joint Chief Finance Officer
32. Authorisation of New Drugs			
	Authorisation of new drugs	Joint Chief Executive	Quality Committee
33. Authorisation of Research Projects			
	Authorisation of Research Projects	Joint Chief Executive	Quality Committee
34. Authorisation of Clinical Trials			
	Authorisation of clinical trials	Joint Chief Executive	Quality Committee
35. Authorisation of Product Trials			
	Authorisation of product trials	Joint Chief Executive	Head of Department with Head of Procurement & Logistics
36. Infectious Diseases and Notifiable Outbreaks			
	Infectious diseases and notifiable outbreaks	Joint Chief Nursing Officer	Clinical Directors within Directorate
37. Review of Fire Precautions			
	Review of Fire Precautions	Joint Chief Executive	Chief Operating Officer
38. Health and Safety			
	a) Review of all statutory compliance legislation and Health and Safety requirements including control of Substances Hazardous to Health Regulations	Joint Chief Executive	Chief Operating Officer
39. Medicines Inspectorate Regulations			
	a) Review Regulations	Joint Chief Executive	Chief Pharmacist
40. Environmental Regulations			
	a) Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	Joint Chief Executive	Joint Director of Estates & Facilities
41. Relationships with Press			
	a) Non-Emergency General Enquiries	Joint Chief Executive	On Call Director
	b) Emergency Enquiries	Joint Chief Executive	Head of Communications

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Appendix 2 – DELEGATED FINANCIAL LIMITS

DELEGATED FINANCIAL LIMITS (£) (unless otherwise stated, all figures are inclusive of VAT irrespective of recovery arrangements.)													
	Board of Directors	Finance and Performance Committee	Senior Leadership Group	Capital Planning & Space	Chief Executive Officer	Chief Finance Officer	Other Executive Officer	Deputy Director of Finance	Delegated Budget Holders (A)	Delegated Budget Managers (B)	Department/ Ward Delegated	Head of Financial Management	Senior Finance Management
1. Approval Process and Delegated Limits													
Initial Revenue and Capital Budget - approval	Yes	No	No	No	No	No	No	No	No	No	No	No	No
Capital approval outside of initial budget													
Approval of new capital business case proposals (within approved total capital budget but subject to critical patient need)	Yes	£500,000	No	£250,000	£50,000	£50,000	No	£50,000	No	No	No	£25,000	£25,000
Revenue approval process outside of initial budget													
Authorisation to Proceed to Bid for new business	Yes	£500,000	No	No	£250,000	£50,000	No	No	No	No	No	No	No
New Revenue Business cases - Approval outside planning cycle	Yes	£500,000	£250,000	No	£50,000	£50,000	No	No	No	No	No	No	No
2. Budget Virement													
Authorisation of Virement (adjustments to budgets) from Reserves/Additional Income	Yes	No	No	No	£2,000,000	£1,000,000	No	£500,000	No	No	No	£250,000	£25,000
Authorisation of Virement (adjustments to budgets) within Divisions	Yes	No	No	No	£2,000,000	£1,000,000	No	£500,000	£20,000	No	No	£250,000	£30,000
3. Cash and Banking													
Investment of Surplus Operating Cash	Yes	No	No	No	£25,000,000	£25,000,000	No	£5,000,000	No	No	No	£2,500,000	No
Petty Cash Disbursements	No	No	No	No	No	Yes	Yes	Yes	No	No	No	Yes	Yes
4. Capital Assets													
Disposal and Condemnations of Capital Assets - Items obsolete, unserviceable, irreparable or cannot be cost-effectively repaired	Yes	No	No	No	Yes	£50,000	No	£25,000	No	No	No	£15,000	No
All leases and ALL property purchase contracts and Termination: Where Board approval to the business case has been given and procurement process has	Yes	No	No	No	250000	£250,000	No	No	No	No	No	No	No

been followed: For leases authorisation level relates to cost over total contract period.														
5. Losses and Special Payments (reported to Audit Committee)														
Losses														
Fruitless payments (including abandoned Capital Schemes) and constructive losses	Yes	No	No	No	Yes	Yes	£5,000	No	No	No	No	No	Under £500	No
Other Losses														
Losses of cash due to theft, fraud, overpayment & others.	Yes	No	No	No	Yes	Yes	£5,000	£5,000	No	No	No	No	£500	No
Bad debts and claims abandoned.	Yes	No	No	No	Yes	Yes	£5,000	£5,000	No	No	No	No	£500	No
Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use	Yes	No	No	No	Yes	Yes	£20,000	No	No	No	No	No	No	No
Culpable causes (eg fraud, theft, arson).	Yes	No	No	No	Yes	Yes	£5,000	£5,000	No	No	No	No	£500	No
Special Payments														
Compensation payments by Court Order	Yes	No	No	No	Yes	Yes	£5,000	No	No	No	No	No	No	No
Extra contractual payments to contractors	Yes	No	No	No	Yes	Yes	£5,000	No	No	No	No	No	No	No
Ex-gratia Payments:-														
To patients / staff for loss of personal effects	Yes	No	No	No	£10,000	£5,000	£1,000	£1,000	No	No	No	No	£100	No
Other ex-gratia payments	Yes	No	No	No	£10,000	£5,000	£1,000	£1,000	No	No	No	No	£100	No
6. Patients Property (Release of property of a deceased patient)														
Up to £5,000	Production of Probate or Letters of Administration shall be required before any of the property is released													
Over £5,000	Forms of indemnity shall be obtained													
7. Income														
Threshold limits represent the contract's lifetime value														
Renewal of existing contracts and new contracts with business case approval	Yes	No	No	No	£10,000,000	£1,000,000	One approval - £1,000,000 Two approvals - £3,000,000	£1,000,000	£250,000	No	No	No	£500,000	No
Debtor Request Forms	N/A	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes

9. Sections 9a and 9b are ex VAT unless otherwise specified.		Threshold limits represent the contract's lifetime value e.g. a 5-year contract of £25,000 per year requires £125,000 method and authorisation.
9.a Procurement Process for Products & Services		
Quotations for all purchases : 1 written quote		under £10,000
Quotations - where possible, obtain a minimum of 3 written quotations		£10,000 to <£25,000
Formal quotation process run by procurement - Minimum number invited to quote -3		£25,000 to <£75,000
Formal Local Tender- Minimum number invited to tender -4		£75,001 to Procurement Regulation Thresholds including VAT
The Procurement Regulation processes apply		over Procurement Regulation Thresholds including VAT
9.b Procurement Process for Building & Estates Engineering Procurement		
Quotations for all purchases : 1 written quote		under £10,000
Quotations - where possible, obtain a minimum of 3 written quotations		£10,000 to <£25,000
Formal quotation process run by procurement - Minimum number invited to quote -3		£25,000 to <£100,000
Formal Local Tender- Minimum number invited to tender -4		£100,001 to Procurement Regulation Thresholds including VAT
The Procurement Regulation processes apply		over Procurement Regulation Thresholds including VAT

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Appendix 3 – Establishment and Pay Control

Establishment delegation

	Approve Increase to Establishment (new post or unfunded change) incremental	Approve Changes to Structure within existing establishment and within level of financial authority	New Post(s) matched by Post(s) disestablished for skill mix changes – cost neutral or delivering a financial saving in year	Appointing to Posts in Establishment
Joint Chief Executive	Yes	Yes	Yes	Yes
Joint Chief Finance Officer	No	Yes	Yes	Yes
Other Director	No	Yes	Functional Director plus Joint Chief Finance Officer	Yes
Deputy Director / Associate Director / Head of Service	No	Yes	No	Yes
Budget Holder / Manager	No	Yes	No	Yes

Pay delegation

Officer	Joint Chief Executive	Joint Chief Finance Officer	Other Executive Directorz	Deputy Director/ Associate Director / Head of Service	Budget Holder	Budget Manager
Certify Time Sheets - completion and authorisation of positive reporting forms	Yes	Yes	Yes	Yes	Yes	Yes
Agency & Temporary Staff*	Yes	Yes	Yes	Yes	No	No
Increase of Consultant Pas in excess of Whole-time (10pas)	Yes	Yes	Yes	Yes	Yes	No
Additional recurring allowances excluding Consultant PA's and Contractual Payments	Yes	Yes	Yes	Yes	Yes	No
Termination Forms	Yes	Yes	Yes	Yes	Yes	Yes
Lease Car approvals	Yes	Yes	No	No	No	No
Staff Appointment forms*	Yes	Yes	Yes	Yes	Yes	Yes
Annual leave buy back (rostered staff only)	Yes	Yes	Yes	Yes	Yes	Yes
Annual Leave C/ Fwd	Yes	Yes	Yes	Up to 1 week of basic contracted hours		
Compassionate and special leave	Yes	Yes	Yes	Up to 6 days		
Unpaid leave	Yes	Yes	Yes	Up to 5 days		
Approval of business travel and subsistence expenses (per claim) maximum limit	£5000	£5000	£1,500	£1,500	£500	£500
Salary Changes	Yes	Yes	Yes	No	No	No
Salary Advances	Yes	Yes	Yes	No	No	No
Salary arrears of Pay authorisation	Yes	Yes	£10,000	No	No	No
Overtime and On Call within T&Cs of Service	Yes	Yes	Yes	Yes	Yes	Yes
Overtime and On Call outside T&Cs of Service	Yes	Yes	Yes	No	No	No
Relocation Expenses (in accordance with policy)	£6,000	£6,000	£6,000	No	No	No
Voluntary Severance terms & payments	Yes	Yes	No	No	No	No
Redundancy	£50,000	£50,000	No	No	No	No
Premium Payments (Medical Staff)	Yes	Yes	Yes	No	No	No

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Officer	Change Forms which do not effect pay – e.g. ESR Personal Data Changes	Increase in hours	Increase in Banding	Acting Up Arrangements	Extension to Fixed Term Contract	Commencement Forms* (these are forms which notify payroll of the start of a new employee to an established post)
		Within Authorised Financial Limits				
		Within Establishment				
Joint Chief Executive	Yes	Yes	Yes	Yes	Yes	Yes
Joint Chief Financial Officer	Yes	Yes	Yes	Yes	Yes	Yes
Other Director	Yes	Yes	No	Yes	Yes	Yes
Deputy Director / Associate Director / Head of Service	Yes	Yes	No	Yes	Yes	Yes
Budget Holder	Yes	Yes	No	Yes	Yes	Yes
Budget Manager	Yes	Yes	No	Yes	Yes	Yes

In exceptional circumstances the Joint Chief Executive may authorise other employees than those listed to authorise those items on the previous page. New posts include changes which are entered ESR where a new post is added, even where this is on the basis of deleting existing posts to support the change

* Note that additional requirements apply in respect of engagement of consultants and non-clinical agency staff

Definitions:

Staff Appointment Form – approval to employ a particular individual
Staff Commencement Form – provision of details to payroll regarding a new employee, including salary, cost centre and personal data
These relate to appointments / commencements to approved posts only – they do not confer authority to approve new or changed posts.

SCHEME OF DELEGATION AND
RESERVATION OF POWERS TO
THE BOARD

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RESERVATION OF POWERS TO THE BOARD

1. Introduction

The purpose of this document is to set out those powers that the Board has decided it will retain rather than delegate to a committee, sub-committee or officer of the Trust. These reserved powers, when read in conjunction with the Terms of Reference of the Board, set out the remit, role and purpose of the Board.

This schedule should be read in conjunction with Standing Orders and Standing Financial Instructions (both of which set out delegations to officers), and the terms of reference of committees, to provide an overall view of delegated powers within the Trust.

2. Decisions Reserved to the Board

The following sets out those powers which the Board has decided only it will exercise.

General Enabling Provision	
The Board may determine any matter for which it has statutory authority.	
Strategy, Plans and Budgets	
i)	Approve the vision, strategic aims, forward plans and objectives of the Trust
ii)	Approve Trust-wide strategies
iii)	Approve the Trust Operational Plan for submission to NHS England
iv)	Approve the annual Trust Budget
v)	Approve the Annual Report and Accounts
vi)	Approve the Quality Accounts
vii)	Approve the Trust's proposed organisational development proposals
viii)	Approve outline and final business cases for capital investment
ix)	Ratify proposals for acquisition, disposal or change of use of land and/or building
Regulation and Control	
i)	Approve Standing Orders (and any decision regarding their suspension), the schedule of matters reserved to the Board and Standing Financial Instructions
ii)	Approval of the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto
iii)	Approve arrangements for the discharge of responsibilities in respect of funds held on Trust as a corporate trustee
iv)	Appoint, set the terms of reference of, agree membership of and dissolve committees that are directly accountable to the Board
v)	Approve Trust's strategies and policies for the management of risk

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3. Delegations to Board Committees

3.1 The Board may, as permitted by Trust Standing Orders, delegate decision-making powers and duties to committees.

3.2 The Board has delegated specific powers and duties to the following committees, the terms of reference of which are set out in the Trust Governance Manual

Audit Committee
Appointments and Remuneration Committee
Quality Governance Committee
Mental Health Legislation Assurance Committee
Transformation Committee

4. Delegation to Officers

4.1 Various duties and responsibilities are delegated to officers of the Trust. These powers are derived from Standing Orders and Standing Financial Instructions. These documents can be viewed in the Trust Governance Manual.

5 Roles and responsibilities of the Council of Governors

5.1 The general duties of the Council of Governors are:

5.1.1 to hold the non-executive directors individually and collectively to account for the performance of the board of directors; and

5.1.2 to represent the interests of the members of the Trust as a whole and the interests of the public.

5.2 The Council of Governors also has the following specific statutory duties and responsibilities:

5.2.1 to appoint and, if appropriate, remove the chair;

5.2.2 to appoint and, if appropriate, remove the other non-executive directors;

5.2.3 to decide the remuneration and allowances and other terms and conditions of office of the chair and the other non-executive directors;

5.2.4 to approve any new appointment of a chief executive;

5.2.5 to appoint and, if appropriate, remove the external auditor;

5.2.6 to receive the Trust's annual accounts, any report of the external auditor on them and the annual report at a general meeting of the Council of Governors;

5.2.7 to approve significant transactions (as defined in the Trust's constitution);

5.2.8 to approve an application by the Trust to enter into a merger, acquisition, separation or dissolution;

5.2.9 to decide whether the Trust's non-NHS work would significantly interfere with its principal purpose, which is to provide goods and services for the health service in England, or performing its other functions;

5.2.10 to approve the implementation of any proposal to increase by 5% or more the proportion of the Trust's total income in any financial year attributable to activities other than the provision of goods and services for the purpose of the health service in England

5.2.11 to approve amendments to the Trust's constitution;

5.2.12 to provide its views on the Trust's forward plan; and

5.2.13 to require one or more of the directors to attend a meeting of the Council of Governors for the purpose of obtaining information about the Trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the Trust's or directors' performance).

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6 Resolution of Disagreements between the Council of Governors and the Board

- 6.1 Any disagreement between the Council of Governors and the Board shall be resolved in accordance with the Policy for Engagement with the Board of Directors and the Code of Conduct for Governors.

Last reviewed: October 2022

Next review: May 2025

Document Owner: Director of Corporate Governance

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Report to	Board in Common (DHC Board)	
Date of Meeting	09/12/2025	
Report Title	Guardian of Safe Working Report of Safe Working Hours of Doctors in Training Q1 (Feb-Apr 2025)	
Prepared By	Dr Ian Rodin (Director of Medical Education), in the absence of Claire Vick (Guardian of Safe Working Hours)	
Approved by Accountable Executive	Dr Lucy Knight Chief Medical Officer	
Previously Considered By	People and Culture Committee in Common 24/11/2025	
Action Required	Approval	N
	Assurance	Y
	Information	N
Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? <i>Delete as required</i>	
Care	Yes	
Colleagues	Yes	
Communities		No
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 Safety & Quality.	
Financial	Fines are incurred for breaches of safe working	
Statutory & Regulatory	NA	
Equality, Diversity & Inclusion	Adherence to the GOSW provisions helps us treat resident doctors fairly and consistently.	
Co-production & Partnership	NA	
Executive Summary		
The introduction of the 2016 contract for resident doctors established the role of the Guardian of Safe Working Hours, who is required to provide assurances to the Trust Board in relation to the compliance with these hours on a quarterly basis. • This report covers the time period 02/05/2025 – 05/08/2025, in-line with the rotation of resident doctors • There were 14 exception reports raised during this period. All these were reviewed by the Guardian of Safe Working. • Seven of the exception reports raised were in relation to breaches of working times during on-call shifts • Seven of the reports related to work during normal office hours. Four of these reports, all raised by the same resident during a two week period, related to inadequate supervision • There were no other reports relating to missed educational opportunities. • Eight reports resulted in fines to the Trust • No reports raised an immediate safety concern. • No reports required an escalation. The Director of Medical Education is assured that Resident Doctors working hours are safe and the Guardian of Safe Working has raised no safety concerns		
Recommendation		
Members are requested to receive the report for assurance		

1. Background

- 1.1 Following the introduction of the 2016 resident doctor contract, the role of guardian of safe working hours (GOSWH) was created to provide assurances to both the board and resident doctors that their working hours would be safe (in line with the new contract.) These reports are intended to provide an overview and assurance of the Trust's compliance with safe working hours for doctors in training and to detail any areas of concern.
- 1.2 All doctors in training are issued with a work schedule (which details hours to be worked and educational opportunities expected in each job) and a proposed Rota (detailing frequency as well as Rota dates) prior to the start of each rotation. The Trust currently operates a normal intensity Rota which is compliant in terms of weekend frequency and number of consecutive days worked.
- 1.3 Deviations from the work schedule that result in additional hours worked or inability to take appropriate rest periods during a scheduled workday should result in the resident raising an exception report. Residents should also raise an exception report if they do not achieve the required 5 hours continuous rest between 10pm and 7am and or 8 hours total rest during a 24 hour on-call period. These exception reports are overseen by the Guardian of Safe Working Hours.
- 1.4 The amendments to the contract also require residents to raise an exception report when they have been unable to attend training related activities due to clinical commitments. These are discussed with their educational or clinical supervisor in the first instance as above and are passed to the Director of Medical Education for information. Exception reports raised in relation to education are beyond the remit of the Guardian of Safe Working Hours but the number of reports raised will however be added to this report for completeness.
- 1.5 All the doctors in training in this Trust are on the new contract.
- 1.6 Exception reports raised by Foundation Doctors are dealt with by the GOSW in the acute trusts and are therefore beyond the remit of this report.

2 Information for consideration

2.1 Exception reports relating to working hours from 02/05/2024- 05/08/2025

Training programme	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
CT/ GPVTS	14	14	0
ST	0	0	0
Total	14	14	0

2.2 Outcomes of exception reports

- 2.2.1 The 14 exception reports were all reviewed and closed by the Guardian of Safe Working.

- 2.2.2 Seven of the exception reports raised were in relation to breaches of working times during on-call shifts - six of these involved residents having less than five hours of continuous rest between 10pm and 7am, and one to differences in hours worked or missed breaks.
- 2.2.3 Seven of the reports related to work during normal office hours, four relating to inadequate supervision and three to differences in hours worked or missed breaks
- 2.2.4 The resident doctor who made 16 exception reports relating to their work in normal hours during Q1 made three such reports during Q2. This reduction followed work done by the resident and their clinical supervisor to review responsibilities and processes.
- 2.2.5 All reports were from resident doctors placed in psychiatry posts. There were no issues raised by residents in community hospital or sexual health posts, which do not entail on-call work with the Trust.
- 2.2.6 There have been no instances of exception report outcomes not being agreed by a trainee and therefore needing a level 2 or 3 resolution.

2.3 **A: Exception report raising immediate safety concern**

- 2.3.1 There were no exception reports raising an immediate safety concern.

2.4 **B: Exception reports related to missed education/ training**

- 2.4.1 Four exception reports were raised in relation to inadequate supervision, all by the same resident doctor during a two week period. There were no other reports related to missed education or training.

2.5 **C: Work schedule reviews**

- 2.5.1 There have been no new work schedule reviews required over the last period

2.6 **D: Vacancies and locum bookings**

- 2.6.1 The core resident and specialist resident posts on Alumhurst Ward at St Anns were both vacant during this quarter and a full-time locum doctor and a peripatetic Trust resident were deployed on the ward. There were four other vacant specialist psychiatry resident posts, all in community teams, and one vacant sexual health specialist resident post.

2.7 **E: Fines**

- 2.7.1 The amendments to the contract which have been rolled out since September 2019 have introduced stricter adherence to aspects of the contract, which has increased the number of fines.

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2.7.2 Fines are payable in two parts with one part going directly to the doctor and the remainder going to the Guardian of Safe Working Hours to be spent on training and education in agreement with the Resident Doctors Forum.

2.7.3 Eight of the exception reports registered in Q2 resulted in fines to the Trust for breaches of working times.

2.7.4 Monies raised through the fines process are to be used to improve the education, training and working environment for trainees. Disbursement of these funds are discussed at each quarterly Resident Doctors Forum.

2.7.5 Fines by Rota:

Fines by Rota		
Rota	Number of fines levied	Value of fines levied against department
CT/ GPVTS	8	£1482.99
ST	0	-
Total	0	£1482.99

2.7.6 Cumulative Balance in Guardian Cost Centre

Cumulative fines in Guardian Cost Centre (Total fines less payment to Trainee)			
Balance at end of last quarter	Fines this quarter	Disbursements this quarter	Balance at end of this quarter
£1235.00	£1482.99	0	£2717.99

2.8 F: Additional Information

2.8.1 The Resident Doctors Forum continues to meet quarterly and is well attended.

3 Guardian of Safe Working Hours Safety Statement

3.1 As Director of Medical Education, I am assured that the working hours for doctors in training are safe. The Guardian of Safe Working carried out her usual duties during the reporting period and did not raise safety concerns with me.

Contact for further information:

Dr Ian Rodin, Director of Medical Education

Dr Claire Vick, Consultant Psychiatrist and Guardian of Safe Working Hours for the Trust

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Report to	Board in Common (DCH Board)	
Date of Meeting	09 December 2025	
Report Title	Quarterly Guardian Report of Safe Working report: Doctors in Training (1 st July 2025 – 30 th September 2025)	
Prepared By	Dr Andy Macklin, Guardian of Safe Working (GoSW)	
Accountable Executive	Dr Rachel Wharton, Chief Medical Officer, DCH	
Previously Considered By	People and Culture Committee in Common (24/11/25)	
Action Required	Approval	-
	Assurance	X
	Information	-

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives	
Care	Yes	
Colleagues	Yes	
Communities		No
Sustainability		No
Implications	Describe the implications of this paper for the areas below	
Board Assurance Framework	Relates to Board Assurance Framework: SR1: Safety and Quality SR2: Culture SR3: Workforce Capacity The guardian of safe working ensures that issues of compliance with safe working hours are addressed by the doctor and the employer or host organisation as appropriate. It provides assurance to the board of the employing organisation that doctors' working hours are safe.	
Financial		
Statutory & Regulatory	Adhering to requirements of the Junior Doctor Contract 2016	
Equality, Diversity & Inclusion	People Plan Principle – we will improve safety and care by creating a culture of openness, innovation, and learning, where staff feel safe themselves	
Co-production & Partnership	The report is also shared with the Local Negotiating Committee for Medical and Dental staff once seen by PCCiC.	

Executive Summary
1. First report using structured data extracted from the Healthrota IT system for Exception Reporting (data collection started on the 1st April 2025) with challenges in extracting & validating data. This has presented opportunities for analysing data & expanded options for data presentation. 2. During this period of time there were 247 Exception reports, 9 were Immediate Safety Concerns (ISCs). (106 & 14 respectively in Q1) 3. Areas with the highest number of ERs were Trauma & Orthopaedics (62), ENT (21), Urology (18), General Surgery (18), Geriatric Medicine (17) & Gastroenterology (16) 4. Changes in the 2016 T&Cs as well as the ER reporting system have led to the identification of fineable Exception reports, which will feature in the next quarter's reporting.

Recommendation
The People and Culture Committee in Common is requested to: • Receive the report for assurance



Introduction

All eligible doctors in training between July and September 2025 were working under the terms of the 2016 Junior Doctors Contract with 2019 Updates (“the 2016 Contract”) and as such have had access to formally report occasions when their actual working pattern diverged from their contracted work schedules, as “Exception Reports”, for review by the Trust’s Guardian of Safe Working (GoSW). The trust extends Exception reporting access & safe working hours limitations to the locally employed resident doctors. Exception reporting analysis uses all submitted reports.

All work schedules provided to doctors in training within 2025 complied with contractual commitments under the 2016 Contract.

The provision of three quarterly reports and one annual report from the Guardian of Safe Working is a contractual requirement outline in the T&CS of the 2016 Contract.

High level data for Dorset County Hospital NHS trust

- Number of training posts (total):219
- Number of doctors in training post (total):203.3
- Annual average vacancy rate among this staff group: 19.2
- Amount of time available in job plan for Guardian of Safe Working 1 PA
- Amount of job planned time for educational supervisor 0.25 PA per trainee

Exception reports

Specialty	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Acute Medicine (Including Medical On-call)	11	11	0
Anaesthetics	0	0	0
Cardiology	14	14	0
Clinical Oncology	0	0	0
Dermatology	1	1	0
D&E	0	0	0
Emergency Dept	8	8	0
ENT	22	21	1
Gastroenterology	16	16	0
General Medicine / Including Fortuneswell Medical outliers	18	18	0
General Practice	1	1	0
General Surgery	15	15	0

Geriatric Medicine (Medical On-call included)	11	11	0
Haematology	3	3	0
Obstetrics & Gynaecology	0	0	
Paediatrics	0	0	0
Psychiatry	2	2	0
Renal	1	1	0
Respiratory Medicine	14	13	1
Stroke	11	11	0
Trauma & Orthopaedics	64	58	6
Urology	16	16	0
Total	228	220	8

Grade	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	137	134	3
F2	50	44	6
CT1	3	3	0
CT2	0	0	0
CT3	5	5	0
ST1	14	14	0
ST2	0	0	0
ST3	0	0	0
ST4	0	0	0
ST5	0	0	0
ST6	0	0	0
ST7	0	0	0
ST8	0	0	0
MT01	0	0	0
MT02	0	0	0
MT03	15	15	0
MT04	4	4	0
MT05	0	0	0
Total	228	219	9

Work schedule reviews

Upon the submission of an Exception Report that suggests a mismatch between a junior doctor's work schedule and the actual clinical demands required in that post, it is the responsibility of the guardian of Safe Working to request that the reporting doctor's educational supervisor to trigger a *Level 1 (Work Schedule) Review*. Example outcomes of such a review include no requirement for change, a prospective requirement to adjust existing work



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schedules, or even institutional change. The Exception Report is closed at Level 1 if the junior doctor and educational supervisor agree an outcome or escalated to *Level 2 Review* (with involvement of Guardian/DME and service management) if the junior doctor is not in agreement with the outcome. *Level 3 Review* constitutes a formal grievance hearing with HR representation.

Exception Reports taken to Level 1 Work Schedule Review

Vacancies

Appendix 1 Details all vacancies among the medical training grades during the Q2 of this year, split by specialty and grade.

Appendix 2 – Exception report submission since 2023/4 until Q1 2025/26

Appendix 3 – Exception report submission since 2016 – 2023/2024

Fines

There were no fines levied during this period, although there are Exception reports which have breached the threshold for levying fines & these will be applied retrospectively once the appropriate financial structures are in place.

There were 33 rule breaks identified in the quarter, with 32 of these breaching maximum shift length (13 hours) & 32 breaching the minimum rest period (11 hours). Resident doctors requested payment for 16 of these events (16 requests were for time off in lieu).

Immediate Safety Concerns

9 ISCs were submitted. These all attract a review by the GoSW & following agreement at the Resident Doctors Forum these will, in future, be added to the Datix system by the GoSW.

One ISC was an extension of one submitted earlier in the day, making a total of 8 ISC events overall. The most common source of events was the Trauma & Orthopaedics Specialty, with no more than one ISC from any other area. All of the ISCs were submitted by F1/F2 grade doctors.

Qualitative information

Part of overseeing the Exception Reporting mechanism involves constant awareness of under reporting and a constant effort to promote appropriate engagement with the mechanism via the Medical Director, DME, GMC regional officer and the local BMA representatives.

Data for the Q2 Report has been extracted from the Healthrota IT system, which has been the sole source of ER reports for Q1 2025 onwards. The reporting processes are less supportive than they could be & much of the data presented here has been post-processed after downloading data in bulk. The information I have obtained is to the best of my knowledge.

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Empowered citizens



Thriving communities

Any numbers of reporting less than 5 are not disclosed, to prevent any risk of identifiability moving forward.

There are plans for more training and development to improve data collection from the Healthrota.

The areas that generated the highest number of ERs were Trauma & Orthopaedics(62), ENT(21), Urology(18), General Surgery(18), Geriatric Medicine(17) & Gastroenterology(16). The free text descriptions refer to high on call referral rates, deteriorating ward patients, relatively high patient numbers per doctor in the team/feeling under -supported, taking on tasks at the end of a shift that were larger than the time remaining &, relatively frequently, to administrative tasks & handing over cases.

Graphical summaries of the exception report data are included in the appendices & include duration, planned end time for the affected shift & the relationship with work location & day of the week. A word cloud extracted from the description of the ERs is included. For brevity these are not described here. The main patterns are that the surgical rotas tend to cause longer & later exception reports & that there are notably fewer exception reports at weekends. Please note that Healthrota uses some “unexpected” data formats, notably that shifts that run past midnight have an end time of >24:00!

Within the Immediate Safety Concerns the majority were from F2 grades, with T&O being the originating main specialty. Half of the T&O ISCs were related to on call workload, with the others related to inadequate staffing for the normal working day duties.

There are no clear trends in the other ISCs: half of these were for unpredictable & short notice “one off” events, the others related to excessive/inappropriate workload for the staffing.

It is important to appreciate there has been a significant increase in ERs this quarter; related partly to the new Healthrota System, partly to changes in reporting practices encouraged by changes in the T&Cs & by the BMA, & partly an improvement in the supporting processes lowering the barrier to submitting an ER. This trend seems likely to continue & offers an opportunity to detect & remedy structural issues in the work schedules, as well as opportunities to support changes in doctors’ expectations in managing workload. HR now approve the majority of ERs; exception being any over 2 hours; Immediate Safety Concerns (For GOSW) or Educational Concerns (For DME).

The Guardian acknowledges the Trust’s compliance with the safeguarding aspects of the 2016 contract; recognizes good practice within the Trust and a concerted effort to support Resident Doctor’s as much as possible.

1. Recommendations

The Guardian asks the Board to note this quarterly report for assurance, considering it to provide an assurance of compliance with the safeguarding aspects of the 2016 Junior Doctors Contract



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Thriving communities

Report to	Board in Common (DHC Board)	
Date of Meeting	9th December 2025	
Report Title	Emergency Planning Annual Report and Annual Assessment Outcome	
Prepared By	Sandra Hodgkins Head of Emergency Planning & Deputy Accountable Emergency Officer	
Approved by Accountable Executive	Rachel Small Chief Operating Officer & Accountable Emergency Officer	
Previously Considered By	Finance and Performance Committee In Common, 26/11/2025	
Action Required	Approval	N
	Assurance	Y
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? <i>Delete as required</i>	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	Some links to SR10 – Cyber security – as EPRR includes resilience arrangements for IT. SR1 – Safety and Quality – assurance regarding EPRR activities supports and mitigates safety and quality risks to the organisation.	
Financial	No implication	
Statutory & Regulatory	The Civil Contingencies Act 2004, Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005, NHS Act 2006 and Health and Care Act 2022 underpin EPRR within health. All acts place EPRR duties on NHS England and the NHS in England. Additionally, the NHS Standard Contract Service Conditions (SC30) require providers of NHS-funded services to comply with the NHS EPRR Framework and other NHS England guidance.	
Equality, Diversity & Inclusion	No implication	
Co-production & Partnership	No implication	

Executive Summary
This annual report is submitted to the Trust Board as a summary of the Trust's Emergency Preparedness Resilience and Response (EPRR) management processes from our last Assurance period ending in Autumn 2024 through 2025, in accordance with NHS England's EPRR Core Assurance Standards. This report will present Trust Board with the outcomes of our NHSE EPRR Core Standard Assurance process, following our self-assessment and the subsequent Confirm and Challenge meeting with NHS Dorset. It will also include a summary of our emergency planning priorities for 2026. As detailed in our 2024 EPRR report, we were keen to refocus our efforts on more of the traditional EPRR work programmes whilst continuing to develop a trend for improvements within EPRR and provide continual service and support to the Trust.

Through feedback provided by our Trust On-Call staff as well learning from incidents, the EPRR team were able to enhance the delivery of training to the organisations Strategic Commanders, develop and deliver cyber related exercises and support partners in incident response.

The review and development of local business continuity plans has increased significantly. The EPRR team continue to respond to the ever-changing ways of working to support the Trusts operational delivery of services.

Once again Dorset Healthcare University Health Care NHS Foundation Trust EPRR Team have achieved full compliance with the NHS EPRR Core Assurance Standards for the fourth year. We are the only Trust in the System to have continuously maintained this standard with NHSD who identified several areas of good practice.

The EPRR Team, will continue the same drive and enthusiasm through 2026 and support Dorset Healthcare and the system through any incidents, that requires our response, advice or support.

Recommendation

Members are requested to receive the report for **assurance**.

Setchell, Ryan
04/12/2025 09:14:16

Emergency Planning Response and Resilience Annual Report 2025

1. Executive Summary

- 1.1. This report has been prepared to document the self-assessment outcomes of the Trust's Emergency Preparedness Resilience and Response (EPRR) compliance standard, in accordance with NHS England's EPRR Core Assurance Standards.
- 1.2. All NHS- funded organisations must meet the requirements of
 - a. the Civil Contingency Act 2004
 - b. the NHS Act 2006
 - c. the Health and Care Act 2002
 - d. the NHS Standard contract
 - e. the NHS Core Standards for EPRR and;
 - f. NHS England business continuity management framework

2. Introduction

- 2.1. This report has been prepared to provide a summary of the Trust's Emergency Preparedness Resilience and Response (EPRR) activities for 2025 that supports the Trust with its formal notification and evidence of the EPRR core standards.
- 2.2. The Trust remains committed to achieving full compliance to NHS England's EPRR Core Assurance Standards following the continual success for 2026.

3. Duties

- 3.1. The EPRR team is responsible for:
 - Developing and delivering the organisations EPRR and business continuity functions. Improving standards of preparedness across the organisation and provide advice to the Chief Operating Officer (COO) / Accountable Emergency Officer (AEO) on highly complex specialist emergency preparedness and business continuity issues.

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- Ensuring that the Trust has in place fully effective arrangements that will provide the appropriate operational response for all major incidents and ensure service continuity.
- Ensuring that EPRR corporate responsibilities are fully met and provide assurance to the AEO that maintains and complies with current legislation, standards, and guidance.
- Producing reports to the Trust Board on EPRR and business continuity as they arise.
- Testing the Trust's response by designing and delivering local exercises and training programmes, including accurate records of all such events and for producing reports with clear actions identified to address and maximise lessons learned.
- Convene, support and if appropriate chair, emergency planning groups on either general or specific issues as required.
- Maintain, administer and support the Trust On-Call arrangements with Directors and Managers.

4. Assurance

4.1. The NHS Core Standards set for 2025 has 67 standards. 58 with relevance for Community & Mental Health Trusts contained within. These are subdivided into 10 key domains:

- Governance (NHS Core Standards 1 – 6)
- Duty to Risk Assess (NHS Core Standards 7 – 8)
- Duty to Maintain Plans (NHS Core Standards 9 – 19)
- Command and Control (NHS Core Standards 20 - 21)
- Training and Exercising (NHS Core Standards 22 - 25)
- Response (NHS Core Standards 26 – 30)
- Warning and Informing (NHS Core Standards 33 – 36)
- Cooperation (NHS Core Standards 37 – 39 & 43)
- Business Continuity (NHS Core Standards 44 – 53)
- Chemical, Biological, Radiological & Nuclear (CBRN) (NHS Core Standards 55, 56, 57, 58, 60, 61, 63, 64, 65 and 66)

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- 4.2. Other standards outside of these numbers are not applicable to DHC and are based upon other NHS organisations criteria e.g. Acute Hospitals or Ambulance Trusts.
- 4.3. After reviewing our evidence for the Core Standard Assurance, in July 2025 the Trusts Chief Operating Officer / Accountable Emergency Officer and Head of Emergency Planning / Deputy Accountable Emergency Officer determined that Dorset Healthcare were Fully Compliant against the standards and advised the Finance and Performance Committee and Trust Board of the Self-Assessment findings.
- 4.4. Following the Self-Assessment all evidence against the standards was submitted to NHS Dorset for review, prior to the Check and Challenge meeting which took place on 1st October 2025.
- 4.5. The Trust is assessed against the criteria shown in the below table and NHS Dorset agreed with our self-assessment:

FULLY COMPLAINT

Organisational Rating	Criteria
Fully	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards
*Substantial	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non- Compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

- 4.6. Once again Dorset Healthcare University Health Care NHS Foundation Trust EPRR Team have achieved full compliance with the NHS EPRR Core Assurance Standards for the fourth year. We are the only Trust in the System to have maintained this standard with NHSD identify several areas of good practice. (Appendix 1 NHS Dorset – DHC Areas of good practice identified)

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5. Incident and Events

- 5.1. Dorset Healthcare have responded to a number of incidents and events across the county during this assurance period. We have supported the wider community and system partners during incidents and also responded to our own incidents that have impacted on service delivery in various way. The incidents and events have been detailed in Appendix 1

6. Exercising, Testing & Training

- 6.1. The Emergency Planning Team are pleased to have delivered a variety of high-quality training that has been well received by those who have attended both internally and externally. The training has been specific to the needs of those in Trust On-Call roles specific to Strategic and Tactical and wider training including specific Cyber and Mass Casualty exercises and Nationally Lead Exercises such and Pegasus. The main training and exercising provided this year is detailed in Appendix 2

7. Emergency Planning Group (EPG)

- 7.1. EPG is Chaired by the Chief Operating Officer / Accountable Emergency Officer and were held quarterly throughout 2025. The Terms of Reference is reviewed annually. Agenda topics for 2025 included but were not limited to:
- Mobile phone risks for Trust On-Call.
 - Update on cyber security
 - Review and approval of EPRR plans
 - Responses to incidents / lesson learnt
 - Training and exercising
 - Trust On-Call activity tracker

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8. Risks

- 8.1. As a Category 1 responder, we have a duty to assess and record risks in line with the Local Resilience Forum (LRF) and national risk register. These align with the current EPRR-related risks listed on the Trust Risk Register:

National Power Outage	Power Failure
Cyber Security Risks	CBRN Self presenting patient
Severe Weather	Pandemic /Workforce BC

EPRR has created and maintains a flood risk profile for all Trust Main sites.

9. Business Continuity

- 9.1. Significant improvements have been seen in the delivery of local business continuity plans. The EPRR Team continued to provide advice, support and engage with teams.

10. Plans & Policies

- 10.1. All nine EPRR plans / policies are in date, a number of which have been recently updated. Plans are approved by Emergency Planning Group members and support compliance through the year.
- We also lead on the Psychosocial Plan with BCP Council for the Local Resilience Forum (LRF).

11. Partnership working

- 11.1. Partnership working is key for health and equally in Emergency Planning. The EPRR team has developed and maintained relations with the ICB as well as NHSE SW and the Local Resilience Forum (LRF).
- 11.2. EPRR links in with our local Acute colleagues in Dorset and with others outside of the system where specific training has been shared.

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- 11.3. The Head of EPRR retains membership of the EPRR National Performance Advisory Group that forms networking links for benchmarking, learning, best practice and is also the Vice Chair.

12. Work plan

- 12.1. The team maintains a developed work plan that highlights key focuses for the coming year with the aim of continuing to maintain the Trusts level of compliance with NHS Core Standards. We have been able to meet all our targets on our work plan for 2025.

13. Conclusion

- 13.1. The team has remained on track and has delivered its established workplan, throughout incidents and challenges that have been presented. The EPRR team have ensure that accountability and progress is maintained.
- 13.2. Whilst the Trust is rated 'Fully Compliant' it remains an ongoing objective to achieve this again for 2026.
- 13.3. The team continues to plan, prepare and respond to the ever-changing ways of working to support the Trusts operational delivery of healthcare services whilst dealing with emergency situations.

14. Recommendations

- 14.1. The Board is recommended to:
 - a. Receive the report for **information**
 - b. Receive the report for **assurance**

Name and Title of Author: Sandra Hodgkyns Head of Emergency Planning and Deputy Accountable Emergency Officer

Date 14/11/2025

15. Appendices

- 15.1. Appendix 1 Incidents and Events
- 15.2. Appendix 2 Exercise & Training Events
- 15.3. Appendix 3 NHS Dorset — DHC Areas of good practice identified.
- 15.4. Appendix 4 Compliance outcome letter

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- 15.5. Appendix 5 Internal Learning & recommendations Gainsbrough NH
- 15.6. Appendix 6 Internal Learning & Recommendations 1 day snow event
- 15.7. Appendix 7 Internal Learning & Recommendations Holt Heath Fire

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Appendix 1 Incidents and Events

Date	Incident	Summary
October 2024	Gainsbrough Nursing Home	Our Teams supported at the rest centre as well as 'making ready' Swanage Hospital and activating our plans to open space at other locations across our Trust's foot print to receive residents from the nursing home who needed to be re-homed in the immediate response. There was an excellent response from colleagues across the Trust who responded to this incident, which was noted by NHS Dorset.
November 2024	Parkhome flooding & snow	During November we received several requests to activate our Health Dispatch Team due to flooding which was impacting park homes residents were being evacuated. In addition, Major roads across parts of Dorset had significant flooding, which caused difficulties for some communities teams. We also experienced a 1 day snow event across the county, impacting on service users & staff travelling to work. The initial points of impact in the west of the county. The snow arrived very quickly. A virtual Touchpoint ICC was established with 4 touchpoints during the day with the last concluding at 17.00 following assurance on patient care and staff availability for shifts.
January 2025	Weather Issues	During the remainder of January, we received numerous weather warnings that were cascaded and additional potential concerns regarding the closure of the Portland Causeway, which impacts on vulnerable patients as well as Portland Hospital.
February 2025	111 Planned re location	As part of a planned BCP activation due to essential maintenance work at the St Leonards Hub, colleagues from our integrated urgent care services (IUCS) relocated to Sentinel House from the 3rd -14th February 2025. The EPRR Team, along with Facilities Managers and IUCS colleagues plan these moves to ensure minimum disruption to staff at Sentinel and the IUCS, but more over to ensure that there is no impact on service deliver to the patients that we serve.
July 2025	Industrial Action	The Residents Doctors had a lower impact on our day-to-day response than previous industrial actions. Whilst there was still planning and scheduled touchpoint meetings during the periods of industrial action. These were diary holds by exceptions rather than for necessity due pre planning and past experience – touch points were limited or not needed.

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August 2025	Holt Heath Fire	The Emergency Planning Team were contacted by NHS Dorset's EPRR Team, who requested support from our Health Dispatch Team (HDT) to assist the Fire Officers recovering on scene. Our UCR vehicle was deployed to scene for 4 days to support exhausted and dehydrated fire service personnel. In October the Head of EPRR / Deputy AEO attended the Multi Agency Debrief. During this Multi-Agency debrief, DHC's response was highly praised and was considered as a model that may be considered going forward for such incidents. (Appendix 4 Internal Learning & Recommendations Holt Heath Fire)
October 2025	111 Planned re location	As part of planned BCP Activation due to essential maintenance work at the St Leonards Hub, Integrated Urgent Care Services (IUCS) relocated to Sentinel House. The EPRR Team, along with Facilities Manager Services and IUCS colleagues plan these moves to ensure minimum disruption to staff at Sentinel and IUCS, but more over to ensure that there is no impact on service deliver to the patients that we serve.
October 2025	Vodafone failure	Vodafone experienced an outage in the system (nationally) which effected 4/5G. This impacted staff who were using Trust laptops only using SIMs and for staff wishing to use their Trust mobile phones for data purposes, e.g. emails, MS Teams, internet. This additionally impacted, anyone who was working from home where their broadband network provider was Vodafone. Mobile phone calls & texts were able to be sent and received and this was tested with both the On-Call Manager and On-Call Director in case of an incident. The incident has recovered for the Trust by the following morning.

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Appendix 2 Exercise and Training Events

Exercise	Summary
Pheonix	The Strategic On-Call Team, explored the whole evacuation of our largest Mental Health Hospital, following a no – notice fictitious, but possible scenario. This Exercise preceded a training session provided by Barrister Graham Waston, in Defensible Decision & Inquest and Inquiries Training, which forms part of the requirements for Strategic On-Call.
Wispa	Was a 3 ½ hour Strategic-level, Cyber Incident tabletop exercise with colleagues supporting from Trusts outside of the system, the NHSDorset and our own staff. The scenario was based on a fictitious patient records and rostering system which DHC had adopted in collaboration with the ICB and partners from UHD and DCH. The provider of the system experienced a data breach due to being hacked. The hack was not into the Trust systems but into the owner (suppliers) system, which identified its own difficulties. This exercise provided evidence for the Trusts Data Protection Security Toolkit (DPST).
Sparkle	The Head of EPRR, has continued to run Exercise Sparkle for Minor Injury Units focusing on a self-presenting patient who arrives with a contamination. This focus on our requirements for Chemical, Biological, Radiological, & Nuclear (CBRN). Due to our locality, it is import for our teams to consider self-presenting patient who may attend an MIU, rather than initially calling an ambulance.
Touchwood / Mass Casualty Distribution	This was a Dorset system exercise which included our Urgent Treatment Centre. Players included the EPRR Team, a Strategic Commander, Tactical Command and Clinical Lead from DHC The aim of the exercise was to test the Casualty Distribution 'Plan' against a mass casualty scenario and support with the continual development of incident plans.
Ex Boom	Tactical Commander specific training, the exercise was based on a building work accident at one of the Trust's mental health facilities, where a delivery lorries caused damage to the facility and knocking out the power to the site. The exercise aimed to test the response, processes and procedures of our Tactical Commanders and to manage / facilitate a 'no notice' incident at one of the Trust's mental health sites.

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Appendix 3 NHS Dorset — DHC Areas of good practice identified

Best Practice

Ref (CS)	Standard Name	Compliance	Comments
D10	CBRN	Fully compliant	Dorset HealthCare has demonstrated significant progress within the CBRN (Chemical, Biological, Radiological and Nuclear) work programme. Several exercises, including Exercise Sparkle, have been conducted involving Minor Injury Units (MIUs) and Urgent Treatment Centres (UTCs), with additional staff undertaking RAR (Responder Awareness and Readiness) training. Furthermore, the Head of EPRR is currently supporting the development of a regional CBRN training programme to support both acute and community healthcare providers.
CS23	EPRR exercising and testing programme	Fully compliant	Over the past 12 months, Dorset HealthCare's EPRR team has delivered a comprehensive and robust exercise programme, enhancing organisational preparedness and resilience. As part of this programme, ICB staff were invited to observe Exercise Wispa in June 2025; an internally-led cyber exercise designed to test response capabilities. The exercise successfully strengthened cross-organisational collaboration and improved understanding of internal procedures related to cyber incident management.
CS26	Incident Coordination Centre (ICC)	Fully compliant	During the site visit with Dorset HealthCare, the ICC activation process was demonstrated and walked through in detail. The organisation and layout of role-specific equipment boxes and action cards were reviewed, along with video instructions available for on-call staff access. A secondary site has also been identified and is scheduled to be operational in the near future.
D6	Response	Fully compliant	Dorset HealthCare demonstrated a high level of collaboration and operational readiness in response to the Gainsborough and wildfire incidents. These events required the rapid coordination and deployment of health dispatch teams to support affected communities and multi-agency partners. The Trust's ability to mobilise resources, communicate effectively across teams, and integrate with wider system partners highlighted its robust response mechanisms and commitment to community safety. This response also reflected well-established internal processes and a proactive approach to emergency preparedness and resilience.

**Our
Dorset**

Appendix 4 Compliance Outcome Letter 2025 below

Satchell, Ryan
04/12/2025 09:14:16



To: Rachel Small (Chief Operating Officer & Accountable Emergency Officer)
Copy: Sandra Hodgkyns (Head of Emergency Planning & Deputy Accountable Emergency Officer)

Dean Spencer
ICB AEO
County Hall,
Colliton Park,
Dorchester,
Dorset
DT1 1XJ
Tel: 07770657679
Email: Dean.spencer@nhsdorset.nhs.uk

Sent by email

27th October 2025

Dear Rachel,

Dorset Health Care Emergency Preparedness, Resilience and Response core standard assurance confirm and challenge outcome.

Many thanks for preparing the self-assessment, supporting evidence and your engagement at the EPRR assurance review meeting held on 1st October 2025. This letter summarises the outcomes from the meeting, capturing agreed actions and points from our discussions.

Outcome from the 2025 EPRR Core Standards review

This year a full assurance process took place. The table below summarises the outcomes of the assurance review and provides the overall compliance rating. A Deep Dive review was not undertaken in 2025.

Please select type of organisation:		Community Service Providers		
Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	11	0	0
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	5	5	0	0
Warning and informing	4	4	0	0
Cooperation	4	4	0	0
Business Continuity	10	10	0	0
Hazmat/CBRN	10	10	0	0
CBRN Support to acute Trusts	0	0	0	0
Total	58	58	0	0

Compliance level (see annex 1 for descriptors): **Full Compliance**

Good Practice and Innovation

1. Dorset HealthCare has demonstrated significant progress within the CBRN (Chemical, Biological, Radiological and Nuclear) work programme. Several exercises, including Exercise Sparkle, have been conducted involving Minor Injury Units (MIUs) and Urgent Treatment Centres (UTCs), with additional staff undertaking RAR (Responder Awareness and Readiness) training. Furthermore, the Head of EPRR is currently supporting the development of a regional CBRN training programme to support both acute and community healthcare providers.
2. Dorset HealthCare's EPRR team has delivered a comprehensive and robust exercise programme, enhancing organisational preparedness and resilience
3. The ICC provision at Dorset HealthCare was noted as excellent with video instructions available for on-call staff access.
4. Dorset HealthCare demonstrated a high level of collaboration and operational readiness in response to incidents in 2024-25. The Trust's ability to mobilise resources, communicate effectively across teams, and integrate with wider system partners highlighted its robust response mechanisms and commitment to community safety. This response also reflected well-established internal processes and a proactive approach to emergency preparedness and resilience.

Next Steps

1. Plans are underway to review and enhance the overarching EPRR and Business Continuity Policy.
2. Dorset HealthCare is committed to the ongoing development of its team, with a particular focus on supporting those new to post through targeted training and development opportunities.
3. To improve efficiency in Business Continuity processes, DHC is implementing an automated system to replace the current use of multiple spreadsheets. This will include automated reminders to teams, enhancing compliance and streamlining workflows.
4. It was noted that maintaining agility within the EPRR team is essential, given the dynamic and evolving challenges faced by NHS organisations.

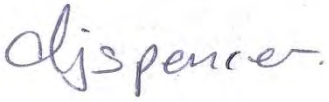
The ICB will be required to present a system summary of the assurance process to the LHRP and your assistance will be required to address any specific questions or queries from members.

NHS England will produce and present a regional report to the Local Health Resilience Partnership Executive Group in November prior to submitting a Regional return to the NHS England National Team.

Finally, thanks must go to the EPRR team for their hard work over the last year, while managing other concurrent issues and incidents.

Yours Sincerely,

04/10/2025 09:14:16
F:\chris.ryan

	
Dean Spencer Chief Operating Officer Accountable Emergency Officer NHS Dorset	Lauren Jarrad Head of Operations & EPRR NHS Dorset

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Annex 1: Compliance Levels

Organisational rating	Criteria
Full compliance	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial compliance	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial compliance	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non-compliance	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

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Appendix 5 Internal Learning & recommendations Gainsbrough Nursing Home

Number	Theme / Topic	Recommendation Gainsborough Care Home Swanage	Lead/s	Target Date
1	Notification of incident	To identify a clear notification/alert process between all partnerships when an incident occurs. The alert should then be cascaded throughout the Trust as appropriate - ensuring that LRF also understand DHC responses in an incident.	EPRR/	Feb 2024
2	Communication	At the Rest Centre, when SWAST stood down as Incident Command, there was a lack of communication and command structure for the remainder of the incident despite several agencies being involved in the response at the Rest Centre. Future plans should consider who takes primacy and command. This must be feedback into the System debrief for confirmation.	EPRR/ Rachel Small	Feb 2024
2a	Communication	Standing down – Where possible all internal media should be used to contact staff following the standing down of an incident/event to reduce the likelihood of staff attending sites after the incident/event. This should be led by, where possible, Trust Comms, Incident Commanders, & Service Managers.	EPRR to share at EPG to Cascade/ all service leads	Dec 2024
3	Resident Information	The lack of information provided relating to vulnerable residents and potentially NHS patients was a concern to DHC. This will be raised at the system debrief to ensure improved communications in similar incident types.	EPRR/ Rachel Small	Feb 2024
4	Information Sharing	To ensure that all DHC responders, have an established route for communication during the incident, potentially using a single point of contact (SPOC) in an event or incident response as well as the MS Teams channel that was well received by those who could use it.	EPRR to share at EPG to Cascade.	Dec 2024
5	Grab Bag / Hi Vis	Staff who are responding in a fully set up ICC in Sentinel or Forston have Hi-Vis tabards to identify themselves. Staff who are responding outside of the Trust did not have Hi Vis tabards and were not easily identifiable at the rest centre in this incident. When HDT are activated the Hi – Vis vests should be distributed to DHC staff at the rest centre from the GRAB BAG and collected when they leave.	Alex Lister / Brad Roots	Dec 2024
6	DORIS / BCP Plans	During incident/events access to Doris may not always be accessible, fire, power failure, service failure. All services with BCP should have up to date plans printed (hard copied) in their BCP/ Major Incident Folders. This should include as a minimum local BCP plans, the Trust Major Incident plan, Lockdown plans & action cards.	EPRR to share at EPG to Cascade/ All Service Leads	Dec 2024
7	PPE	At the start of any incident, Commanders should consider & take advice from IPC, via TCG UKHSA (if required) on the need for staff to wear PPE.	EPRR to share at EPG/ Cascade to all On-Call Directors.	Dec 2024

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8	Welfare	Following any incident, Incident Commanders/Service Managers should review DHC services to confirm who had attended the incident (including those not necessarily involved in the response directly). <i>E.g. may have attended prior to incident/event being declared and therefore may have experienced Trauma or exposure, not captured by the Trust ICC.</i>	EPRR to share at EPG/ Cascade to all On-Call Directors	Dec 2024
9	Strategic Escalation/ own declarations	EPRR will discuss with NHSE our individual debrief, if they have a different view on DHC non declaration – as DHC responded to the incident but was not declared for us. As above EPRR will raise for learning the wish for an earlier strategic health response in this type of incident.	EPRR/ Alex Lister	Nov 2024
10	IT Support / Comms	EPRR will link with IT to see if there is anything available that the HDT could hold to support Wi-Fi enhancements.	EPRR/Andrew Harrison	Feb 2024

Appendix 6 Internal Learning & Recommendations 1 day snow event

Number / Name	Theme / Topic	Recommendation 1 Day Snow Event	Lead	Target Date
1	Communication / Access to	EPRR/ COO/OCD to be able to update Social Media quickly and out of hours. Guide to be provided and held in On-Call drive to update social media (Sign off from COO or OCD)	Sandra Hodgkyns/ Comms	31 st Dec 2024
3	Review of 4x4 /AWD provision/ training and equipment	There is a need to review the Trusts provision of 4x4/AWD vehicles, to understand what provision can be supplied in the event of Severe Weather to support the Trust. Currently the Trust has to rely on other services, which may not be able to support us.	Sandra Hodgkyns Chris Bowden Transport Services H&S	28 th Feb 2025
5	Consideration for earlier ICC for Snow Yellow warnings	Severe Weather Plan – in the event of this type of warning for snow – consider discussing having an ICC the day previous to discuss actions	EPRR COO	On going winter season

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Appendix 7 Internal Learning & Recommendations Holt Heath Fire

Number / Name	Theme / Topic	Recommendation Holt Heath Fire	Lead	Target Date
1	Communication	Always first point of call, it is better to have a phone call.	EPRR/ On-Call Manager	On going
2	Plans/ Flow Charts (Right Team)	Review the current process for HDT and consider the approach used in this incident where UCR vehicle and staff were dispatched. Please consider the rest centre approach and offer in a larger scale incident. New flow chart to be created and shared with EPRR for On-Call File, the ICB for awareness and service provider (IUCS).	Shaun Carthew	October 31 st 2025
3	Clarity on provision	In line with the above review – clarity needs to be provided to ensure that OCM is aware of the provision and how to activate that provision. Additionally, our partners need to be aware formally of what we may be able to provide and the time needed to set up the provision.	EPRR Shaun Carthew	October 31 st 2025
4	Equipment Review (Non Clinical)	Undertake review of current non clinical equipment within UCR Vehicles and what is needed going forward for response. Look to purchase.	Shaun Carthew UCR Teams	Nov 30 th 2025
4a	Equipment Review (Clinical)	Undertake review of current clinical equipment within UCR Vehicles and what is needed going forward for response including electrolytes. Look to purchase.	Shaun Carthew UCR Teams	Nov 30 th , 2025
5	Recording Patient Data	How are patients that are seen going to be recorded and documented (SBAR) performance paper work as a pack. These would be intermediate notes, either for GP or going forward with the patient in the ambulance for further care.	Shaun Carthew UCR Teams Clinical Governance Data Protection Team	Nov 30 th , 2025
6	Hydration/ Electrolytes	EPRR Team to raise the concerns about our request for aid, to support the teams on the ground to meet health needs and reduce risk to Fire staff becoming patients and impacting of health partners.	EPRR / Feedback into LRF Debrief	Date to be confirmed by LRF
7	Pathways for hydration and electrolytes	For clinicians, there needs to be a clinical path way for staff to ensure there is clear guidance on what should be administered to patients.	UCR Teams Clinical Governance Jo Clarke	Nov 30 th , 2025

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Report to	Board in Common (DCH Board)	
Date of Meeting	09 December 2025	
Report Title	DCH - EPPR Core Standards Assurance Confirm and Challenge Process Outcome	
Prepared By	Anita Thomas, Chief Operating Officer	
Approved by Accountable Executive	Anita Thomas, Chief Operating Officer	
Previously Considered By	EPPR Annual Submission reviewed at September 2025 Finance and Performance Committee and October 2025 Board of Directors. Finance and Performance – November 2025	
Action Required	Approval	No
	Assurance	Yes
	Information	No

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? <i>Delete as required</i>	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	These are the risks from the BAF assigned to this Committee	
Financial	No financial implications arising from the BAF	
Statutory & Regulatory	The Civil Contingencies Act 2004, Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005, NHS Act 2006 and Health and Care Act 2022 underpin EPPR with the healthcare sector. The NHS Standard Contract Service Conditions (SC30) require providers of NHS-funded services to comply with the NHS EPPR Framework and other NHS England guidance	
Equality, Diversity & Inclusion	There are no specific EDI implications arising from this report	
Co-production & Partnership	There are no specific co-production and partnership implications arising from this report	

Executive Summary
We have previously report on the outcome of the Trusts Self-Assessment against the NHS England EPPR Core Standards for 2025 (Finance and Performance Committee September 2025 and Board of Directors October 2025). At that time we reported that we were awaiting the formal outcome of the NHS Dorset 'Confirm and Challenge' process of our self-assessment that took place on 10 September 2025. The formal outcome of the 'DCH EPPR Core Standards Assurance Confirm and Challenge Process' has been received and is appended to this report. The outcome of this assessment is that the Trust has been assessed as 'Fully Compliance' against all 62 standards that apply to acute providers.

Recommendation
Members are requested to: Receive assurance on the EPPR arrangements in place and note the assurance received via the ICB EPPR Core Standards Assurance Confirm and Challenge Process



To: Adam Savin (Director of Operational Planning and Performance & Deputy Accountable Emergency Officer)
Copy: Ian Kilroy (Head of EPRR & Security)

Sent by email

Dean Spencer
ICB AEO
County Hall,
Colliton Park,
Dorchester,
Dorset
DT1 1XJ
Tel: 07770657679
Email: Dean.spencer@nhsdorset.nhs.uk

27 October 2025

Dear Adam,

Dorset County Hospital Emergency Preparedness, Resilience and Response (EPRR) core standard assurance confirm and challenge outcome.

Many thanks for preparing the self-assessment, supporting evidence and your engagement at the EPRR assurance review meeting held on 10th September 2025. This letter summarises the outcomes from the meeting, capturing agreed actions and points from our discussions.

Outcome from the 2025 EPRR Core Standards review

This year a full assurance process took place. The table below summarises the outcomes of the assurance review and provides the overall compliance rating. A Deep Dive review was not undertaken in 2025.

Please select type of organisation:				
Acute Providers				
Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	11	0	0
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	7	7	0	0
Warning and informing	4	4	0	0
Cooperation	4	4	0	0
Business Continuity	10	10	0	0
Hazmat/CBRN	12	12	0	0
CBRN Support to acute Trusts	0	0	0	0
Total	62	62	0	0

Compliance level (see annex 1 for descriptors): **Full Compliance**

Good Practice and Innovation

- 1. Demonstrated consistent engagement with the wider EPRR community. This includes the LHRP at both BMG & Executive groups and various LRF groups.
- 2. Strong evidence of learning being taken forwards from Business Continuity exercises as well from Business Continuity incidents to strengthen preparedness.
- 3. Demonstrated improvements to BCP's & 57 BIA's managed through EPRG.
- 4. Noted that EPRR Manager is attending a Business Continuity Institute training course in Oct 2025 to develop knowledge and best practice which will build capacity and skillset within DCH.
- 5. Good standard of compliance throughout the CBRN domain with SWASFT and NHS Dorset noting the strong competencies of the Emergency Department Senior Sister and Head of EPRR with respect to this during the onsite visit in August 2025

Next Steps

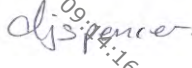
- 1. Improved resilience for the EPRR post noting that the post has joint responsibilities of EPRR and Security. The ICB noted the DCH assurance that:
 - a. conversations exploring sharing of EPRR resource between other providers are underway.
 - b. the DCH Deputy Accountable Emergency Officer intends to undertake a Diploma in Health EPRR qualification and provide a degree of resilience to the EPRR Manager role.
- 2. Continuous improvement in Business Continuity via:
 - a. Care Groups that have not evidenced updated BIAs and BCPs as of July 2025 are followed up for completion ahead of Winter.
 - b. Noting the last external audit was in 2022/23 a follow up audit takes places to ensure the recommendations identified have been implemented and further areas of good practice are noted.
 - c. Achieving continuous improvement of a Business Continuity Management System requires an organisation-wide commitment, from the board through every department. Work is underway to encourage greater engagement.

The ICB will be required to present a system summary of the assurance process to the LHRP and your assistance will be required to address any specific questions or queries from members.

NHS England will produce and present a regional report to the Local Health Resilience Partnership Executive Group in November prior to submitting a Regional return to the NHS England National Team.

Finally, thanks must go to the EPRR team for their hard work over the last year, while managing other concurrent issues and incidents.

Yours Sincerely,

	
Dean Spencer	Lauren Jarrad

Chief Operating Officer Accountable Emergency Officer NHS Dorset	Head of Operations & EPRR NHS Dorset

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Annex 1: Compliance Levels

Organisational rating	Criteria
Full compliance	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial compliance	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial compliance	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non-compliance	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

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Report to	Board in Common (DHC Board)	
Date of Meeting	9 December 2025	
Report Title	DHC – Provider Capability Assessment (PCA)	
Prepared By	Jenny Horrabin Joint Director of Corporate Affairs	
Approved by Accountable Executive	Jenny Horrabin Joint Director of Corporate Affairs	
Previously Considered By	Joint Executive Management Team 14 October 2025 Confirm and challenge process with Committee Chairs w/c 13 October 2025 Extra-Ordinary Board of Directors 22 October 2025 (approved submission)	
Action Required	Approval	N
	Assurance	N
	Information	Y

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? <i>Delete as required</i>	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	Covers all risks on Board Assurance Framework across all six domains of the PCA	
Financial	No specific implications arising from the report – but one domain is Financial Performance and Oversight	
Statutory & Regulatory	Regulatory requirement to submit PCA to NHS England	
Equality, Diversity & Inclusion	No specific implications arising from the report – but content in individual domains	
Co-production & Partnership	No specific implications arising from the report – but content in individual domains	

Executive Summary
- The NHS Oversight Framework (NOF) NHS England » NHS Oversight Framework sets out how NHS England (NHSE) will use Provider Capability Assessments to determine their improvement response, enabling them to understand how capable an organisation is of improving without additional support. - On 26 August NHSE published the guidance for ‘Assessing provider capability: guidance for NHS trust boards’ NHS England » Assessing provider capability: guidance for NHS trust boards. - The focus is on provider boards’ awareness of the challenges facing their organisations, and what is needed to address them. It is intended to promote board self-awareness as well as transparency with oversight teams, providing a framework for NHSE engagement with providers. - This Board report, with the attached submission, is included today for the Part 1 Board Meeting for information (following approval at an extra-ordinary Board meeting on 22 October 2025).

Recommendation
Members are requested to: Note the Provider Capability Self-Assessment and submission to NHS England.

Provider Capability Assessment (PCA) Submission

Board Approved 22 October 2025

1. Background: Overview of the Provider Capability Assessment

- 1.1. The NHS Oversight Framework (NOF) [NHS England » NHS Oversight Framework](#) sets out how NHS England (NHSE) will use Provider Capability Assessments to determine their improvement response, enabling them to understand how capable an organisation is of improving without additional support.
- 1.2. DHC has been placed in Segment 2 and is ranked 23rd out of 61 trusts in the non-acute trust category [NHS England » Non-acute hospital trust league table](#).
- 1.3. On 26 August NHSE published the guidance for 'Assessing provider capability: guidance for NHS trust boards' [NHS England » Assessing provider capability: guidance for NHS trust boards](#).
- 1.4. The focus is on provider boards' awareness of the challenges facing their organisations, and what is needed to address them. It is intended to promote board self-awareness as well as transparency with oversight teams, providing a framework for NHSE engagement with providers.
- 1.5. The boards will be required to self-assess annually against the six oversight domains set out in The Insightful Provider Board [NHS England » The insightful provider board](#).
 - Strategy, leadership and planning
 - Quality of care
 - People and culture
 - Access and delivery of services
 - Productivity and value for money
 - Financial performance and oversight
- 1.6. Each trust board is required to confirm for each domain that they are satisfied in respect of a number of supporting statements in each domain. There are three possible conclusions for each Domain:
 - Confirmed
 - Partially confirmed
 - Not met
- 1.7. NHSE will triangulate the board self-assessment with third party information to determine which of four capability ratings to allocate: green, green-amber, amber-red, or red. Green denotes high confidence in management. Amber-red and red ratings indicate possible and likely breaches of the provider licence, respectively.
- 1.8. The Board Development session on 2 September 2025 provided an overview of the PCA and the assessment process.

2. Overview of DCH Review Process and Submission

- 2.1. This report seeks approval for the submission of the Provider Capability Assessment (PCA) to NHS England, due on 22 October 2025.
- 2.2. This Board report will be provided with the submission as a supporting narrative (in addition to the required evidence and the submission template included at Appendix A) for each domain to more fully demonstrate how we have reached the conclusion and the board awareness of the challenges. This is detailed in Section 3 of this report.

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Overview of the submission (full template at Appendix A)

Domain	Response
Strategy, leadership and planning	Confirmed
Quality of care	Confirmed
People and culture	Confirmed
Access and delivery of services	Confirmed
Productivity and value for money	Confirmed
Financial performance and oversight	Confirmed

- 2.3 There has been a robust process to build our overall conclusions:
- Each domain has been aligned to a Committee of the Board (see table below)
 - Sign off of domain response by executive leads
 - Review at Joint Executive Management Team to confirm conclusions on 14 October 2025
 - Sharing of detailed narrative against each domain and statement with Committee Chairs and 'Confirm and Challenge' meetings held with Leads and Committee Chairs during w/c 13 October 2025. This will enable assurance to be provided by Committee Chairs to the Board to support approval.

- 2.4 Going forwards, we plan to use this self-assessment framework to support our ongoing in year review and to use it as a development tool for the Committees and the Board to identify areas of focus. It will also inform the future annual submission process and provide a mechanism for identifying any in year changes. The aligned Committees are set out in the table below:

Domain	Committee
Strategy, leadership and planning	Strategy Transformation and Partnerships Committee
Quality of care	Quality Committee
People and culture	People and Culture Committee
Access and delivery of services	Finance and Performance Committee
Productivity and value for money	Finance and Performance Committee
Financial performance and oversight	Finance and Performance Committee

3. DCH Submission and rationale for conclusions

- 3.1 This section provides the supporting narrative and conclusions for each of the six domains. Appendix A is the submission document (using the NHSE template). We are required to submit an 'evidence locator' which references specific documents and pages etc. This is not included with this report – but we have listed the evidence we will submit in this section of the report. The detailed narrative to support the overall summary narrative has been reviewed by Committee Chairs as part of a 'confirm and challenge' process, with some amendments and updates made to the narrative and evidence list as part of these discussions.

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Domian 1: Strategy, Leadership and Planning

Domain	Strategy, Leadership and Planning
Supporting Statements	- The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners. - The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHS England. - The board has the skills, capacity and experience to lead the organisation. - The trust is working effectively and collaboratively with its system partners and NHS trust collaborative for the overall good of the system(s) and population served.
Committee Alignment	Strategy, Transformation and Partnership Committee
Confirm and Challenge	15 October 2025, David Clayton Smith, Chair
Conclusion	Confirmed
Supporting narrative	Dorset County Hospital NHS Foundation Trust (DCH) and Dorset HealthCare University NHS Foundation Trust (DHC) have been working as a Federation since 2022, with Joint Chair, CEO and Executives and NEDS, in addition to individual Trust Execs and NEDS to ensure we maintain organisational focus whilst working collaboratively. We engaged in an externally facilitated joint Board Development Programme to build trust and collaborative relationships which has provided a strong foundation for our federated working and have enabled us to accelerate the implementation of our shared governance structure with Committees and Boards meeting as 'in common'. In 2024 we published a Joint Strategy across DCH and DHC – 'Healthier Lives, Empowered Citizens, Thriving Communities' with objectives focussed on Care; Communities; Colleagues and; Sustainability. The strategy was developed to align with the ambitions of the Dorset's Integrated Care System (ICS) Joint Forward Plan. It also aligns with Dorset Integrated Care Partnership Strategy and the objectives of the 10 Year Plan. This ensures the Trust is positively contributing to the health and wellbeing of the Dorset population, with a strong focus on population health and partnership working. The strategy is supported by enabling plans that show clear priorities and plans. We have financial plans in place that are triangulated and consolidated across Dorset (including other providers and the ICB). Regular briefings are provided to the Board on the financial plans through formal reporting (Committee and Board) and regular scheduled briefings. The Trust is compliant with licence conditions and is not currently under any regulatory instruments. This is reported through the Audit Committee and to Board annually. This includes compliance with the NHS Provider Licence, NHS Code of Governance and our annual Committee and Board Effectiveness reviews. This is also reported in the Annual Governance Statement. Any in year changes would be reported to the Board. We do not have any Board vacancies - with a conscious decisions made where posts not recruited to in place in the context of federated working across DCH and DHC. Executive portfolios are clearly defined, and we have in place a skills matrix

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	for Non-Executive Directors. Our Annual Governance Statement and review of the NHS Code of Governance confirms our review of board capability and capacity. DCH, DHC and University Hospitals Dorset NHS Foundation Trust (UHD) have been working collaboratively and whilst we recognise there is more to do we have significant examples of the benefits derived from working collaboratively with system partners, including the Dorset GP Alliance representing primary care. • In 2022 we established the Our Dorset Provider Collaborative (ODPC) as the collective vehicle for joint working and collective decision making, enabling us to work collaboratively with a shared purpose at scale. Significant examples of the benefits include: Future Care programme; single EHR, Integrated Neighbourhood Teams (where we are leading a significant part of the change work within the system). • We have a 'Strategy, Transformation and Partnership Committee' and representatives from the Dorset GP Alliance and Dorset Mental Health Forum, as co-opted members of this Committee, bring a valuable insight to the work of this Committee and demonstrate our commitment to working collaboratively with system partners. • Our digital plans are aligned across Dorset with a Dorset wide Chief Digital Officer in post and the development of a Dorset Digital Strategy is well advance (due November 2025) and we are well progressed in the process for procuring a Dorset and Somerset wide Electronic Health Record (EHR). • We have submitted an Expression of Interest as three Dorset providers (DHC, DCH and UHD) to participate in an NHSE Board Development programme (outcome awaited). • We hold regular Board to Board meetings with system partners, with the most recent in September 2025 including the Dorset GP Alliance. As a system we are seeking a strategic partner to undertake a clinical services review across Dorset. This was initiated by the Dorset providers and has been supported and shaped by NHS Dorset ICB and the Southwest NHS England regional team. This demonstrates our shared commitment to finding a sustainable clinical services model for Dorset.
Evidence	• Joint Strategy • Enabling Plans • Governance Report to Board (including compliance with the NHS Provider Licence and NHS Code of Governance and annual Committee and Board effectiveness review) • Our Dorset Provider Collaborative Terms of Reference • Digital Strategy Development Report • NHSE Board Development Programme Expression of Interest • Annual Report (including Annual Governance Statement) • Board and Executive Director structure and portfolios • Committee in Common Terms of Reference • Board in Common Report • Clinical Services Review Terms of Reference • Board to Board to Board Agenda March 25 and September 25 <i>Note – Financial Plans included as evidence under the Financial Performance and Oversight Domain</i>

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Domain 2: Quality of care

Domain	Quality of care
Supporting Statements	- Having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients. - Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board.
Committee Alignment	Quality Committee
Confirm and Challenge	16 October 2025, Eiri Jones, NED and Deputy Chair
Conclusion	Confirmed
Supporting narrative	There is clear quality governance framework in place with clear allocation of roles and responsibilities. As we have developed our federation across DCH and DHC we have reviewed and updated our practices to reflect shared learning and our commitment to continuous improvement. These will continue to be reviewed as part of federated working across DCH and DHC with joint governance where it adds value and provides opportunity to share learning. From April 2025 we have had a Committee in Common across DCH and DHC. There is an annual workplan in place that is aligned to the Committee Terms of Reference. The Quality Committee receive reports on a bi-monthly basis with data covering the period up to the end of the previous month before meeting. Alignment of corporate quality related risks occurs through the triangulation of reports, risks and discussions between corresponding committees including formal requests to undertake action. Incident reporting, themes and trends are monitored and reported via Quality Reports to the Quality Committee. The Risk Management Strategy and the Patient Safety Incident Response Policy outline the requirements for high level reporting, low level harm. This is operationalised through Patient Safety Incident Response Framework (PSIRF) and Patient Safety Incident Response Plan (PSIRP) and evidenced through monitoring the levels of reporting, thematic reviews, safety huddles and the promotion and assertion of learning opportunities. It recognised by the Board that the quality of care is a collective responsibility. Whilst there is a Quality Committee in place to ensure the required level of scrutiny of this agenda there is a golden thread across all Committees and through to Board. This is well evidenced through Board level discussions and the referral of matters across Committees. In response to national incidents and enquiries we have undertaken significant learning exercises and reported the outcomes of these to the Quality Committee and to Board through our assurance reports. This has included: - Learning from multiple reviews into the Greater Manchester MH trust (2023 reports into failures in oversight, assurance and governance) - Learning from and improvements around provision of community mental health services for adults (including assertive outreach services) - following the findings of the review into Nottinghamshire Healthcare FT

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The Trust has established quality assurance processes, results from which are regularly fed back through the robust governance structures. In the last two years, a concerted effort has been to further strengthen these processes. This has included:

- establishment of self-assessment processes and tools where the services have been mapping themselves against all CQC fundamental standards.
- formalisation of tiered approach to quality assurance, which has culminated in development and agreement of the Quality Assurance Framework for the Trust. It has established 3 tiers of assurance.
- ongoing preparation and then compliance checks around compliance with CQC standards as well as Mental Health Act.
- strengthening organisational approaches to concerns around patient safety and clinical practice with structured action planning and oversight arrangements.
- continued learning from patient safety events as well as any coronial processes, including improvements in response to Regulation 28, and their sustainability over time (assessed via both internal as well as external levels of assurance).

As continued development of these arrangements, a specific programme of work began in 2025 to establish and formalise all three tiers of the quality assurance, starting from Tier 1 and development of the peer-led Ward Accreditation Framework (for inpatient services) and the Peer Review Framework (for community services), which is currently in the testing phase and is expected to be launched in March 2026. This will enable Board reporting on the level of compliance, whilst also creating multiple improvement opportunities for the services involved.

As part of the Trust's Patient Safety Incident Response Plan (PSIRP) for the current year, a Patient Safety Incident Investigation (PSII) on organisational learning is being undertaken. We are piloting a centralised approach to horizon scanning and seeking opportunities for improvements as well as creating database of organisational improvement (to enable triangulation and oversight).

A Joint Health Inequalities Committee has been established with demographic data analysis using DiiS used to inform our population health focus and areas for improvement. A local Health Inequalities dashboard has been established and will be used routinely to support delivery of the Health Inequalities Improvement Plan (currently draft).

We recognise there is more to do in terms of our quantitative information and use of benchmarking and also in terms of reporting on variation of care for those with protected characteristics and this will be our focus in the coming year.

We have adopted the National Quality Board Equality and Quality Impact Assessment (EQIA) template for all transformation and cost improvement programmes. We have in place an EQIA panel and clear routes of reporting to Quality Committee. Work continues to ensure there is ongoing oversight of impact.

We have been developing a Joint Improvement Framework as part of the federation to support continuous improvement in line with NHS Impact.

The Board Development Programme has a strong focus on quality of care - in 25/26 areas covered include Patient Safety Incident Response Plan, Children and

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	Young People (co-produced and delivered with young people with lived experience) and Risk Management. In the current challenging climate, whilst we believe we have a strong focus on quality we are aware of challenges ahead and remain committed to continuous improvement as the foundation of how we work.
Evidence	Annual Report (including Annual Governance Statement) Quality Account and Quality Priorities CQC Reports Internal Audit review of Divisional Governance – Scope Committee Terms of Reference Quality Committee Workplan Quality Governance Structure Board Development Plan Patient Safety Incident Response Plan Integrated Performance Report Senior Leadership Walkarounds Report Infection Prevention and Control Annual Report Safeguarding Children and Adults Annual Report Trust response to Greater Manchester Report Trust response to Nottingham Report Health Inequalities Report Equality and Quality Impact Assessment Report

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Domain 3 People and Culture

Domain	People and Culture
Supporting Statements	- Staff feedback is used to improve the quality of care provided by the trust. - Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels. - Staff can express concerns in an open and constructive environment.
Committee Alignment	People and Culture Committee
Confirm and Challenge	14 October 2025, Frances West, NED and Deputy Chair
Conclusion	Confirmed
Supporting narrative	We have strong strategies, plans and reporting in place to demonstrate how we engage with and listen to our staff. This is through formal reporting processes and through our approach to co-production. The People and Culture Committee, reporting directly to Board, ensures that we prioritise staff feedback and experience at the highest level of our organisation with clear triangulation through to the quality of care. This is presented to Board in the Integrated Corporate Dashboard where people metrics are triangulated alongside quality, operational performance and financial metrics. The People & Culture Committee has oversight of the action plans for the Joint Inclusion and Belonging Strategy, the Joint Workforce Wellbeing Strategy and the overall Joint People Enabling Plan and Delivery Framework. The Joint People Enabling Plan and Delivery Framework underpins the delivery of our Joint Strategy and set out how the actions have been determined in response to staff feedback, wider engagement and our overall workforce performance indicators. The Joint Strategy and all of the strategy Enabling Plans have been developed following substantial engagement with wider staff groups and colleagues. A Joint Culture and Belonging Reference Group has recently been established. This is chaired by the CEO with Executive Directors members alongside the Chairs of the Staff Networks, Staff Governors and Staff Side representatives, to bring together the diverse voices and experiences of our staff via their representatives and peers. Part of the Groups role is to monitor progress against our Joint Equality and Inclusion Strategy, as well as review our staff survey insights. This Group reports through to the People and Culture Committee. Our Workforce Race Equality Standard and Workforce Disability Standard Reports and Action Plans are presented to Board and these, alongside the Patient and Carer Race Equality Framework (PCREF), tell us that there is more to do to become an anti-racist organisation. The Board has identified this as a priority area in the second part of the year with a Board Development session to be held in November 20225 to give this the required level of focus. Our senior leaders are engaged in this work from a multi-disciplinary perspective to ensure that we achieve the breadth required. Acting on staff feedback and experience is integral to business-as-usual management and leadership practice. A core component of this is routine co-production with staff and their involvement in service improvements and

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	transformation, for example Access to Wellbeing and Children and Young People business cases. Ongoing service improvement is actively encouraged based on staff experience. Service improvements and transformations are routinely reported to the Strategy, Transformation and Partnerships Committee. The Board receives a report on the annual NHS Staff Survey results and resultant actions. In 2024/25 we undertook a significant programme of activity funded by NHS England in relation to the NHS People Promise exemplar programme, founded in significant staff feedback and engagement. We have in place a dedicated Freedom to Speak Up (FTSU) Guardian and NED Champion for 'speaking up'. When staff speak up, whether through FTSU Guardian or any route to raise concerns, dedicated improvement action plans are put together in response when needed. The Quality Committee and Board receive a bi-annual report from the FTSU Guardian. A report was provided to the Audit Committee in March 2025 to provide assurance on our overall governance arrangements for speaking up. Safer Staffing Reports are presented to the Board, including a mid-year review. In addition a report on Developing Workforce Safeguards is presented to the Board annually and our arrangements are also detailed in the Annual Governance Statement each year.
Evidence	Committee Terms of Reference People and Culture Committee Workplan Joint People Enabling Plan and Delivery Framework Joint Inclusion and Belonging Strategy Joint Inclusion and Belonging Reference Group Terms of Reference Annual Staff Survey 2024 Workforce Race Equality Standard and Workforce Disability Standard Reports and Action Plans Patient Carer Race Equality Framework (PCREF) NHS People Promise Exemplar Programme Report Freedom to Speak Up Bi-annual Report Report on Speaking Up Governance to Audit Committee Mid-Year Safer Staffing Report Developing Workforce Safeguards Report and Annual Governance Statement Access to Wellbeing Business Case

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Domain 4 Access and Delivery of Services

Domain	Access and delivery of services
Supporting Statements	- Plans are in place to improve performance against the relevant access and waiting times standards. - The trust can identify and address inequalities in access/waiting times to NHS services across its patients. - Appropriate population health targets have been agreed with the integrated care board.
Committee Alignment	Finance and Performance Committee
Confirm and Challenge	16 October 2025, Dave Underwood, NED
Conclusion	Confirmed
Supporting narrative	Whilst we are performing well against some of the national standards we are below thresholds in some areas. Where this is the case there is a clear understanding of the underlying issues and improvement plans and/or agreed recovery trajectories are in place - working closely with the ICB to agree these. We work closely with system partners to develop our work on population health and addressing unwarranted variation in access and delivery of services We have clear reporting in place against access and waiting times standards for services are available down to individual locality team level with live data. Monthly performance reports monitored at service level at Directorate Management Groups. Whilst we are performing well against some of the national standards, we are below thresholds in some areas. As at September 2025 the position for the planning guidance metrics is as follow: - Reduce Average length of Stay (ALOS) for adult acute Mental health (MH) beds - threshold set agreed as part of the operational planning with the ICB at ALOS not to exceed 83 days and we are on target to achieve this – however the national metrics have been set at a maximum of 60 days and we are developing a plan to achieve this through the local improvement network and we will report this through to Finance and Performance Committee in November 2025. - Increase Children and Young people (CYP) accessing MH services - current performance is 7360 contacts against target of 8137 contacts. Year to date the performance has not been achieved as we are awaiting transformation investment to be agreed. This has now been agreed in July 25 and mobilisation plans are underway. The current forecast is that the target would be missed by c.250 contacts at year end due to the time left available for mobilisation – a recovery plan is to be developed if this remains the case by the start of Q4. This will be shared with NHSE as part of regional oversight processes. - Deliver 10% reduction in reliance on MH inpatient care for people with Learning Disabilities or autism - this metric is manually reported by the ICB. The operational plan trajectory was to have 19 patients in Q2. Current performance as at August 25 is reported as 35 people. However, there are significant data quality issues with the information and a service improvement project has been commenced by the ICB to improve data quality.

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	Where below thresholds there is a clear understanding of the underlying issues and improvement plans and/or agreed recovery trajectories are in place or in development (as noted above) - working closely with the ICB to agree these. Overall performance reports to Finance and Performance committee and metrics of concern are routinely included by exception in the Performance Report (with exceptions identified via SPC chart methodology) with accompanying narrative provided on anticipated recovery plan. Plans to deliver improvement will vary according to service line but will either include wait list initiative, data validation exercises, transformation programmes, service reconfigurations. Where recovery is not possible within these, issues are escalated into the formal contracts meeting with commissioners. We work closely with system partners to develop our work on population health and addressing unwarranted variation in access and delivery of services
Evidence	Finance and Performance Committee Assurance Report to Board Integrated Corporate Dashboard Report on development of Integrated Performance Report to Finance and Performance Committee Deep Dive into performance at Finance and Performance Committee June 25 Access to Wellbeing Business Case

Domain 5 Productivity and Value for Money

Domain	Productivity and value for money
Supporting Statements	Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant.
Committee Alignment	Finance and Performance Committee
Confirm and Challenge	16 October 2025, Dave Underwood, NED
Conclusion	Confirmed
Supporting narrative	We have mapped the current Integrated Corporate Dashboard that is reported to Board against both the Performance Assessment Framework and the Insightful Board Guidance to ensure the board is sighted on the key metrics. A report on this work was presented to the September 2025 Finance and Performance Committee. The Trust has previously engaged in NHS benchmarking reviews with access to performance data for peers for comparison and learning purposes - this has paused in 2025 due to costs associated with membership however is likely to resume 2026. During 2025, targeted benchmarking has taken place as part of the system wide 'Future Care' programme which has appointed strategic partner Newton including benchmarking against national average and similar areas for Urgent and Emergency Care (UEC) flow. This has included deep dive sessions with other similar systems to consider areas of best practice and learning. In addition, in respect of productivity, the NHSE data dashboard is regularly used to compare

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	performance with similar regions as well as the specific Southwest benchmarking reports for Mental Health that are issued. The Trust is fully engaged in three Local Improvement Networks (UEC, elective and MH) to further our improvement work on productivity learning from other areas. We have worked with NHSE on the productivity packs issued to community MH Trusts at the start of 25/26 to help understand and improve some of the data metrics that were included for development. The feedback received was that the work of the DHC Business Intelligence team was exceptional in this area to improve the quality of the data flow. DHC has also offered to be a host organisation looking at productivity in MH with the current NHSE work on this - awaiting confirmation if selected. All transformation programmes include specific demand and capacity and productivity modelling to help improve the performance management of services. This has been completed for all adult community MH teams, inpatient and crisis services, MH Rehab Teams and CAMHS. This work is ongoing for community services through the Future Care programme (P2 beds) and the neighbourhood work for community teams. As an example, the Access to wellbeing business case included demand and capacity modelling for a productive community mental health model. This was presented to the Board. This provided a blueprint for our approach which is currently being mobilised.
Evidence	Future Care update P2 Board Aug 25 Future Care Early Diagnostic Deep Dive into performance at Finance and Performance Committee June 25 Access to Wellbeing Business Case

Domain 6 Financial performance and oversight

Domain	Financial performance and oversight
Supporting Statements	- The trust has a robust financial governance framework and appropriate contract management arrangements. - Financial risk is managed effectively and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes. - The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn.
Committee Alignment	Finance and Performance Committee
Confirm and Challenge	16 October 2025, Dave Underwood, NED
Conclusion	Confirmed
Supporting narrative	We have in place robust financial governance arrangements and our Board maintain a strong focus on ensuring that financial considerations do not adversely affect patient care and outcomes, and this is evidenced through our Board

discussions and the Equality and Quality Impact Assessment (EQIA) process. We recognise that there is more to do to embed our EQIA process and triangulate the reporting of this through the Quality Committee to ensure the required assurance is provided to the Finance and Performance Committee.

To provide additional insight and assurance we commissioned an independent review. This was reported to the Board (and shared with the ICB and NHSE).

- DCH and DHC Diagnostics and Deliverability Review for 25/26 (Financial Plan and CIP Delivery) (undertaken by David Moon and Mark Mansfield)

The Diagnostics and Deliverability Review provided assurance on the arrangements in place and the efficiency plans and provided recommendations to strengthen this to achieve the required pace of delivery. We have acted on this by establishing a Financial Recovery Board that meets on a fortnightly basis to ensure we have the required grip and pace in respect of our delivery. This will be observed by the NED Chair of the Finance and Performance Committee to enable further assurance to be provided to Board.

We have also recently appointed a Financial Delivery Director to ensure we maintain the required level of grip and pace as we progress into the second half of the year. The Financial Delivery Director will also be involved from the outset in our planning for 26/27 and the development of robust efficiency plans. Recruiting an individual to this role with the required skills and experience took longer than anticipated but we are confident that now this individual is in post the impact will be immediate.

As part of our ongoing focus on grip and control we have completed a detailed and robust review of our financial controls using the NHSE recommended best practice 'Grip and Control' templates. This has been shared with the ICB and NHSE and is an iterative process. Oversight of this is within the scope of the Financial Recovery Board.

We have financial plans in place that are triangulated and consolidated across Dorset (including other providers and the ICB). Regular briefings are provided to the Board on the financial plans through formal reporting (Committee and Board) and regular scheduled briefings.

Over the past three years the trust has supported the system position financially (£14.5m in 2024/25) in addition to the delivery of planned savings. For this year, we agreed a very challenging plan that set as an objective the achievement of a surplus of £9.8 million and in year savings of 8.7% of our operating budget. Achieving this plan was predicated on establishing a wholly owned subsidiary for estates and facilities and assumptions relating to this were built in at the early stage. In addition, there were a number of system transformation projects that had not been determined as we started the financial year, although the core of our plan was well developed. In response to this position we have worked with external advisors and revised our programme and a system agreement is in the process of being reached to enable all three Dorset providers to achieve the planned position for 25/26. The Trust and Dorset system are working with NHSE in relation to agreeing an acceptable H2 plan.

We work closely with system partners including Dorset providers, Dorset ICB and the Southwest NHSE regional team on our financial plans. As a Board we

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	recognise the scale of the financial challenge and reporting of this to the Board is transparent and timely.
Evidence	Annual Head of Internal Audit Opinion - summarised in Annual Governance Statement (link) Audit Committee March 2025 - 25/26 internal audit plan (doc) Audit Committee August 2025 – Budgetary Controls Report (doc) Finance Report to Board P1 Board Oct 25 Quality Impact Assessment Report to Quality Committee June, July and September 2025 Finance Report to Board - P1 Board June 25, Aug 25, Oct 25 (link) DCH and DHC Diagnostics and Deliverability Review for 25/26 (Financial Plan and CIP Delivery) (undertaken by David Moon and Mark Mansfield) Finance and Operational Plan 25/26 P2 Board April 2025 Finance and Operational Plan 25/26 P1 Board June 2025

4. Appendices

Appendix A Self-Assessment Submission

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Appendix A: DHC Provider Capability Assessment Submission

Provider Capability - Self-Assessment Template - Dorset HealthCare University NHS Foundation Trust

	The Board is satisfied that...		(Mitigating/contextual factors where boards cannot confirm or where further information is helpful)
Strategy, leadership and planning	- The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners - The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE - The board has the skills, capacity and experience to lead the organisation - The trust is working effectively and collaboratively with its system partners and provider collaborative for the overall good of the system(s) and population served	Confirmed	If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:
Quality of care	- Having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients - Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	Confirmed	If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:
People and Culture	- Staff feedback is used to improve the quality of care provided by the trust - Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels - Staff can express concerns in an open and constructive environment	Confirmed	If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:
Access and delivery of services	- Plans are in place to improve performance against the relevant access and waiting times standards - The trust can identify and address inequalities in access/waiting times to NHS services across its patients - Appropriate population health targets have been agreed with the ICB	Confirmed	If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:
Productivity and value for money	Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	Confirmed	If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:
Financial performance and oversight	- The trust has a robust financial governance framework and appropriate contract management arrangements - Financial risk is managed effectively and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes - The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outcome	Confirmed	If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:
	In addition, the board confirms that it has not received any relevant third-party information contradicting or undermining the information underpinning the disclosures above.	Confirmed	If the Board cannot make this certification, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:

Signed on behalf of the board of directors

Signature

Name

David Clayton-Smith, Chair Dorset healthCare University NHS Foundation Trust and Dorset County NHS Foundation Trust

Date

22 October 2025

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Report to	Board in Common (DCH Board)	
Date of Meeting	9 December 2025	
Report Title	DCH – Provider Capability Assessment (PCA)	
Prepared By	Jenny Horrabin Joint Director of Corporate Affairs	
Approved by Accountable Executive	Jenny Horrabin Joint Director of Corporate Affairs	
Previously Considered By	Joint Executive Management Team 14 October 2025 Confirm and challenge process with Committee Chairs w/c 13 October 2025 Extra-Ordinary Board of Directors 22 October 2025 (approved submission)	
Action Required	Approval	N
	Assurance	N
	Information	Y

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? <i>Delete as required</i>	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	Covers all risks on Board Assurance Framework across all six domains of the PCA	
Financial	No specific implications arising from the report – but one domain is Financial Performance and Oversight	
Statutory & Regulatory	Regulatory requirement to submit PCA to NHS England	
Equality, Diversity & Inclusion	No specific implications arising from the report – but content in individual domains	
Co-production & Partnership	No specific implications arising from the report – but content in individual domains	

Executive Summary
- The NHS Oversight Framework (NOF) NHS England » NHS Oversight Framework sets out how NHS England (NHSE) will use Provider Capability Assessments to determine their improvement response, enabling them to understand how capable an organisation is of improving without additional support. - On 26 August NHSE published the guidance for ‘Assessing provider capability: guidance for NHS trust boards’ NHS England » Assessing provider capability: guidance for NHS trust boards. - The focus is on provider boards’ awareness of the challenges facing their organisations, and what is needed to address them. It is intended to promote board self-awareness as well as transparency with oversight teams, providing a framework for NHSE engagement with providers. - This Board report, with the attached submission, is included today for the Part 1 Board Meeting for information (following approval at an extra-ordinary Board meeting on 22 October 2025).

Recommendation
Members are requested to: Note the Provider Capability Self-Assessment and submission to NHS England.

Provider Capability Assessment Submission

Board Confirmed 22 October 2025

1. Background: Overview of the Provider Capability Assessment

- 1.1. The NHS Oversight Framework (NOF) [NHS England » NHS Oversight Framework](#) sets out how NHS England (NHSE) will use Provider Capability Assessments to determine their improvement response, enabling them to understand how capable an organisation is of improving without additional support.
- 1.2. DCH has been placed in Segment 3. This is primarily driven by the 'financial overdue' whereby Trusts with a financial deficit cannot be placed higher than segment 3. In the league tables the trust is ranked 48 out of 134 acute trusts nationally. [NHS England » Acute trust league table](#)
- 1.3. On 26 August NHSE published the guidance for 'Assessing provider capability: guidance for NHS trust boards' [NHS England » Assessing provider capability: guidance for NHS trust boards](#).
- 1.4. The focus is on provider boards' awareness of the challenges facing their organisations, and what is needed to address them. It is intended to promote board self-awareness as well as transparency with oversight teams, providing a framework for NHSE engagement with providers.
- 1.5. The boards will be required to self-assess annually against the six oversight domains set out in The Insightful Provider Board [NHS England » The insightful provider board](#).
 - Strategy, leadership and planning
 - Quality of care
 - People and culture
 - Access and delivery of services
 - Productivity and value for money
 - Financial performance and oversight
- 1.6. Each trust board is required to confirm for each domain that they are satisfied in respect of a number of supporting statements in each domain. There are three possible conclusions for each Domain:
 - Confirmed
 - Partially confirmed
 - Not met
- 1.7. NHSE will triangulate the board self-assessment with third party information to determine which of four capability ratings to allocate: green, green-amber, amber-red, or red. Green denotes high confidence in management. Amber-red and red ratings indicate possible and likely breaches of the provider licence, respectively.
- 1.8. The Board Development session on 2 September 2025 provided an overview of the PCA and the assessment process.

2. Overview of DCH Review Process and Submission

- 2.1 This report seeks approval for the submission of the Provider Capability Assessment (PCA) to NHS England, due on 22 October 2025.
- 2.2 This Board report will be provided with the submission as a supporting narrative (in addition to the required evidence and the submission template included at Appendix A) for each domain to more fully demonstrate how we have reached the conclusion and the board awareness of the challenges. This is detailed in Section 3 of this report.

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Overview of the submission (full template at Appendix A)

Domain	Response
Strategy, Leadership and Planning	Confirmed
Quality of care	Confirmed
People and Culture	Confirmed
Access and Delivery of Services	Confirmed
Productivity and Value for Money	Partially Confirmed
Financial performance and oversight	Partially Confirmed

- 2.3 There has been a robust process to build our overall conclusions:
- Each domain has been aligned to a Committee of the Board (see table below)
 - Sign off of domain response by executive leads
 - Review at Joint Executive Management Team to confirm conclusions on 14 October 2025
 - Sharing of detailed narrative against each domain and statement with Committee Chairs and 'Confirm and Challenge' meetings held with Leads and Committee Chairs during w/c 13 October 2025. This will enable assurance to be provided by Committee Chairs to the Board to support approval.

- 2.4 Going forwards, we plan to use this self-assessment framework to support our ongoing in year review and to use it as a development tool for the Committees and the Board to identify areas of focus. It will also inform the future annual submission process and provide a mechanism for identifying any in year changes. The aligned Committees are set out in the table below:

Domain	Committee
Strategy, leadership and planning	Strategy Transformation and Partnerships Committee
Quality of care	Quality Committee
People and culture	People and Culture Committee
Access and delivery of services	Finance and Performance Committee
Productivity and value for money	Finance and Performance Committee
Financial performance and oversight	Finance and Performance Committee

3. DCH Submission and rationale for conclusions

- 3.1 This section provides the supporting narrative and conclusions for each of the six domains. Appendix A is the submission document (using the NHSE template). We are required to submit an 'evidence locator' which references specific documents and pages etc. This is not included with this report – but we have listed the evidence we will submit in this section of the report. The detailed narrative to support the overall summary narrative has been reviewed by Committee Chairs as part of a 'confirm and challenge' process, with some amendments and updates made to the narrative and evidence list as part of these discussions.

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Domian 1: Strategy, Leadership and Planning

Domain	Strategy, Leadership and Planning
Supporting Statements	- The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners. - The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHS England. - The board has the skills, capacity and experience to lead the organisation. - The trust is working effectively and collaboratively with its system partners and NHS trust collaborative for the overall good of the system(s) and population served.
Committee Alignment	Strategy, Transformation and Partnership Committee
Confirm and Challenge	15 October 2025, David Clayton Smith, Chair
Conclusion	Confirmed
Supporting narrative	Dorset County Hospital NHS Foundation Trust (DCH) and Dorset HealthCare University NHS Foundation Trust (DHC) have been working as a Federation since 2022, with Joint Chair, CEO and Executives and NEDS, in addition to individual Trust Execs and NEDS, to ensure we maintain organisational focus whilst working collaboratively. We engaged in an externally facilitated joint Board Development Programme to build trust and collaborative relationships which has provided a strong foundation for our federated working and have enabled us to accelerate the implementation of our shared governance structure with Committees and Boards meeting as 'in common'. In 2024 we published a Joint Strategy across DCH and DHC – 'Healthier Lives, Empowered Citizens, Thriving Communities' with objectives focussed on Care; Communities; Colleagues and; Sustainability. The strategy was developed to align with the ambitions of the Dorset's Integrated Care System (ICS) Joint Forward Plan. It also aligns with Dorset Integrated Care Partnership Strategy and the objectives of the 10 Year Plan. This ensures the Trust is positively contributing to the health and wellbeing of the Dorset population, with a strong focus on population health and partnership working. The strategy is supported by enabling plans that show clear priorities and plans. We have financial plans in place that are triangulated and consolidated across Dorset (including other providers and the ICB). Regular briefings are provided to the Board on the financial plans through formal reporting (Committee and Board) and regular scheduled briefings. The Trust is compliant with licence conditions and is not currently under any regulatory instruments. This is reported through the Audit Committee and to Board annually. This includes compliance with the NHS Provider Licence, NHS Code of Governance and our annual Committee and Board Effectiveness reviews. This is also reported in the Annual Governance Statement. Any in year changes would be reported to the Board. We do not have any Board vacancies - with a conscious decisions made where posts not recruited to or interim arrangements (Chief Medical Officer) in place in the context of federated working across DCH and DHC. Executive portfolios are clearly defined, and we have in place a skills matrix for Non-Executive Directors. Our

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	Annual Governance Statement and review of the NHS Code of Governance confirms our review of board capability and capacity. DCH, DHC and University Hospitals Dorset NHS Foundation Trust (UHD) have been working collaboratively and whilst we recognise there is more to do we have significant examples of the benefits derived from working collaboratively with system partners, including the Dorset GP Alliance. • In 2022 we established the Our Dorset Provider Collaborative (ODPC) as the collective vehicle for joint working and collective decision making, enabling us to work collaboratively with a shared purpose at scale. Significant examples of the benefits include: Future Care programme; single EHR, Integrated Neighbourhood Teams. • We have a 'Strategy, Transformation and Partnership Committee' and representatives from the Dorset GP Alliance and Dorset Mental Health Forum, are co-opted members of this Committee, bring a valuable insight to the work of this Committee and demonstrate our commitment to working collaboratively with system partners. • Our digital plans are aligned across Dorset with a Dorset wide Chief Digital Officer in post and the development of a Dorset Digital Strategy is well advance (due November 2025) and we are well progressed in process for procuring a Dorset and Somerset wide Electronic Health Record (EHR). • We have submitted an Expression of Interest as three Dorset providers (DHC, DCH and UHD) to participate in an NHSE Board Development programme (outcome awaited). • We hold regular Board to Board meetings with system partners with the most recent in September including the Dorset GP Alliance. As a system we are seeking a strategic partner to undertake a clinical services review across Dorset. This was initiated by the Dorset providers and has been supported and shaped by NHS Dorset ICB and the Southwest NHS England regional team. This demonstrates our shared commitment to finding a sustainable clinical services model for Dorset.
Evidence	• Joint Strategy • Enabling Plans • Governance Report to Board (including compliance with the NHS Provider Licence and NHS Code of Governance and annual Committee and Board effectiveness review) • Our Dorset Provider Collaborative Terms of Reference • Digital Strategy Development Report • NHSE Board Development Programme Expression of Interest • Annual Report (including Annual Governance Statement) • Board and Executive Director structure and portfolios • Committee in Common Terms of Reference • Board in Common Report • Clinical Services Review Terms of Reference • Board to Board to Board Agenda March 25 and September 25 <i>Note – Financial Plans included as evidence under the Financial Performance and Oversight Domain</i>

Domain 2: Quality of care

Domain	Quality of care
Supporting Statements	- Having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients. - Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board.
Committee Alignment	Quality Committee
Confirm and Challenge	16 October 2025, Eiri Jones, NED and Deputy Chair
Conclusion	Confirmed
Supporting narrative	There is a clear quality governance framework in place with clear allocation of roles and responsibilities, to gain independent assurance on this we have commissioned a review by our internal auditors of the effectiveness of this at divisional level. As we have developed our federation across DCH and DHC we have reviewed and updated our practices to reflect shared learning and our commitment to continuous improvement. These will continue to be reviewed as part of federated working across DCH and DHC with joint governance where it adds value to patients, population and staff and provides opportunity to share learning. From April 2025 we have had a Committee in Common across DCH and DHC. There is an annual workplan in place that is aligned to the Committee Terms of Reference. The Quality Committee receive reports on a bi-monthly basis with data covering the period up to the end of the previous month before meeting. Alignment of corporate quality priorities, related risks and the Board Assurance Framework (BAF) occurs through the triangulation of reports, risks and discussions between corresponding committees including formal requests to undertake action. It recognised by the Board that the quality of care is a collective responsibility. Whilst there is a Quality Committee in place to ensure the required level of scrutiny of this agenda there is a golden thread across all Committees and through to Board. This is well evidenced through Board level discussions and the referral of matters across Committees. Incident reporting, themes and trends are monitored and reported via our quality governance framework. The Risk Management Strategy and the Patient Safety Incident Response Policy outline the requirements for high level reporting, low level harm. This is operationalised through Patient Safety Incident Response Framework (PSIRF) and Patient Safety Incident Response Plan (PSIRP) and evidenced through monitoring the levels of reporting, thematic reviews, safety huddles and the promotion and assertion of learning opportunities. Recent CQC inspections, particularly in respect of maternity services have recognised our improvement journey. Since May 2025 our maternity services have been received patients from Somerset following the temporary closure of Yeovil District Hospital (YDH). At the same time as this increased level of activity we were inspected by the CQC (following a previous inspection in 2023 as part of the

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national review) and received a rating of 'Good'. This is testament to the significant improvements made in our maternity services over the last two years. We provide comprehensive reports on our maternity services to our Quality Committee and Board on a bi-monthly basis. Our NED lead for maternity undertakes regular walkabouts of maternity services with members of the Maternity Neo Natal Voices Partnership demonstrating our commitment to hearing experiences of care to provide added assurance and inform our improvement journey.

Experience of care is reported through bi-monthly reporting through the Experience of Care meeting. This includes regular reporting on the Friends and Family test (FFT), national surveys, HealthWatch reports, and feedback from the Your Voice Group, complaints and PALS. Patient and Lived Experience representatives are invited to a number of groups and committees and we have an established Patient Experience Council called the Your Voice Group. Patient and staff stories are heard at each meeting of the Board to set the tone and focus for the meeting.

Executive Senior Leadership Walkarounds, following the fifteen steps challenge and Institute of Health Improvement (IHI) approach, take place on a programmed and ongoing basis (comprised of Executive Directors, Senior Leaders, Non-Executive Directors and Governors). The outputs of these walkarounds are reported bi-annually to the Board.

National patients experience surveys are reported through our quality governance framework. Most recently, the Annual Inpatient Survey 2024 provided positive assurance on patient experience. The Maternity Patient Survey is not yet published and is due November 2024. We are reviewing our future reporting of all surveys related to experience of care to ensure board level oversight and in line with the Dash review.

The Trusts utilises a variety of resources and evidence-based standards including Model Health, National Surveys, National Audit, GIRFT and accreditation programmes to monitor and progress improvements in accordance with national best practice. Internal audit programmes are designed and agreed to ensure regular assessment of internal governance arrangements, with reporting to the Audit Committee.

A Joint Health Inequalities Committee has been established with demographic data analysis using DiiS used to inform our population health focus and areas for improvement. A local Health Inequalities dashboard has been established and will be used routinely to support delivery of the Health Inequalities Improvement Plan (currently draft).

We recognise there is more to do in terms of our quantitative information and use of benchmarking and also in terms of reporting on variation of care for those with protected characteristics and this will be our focus in the coming year.

We have adopted the National Quality Board Equality and Quality Impact Assessment (EQIA) template for all transformation and cost improvement programmes. We have in place an EQIA panel and clear routes of reporting to Quality Committee. Work continues to ensure there is ongoing oversight of impact and routes of report via both Finance and Performance Committee and Quality Committee through to Board.

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	We have been developing a Joint Improvement Framework as part of the federation to support continuous improvement in line with NHS Impact. The Board Development Programme has a strong focus on quality of care - in 25/26 areas covered include Patient Safety Incident Response Plan, Children and Young People (co-produced and delivered with young people with lived experience) and Risk Management. In the current challenging climate, whilst we believe we have a strong focus on quality we are aware of challenges ahead and remain committed to continuous improvement as the foundation of how we work. Whilst the detailed breakdown of indicators under the NOF placed the trust in segment 3 (below average) for the 'effectiveness and experience of care' domain segment, this was driven by the effective flow and discharge indicator with both patient experience indicators in this domain segment scored as 2 (above average).
Evidence	Annual Report (including Annual Governance Statement) Quality Account and Quality Priorities Committee Terms of Reference Quality Committee Workplan Quality Assurance Committee Reports to Board Quality Governance Structure Board Development Plan CQC Report – Maternity 2025 Maternity Report to Board Maternity Improvement Journey (doc) Annual Inpatient Survey 2024 Internal Audit review of Divisional Governance – Scope Patient Safety Incident Response Plan Integrated Performance Report Senior Leadership Walkarounds Report Infection Prevention and Control Annual Report Safeguarding Children and Adults Annual Report Trust Response to NHS England Letter – Quality and Safety in highly pressurised services Morecambe Bay Report Health Inequalities Reporting Metrics Equality and Quality Impact Assessment Report

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Domain 3: People and Culture

Domain	People and Culture
Supporting Statements	- Staff feedback is used to improve the quality of care provided by the trust. - Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels. - Staff can express concerns in an open and constructive environment.
Committee Alignment	People and Culture Committee
Confirm and Challenge	14 October 2025, Frances West, NED and Deputy Chair
Conclusion	Confirmed
Supporting narrative	We have strong strategies, plans and reporting in place to demonstrate how we engage with and listen to our staff. This is through formal reporting processes and through our approach to co-production. The People and Culture Committee, reporting directly to Board, ensures that we prioritise staff feedback and experience at the highest level of our organisation with clear triangulation through to the quality of care. This is presented to Board in the Integrated Corporate Dashboard where people metrics are triangulated alongside quality, operational performance and financial metrics. The People & Culture Committee has oversight of the action plans for the Joint Inclusion and Belonging Strategy, the Joint Workforce Wellbeing Strategy and the overall Joint People Enabling Plan and Delivery Framework. The Joint People Enabling Plan and Delivery Framework underpins the delivery of our Joint Strategy and set out how the actions have been determined in response to staff feedback, wider engagement and our overall workforce performance indicators. The Joint Strategy and all of the strategy Enabling Plans have been developed following substantial engagement with wider staff groups and colleagues. A Joint Culture and Belonging Reference Group has recently been established. This is chaired by the CEO with Executive Directors members alongside the Chairs of the Staff Networks, Staff Governors and Staff Side representatives, to bring together the diverse voices and experiences of our staff via their representatives and peers. Part of the Groups role is to monitor progress against our Joint Equality and Inclusion Strategy, as well as review our staff survey insights. This Group reports through to the People and Culture Committee. Our Workforce Race Equality Standard and Workforce Disability Standard Reports and Action Plans are presented to Board and these, alongside the Patient and Carer Race Equality Framework (PCREF), tell us that there is more to do to become an anti-racist organisation. The Board has identified this as a priority area in the second part of the year with a Board Development session to be held in November 20225 to give this the required level of focus. Our senior leaders are engaged in this work from a multi-disciplinary perspective to ensure that we achieve the breadth required. Acting on staff feedback and experience is integral to business-as-usual management and leadership practice. A core component of this is routine co-production with staff and their involvement in service improvements and

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	transformation. The development of the Stroke Business Case, the Mary Anning Improvement Plan and the ongoing Maternity improvements are examples of this were developed with input from staff. Ongoing service improvement is actively encouraged based on staff experience. Service improvements and transformations are routinely reported to the Strategy, Transformation and Partnerships Committee. The Board receives a report on the annual NHS Staff Survey results and resultant actions. In 2024/25 we undertook a significant programme of activity funded by NHS England in relation to the NHS People Promise exemplar programme; founded in significant staff feedback and engagement, outputs included an updated flexible working scheme and detailed retention data work We have in place a dedicated Freedom to Speak Up (FTSU) Guardian and NED Champion for 'speaking up'. When staff speak up, whether through FTSU Guardian or any route to raise concerns, dedicated improvement action plans are put together in response when needed. The Quality Committee and Board receive a bi-annual report from the FTSU Guardian. We undertake an annual Learning Needs Analysis which is reported to the Education Committee. A key part of the appraisal process is a career conversation to identify future learning/skills needs. Safer Staffing Reports are presented to the Board, including a mid-year review. In addition, a report on Developing Workforce Safeguards is presented annually and our arrangements are also detailed in the Annual Governance Statement each year.
Evidence	Committee Terms of Reference People and Culture Committee Workplan People and Culture Committee Assurance Reports to Board Joint People Enabling Plan and Delivery Framework Joint Inclusion and Belonging Strategy Joint Inclusion and Belonging Reference Group Terms of Reference Annual Staff Survey 2024 Workforce Race Equality Standard and Workforce Disability Standard Reports and Action Plans Stroke Business Case Mary Anning Improvement Plan NHS People Promise Exemplar Programme Report Freedom to Speak Up Bi-annual Report Report on Speaking Up Governance to Audit Committee Mid-Year Safer Staffing Report Developing Workforce Safeguards Report and Annual Governance Statement

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Domain 4: Access and Delivery of Services

Domain	Access and delivery of services
Supporting Statements	- Plans are in place to improve performance against the relevant access and waiting times standards. - The trust can identify and address inequalities in access/waiting times to NHS services across its patients. - Appropriate population health targets have been agreed with the integrated care board.
Committee Alignment	Finance and Performance Committee
Confirm and Challenge	16 October 2025, Dave Underwood, NED
Conclusion	Confirmed
Supporting narrative	Board oversight of performance is provided through the Finance and Performance Committee to Board, with a governance structure that provides ward to Board reporting. Our reporting to the Finance and Performance Committee and Board includes actions to address poor or deteriorating performance. Whilst in National Oversight Framework (NOF) 3 this is driven by the financial override and not operational performance. In the latest NOF the trust was ranked 48th out of 134 providers and under the 'Access to services' domain segment the trust was in segment 2 (above average) and is the 5th highest performing small trust nationally with the NOF assessment. As at September 25 (Q2 data) we have strong performance across all operating plan metrics. We work closely with system partners to develop our work on population health and addressing unwarranted variation in access and delivery of services, with inequalities within waiting lists reported to the Finance and Performance Committee with escalation to Board if required. The trust is actively involved in working with system partners in this area with system-wide agreed priority focus, specifically targeting high DNA rates demonstrated in the inequalities data. The trust Strategy and strategic objectives are aligned to ICB and appropriate population health targets. There is an ICB Health Inequalities plan, agreed EDS2 service priorities and aligned programmes of work. We are a member of the Dorset Unwarranted Variations Group, and we have established a Joint Health Inequalities Group across the Federation. Trust Induction introduces staff to the links between the wider health and wellbeing of people across the system and the contribution of the Trust and services to outcomes and improvements. The Clinical Strategy further reinforces this within clinical teams and encourages collaboration and developments as part of strategic planning.
Evidence	Integrated Performance Report to Board Finance and Performance Committee Assurance Reports to Board Documentation from care Group to Division and through to Finance and Performance Committee and Board Trust Induction Pack Joint Health Inequalities Steering Group (Doc) Health Inequalities Report and EDS2

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Domain 5: Productivity and Value for Money

Domain	Productivity and value for money
Supporting Statements	Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant.
Committee Alignment	Finance and Performance Committee
Confirm and Challenge	16 October 2025, Dave Underwood, NED
Conclusion	Partially Confirmed
Supporting narrative	There is a strong focus on productivity and value for money through board activity. Board and Finance and Performance Committee regularly review productivity and benchmarking information. On most recent data DCH is the most efficient acute provider within the Dorset system, with a reference cost of 106. DCH has also had strong productivity performance. However, due to the size, rurality and range of services provided by DCH it is extremely challenging to achieve the national benchmark index of 100. This is evidenced by the 'Structural Review and Deficit Drivers Review' (undertaken by Adrian Roberts) as also referenced in Domain 6. The identified structural challenges mean that DCH cannot deliver the required financial efficiency gains through productivity improvements without a change in the commissioning framework. Performance Reports to Finance and Performance Committee include Model System Productivity reports alongside monthly regional reports on implied productivity. Current performance is high in majority of areas. Th model hospital data shows that we are predominantly delivering across all model hospital metrics except for the outpatient metrics. We have commenced a deep dive into this which will be reported to the Finance and Performance Committee. We have considered how to further develop our reports in line with the Insightful Board Guidance and the National Oversight Framework and plan for further development was presented to the Finance and Performance Committee in September 25. At the same time, we are aligning our reporting across the DCH and DHC federation as we operate with a shared Committee and Board reporting framework, whilst maintaining distinct reporting for each organisation. We are working closely with our coding partner, IQVIA, to review all of our inpatient coding for any opportunities for improvement linked to our coding of our activity and resulting income.
Evidence	DCH Structural Review and Deficit Drivers (undertaken by Adrian Roberts) Integrated Performance Report P1 Board Finance and Performance Committee Assurance Reports to Board Report on development of Integrated Performance Report to Finance and Performance Committee

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Domain 6: Financial performance and oversight

Domain	Financial performance and oversight
Supporting Statements	- The trust has a robust financial governance framework and appropriate contract management arrangements. - Financial risk is managed effectively and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes. - The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn.
Committee Alignment	Finance and Performance Committee
Confirm and Challenge	16 October 2025, Dave Underwood, NED
Conclusion	Partially Confirmed
Supporting narrative	We have in place robust financial governance arrangements and our Board maintain a strong focus on ensuring that financial considerations do not adversely affect patient care and outcomes, and this is evidenced through our Board discussions and the Equality and Quality Impact Assessment (EQIA) process. We recognise that there is more to do to embed our EQIA process and triangulate the reporting of this through the Quality Committee to ensure the required assurance is provided to the Finance and Performance Committee. To provide additional insight and assurance we commissioned two independent reviews. These were both reported to the Board (and shared with the ICB and NHSE). - DCH Structural Review and Deficit Drivers (undertaken by Adrian Roberts) - DCH and DHC Diagnostics and Deliverability Review for 25/26 (Financial Plan and CIP Delivery) (undertaken by David Moon and Mark Mansfield) The first review in respect of the drivers of the deficit provided greater insight into the three key elements that contribute to the deficit in DCH and, in particular the structural deficit that exists. The Diagnostics and Deliverability Review provided assurance on the arrangements in place and the efficiency plans and provided recommendations to strengthen this to achieve the required pace of delivery. We have acted on this by establishing a Financial Recovery Board that meets on a fortnightly basis to ensure we have the required grip and pace in respect of our delivery. This will be observed by the NED Chair of the Finance and Performance Committee to enable further assurance to be provided to Board. We have also recently appointed a Financial Delivery Director to ensure we maintain the required level of grip and pace as we progress into the second half of the year. The Financial Delivery Director will also be involved from the outset in our planning for 26/27 and the development of robust efficiency plans. Recruiting an individual to this role with the required skills and experience took longer than anticipated but we are confident that now this individual is in post the impact will be immediate. As part of our ongoing focus on grip and control we have completed a detailed and robust review of our financial controls using the NHSE recommended best practice

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	'Grip and Control' templates. This has been shared with the ICB and NHSE and is an iterative process. Oversight of this is within the scope of the Financial Recovery Board and will be reported in October 25. We have financial plans in place that are triangulated and consolidated across Dorset (including other providers and the ICB). Regular briefings are provided to the Board on the financial plans through formal reporting (Committee and Board) and regular scheduled briefings. We approved a financial plan at the beginning of the year that included a challenging efficiency plan of £29.1m, which is circa 9% of expenditure budgets. Achieving this plan was predicated on establishing a wholly owned subsidiary for estates and facilities. Whilst our plans were well developed, due to a change in national guidance related to the establishment of wholly owned subsidiary companies, there is an increased risk to delivery of £11.6m which was originally attributed which was originally attributed to the establishment of a wholly own subsidiary company in Dorset. Since this became apparent at the end of September 2025, we have worked at pace to develop further efficiency plans and these have been reported to our board as these are developing. We have been working closely with system partners including Dorset providers, Dorset ICB and the Southwest NHSE regional team to agree our financial plans for H2 trajectory recovery. As a Board we recognise the scale of the financial challenge and reporting of this to the Board is transparent and timely.
Evidence	Annual Head of Internal Audit Opinion - summarised in Annual Governance Statement Audit Committee March 2025 - 25/26 Internal Audit Plan Audit Committee August 2025 – Budgetary Controls Report Finance and Performance Committee Assurance Reports to Board Quality Impact Assessment Report to Quality Committee June, July and September 2025 Finance Reports to Board DCH Structural Review and Deficit Drivers (undertaken by Adrian Roberts) DCH and DHC Diagnostics and Deliverability Review for 25/26 (Financial Plan and CIP Delivery) (undertaken by David Moon and Mark Mansfield) Finance and Operational Plan 25/26 P2 Extra Board April 25 Finance and Operational Plan 25/26 P1 Board June 25

4. Appendices

Appendix A Self-Assessment Submission

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Appendix A: Provider Capability Assessment Submission

Provider Capability - Self-Assessment Template - Dorset County Hospital NHS Foundation Trust

The Board is satisfied that...		(Mitigating/contextual factors where boards cannot confirm or where further information is helpful)	
Strategy, leadership and planning	- The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners - The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE - The board has the skills, capacity and experience to lead the organisation - The trust is working effectively and collaboratively with its system partners and provider collaborative for the overall good of the system(s) and population served	Confirmed	If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:
Quality of care	- Having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients - Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	Confirmed	If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:
People and Culture	- Staff feedback is used to improve the quality of care provided by the trust - Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels - Staff can express concerns in an open and constructive environment	Confirmed	If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:
Access and delivery of services	- Plans are in place to improve performance against the relevant access and waiting times standards - The trust can identify and address inequalities in access/waiting times to NHS services across its patients - Appropriate population health targets have been agreed with the ICB	Confirmed	If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:
Productivity and value for money	Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	Partially confirmed	There is a strong focus on productivity and value for money through board activity. Board and Finance and Performance Committee regularly review productivity and benchmarking information. On most recent data DCH is the most efficient acute provider within the Dorset system, with a reference cost of 106. DCH has also had strong productivity performance. However, due to the size, rurality and range of services provided by DCH it is extremely challenging to achieve the national benchmark index of 100. This is evidenced by the 'Structural Review and Deficit Drivers Review' (undertaken by Adrian Roberts) as also referenced in Domain 6. The identified structural challenges mean that DCH cannot deliver the required financial efficiency gains through productivity improvements without a change in the commissioning framework.
Financial performance and oversight	- The trust has a robust financial governance framework and appropriate contract management arrangements - Financial risk is managed effectively and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes - The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outcome	Partially confirmed	We approved a financial plan at the beginning of the year that included a challenging efficiency plan of £29.1m, which is circa 9% of expenditure budgets. Achieving this plan was predicated on establishing a wholly owned subsidiary for estates and facilities. Whilst our plans were well developed, due to a change in national guidance related to the establishment of wholly owned subsidiary companies, there is an increased risk to delivery of £11.6m which was originally attributed which was originally attributed to the establishment of a wholly own subsidiary company in Dorset. Since this became apparent at the end of September 2025, we have worked at pace to develop further efficiency plans and these have been reported to our board as these are developing. We have been working closely with system partners including Dorset providers, Dorset ICB and the Southwest NHSE regional team to agree our financial plans for H2 trajectory recovery. As a Board we recognise the scale of the financial challenge and reporting of this to the Board is transparent and timely.
In addition, the board confirms that it has not received any relevant third-party information contradicting or undermining the information underpinning the disclosures above.		Confirmed	If the Board cannot make this certification, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:
		Signed on behalf of the board of directors	
		Signature	
Name		David Clayton-Smith, Chair Dorset County Hospital NHS Foundation Trust (DCH) and Dorset Healthcare University NHS Foundation Trust (DHC)	
Date		22 October 2025	

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DCH SubCo Ltd Assurance Report for the meeting held on 03 November 2025

Chair	Stephen Tilton
Executive Lead	Anita Thomas, Claire Abraham (DCH SubCo Directors)
Quoracy met?	Yes
Purpose of the report	To provide assurance on the main items discussed and, if necessary, escalate any matter(s) of concern or urgent business.
Recommendation	To receive the report for assurance
Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework	• Welcomed AT to her first meeting of the DCH SubCo Ltd Board • New contract between the Trust and the company is in the process of being signed • Recruitment ongoing to staff the pharmacy following the expansion of the footprint. Discussions also ongoing to extend the services offered by the pharmacy. • The continued need for a fourth director to be appointed to the Board, to prevent issues with quoracy and in light of the growing business.
Key issues / matters discussed at the meeting	The DCH SubCo board received, discussed and noted the following reports: • Finance report, noting performance slightly above plan with a quarterly profit of £52,000 • Q2 Performance Report and Review of Risk Register, Incidents and Complaints and Mitigating Actions noting: - o All KPIs continue to be met. Discussion around the need to review the KPIs to ensure they were still appropriate - o No new complaints or incidents in quarter • Contract Review Feedback with no areas of concern raised • Update on Recruitment and Expansion of Services, noting that until additional staff were recruited there was limited capacity to take on additional activity, as the pharmacy was currently operating at capacity. Recruitment and expansion of services should be coterminous.
Decisions made at the meeting	• Nil
Issues / actions referred to other committees / groups	• Nil

Report to	Board in Common	
Date of Meeting	09 December 2025	
Report Title	DCH SubCo Ltd Performance Report	
Prepared By	Andrew Harris, Superintendent Pharmacist	
Accountable Executive	Anita Thomas, DCH Chief Operating Officer and DCH SubCo Ltd Director	
Previously Considered By	DCH SubCo Ltd Board 03/11/2025 Finance and Performance Committee in Common 26/11/2025	
Action Required	Approval	N
	Assurance	Y
	Information	N

Executive Summary
Activity continues at similar levels to the preceding 12 month period, which has been reduced since June 2023 to match capacity limitations. All KPIs are currently green for the year to date. The new build Fortuneswell opened on Friday 11th July – The risk register will be fully reviewed following this to reflect the new premises.

Recommendation
Members are requested to: Receive the report for assurance

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Performance Report

Andrew Harris

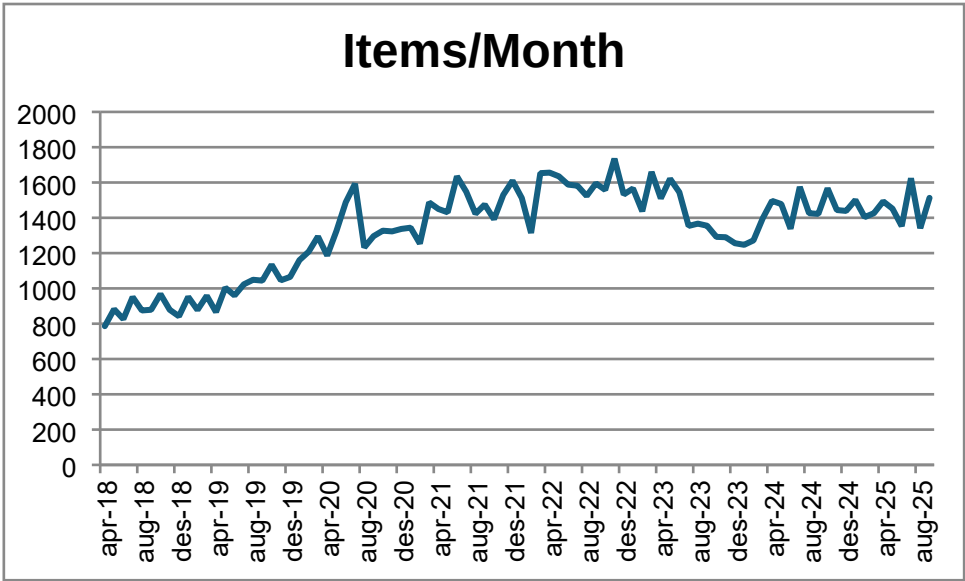
Superintendent Pharmacist

October 2025

Key Performance Indicators (KPIs)

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Total Number of Customers per Month	179	137	141	161	127	194
Total Items Dispensed	1493	1452	1353	1624	1341	1513
Average Items/day	74.7	72.6	61.5	70.6	67.1	68.8
No. of same day Prescriptions	194	202	137	221	235	217
No. of Advance Prescriptions	501	424	505	520	419	531

Activity levels from April 2018 to current:



Fortuneswell Pharmacy has returned to cancer only related activity which is reflected in the reduced activity from August 2020, though cancer related activity is now climbing.

A review of dispensing activity was undertaken in June 2023 in conjunction with the Chief Pharmacist and Lead Cancer Nurse to identify activity that could be relocated elsewhere (main hospital pharmacy or community pharmacy) to manage the increasing workload.

All contractual KPIs year to date are green.

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Performance measure	Key Performance Indicator	Target performance	Green	Amber	Red	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Rate of dispensing errors detected post issue	Number of errors made per total volume of prescriptions dispensed that have LEFT the department	<2.0%	<1.0%	1.0-2.0%	>2.0%	0.00%	0.00%	0.22%	0.23%	0.23%	0.00%
Near Miss Monitoring	Number of errors made per total volume of prescriptions dispensed that have NOT LEFT the department	<2.0%				0.94%	1.10%	1.03%	0.86%	1.04%	0.93%
Availability of service	Responsible Pharmacist Availability	0	0 to 45 mins	45 to 90 mins	> 90 mins	0	0	0	0	0	0
Availability of medicines	The % of prescription items dispensed in full at the first time of presentation excluding manufacturer can't supply	98%	100% - 98%	97.9% - 96%	< 95.9%	99.73 %	99.59 %	99.93 %	99.94 %	99.85 %	99.93 %
MHRA Recall Assurance	100% of all SABs alerts, MHRA and Company-Led recalls are managed in accordance with Class status	100%				100%	100%	100%	100%	100%	100%
All Mosaic advance prescription prepared the day in advance of collection	The completion time should be the day in advance of collection/ delivery to chemotherapy nurses.	>90%	100% - 90%	89.9% - 80%	<80%	93.4%	91.0%	97.4%	92.9%	95.2%	97.0%
The waiting time for dispensing prescriptions, during a monthly period shall be: (i) 30 minutes or less in respect of 95% of all prescriptions; and (ii) 20 minutes or less in respect of 80% of all prescriptions	The time taken for a patient to wait for their prescription from the time they present it to the Pharmacy.	(i) 30 minutes or less in respect of 95% of all prescriptions (ii) 20 minutes or less in respect of 80% of all prescriptions	For (i) Greater than or equal to 95% For (ii) Greater than or equal to 80%	For (i) 80% - 94.9% For (ii) 65% - 79.9%	For (i) Less than 80% For (ii) Less than 65%	(i) 100% (ii) 95.2%	(i) 99.2 % (ii) 95.3%	(i) 99.0% (ii) 98.0%	(i) 100% (ii) 99.3%	(i) 100% (ii) 97.1%	(i) 99.3% (ii) 97.3%
Index of customer satisfaction	The patient overall satisfaction level		100% of Customers to be offered Customer Feedback Survey Monthly Reporting on KPIs to record; Total Number of Customers			100%	100%	100%	100%	100%	100%

			per Month Completion / Uptake Rate (%)								
Number of complaints	The number of upheld complaints		1 or fewer complaints per quarter	0	0	0	0	0	0	0	0
Number of non-agreed non-formulary items supplied	Number of items that appear on total non-formulary supply report	0%	0% - 0.049%	0	0	0	0	0	0	0	0
Controlled drug management	Correct procedure against SOPs followed at all times	100%	No Tolerance			100%	100%	100%	100%	100%	100%
Provision of financial, clinical and management information	financial, clinical and management information to be provided within 5 working days following the end of the previous month	100%	100% - 99%	98.9% - 97.5%	< 97.5%	100%	100%	100%	100%	100%	100%
Waste/Expiry management*	Waste Costs below £200 per month - Stock waste to be managed	<£200	<£200			£5.87	£0.00	£39.46	£0.00	£0.00	£0.00

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Month End Stock Value £k (i/c VAT)	363	446	384	341	366	375

Incidents

1 dispensing error left the department on 17th June. No harm to patient. £3,600 of stock had to be written off.

Complaints

Nil

Keys Risks

- The original business was for a dedicated Cancer Services Outpatient Pharmacy with an estimated dispensing activity of ~700 items per month. Activity has steadily increased over the two year period and is now 1,400 per month, double the anticipated level of activity in the original business case. There is now a risk the Outpatient Pharmacy would no longer meet the General Pharmaceutical Council (GPhC) premises standards if re-inspected. **Some of this has been resolved with moving into the new build Fortuneswell Pharmacy on Thursday 10th July, and the risk register needs updating accordingly.**
- HM Treasury commenced a consultation in August 2020 on "VAT and the Public Sector: Reform to VAT refund rules". This has significant implications for the Public sector including the NHS which if the recommendation is implemented, would permit full refunds of the VAT incurred on all goods and services during the course of non-business activities (full refund model). This represents a significant risk to the long term sustainability of the subsidiary company.

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DCH Charitable Funds Committee Assurance Report for the meeting held on 18.11.2025

Chair	Dave Underwood, NED
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	None

Key issues / matters discussed at the meeting	The committee received, discussed and noted the following reports: CFC Minutes (30.9.25) – approved as an accurate record. CFC Actions (30.9.25) – All actions completed or in progress. DCH Charity Financial Reports 25/26 (M6) – reports were received. Total income as of end Sep 2025 £216,257 (In addition, charity notified of major c.£330K legacy for General Fund). Unrestricted funds were £395,750 providing a surplus of £122,750 against the approved reserves target of £273,000. £2.5M Capital Appeal (ED/CrCU) report (Oct 2025) – report received. £1.195M income and pledges received to date. Nearing half-way mark of £2.5M target. Major high value events planned for 2026. Fundraising & Communications report – overview of current key fundraising activities and communications. DCH Charity Risk Register review (6mth)-key risks reviewed. One change-reduce 'Loss of key Charity staff' risk from 16 (High) to 12 (Moderate) as new Fundraising Manager appointed 4.11.25 Innovation Fund – agreed to set up Working Group to progress development of DCH Innovation Fund; with option to widen to DHC in due course. Lillian Martin legacy – Awaiting payment of c£30K from sale of parcel of land. Beneficiaries advised of trees on land overhanging neighbouring property; consideration needed of liability for costs of tree cutting. AOB - Chair informally proposed committing a proportion (c.50% tbc) of pending major legacy (value est.c£300K for General Fund) once

	received in support of the ED/Critical Care Appeal. Formal paper will be provided for consideration in due course. 2. CFC (Jan 26) proposed to be held on 20.1.26 to consider draft DCHC Business Plan 26/27 prior to submission for Board on 9.2.26
Decisions made at the meeting	Innovation Fund – agreed to set up Working Group to progress development of DCH Innovation Fund; with option to widen to DHC in due course.
Issues / actions referred to other committees / groups	None

Quoracy and Attendance				
	20.5.25	22.7.25	30.9.25	18.11.25
Quorate?	Y	Y	Y	Y
Dave Underwood	Y	Y	Y	Y
Chris Hearn	Y	N	Y	Y
Jo Howarth	Y	Y	N	Y
Anita Thomas	Y	Y	N	Y
Margaret Blankson	Y	Y	Y	Y
Stephen Tilton	Y	N	Y	Y

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Report to	Board in Common (DHC Board)	
Date of Meeting	9 December 2025	
Report Title	Mental Health Act Panel Member Re-approval	
Prepared By	Gavin Macfarlane, Mental Health Legislation Manager	
Approved by Accountable Executive	Dawn Dawson, Joint Chief Nursing Officer Cara Southgate, Director of Nursing, Therapies and Quality	
Previously Considered By	Mental Health Legislation Assurance Committee Dec 2025	
Action Required	Approval	Y
	Assurance	N
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? <i>Delete as required</i>	
Care	Yes	
Colleagues		No
Communities		No
Sustainability		No
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 Quality and Safety	
Financial	Not Applicable	
Statutory & Regulatory	Mental Health Act panel members should be re-approved following the ending of the current period of appointment.	
Equality, Diversity & Inclusion	Not Applicable	
Co-production & Partnership	Not Applicable	

Executive Summary
Section 23 of the Mental Health Act gives hospital managers the power to discharge most detained patients and all Community Treatment Order (CTO) patients. The hospital managers (meaning the organisation or individual in charge of the hospital) must either consider discharge themselves or arrange for their power to be exercised on their behalf by a “managers” panel. In NHS trusts and NHS foundation trusts, none of the people on managers’ panels may be employees of the body concerned (or executive directors of the boards of NHS foundation trusts). The organisation should ensure that people appointed to a managers’ panel receive suitable training to understand the law, work with patients and professionals, to be able to reach sound judgements and properly record their decisions. Appointments to managers’ panels should be made for a fixed period. Reappointment (if permitted) should not be automatic and should be preceded by a review of the person’s continuing suitability. Following reviews, there are seven Mental Health Act panel members who require re-appointment for a further period of two years. On conclusion of the reviews, it is recommended that these seven members are reappointed.

Recommendation
Board Members are requested to approve the requirement for re-approval

Mental Health Act Panel Member Re-approval

1. Executive Summary

- 1.1 Section 23 of the Act gives hospital managers the power to discharge most detained patients and all CTO patients. The hospital managers – meaning the organisation or individual in charge of the hospital – must either consider discharge themselves or arrange for their power to be exercised on their behalf by a “managers” panel.
- 1.2 In NHS trusts and NHS foundation trusts, none of the people on managers’ panels may be employees of the body concerned (or executive directors of the boards of NHS foundation trusts).
- 1.3 The organisation should ensure that people appointed to a managers’ panel receive suitable training to understand the law, work with patients and professionals, to be able to reach sound judgements and properly record their decisions.
- 1.4 Appointments to managers’ panels should be made for a fixed period. Reappointment (if permitted) should not be automatic and should be preceded by a review of the person’s continuing suitability.
- 1.5 Following review of suitability meetings, seven Mental Health Act panel members now require re-appointment for a further period of two years. These are:
- 1.6 On conclusion of the reviews, it is recommended that these seven members are reappointed.

2. Introduction

- 2.1 The Mental Health Act panel members hold the delegated power to discharge most detained and all Community Treatment Order (CTO) patients. This is a delegated power from the Hospital Managers – meaning the organisation or individual in charge of the hospital.
- 2.2 Appointments to managers’ panels should be made for a fixed period. Reappointment (if permitted) should not be automatic and should be preceded by a review of the person’s continuing suitability.

3. Mental Health Act Panel Members

- 3.1 Within Dorset HealthCare Mental Health Act panel members are initially appointed for one year. Following review and confirmation of suitability to continue in the role, any further period of appointment runs for 2 years before appraisal is once again undertaken.
- 3.2 The Mental Health Act panel members undertake robust induction training required for the role, which includes information relating to the Mental Health Act, its use and criteria for continued detention, medications for mental disorder, the interface between the Mental Health Act and Mental Capacity Act, and guidance on panel member role. All new Mental Health Act panel members are appointed a mentor and a series of observations must take place before new panel members are deemed ready to sit on panels.

- 3.3 Quarterly forum meetings take place, where additional training is provided for ongoing

learning and education. The forum meetings also provide the opportunity for panel members to learn from difficult, complex or unusual hearing scenarios. As well as an opportunity for caselaw updates to be presented and discussion to take place relating to any issues, concerns or matters that require attention.

3.4 The Mental Health Act panel includes both a Chair and a Deputy Chair. The Chair is responsible for leading the panel and ensuring that hearings are conducted fairly and in accordance with statutory requirements.

3.5 The Deputy Chair supports the Chair in these duties and may act in their place when necessary. In addition to this leadership function, the Deputy Chair also serves as a Mental Health Act panel member, participating in hearings and contributing to decision-making processes in the same capacity as other panel members

3.5 Following a review of continuing suitability, which is undertaken by the Chair or Deputy Chair of the Mental Health Act panel members and either the Mental Health Legislation Manager or Deputy Mental Health Legislation Manager - seven Mental Health Act Panel Member's require re-approval by the Mental Health Legislation Assurance Committee (MHLAC).

3.6 Confirmation has also been sought that individual Mental Health Act Panel Member's wish to continue in their role. The panel members requiring re-approval are:

- Lorraine Jones
- Leeanne Dove
- Maria Teo
- Ashleigh Dunford-Bishop
- Caroline Foster
- Allan Brown
- Callie Greenslade

3.7 Subject to approval, the Mental Health Act panel member's re-approval will be for a period of two years.

4. Conclusion

4.1 Those responsible for carrying out the reviews of continuing suitability are satisfied that the Mental Health Act panel members meet the required criteria to serve in this role

4.2 The Mental Health Legislation Assurance Committee is asked to re-approve the seven Identified persons as an Appointed Mental Health Act Panel Members.

5. Recommendation

5.1 Members are requested to:

- **Approve** the requirement for re-approval

Author: Gavin Macfarlane

Title: Mental Health Legislation Manager

Date: November 2025

Setchell, Ryan
04/12/2025 14:16

Report to	Board in Common (DCH & DHC)	
Date of Meeting	9 December 2025	
Report Title	Mental Health Legislation Committee in Common Terms of Reference	
Prepared By	Jenny Horrabin, Joint Executive Director of Corporate Affairs	
Approved by Accountable Executive	Jenny Horrabin, Joint Executive Director of Corporate Affairs	
Previously Considered By	N/A	
Action Required	Approval	Y
	Assurance	N
	Information	N

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

Executive Summary
- It is proposed that Executive membership of the Mental Health Legislation Committee in Common is increased from two to three to now include the Joint Director of Corporate Affairs. - This aligns with membership arrangements for the other Federated Committees in Common and will strengthen quoracy arrangements.

Recommendation
The DHC Mental Health Legislation Committee / DCH Mental Health Steering Group is requested to: Approve the amended Terms of Reference for the Mental Health Committee in Common

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Dorset County Hospital NHS Foundation Trust Mental Health Legislation Committee in Common TERMS OF REFERENCE	
Committees in Common	1.1 The Dorset County Hospital NHS Foundation Trust is putting in place a governance structure, which will enable it to work together with the Dorset HealthCare University NHS Foundation Trust. 1.2 Each Trust has agreed to establish a committee which shall work in common with the other (Committee in Common or CiC), but which will each take its decisions independently on behalf of its own Trust. 1.3 Each Trust has decided to adopt terms of reference in substantially the same form, except that the membership of each CiC will be different. 1.4 The CiC shall meet together with the associated committee from Dorset HealthCare University NHS Foundation Trust as the Dorset Trust Mental Health Legislation CiCs
Responsibilities	2.1 The Committee-in-Common has been established by the Board of Dorset County Hospital NHS Foundation Trust as a committee with these terms of reference, to be known as the Dorset HealthCare Mental Health Legislation CiC. 2.2 These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Dorset County Hospital Mental Health Legislation CiC. It is supported in its work by other committees established by the Board. 2.3 The Dorset County Hospital Mental Health Legislation CiC is authorised to investigate any activity within these terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to cooperate with any request made by the Committee-in-Common. 2.4 The Dorset County Hospital Mental Health Legislation CiC is authorised to obtain external legal or other independent professional advice if it considers this necessary, taking into consideration any issues of confidentiality and the Trust's standing financial instructions. 2.5 The Dorset County Hospital Mental Health Legislation CiC is a committee of the Trust and therefore can only make decisions binding Dorset County Hospital NHS Foundation Trust. None of the Trusts other than Dorset County Hospital NHS Foundation Trust can be bound by a decision taken by Dorset County Hospital Mental Health Legislation CiC. 2.6 The Dorset County Hospital Mental Health Legislation CiC will form part of a governance structure to support collaborative leadership and relationships with system partners and follow good governance in decision making (as set out in the updated Code of Governance for NHS Provider Trusts). 2.7 The overall aim of the Dorset County Hospital Mental Health Legislation CiC is to monitor, review and provide assurance to the Board the adequacy of the Trust's processes to support the operation of mental health

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	legislation. This includes the mental health act, the mental capacity act and deprivation of liberty safeguards
Role and Purpose	3.1 Paragraph 15(2) and (3) of Schedule 7 of the National Health Service Act 2006 allows for any of the functions of a Foundation Trust to be delegated to a committee of directors of the Foundation Trust. This power is enshrined in Dorset County Hospital NHS Foundation Trust's Constitution. 3.2 The Mental Health Legislation CiC will, together with the other Committees in Common, advise, support and assure the Board of Dorset County Hospital NHS Foundation Trust and Dorset HealthCare University NHS Foundation Trust: - the Trust is operating and will continue to operate in accordance with the law and best practice in relation to the rights of mental health services users and specifically the legislation below (and any subsequent updates) and care and treatment in the Trust embraces the core values of current mental health legislation and protects service users and the community of which they are members. - the lawful detention and treatment of service users in accordance with the Mental Health Act 1983 and Mental Health Act 1983: Code of Practice; - the appropriate application of Deprivation of Liberty Safeguards and the requirements of the Mental Capacity Act 2005; and - Mental Health Units (Use of Force) Act 2018 and associated statutory guidance.
Responsibilities	The Dorset County Hospital Mental Health Legislation CiC will: 4.1 Monitor, review and report to the Board, on compliance with all aspects of mental health legislation. 4.2 Be assured that there are systems, structures and processes in place to support the operation of mental health legislation, within both inpatient and community settings and ensure compliance with associated codes of practice and recognised best practice. 4.3 maintain oversight of Care Quality Commission (CQC) inspection action plans specifically relating to mental health legislation and any mental health legislation matters arising from routine CQC related activity other external inspections. 4.4 Review national reports related to mental health legislation and consider actions arising for the Trust. 4.5 Be assured that the Trust has in place and utilises appropriate policies and procedures in relation to mental health legislation and to facilitate the publication, distribution and explanation of the same to all relevant staff, service users and manager. 4.6 Ensure that there is a scheme of delegation in place for the Mental Health Act 1983 and receive assurance that the trust is operating in accordance with the Scheme of Delegation. 4.7 Be assured that appropriate staff groups receive guidance, education and training in order to understand and be aware of the impact and implications of all new relevant mental health associated legislation.

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	4.8 Provide oversight of the process of recruitment, induction, appraisal and development of Associate Hospital Managers.
Accountability Arrangements	5.1 The Dorset County Hospital Mental Health Legislation CiC is accountable to the Board of Dorset County Hospital NHS Foundation Trust. 5.2 The Committee Chair will provide an assurance report following each meeting to the Board of Directors of Dorset County Hospital NHS Foundation Trust. 5.3 Dorset County Hospital Mental Health Legislation CiC shall provide such other reports and communications briefings as requested by Dorset County Hospital NHS Foundation Trust's Board for inclusion on the agenda of Dorset County Hospital NHS Foundation Trust's Board meeting.
Membership / Attendance	6.1 <u>Non-Executive</u> - Three Non-Executive Directors (at least one and no more than two may be Joint NEDS across DCH and DHC) and one of whom will either be the Chair or the Vice Chair of the Committee 6.2 <u>Executive</u> - Joint Chief Nursing Officer (or nominated Deputy) - Chief Medical Officer – DCH (or nominated deputy) Joint Director of Corporate Affairs 6.3 <u>In attendance</u> - DCH - Director of Nursing and Quality - Joint Director of Corporate Affairs or nominated deputy - Nominated Governor(s) - Other staff of the Trust may be requested to attend for specific matters. - Mental Health Legislation Manager - Deputy Director of Nursing & Quality - Head of Safeguarding - Medical Director for Mental Health 6.4 Where a member is unable to attend routinely an appropriate deputy who will attend on a regular basis should be nominated and notified to the Chair.
Chair	7.1 When the Dorset County Hospital Mental Health Legislation CiC meets with the associated committee from Dorset HealthCare University NHS Foundation Trust as committees in common, one person nominated from the Members of each of the CiCs shall be designated the Chair and one from the other Trusts CiC membership as the Vice Chair. 7.2 The Chair and Vice Chair shall preside over and run the common meetings with the roles then rotating on an annual basis between the Trusts members.
Quorum	8.1 Members of the Dorset County Hospital Mental Health Legislation CiC have a responsibility for the operation of the Dorset County Hospital Mental Health Legislation CiC. They will participate in discussion, review evidence and provide objective expert input as part of the Dorset County Hospital Mental Health Legislation CiC to the best of their knowledge and ability, and endeavour to reach a collective view.

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	8.2 Each Member of the Dorset County Hospital Mental Health Legislation CiC shall have one vote. The Dorset County Hospital Mental Health Legislation CiC shall reach decisions by consensus of the Members present. 8.3 The quorum shall be three (3) Members. This must include at least two Non-Executive Directors from the Trust (which may include Joint NEDS acting for both Trusts) and an Executive Director. 8.4 If any Member is disqualified from voting due to a conflict of interest, they shall not count towards the quorum for the purposes of that agenda item.
Administrative Support	9.1 Administrative support will be arranged by the Corporate Affairs Directorate. 9.2 Agenda and papers will be circulated one week prior to the meeting
Frequency of Meeting	10.1 Agenda and papers will be circulated one week prior to the meeting. 10.2 Subject to the below, Dorset County Hospital Mental Health Legislation CiC meetings shall take place quarterly. 10.3 Any Trust CiC Member may request an extraordinary meeting of the Dorset County Hospital Mental Health Legislation CiC (working in common) on the basis of urgency etc. by informing the Chair. In the event it is identified that an extraordinary meeting is required the Chair shall give five (5) Working Days' notice to the Trusts.
Conflict of Interest	11.1 Members of the Dorset County Hospital Mental Health Legislation CiC shall comply with the provisions on conflicts of interest contained in Dorset County Hospital NHS Foundation Trust Constitution/Standing Orders and NHS Conflicts of Interest guidance. For the avoidance of doubt, reference to conflicts of interest in Dorset County Hospital NHS Foundation Trust Constitution/Standing Orders also apply to conflicts which may arise in their position as a Member of the Dorset County Hospital Mental Health Legislation CiC. All Members of the CiC shall declare any new interest at the beginning of the meeting and at any point during a meeting if relevant.
Date Approved	12.1 Approved by Executive Director members May 2025 12.2 Ratified by Dorset County Hospital NHS Foundation Trust Board of Directors 10 June 2025
Date Review	31 March 2026

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**Dorset HealthCare University NHS Foundation Trust
Mental Health Legislation Committee in Common**

TERMS OF REFERENCE

Committees in Common	1.1 The Dorset HealthCare University NHS Foundation Trust ('Dorset HealthCare') is putting in place a governance structure, which will enable it to work together with the Dorset County Hospital NHS Foundation Trust. 1.2 Each Trust has agreed to establish a committee which shall work in common with the other (Committee in Common or CiC), but which will each take its decisions independently on behalf of its own Trust. 1.3 Each Trust has decided to adopt terms of reference in substantially the same form, except that the membership of each CiC will be different. 1.4 The CiC shall meet together with the associated committee from Dorset County NHS Foundation Trust as the Dorset Trust Mental Health Legislation CiCs
Responsibilities	2.1 The Committee-in-Common has been established by the Board of Dorset HealthCare University NHS Foundation Trust as a committee with these terms of reference, to be known as the Dorset HealthCare Mental Health Legislation CiC. 2.2 These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Dorset HealthCare Mental Health Legislation CiC. It is supported in its work by other committees established by the Board. 2.3 The Dorset HealthCare Mental Health Legislation CiC is authorised to investigate any activity within these terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to cooperate with any request made by the Committee-in-Common. 2.4 The Dorset HealthCare Mental Health Legislation CiC is authorised to obtain external legal or other independent professional advice if it considers this necessary, taking into consideration any issues of confidentiality and the Trust's standing financial instructions. 2.5 The Dorset HealthCare Mental Health Legislation CiC is a committee of the Trust and therefore can only make decisions binding Dorset HealthCare University NHS Foundation Trust. None of the Trusts other than Dorset HealthCare University NHS Foundation Trust can be bound by a decision taken by Dorset HealthCare Mental Health Legislation CiC. 2.6 The Dorset HealthCare Mental Health Legislation CiC will form part of a governance structure to support collaborative leadership and relationships with system partners and follow good governance in decision making (as set out in the updated Code of Governance for NHS Provider Trusts). 2.7 The overall aim of the Dorset HealthCare Mental Health Legislation CiC is to monitor, review and provide assurance to the Board the adequacy of the Trust's processes to support the operation of mental health legislation. This

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	includes the mental health act, the mental capacity act and deprivation of liberty safeguards
Role and Purpose	3.1 Paragraph 15(2) and (3) of Schedule 7 of the National Health Service Act 2006 allows for any of the functions of a Foundation Trust to be delegated to a committee of directors of the Foundation Trust. This power is enshrined in Dorset HealthCare University NHS Foundation Trust's Constitution. 3.2 The Mental Health Legislation CiC will, together with the other Committees in Common, advise, support and assure the Board of Dorset HealthCare University NHS Foundation Trust and Dorset County NHS Foundation Trust: - the Trust is operating and will continue to operate in accordance with the law and best practice in relation to the rights of mental health services users and specifically the legislation below (and any subsequent updates) and care and treatment in the Trust embraces the core values of current mental health legislation and protects service users and the community of which they are members. - the lawful detention and treatment of service users in accordance with the Mental Health Act 1983 and Mental Health Act 1983: Code of Practice; - the appropriate application of Deprivation of Liberty Safeguards and the requirements of the Mental Capacity Act 2005; and - Mental Health Units (Use of Force) Act 2018 and associated statutory guidance.
Responsibilities	The Dorset HealthCare Mental Health Legislation CiC will: 4.1 Monitor, review and report to the Board, on compliance with all aspects of mental health legislation. 4.2 Be assured that there are systems, structures and processes in place to support the operation of mental health legislation, within both inpatient and community settings and ensure compliance with associated codes of practice and recognised best practice. 4.3 maintain oversight of Care Quality Commission (CQC) inspection action plans specifically relating to mental health legislation and any mental health legislation matters arising from routine CQC related activity other external inspections. 4.4 Review national reports related to mental health legislation and consider actions arising for the Trust. 4.5 Be assured that the Trust has in place and utilises appropriate policies and procedures in relation to mental health legislation and to facilitate the publication, distribution and explanation of the same to all relevant staff, service users and manager. 4.6 Ensure that there is a scheme of delegation in place for the Mental Health Act 1983 and receive assurance that the trust is operating in accordance with the Scheme of Delegation. 4.7 Be assured that appropriate staff groups receive guidance, education and training in order to understand and be aware of the impact and implications of all new relevant mental health associated legislation. 4.8 Provide oversight of the process of recruitment, induction, appraisal and development of Associate Hospital Managers.

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Accountability Arrangements	5.1 The Dorset HealthCare Mental Health Legislation CiC is accountable to the Board of Dorset HealthCare University NHS Foundation Trust. 5.2 The Committee Chair will provide an assurance report following each meeting to the Board of Directors of Dorset HealthCare University NHS Foundation Trust. 5.3 Dorset HealthCare Mental Health Legislation CiC shall provide such other reports and communications briefings as requested by Dorset HealthCare University NHS Foundation Trust's Board for inclusion on the agenda of Dorset HealthCare University NHS Foundation Trust's Board meeting.
Membership / Attendance	6.1 <u>Non-Executive</u> - Three Non-Executive Directors (at least one and no more than two may be Joint NEDS across DCH and DHC) and one of whom will either be the Chair or the Vice Chair of the Committee 6.2 <u>Executive</u> - Joint Chief Nursing Officer (or nominated Deputy) - Chief Medical Officer – DHC (or nominated Deputy) Joint Director of Corporate Affairs 6.3 <u>In attendance</u> - DHC - Director of Nursing, Therapies and Quality - Joint Director of Corporate Affairs or nominated deputy - Nominated Governor(s) - Other staff of the Trust may be requested to attend for specific matters. - Mental Health Legislation Manager - Deputy Director of Nursing, Therapies & Quality - Head of Safeguarding - Medical Director for Mental Health 6.4 Where a member is unable to attend routinely an appropriate deputy who will attend on a regular basis should be nominated and notified to the Chair.
Chair	7.1 When the Dorset HealthCare Mental Health Legislation CiC meets with the associated committee from Dorset County NHS Foundation Trust as committees in common, one person nominated from the Members of each of the CiCs shall be designated the Chair and one from the other Trusts CiC membership as the Vice Chair. 7.2 The Chair and Vice Chair shall preside over and run the common meetings with the roles then rotating on an annual basis between the Trusts members.
Quorum	8.1 Members of the Dorset HealthCare Mental Health Legislation CiC have a responsibility for the operation of the Dorset HealthCare Mental Health Legislation CiC. They will participate in discussion, review evidence and provide objective expert input as part of the Dorset HealthCare Mental Health Legislation CiC to the best of their knowledge and ability, and endeavour to reach a collective view.

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	8.2 Each Member of the Dorset HealthCare Mental Health Legislation CiC shall have one vote. The Dorset HealthCare Mental Health Legislation CiC shall reach decisions by consensus of the Members present. 8.3 The quorum shall be three (3) Members. This must include at least two Non-Executive Directors from the Trust (which may include Joint NEDS acting for both Trusts) and an Executive Director. 8.4 If any Member is disqualified from voting due to a conflict of interest, they shall not count towards the quorum for the purposes of that agenda item.
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Conflict of Interest	11.1 Members of the Dorset HealthCare Mental Health Legislation CiC shall comply with the provisions on conflicts of interest contained in Dorset HealthCare University NHS Foundation Trust Constitution/Standing Orders and NHS Conflicts of Interest guidance. For the avoidance of doubt, reference to conflicts of interest in Dorset HealthCare University NHS Foundation Trust Constitution/Standing Orders also apply to conflicts which may arise in their position as a Member of the Dorset HealthCare Mental Health Legislation CiC. All Members of the CiC shall declare any new interest at the beginning of the meeting and at any point during a meeting if relevant.
Date Approved	12.1 Approved by Executive Director members May 2025 12.2 Ratified by Dorset HealthCare University NHS Foundation Trust Board of Directors 11th June 2025
Date Review	31 March 2026

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Report to	Board in Common	
Date of Meeting	9 December 2025	
Report Title	Review of Memorandum of Understanding	
Prepared By	Jenny Horrabin, Joint Director of Corporate Affairs	
Approved by Accountable Executive	Matthew Bryant, Chief Executive Officer	
Previously Considered By	Strategy, Transformation and Partnerships Committee in Common 24 November 2025	
Action Required	Approval	Y
	Assurance	N
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? <i>Delete as required</i>	
Care	Yes	No
Colleagues	Yes	No
Communities	Yes	No
Sustainability	Yes	No
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR7 Collaboration	
Financial	No financial implications	
Statutory & Regulatory	Need to ensure statutory and regulatory compliance as individual organisations	
Equality, Diversity & Inclusion	No specific implications arising from this report	
Co-production & Partnership	Plan to further develop partnership working	

Executive Summary

- Since 2023 Dorset County Hospital (DCH) and Dorset Healthcare (DHC) Trusts have been working together as a group provider model (described locally as a Federation). This was agreed in 2023/4 and followed the appointment of a joint chief executive and chair at the start of the year. In March 2024 we entered into a Memorandum of Understanding and since April 2024 the Federation has a single executive team working across two trusts (all posts are shared with the exception of a trust specific Chief Operating Officer and Chief Medical Officer roles) and in August 2024 the federated trust's adopted a joint strategy – Healthier Lives, Empowered Citizens, Thriving Communities.
- The fundamental purpose of this group arrangement is to achieve the objectives set out in the strategy – of making the most difference we can to population health with the resources that we have got by focusing on the objectives of providing safe, high-quality care; a positive environment for colleagues; contributing to strong, healthy local communities and being sustainable – both financially and environmentally.
- We know that almost everything we need to achieve is based on partnerships – and steps have been taken to establish new partnerships with primary care, and to strengthen existing relationships with local authorities, other NHS partners including University Hospital Dorset (UHD) and Somerset Foundation Trust (SFT), and with the voluntary and third sector (where we have a range of formal partnership arrangements in place, mostly associated with mental health pathways). Our partnerships with our service users and carers are also at the heart of what we do, and we have strong arrangements in place for these, including working with Experts by Experience and a long-standing partnership with the Dorset Mental Health Forum.
- To support this, we have done considerable work on our governance arrangements. Alongside the executive team working as one, we have established a number of board committees in common, being careful to set clear objectives and to reflect on and evaluate their effectiveness in providing assurance and strategic direction, as well as their impact on culture and what it feels like to be working in our federation.
- From October 2025, we have moved to a board in common. As with the sub-committee arrangements, each board retains its own sovereignty and responsibilities and there will be

occasions when we need to have organisation specific discussions. However, the majority of strategic discussion, stakeholder and partnership issues, culture and engagement themes will benefit from being discussed together, and having this common forum will enable us to move forward with realising the ambitions of our shared strategy more quickly. In line with this we have reviewed and updated the Memorandum of Understanding between DCH and DHC. This was presented to the Strategy, Transformation and Partnerships Committee on 24 November 2025 (with all changes tracked) for review and comment, prior to presentation to the respective Boards for approval. This document is supported by an information sharing agreement. The Strategy, Transformation and Partnerships Committee recommended the updated Memorandum of Understanding to the DCH and DHC Boards for approval.
Recommendation Members are requested to: • Approve the revised Memorandum of Understanding between DCH and DHC

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MEMORANDUM OF UNDERSTANDING

between

Dorset County Hospital NHS Foundation Trust

and

Dorset HealthCare University NHS Foundation Trust

*Original MOU entered into March 2024 and reviewed and updated
November 2025*

the priorities and principles for

partnership working

and

the process for establishing operational

arrangements and agreeing transformation

priorities.

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1. Parties

1.1 This Memorandum of Understanding (MOU) is made on **9 December 2025** between:

- Dorset County Hospital NHS Foundation Trust of Williams Avenue, Dorchester, Dorset DT1 2JY (**DCH**); and
- Dorset HealthCare University NHS Foundation Trust of Sentinel House, 4-6 Nuffield Road, Poole, Dorset BH17 0RB (**DHC**).

The original MOU was entered into in March 2024, and it has been reviewed and updated November 2025.

- 1.2 Dorset County Hospital serves a population of approximately 250,000 people and is the main provider of acute hospital care to the residents of the west and north of Dorset, Weymouth and Portland, and increasingly serves populations in the Purbeck area. The population served is in large part rural or coastal and has areas of marked deprivation, particularly in Weymouth and Portland. The Trust delivers community based as well as hospital-based services, through providing services in GP practices, in patient homes (through the Acute Hospital at Home and Discharge to Assess teams), and at community hospitals in Weymouth, Bridport, Sherborne and Blandford. The Trust works closely with primary care and social services to ensure integrated services are provided. It has an annual budget of c£300 million and employs approximately 3,500 staff. Dorset HealthCare provides community and inpatient physical and mental health services for more than 830,000 people across Dorset and beyond. It employs around 7,000 staff with a wide range of expertise and specialisms. We deliver healthcare at over 300 sites, including mental health inpatient hospitals, community hospitals, GP surgeries, village halls, schools, care homes and people's own homes. Our annual income is around £419 million. DHC and DCH are partners within Dorset's integrated care system (ICS) which brings together the health and care services in Dorset, with the aim to remove barriers between services so people can access the support and care they need from NHS and social care services when they need it.
- 1.3 Our joint strategy for Dorset HealthCare and Dorset County Hospital – Working together, improving lives was approved in August 2024 after extensive engagement across our organisations and with partners, patients and carers. It sets out our vision for our two trusts for healthier lives, empowered citizens, thriving communities and details the four strategic objectives that will support us to deliver this – great quality care, vibrant and supportive communities, motivated and skilled colleagues and sustainability, both financially and environmentally. Our mission is to work in partnership to provide high quality, compassionate services and to nurture an environment where people can be their best.

2 Background and Context

- 2.1 On 7 September 2022 the boards of directors of DCH and DHC agreed to establish a joint leadership model through the recruitment of both a joint chief executive officer (**CEO**) and a joint chair for DCH and DHC. This followed discussions between the leadership of DCH and DHC over a period of six months, which included commissioning external advisory support to examine the case for greater collaboration between DCH and DHC and meetings and communications with staff and stakeholders including NHS England South West regional team, NHS Dorset Integrated Care Board, Bournemouth, Christchurch and Poole Council, Dorset Council and University Hospitals Dorset NHS Foundation Trust. Since then there have been further developments with the appointment to joint Executive and Non-Executive

Director roles and the creation of an aligned governance structure and the creation of Committees in Common and a Board in Common and the established of our Joint Strategy 'Working Together, Improving Lives' [Working together improving lives - DCH DHC joint strategy.pdf](#)

2.2 The aim of the joint leadership model is to improve the delivery of care to communities by helping to reduce variation and improve quality with the objective of providing responsive, high-quality healthcare for local people with a focus on:

- prevention of ill health.
- tackling health inequalities.
- parity of esteem and better integration between physical and mental health; and
- joined-up workforce planning and development.

2.3 This approach recognises that the challenges faced by health and care providers can be better dealt with by working in partnership and building on existing strong partnership working and learning from our collective response in Dorset to the challenges presented by the pandemic and the vision for the Dorset Integrated Care System as set out in Dorset Integrated Care Partnership's Strategy for Dorset.

3 This MoU

3.1 This MoU set outs:

- the purpose and principles for collaboration.
- the intent to establish programme arrangements; and
- the agreement practicalities such as funding and information sharing.

3.2 The intent of this MoU is to provide an overview of the key elements of the agreement to collaborate between DCH and DHC.

3.3 This MoU is not intended to be legally binding. It describes the understanding that has been reached between DCH and DHC and has been approved by the boards of directors of both DCH and DHC.

3.4 This MoU will sit alongside existing legal and regulatory frameworks that apply to NHS foundation trusts and the individual constitutions of DCH and DHC. The board of directors of each of DCH and DHC will retain responsibility for exercising all powers of the individual trusts subject to delegation in accordance with their respective constitutions under the leadership of a joint chair.

4 Purpose

4.1 The joint arrangements between DCH and DHC aim to create a partnership strengthened by shared leadership, which will drive a more integrated approach to quality of care and patient experience, by improving joint working and simplifying decision-making.

4.2 In line with strategic objectives identified by DCH and DHC, the Integrated Care Partnership strategy for Dorset and nationally, DCH and DHC will seek to deliver in key areas including:

- taking a preventative approach to wellbeing and ill health in the first place.
- care enabled by patient self-management, better partnership working and integration across public services including the NHS.
- supporting a needs-based, patient-focus approach; delivering care where it is needed, by the most suitable team in the most appropriate setting to facilitate improved lifetime outcomes.
- tackling health inequalities and ensuring everyone has the same excellent access and experience of care and services regardless of postcode or demography.
- encouraging a parity of esteem across mental and physical health through integrating the offering for patients.
- focussing on staff wellbeing including driving diverse career opportunities to encourage retention and recruitment of the best local talent; and
- working together more and working together better to serve as a conduit for improved system working with partners at all levels.

4.3 To support the delivery in these areas DCH and DHC has:

- appointed to the roles of joint CEO and joint chair for DCH and DHC and entered into agreements with the individuals in those roles and/or each other to facilitate their effective joint working and remuneration.
- appointed to other joint Executive and on-Executive Director roles and entered into agreements with the individuals in those roles and/or each other to facilitate their effective joint working and remuneration.
- in our overall aim of reducing variation and improving the quality of care through the delivery of responsive, high-quality healthcare for local people developed a Joint Strategy; define a series of clear objectives and benefits against which the success of the collaboration can be measured and reported.
- ensured that any potential conflicts of interest arising as a result of the appointment to joint roles are declared and managed appropriately and authorised by the board of directors of each of DCH and DHC in a way that facilitates the Trusts working together and sharing of information and the full participation of the joint postholders in decision-making;
- continued to engage with stakeholders in a coordinated and proactive way defined by a joint partner impact assessment.
- identified ongoing opportunities for the leadership of both organisations to come together and developed joint meetings of executive teams, members of the boards of directors, non-executive directors and governors; and
- established a programme with appropriate and proportionate governance and appropriate resources to support successful and meaningful partnership and the delivery of shared objectives.

5 Underpinning Principles

5.1 DCH and DHC will, individually and together, continue to work as partners in the Dorset ICS, and any successor bodies, to deliver the strategy and plans agreed with system partners.

5.2 DCH and DHC will adopt the values of the Dorset ICS, and any successor bodies, in their partnership working:

- **Working together with people and communities.** We will co-design and co-produce services with the people and communities of Dorset, putting them at the heart of decision-making, governance, service planning and delivery to improve outcomes and experience. **Respect, dignity and inclusion.** We value every person – whether patient, their families or carers, or staff - as an individual. We respect their differences, their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits. We will be inclusive.
- **Commitment to quality of care.** We earn the trust placed in us by insisting on quality and striving to get the basics of quality of care – safety, effectiveness and patient experience – right every time.
- **Compassion.** We ensure that compassion is central to the care we provide and respond with humanity and kindness to each person's pain, distress, anxiety or need.
- **Improving lives.** We strive to improve health and wellbeing and people's experiences of the NHS.
- **Everyone counts.** We maximise our resources for the benefit of the whole community, and make sure nobody is excluded, discriminated against, or left behind.

6 Programme Arrangements

6.1

6.2 The boards of directors of DCH and DHC have established a Strategy, Partnerships and Transformation Committees in Common which includes oversight of our federated working arrangements.

6.3 Any powers currently exercisable by the board of directors of each of DCH and DHC, committees of those boards of directors or individual executive directors will continue to be exercisable in this way and any delegation of powers to support the collaboration will require approval by the appropriate board of directors.

7 Information Sharing and Confidentiality

7.1 DCH and DHC agree to facilitate information sharing to support the objectives of their partnership working in accordance with applicable legislation and guidance. DCH and DHC will enter into a separate information sharing agreement governing the sharing of information for this purpose. This is attached as an Annex to this MoU.

7.2 Each of DCH and DHC will respect the confidentiality of the other's information, taking all reasonable precautions to prevent any third party (other than employees, agents or consultants under a similar duty of confidentiality) from having access to it.

7.3 Neither DCH or DHC will use the other's confidential information for any other purpose than in connection with this MoU and delivering the benefits and objectives of their partnership working.

- 7.4 Where either DCH or DHC receives a request under the Freedom of Information Act 2000 or Environmental Information Regulations 2004 for confidential information disclosed to it by the other, it will immediately notify the other and DCH and DHC will work together to agree a response while recognising the decision about what to disclose and whether information is exempt from disclosure must be made by the organisation receiving the request for information.

8 Monitoring delivery of this MoU

- 8.1 DCH and DHC recognise the need to review the scope and nature of their partnership working on a regular basis, and that they will need to be flexible and responsive to changes in circumstances locally and nationally.
- 8.2 The responsible Committee will monitor delivery of this MoU and the risks to delivery on an ongoing basis, escalating any concerns and agreeing a recovery plan with the joint CEO. Should the recovery plan fail to resolve the issue, the concerns will be escalated to the board of directors of each of DCH and DHC.
- 8.3 The board of directors of each of DCH and DHC will receive regular updates on how we deliver our Joint Strategy and on any developments in our federated working.

9 Funding

- 9.1 DHC and DCH have committed to funding the remuneration for the joint roles in equal proportions.
- 9.2 This MoU does not represent a commitment to other funding, although both DCH and DHC commit to release reasonable resources as required on an equitable basis to deliver the expected benefits.

10 Duration and Review Periods

- 10.1 This MoU will become effective on the date of signature and will remain in effect until terminated by any one of DCH or DHC or by mutual consent.
- 10.2 A review will take place on or around every anniversary of the MoU coming into effect. This review will be undertaken jointly. The outcome of the review, including any proposed amendments, will be reported to the boards of directors of DCH and DHC.
- 10.3 This MoU can be terminated by either DCH or DHC or by mutual consent, provided the following process has been followed:
- executive directors from both DCH and DHC have worked together in an attempt to address the matters giving rise to the request to terminate.
 - the termination will be authorised by the board of directors of either DCH or DHC or both (as applicable) and will be made in writing and provide for a minimum period of 6 months' notice prior to the termination date.
 - a termination programme will be overseen by a programme board and subject to the terms and conditions of the agreements with the individuals in the joint roles; and
 - a programme board will identify any confidential information relating to either DCH or DHC held by the other and agree arrangements for returning such information or removing it from computers or other devices.
- 10.4 This MoU may only be varied by written agreement of both parties, following review and approval by the boards of directors of both DCH and DHC.

11 Signatories to this MoU

11.1 Each signatory to this MoU has been authorised to sign the MoU by the board of directors of their respective organisation.

Name	
Position	
Organisation	
Address	
E-mail	
Signature	

Name	
Position	
Organisation	
Address	
E-mail	
Signature	