Council of Governors Part One

Mon 18 August 2025, 14:00 - 16:30

DCH HQ and MS Teams

Agenda

14:00 - 14:10
10 min

1. Formalities

1 c DCH Agenda 18.08.2025.pdf (3 pages)

1.1. Welcome, Apologies for Absence, and Quorum

Verbal *David Clayton-Smith*

Information

1.2. Conflicts of Interest

Verbal *David Clayton-Smith*

Information

1.3. Minutes of the Council of Governors Part 1 Meeting Dated 22 April 2025

Enclosure *David Clayton-Smith*

Approval

1 c DCH GoG draft minutes 22.04 (1).pdf (15 pages)

1.4. Actions and Matters Arising From Those Minutes

Enclosure *David Clayton-Smith*

Approval

1. d DCH Action Tracker August.pdf (1 pages)

14:10 - 14:20
10 min

2. Chair's Update

Presentation *David Clayton-Smith*

Information

2. DCH CoG Chair Report 20250818.pdf (11 pages)

14:20 - 14:40
20 min

3. Trust Executive Update, Including 10-Year Plan

Enclosure *Nick Johnson*

Assurance

3. COG DCH - Aug2025 combined.pdf (23 pages)

14:40 - 14:50
10 min

4. Non-NHS Activity

Enclosure *Chris Hearn*

Assurance

4. Front Sheet CoG Non NHS Activity.pdf (2 pages)

14:50 - 15:00
10 min

5. Waiting List Data Update

Presentation *Adam Savin*

Assurance

15:00 - 15:30
30 min

6. NED and Governor Observer Update

Verbal/Presentation *Stephen Tilton/Dave Underwood*

Assurance

15:30 - 15:50
20 min

7. Patient Experience Team Update

Enclosure *Hannah Robinson*

Information

7. PRESENTATION_PE_COG_20250818.pdf (10 pages)

15:50 - 15:55
5 min

8. Membership Engagement Report

Enclosure *Governors*

Information

8. Membership Engagement Report.pdf (3 pages)

15:55 - 16:05
10 min

9. Governor Matters

Verbal *Governors*

Information

16:05 - 16:10
5 min

10. Update on DCH Governor Positions

Enclosure *Jenny Horrabin*

Information

10.Update in DCH Governor positions V2.pdf (5 pages)

16:10 - 16:15
5 min

11. Standing Orders (Annex 6 of the Constitution)

Enclosure *Jenny Horrabin*

Approval

11. Standing orders.pdf (3 pages)
11.a Standing Orders of the Council of Governors.pdf (10 pages)

16:15 - 16:20
5 min

12. Annual Report

Enclosure *Jenny Horrabin*

Assurance

12. DCH Annual Report and Accounts 2024-25 Signed.pdf (181 pages)

16:20 - 16:25
5 min

13. Auditors Report for the Council of Governors

Enclosure *Rees Batley*

Assurance

13. Auditors Annual Report 2024-25.pdf (16 pages)

16:25 - 16:30 5 min

14. Any Other Business

Verbal *David Clayton-Smith*

Information

16:30 - 16:30 0 min

15. Chair's Closing Remarks and Date of Next Public Meetings

Verbal *David Clayton-Smith*

Information

16:30 - 16:30 0 min

Meeting Close

Council of Governors (Part 1) of
Dorset County Hospital NHS Foundation Trust
18 August 2025 at 2.00 pm – 4.30 pm
Board Room, Trust Headquarters, Dorset County Hospital
and via MS Teams

AGENDA

Ref	Item	Format	Lead	Purpose	Timing
1.	**FORMALITIES**				
	a) Welcome, Apologies for Absence, and Quorum	Verbal	David Clayton-Smith, Trust Chair	Information	2.00
	b) Conflicts of Interests	Verbal	David Clayton-Smith	Information	
	c) Minutes of the Council of Governors Part 1 Meeting dated 22 April 2025	Enclosure	David Clayton-Smith	Approve	
	d) Actions and Matters Arising from those minutes	Enclosure	David Clayton-Smith	Approve	
2.	**Chair's Update**	Presentation	David Clayton-Smith	Information	2.10
3.	**Trust Executive Update including 10-year plan**	Enclosure	Nick Johnson Deputy CEO	Assurance	2.20
4.	**Non-NHS Activity**	Enclosure	Chris Hearn	Assurance	2.40
5.	**Waiting list data update**	Presentation	Adam Savin	Assurance	2.50
6.	**NED Update, Feedback and Accountability Session including update from the committee chairs** Stephen Tilton Dave Underwood **Update from Governors observers around the committee effectiveness** **Carol Manton** – Quality Committee in common **Alan Clark** – People and Culture Committee in Common **Jean Pierre Lambert** – Finance and Performance Committee in Common	Verbal/ Presentation/ Questions	Stephen Tilton/Dave Underwood	Assurance	3.00

	Kathryn Harrison – Strategy, Transformation and Partnerships Committee in Common **Maurice Perks/Carol Manton** DCH Audit Committee				
7.	**Patient Experience Team update**	Enclosure	Hannah Robinson Head of Patient Experience	Information	3.30
8.	**Membership engagement report**	Enclosure	Governors	Information	3.50
9.	**Governor Matters** a) There has been considerable good work by the nursing staff and patient experience and discharge team in raising the profile of carers in the hospital. Are there ways we can support this further? b) Is DCH partnering with a local fire brigade something to be considered to help elderly patients return home safely? c) Could the Chair share his perspective on the future of the Council of Governors following the removal of the requirement on foundation trusts to have a Council of Governors? d) Can we be assured that any changes on the quality of dialysis for renal patients will be thoroughly understood when the 5-year plan is developed?	Verbal	Anne Link Jean-Pierre Lambert Simon Bishop	Information	3.55
10.	**Update on DCH Governor positions**	Enclosure	Jenny Horrabin	Information	4.05
11.	**Standing Orders (annex 6 from the constitution)**	Enclosure	Jenny Horrabin	Approval	4.10
12.	**Annual Report**	Enclosure	Jenny Horrabin	Assurance	4.15

13.	**Auditors Report for the Council of Governors**	Enclosure	Rees Batley	Assurance	4.20
14.	**Any other Business**	Verbal	David Clayton-Smith	Information	4.25
15.	**Chair's Closing Remarks and Date of Next Public Meetings:** 17 November 2025 2- 5 pm in THQ Boardroom and via MS teams Annual Members Meeting 15 September 2025 5 pm – 7 pm	Verbal	David Clayton-Smith	Information	4.30
16.	**Meeting Closes**				4.30
	Appended to the papers is an information pack for the Governors				
	There will be a part 2 of this meeting 4.30 – 5 pm				

Quorum:
The quorum of the meeting as set out in the Standing Orders of the Council of Governors is below:

Ten Governors shall form a quorum including not less than five elected Governors, and not less than one appointed Governor

Minutes of a meeting of the Council of Governors of Dorset County Hospital NHS Foundation Trust held on the 22 April at 3.00 pm – 5.30 pm in Trust HQ Board Room and via MS Teams

Present:		
David Clayton-Smith	DCS	Joint Trust Chair
Simon Bishop	SB	Public Governor, North and East Dorset
Mike Byatt	MBy	Public Governor, West and South Dorset
Alan Clark	AC	Public Governor, West and South Dorset
Judy Crabb	JC	Public Governor, West and South Dorset
Kathryn Harrison	KH	Public Governor, West and South Dorset (Lead Governor)
Jean- Pierre Lambert	JPL	Public Governor, West and South Dorset
Anne Link	AL	Public Governor, West and South Dorset
Carol Manton	CM	Public Governor, North and East Dorset
Maurice Perks	MPe	Public Governor, North and East Dorset
Jack Welch	JW	Staff Governor (until 5 pm)
In Attendance:		
Sarah Anton	SA	Governor and Membership Manager
Julie Barber	JB	Head of Organisational Development
Matthew Bryant	MB	Joint Chief Executive Officer
Henry Bull	HB	Corporate Affairs Apprentice
Dawn Dawson	DD	Joint Chief Nursing Officer
Mandy Ford	MF	Deputy Director of Corporate Affairs
Chris Hearn	CH	Joint Chief Finance Officer
Jenny Horrabin	JH	Joint Director of Corporate Affairs
Nick Johnson	NJ	Joint Director of Strategy, Transformation & Partnerships
Nicola Plumb	NP	Joint Chief People Officer
Stuart Parson	SP	Non-executive Director
Adam Savin	AS	Director of Operational Planning and Performance
Lynn Taylor	LT	Member of the public
Rachel Warton	RW	Chief Medical Officer
Apologies:		
Anita Thomas	AT	Chief Operating Officer

CoG25/001	**Formalities**	**Action**
	The Chair declared the meeting open and quorate.	
CoG25/002	**Conflicts of Interest**	
	There were no conflicts of interest declared in the business to be transacted on the agenda.	
CoG25/003	**Minutes of the Meeting held on the 03.03.2025.**	
	The minutes of the meeting held on 03 March 2025 were agreed as an accurate record.	
	Resolved: that the minutes of the meeting held on the 03 March 2025 be approved.	
CoG25/004	**Matters Arising:**	

	The Action Log was considered, and approval was given for the removal of completed items.	
	Resolved: that the action log be received and updates noted.	
CoG25/005	**Chairs Update**	
	DCS presented his update, circulated previously and highlighted the following - • DCS visited the Emergency Department after they had a busy weekend and looked at the new door arrangements • Kings Park hospital, visit to District Nursing and community neurology. • Quality Conference organised by DHC, held in the Dorford Centre and attended by DCH staff. • Pebble lodge, nightingale ward visits. • Joint Extraordinary Board meeting • Visit to Beach building at Bournemouth Hospital • Board to Board-to-Board meeting between UHD, DCH and DHC. • Pan Dorset Governor event, focus on public engagement. Commitment to work together across the county. KH asked for clarity around why we are proposing the creation of a wholly owned subsidiary company – whilst she understands the elements of the joint working, what are the benefits of this. DCS responded that this question will be picked up in part two. SB asked about the wholly owned subsidiary company and the areas that are going into it? Are there more plans to combine these services, such as dentistry? MB responded that we are currently looking at support services in the context of the shared services subsidiary and noted there is a separate work stream related to clinical services. There will be examples of services coming together, noting that the continued distribution of services across the Dorset area ins important for our population. For example, there are plans with the provider collaborative to support the sustainability of services such as maxillofacial surgery, orthodontics and ophthalmology interventional radiology. JW asked regarding the scale of the change itself and there been QIA (Quality Impact Assessments) conducted and the potential impact assessment conducted on the protected characteristics for the staff groups effected? Will staff moving to the wholly owned subsidiary company have the same terms and conditions and NHS pension as part of their existing contracts. Will these staff also have access to Viva access to wellbeing? NJ answered the proposal is that all terms and conditions and pension will be retained by the staff transferring. We would be continuing all the wellbeing support and there may be an increased offer of this for these staff groups. Staff feelings are mixed, some staff are worried about	

	terms and conditions, however once staff begin to understand the opportunities that this will give them, as this arrangement could ring fence some staff against other reductions. Some staff are of course concerned about no longer being directly employed by the NHS. MBy commented that the discussion reflected the fact that the NHS provision is being shaped and there is a vision and idea about how things are going to look in the future.	
	Resolved: that the Chairs Update be received for information.	
CoG25/006	**CEO Report**	
	MB talked to the previously circulated slides and noted that members of the executive team are present to answer questions about the details of the report. • MB highlighted apprentice achievements. There are currently 200 staff undertaking apprenticeships and it is fantastic to see this celebrated. • The current financial challenges the trust is facing - CH will talk through these later. • There is an immense amount of good work that continues within DCH and the report includes an update on waiting times. • The report reflects DCH have done well to reduce waiting times. The ambition is to improve on this. • Headline from the staff survey was that the key question of would you recommend a colleague to come and work in this trust? DCH scored the third highest trust in recommendations to come and work at an acute hospital. This is an improvement. • Validation of the education DCH provide. Quotes from a report from Southampton. 'consistently high standard of medical education that we provide' and 'praises the culture here and how student focused and education is based'. • New NHS England (NHS E) for the SW regional director is Elizabeth O'Mahony is now the Chief Finance Officer in the NHS E Transitional Team. The new regional director is now Sue Doheny. • There is currently much uncertainty for colleagues in the ICB due to requirement to reduce running cost by 50% by end of Q3 of this financial year. • The focus of the NHS for the year ahead is a focus on improving access times. • A continued focus on cancer diagnostics and access to ED, continued focus on quality and safety. DCS reflected there are a lot of encouraging performance indicators in the previously circulated CEO report, in terms of waiting times and reducing the backlog of elective care. The focus on the key metrics will become more important over the next 12 months to measure the funding and delivery. This will need to be tackled alongside transformation.	

	NJ noted that there are a number of announcements being released nationally at the moment, we do have our joint vision and strategy with DHC and need to hold this as a guiding light through these changes. Looking at 2025/26 we will be developing a five year forward plan and medium-term financial plan. MB added the strategy underpins everything we are doing. He noted we await publication of the 10-year plan for the NHS and from this we will shape the vision for the citizens of Dorset. SB congratulated AT and AS on the reduction of the waiting list. DCS introduced RW CMO who joined the meeting in the Boardroom.	
	Resolved: CEO Report be received for assurance.	
CoG25/007	**Finance Report**	
	CH talked through the previously circulated report and highlighted the following - • As we are now into the new financial year, we have the final position now subject to audit. This is an achievement of our financial plan; this is positive news. • System partners have also been in receipt of £13 million to support the deficit. DHC, UHD and ICB have agreed to divert that £13 million to DCH to support the cash position going into the new year. • The cash must be supported and followed with revenue. The DCH year-end position is £13 million surplus, and this is effectively delivering our break-even position over the course of the year. • Efficiency delivery very positive with DCH delivering a 5% cost improvement programme, this is short of £14.4 million target, however higher than previous years. • In terms of the report - Month 11 at end of Feb, 1 million surplus, we had a surplus of £9.4 million however as explained previously this was recovered within month 12. • The reason for the deficit is inflation in gas and electric prices, cost of units of certain drugs, also a volume increase, working with pharmacy to switch to generic drugs, we are taking into account quality. • Operational pressures of no reason to reside remained high, although there has been an improvement over the year. There was an increase in the amount of escalated beds above our established and funded bed base being in use was also a cost pressure.	

- Agency expenditure to month eleven was £6.1 million, that is under half the spend from a year ago of £12.6 million. That is positive news.

- Capital expenditure was broadly in line with the plan, this was positive and at month eleven cash was £11.8 million.

- Plans for next year include the final plan submission due to NHS E is due on Wed, at this point budgets will have been agreed for the year ahead. The Dorset system is planed submit a break-even position, within that DCH hold deficit, however we are working through this.

- We are working towards a 5% efficiency programme, which is consistent across other partners, however on top of that we have reinstatement of any non-recurrent delivery of CIP from the financial year. This results in overall efficiency programme of 26 million for the trust, however there are a number of large-scale transformation programme within the organisation. This will be another challenging year.

DCS asked DD to comment on the quality of care that patients are receiving within the context of the financial challenges.

DD commented that we know that having substantive staff in post that know the systems and the processes where they are delivering care will give better outcomes. We do need to use agency at times to cover shortfall, but we do this as a minimum, we have focussed on filling vacancies first. There has been a focus on nursing and therapy for the last 18 months and the focus is now turning to medical.

RW added the position for DCH medical agency is very good with very few medical agencies staff with good staffing levels, particularly at senior consultant levels. We are looking at reducing bank spend, although the doctors working bank shifts are usually our own doctors undertaking extra hours.

A Governor asked how will the financial challenges impact our ability to be at the front line our digital opportunities.

MBy said it can be a possibility to reduce anything that is not critical, but he asked for reassurance that despite the financial challenges that we do not jeopardise digital opportunities.

NJ answered we now have a Joint Chief Digital Officer across DCH, DHC and UHD. There is recognition that we have some skilled people and can work more closely together to optimise and maximise the capacity to deliver digital services and digital transformation across the system. The teams are working on a digital strategy to decide what to prioritise. NJ explained he is unable to offer MBy assurance around the financial situation that the NHS finds itself in will not have an impact on what we are able to do within the digital transformation space. We are

	prioritising patient safety and NJ is hopeful that working more closely and with Beverly Bryant in the Joint Chief Digital Officer post there is more opportunity to overcome the challenges. The Governors will be kept abreast of these developments. SB asked how will we achieve more CIP when staff have already been heavily focussed on this in the previous year – what strategy will be used for the current year? CH responded that although the last financial year was challenging we delivered more than double in terms of the efficiency programme, we are changing the narrative around cost saving across all levels around the organisation, to understanding the challenges and opportunities to deliver targets. We will be building on this good work and focusing on the transformation across the system, reviewing patient pathways across the system will enable us to focus on unwarranted variation and if this can be eliminated there can be a positive outcome in terms of patient experience and pathways. MB added that the CIP requirements are there year after year and will not go away so it is important to realise what we want to achieve together across the trust, which is to have a well-functioning hospital with quality and safety at the centre - where we are focussing on patient experience, colleague experience and where we are performing highly. MB referenced a good culture; the New Hospital Programme (NHP) development as an important part of that as this will change emergency care; investment and changes made in the stroke service - the past two quarters the stroke teams have been assessed with high results on SSNAP (Sentinel Stroke National Audit Programme). MB explained that we want to empower staff, so change is led from the front line. There are always ideas to have more efficiencies and staff usually have the best ideas for this. The NHS is a competing priority for government funding and we need to exist in this space. JPL asked a question regarding the £13 million from the Dorset partner system. If we receive the £13 million, will we ever have to offer back compensation on any interest income we gain from that, or would that stay with DCH and if we have a cash challenge at DCH will this affect the system partners if they needed the money back for whatever reason? CH answered that we are managed as a system regardless of which trust the £13 million sits within the system it will improve the overall position by £30 million. It was the idea of the partners within the system that the £13 million should sit with DCH to offset the high cash position risk. There are still cash risks, however we will be supported by this as we enter a challenging year. There is not a risk that we would have to pay this back within this financial year, however the risk is that now individual systems do have to manage their own cash risk and may not have access to national cash. DCS concluded by reflecting on some of the changes that have been put into place over the last year into context, we have the four main	

	Board committees – finance, people, transformation and partnerships, and quality which will become a committee in common, if we plot in a sense the questions that have been asked, such as will this have an impact on patients? Will we have the digital development in the right place? The work that NED chairs of the committees do is to make sure we are not distorting one thing at the expenses of another. Governors observing committees can ensure not only that the committee functions correctly but that the committee also functions in relations to other committees.	
	Resolved: that the Finance report be received for assurance.	
CoG25/008	**NED Update, Feedback and Accountability Session**	
	SP, Chair of the Audit Committee, provided an overview on the work of the Audit Committee and highlighted: • Financial Statements are audited by external audit and this has been an area of focus for the Committee. • There have been no concerns related to DCH as a 'going concern'. • There has been a risk of weakness identified around sustainability as when they assessed it was period 9 and the cash was a challenge in year. • The Committee considered governance arrangements, including the Board Assurance Framework (BAF). No significant weaknesses identified to date. • In terms of improving economy efficiency and effectiveness, no significant weaknesses identified. As reported earlier, we will deliver an improvement in CIP in 24/25. • Internal audit- there is a good ongoing working relationship with BDO and the DCH team, led by the executives. The feedback from BDO is that responses are actioned very quickly, as an organisation we have very few overdue actions. • BDO presented their plans for 25/26, and they link this to our BAF strategic risks. One of the plans to highlight is the link to one of the strategic risks- transformation and improvement and the review of productivity and efficiency, as we go through 25/26 this is something that needs to appear on the agenda regularly and is discussed so we can demonstrate that we are doing everything we can to drive that impact on performance considering quality and safety. To drive productivity and efficiency. • TIAA, our counter fraud provider, provided positive assurance on the relationship with DCH. • The counter fraud service will now be handed over to SAFE, a team hosted by DHC. Provided assurance that arrangements in place to provide a smooth handover. • SP confirmed that the third-party positive feedback from KPMG, BDO and TIAA is the best form of assurance to him as a NED to the governors as it is independent. • Reflection on 24/25 has seen feedback from the clinical effectiveness reviews in relation to the clinical risk. Reflected that they need a bit more focus on clinical risk at the Audit	

	committee, although there has been an improvement over the past two years. • SP confirmed that his responsibility as Audit Committee chair in relation to the delivery of the 25/26 financial plan is to ensure that there is discussion, scrutiny and challenge on the CIP delivery with efficiently and productivity across the organisation and to challenge any potential risk to patient safety and quality. • The Audit Committee is an effective committee where members contribute well.	
	Resolved: that the NED Update, Feedback and Accountability Session be received for assurance.	
CoG25/009	**Update from the Governor Observers**	
	JC updated she has been observing Quality Committee (QC) since August 2021 noting: • Very well-run committee, it keeps to time and the members are welcoming. • The agenda is very full, and it takes a long time to read the papers. During the meeting there is good time for debate and discussion. Governors have the opportunity to ask questions at the end. JC asked if the NEDs feel the agenda is appropriate and they have enough time to get through items. How do the speakers that attend committees feel their items are received and do the right things get escalated up to Board? How do members of the Quality Committee look at trends for example if a complaint is consistent how is this reviewed? SP responded that he has raised concerns about length of agendas, but is reassured that NEDs are currently giving feedback through the Corporate Affairs Team about the effectiveness of the committees. He noted an improvement in the timeliness of papers; the front sheets are improved which helps when reading the summary; all reports have an executive sponsor so when thinking about the people attending committees there is the ability to flag items to escalate or celebrate. He noted that in respect of complaints we do look for trends and the Patient Experience team also monitor this. DD added that she has been working with Jo Howarth to make sure the Quality Governance Group (QGG) which is an executive led meeting that sits under the committee will only escalate issues up to committees level that need it. This can help with volume of papers. DD said that she reviews every paper submitted to committee and will give feedback to authors. DD added that we use Patient Safety Incident Response Framework (PSIRF) as a way we learn and triangulate from various sources. KH observes the Strategy, Transformation and Partnership (STP) Committees in Common (CIC) and commented that the chairing is good	

	and it is an interesting committee and good, useful and thoughtful discussions take place. However, the discussion can feel high level and are far removed and disconnected from patient care. DCS asked NJ to illustrate the benefits of what the STP CIC brings for the patients and communities. NJ commented it is a new committee and we are beginning to bring a case study. For the last two meetings we had guests from to talk about the improvement work. At the last meeting we had colleagues who were working on development of frailty and virtual wards, this is one of the ways we are trying to ground the meeting. We are working hard to pull out the benefits and impact of the work that we are doing what we do in STP space. NJ emphasised the importance of the constant connection back to patient care. JPL updated as observer of the Finance and Performance CIC. The committee is well chaired by DU, support by CH and team providing excellent reports, good debate, good timekeeping, DU manages the action points very well. Governors are allowed to ask questions at the end. Good participation of NEDs. Being a CIC causes more challenging questions and sparks ideas on both sides. Summary pages are good quality and start debate. Areas for consideration include observing at informal meetings. It understandable that a space for informal discussion is needed, however this can cause governors to ask questions as we don't see the development happening in the Informal meeting. JPL feedback that performance data is reviewed every meeting and is analytical. He noted it would be good to have an action about what is being done rather than just looking at data. He asked if the data be simplified. CM added that she has just started observing the Quality Committee and the Audit Committee and noted: the content is significant and not something she is familiar; the chair is great, open and welcoming; Stephen Tilton provides good challenge and there is opportunity for debate. The same applied to the Quality Committee. CM reflected that she is impressed by how the NEDs have managed to read the papers in time to effectively challenge. CM asked if the papers can be issued earlier. SB observes charitable committee and noted the very impressed with DU and how he made these improvements in the Committee and the operation of the funds. MP commented on his observation of the Audit Committee. The meeting is very document heavy with a heavy agenda but is Chaired with excellence and reaches the end of the agenda with everything covered. MP noted he has already raised with SP the larger changes happening above DCH which may impact on the Trust.	

	SB added Trevor Hughes added a protocol when he was in post to release papers a week before the meeting. JH responded that papers for Committees and Board for the last couple of months are now going out on time and this remains an area of focus. AC has observed People and Culture Committee. Fed back that this is chaired by FW who is brilliant and made AC very welcome. The committee is long with lots of papers to get through. It is interesting and enjoyable. KH commented on the point about not feeling there is time for questions at the end of a committee. There used to be a system in place where governors met 1-2-1 with the NED Chairs of the committee every six months as an opportunity to ask questions. Can this be picked up again? JH confirmed that the 1-2-1 meeting with the observers and Committee Chairs will be re-instigated. DCS thanked all the governors for their input.	
	Resolved: that the update from the Governor Observers be received for assurance.	
CoG25/010	**Quality Priorities**	
	Dawn Dawson, joint Chief Nursing Officer presented the Quality Priorities. The topics are this year have been rolled over from last year, however the measures are different. The three pillars of clinical governance are Patient safety including - Pressure ulcers, implementation of PSIRF, implementation Matha's rule (called call for concern). Effectiveness including - compliance with consent, ensuring we have a e-consent platform; implementation of the Maternity Incentive Scheme (MIS); achieving a health inequity plan. Patient experience including - public and patient engagement, utilising therapeutic activity, continued work around Children and Young People and Mental Health. This list has come to CoG and DD requests any feedback directly to her, will then go to Quality Committee and then onto Board. JC added that with regard to the Your Voice Group there is plans for more external engagement and there will be opportunities through the HIVE for feedback.	
	Resolved: that the Quality Priorities be received for assurance	
CoG25/011	**Governor Matters**	

	JC - What is the impact on staff and patient care from reduction in staff? DD responded to the broader issue around the CIP plans and ensuring there has been effective Quality Impact Assessments (QIA). She assured Governors that there is an ongoing process in place. Quarterly reports will go to Quality Committee for assurance regarding this. SB asked a questions regarding Peritoneal dialysis nurse training. It was confirmed that AT has sent a written answer to SB. SB added the question was a reverse of JC questions about the impact on staff and patient care from a reduction of staff and SB's questions was impact on staff and patient care from an increase of patients, as this is what we are seeing in the renal side.	
	Resolved: that the governors matters be received for information	
CoG25/012	**Staff Survey Results**	
	Julie Barber, Head of Organisational Development gave a presentation about the staff survey results. • There was an increased response rate this year of 46.4% which was 1747 members of staff. That was an improvement in response rate of 5.4%. • The median response rate for benchmarking was 49% so we are slightly lower than this. • For the seven promise elements and two themes that were scored against we have improved in five of the promise elements and one of the themes. • The changes in scores from 2023 to 2024 is not significant in positive or negative changes. Although there are significant differences in our scores compared to the benchmarking group, we are statistically better in the theme of engagements. • Overall increase of 67.7% in staff saying they would recommend DCH as a place to work. This also saw us rank third in the South West region as a recommended place to work. • Overall results are positive with no statistically significant changes. Apart from two significant differences are Line management, there is an increase. Work pressures scores have a significant negative decreased score. JC asked why less than 50% of the staff responded and only three quarters of staff are up to date with their appraisal. Will this lead to inequalities with access to educational events and career progression.	

	JB answered that the staff appraisal process has changed last year to simply the paperwork, this area will be focussed on this year. We have a management matters course and an appraisals course for managers, we are introducing 'making the most of your appraisal' for all staff. There are touch points throughout the year to look at performance and career aspirations. JC clarified her questions to ask are the 25% of staff that are not having an appraisal experiencing inequality as those staff are missing out? JB answered that JC has raised a wider issue that Organisational Development (OD) and Education are working on to align the Learning Needs Assessment and the timing of appraisals. DD added appraisals are very important for staff wellbeing at work, it is a keyway for a manager to find out what to provide for your staff. We need to feed this back through to NP. It will be interesting to look at appraisal rates raise after the planned work OD are planning this year and we will also see if this affects the staff survey results next year.	
	Resolved: that the Staff Survey Plans be received for assurance.	
CoG25/013	**Update on Non-Executive Director (NED) appointments**	
	JH provided a verbal update around NED appointments We have previously reported to CoG around joint appointments to DCH and DHC. On this occasion we are seeking to appoint a joint NED into DHC from DCH. We do not require a DCH Nomination and Renumeration Committee for this appointment. Kathryn Harrison was on the interview panel as a DCH representative to interview for a new NED for DHC, we will notify of the outcome shortly.	
	Resolved: that the update on NED appointments received for information.	
CoG25/014	**Terms of Reference for Governor Committees**	
Bull Henry 14/08/2025 18:18:56	DCS declares that we cannot approve the Term of Reference due to not being quorate as there are only nine governors present now. Governors present were content to signal their approval. DCS acknowledges that the amendment to the Terms of reference are minor. DCS welcomes any comments, and the remaining governors not here today will be emailed to ask for their approval on this item.	

	KH highlighted the biggest change is a change in the Membership Development Committee and the membership of this committee has now changed to include all governors. We felt membership development was something that all governors need to be included. KH confirmed that all governors are now members. **Post meeting note:** Additional approval received via email was received from Barbara Purnell	
	Resolved: that the terms of reference for governor committees be approved	
CoG25/015	**Feedback from the Membership Development Committee (MDC)**	
	KH reflected about the community events that a group of governors have been involved in. KH raised that she is feeling conflicted about recruiting new members to the trust due to a lack of engagement once they become members. It was agreed that we would send out a newsletter twice a year. This has not yet been issued. JH commented that we have confirmed at the MDC last week we will be doing the written newsletter. We are planning that the newsletter will go out by the end of May. JC commented that last week at Your Voice Group they have changed the Term of Reference, and we would like to have a shared calendar to coordinate events. Your Voice will now hold four formal meetings a year as well as listening events, engagement events, online and face to face meetings. MDC are welcome to come and talk about membership. JC requested to have a regular slot at CoG to update about your voice meetings coming up. JH noted that this was a separate group within the trust governance structure and the patient experience team will attend to talk about their work. KH added that the HIVE that is opening at DCH. HIVE stands for Health and Wellbeing, Information, Volunteering and Engagement. Governors have booked the 21 May 2025 for governors to have a stand and will send the date around to the governors. JH added that SA is working on an engagement calendar to span across both trusts to get the coordination going.	
	Resolved: that the Feedback from the Membership Development Committee be received for information	
CoG25/016	**Frequency of Council of Governor (CoG) meetings and workshops**	
	DCS introduces the next item.	

	JH noted that we have previously discussed this at CoG and it is in the constitution that there must be at least four CoG a year. There are two workshop upcoming as well as NED Chair and Governor meetings. SB asked about what was agreed in previous CoG meetings. As this paper describes going down to four CoG meeting year with two workshops, however on the 12 Feb 2024 we agreed to change from four CoG and four governor workshops to six CoG meetings and two workshop. JH answered that some of this was before her time in post, but it does state in the constitution that we must have at least four CoGs per year. The plan is to have quarterly CoG meetings with two workshop to make sure we had good attendance. SB added in the constitution it states at least four and not just four, his concern is losing time to hold the NEDs to account and losing two more meetings is a retrograde step. KH added she is happy to reduce to four meeting if there can be some reassurance that there will be increased NED attendance at these meetings. DCS added that at CoG is not the only place that governor can hold the NEDs to account, governors can observe committees.	
	Resolved: that the frequency of Council of Governor meetings and workshops be received for information	
CoG25/017	**Governor Election Process**	
	JH updated we have a high number of governor vacancies and 2025 is not a year we would normally hold elections. We propose to work on the recruitment of the appointed governors and we have met with KH to talk about which organisations we are going to approach. Depending on the success of appointing to these roles we will hold the public governor vacancies until the planned election time in 2026. KH raised that the constitution does state we can visit candidates from previous elections to fill vacancies for public and staff governors. Can we think about doing that? JH confirmed yes, we are able to do this. Subject to being able to recruit enough governors we will then hold off having elections until next time. JC asked about a list detailing who was the nominated governor observers. SB asked if this could be circulated to all governors? JH added two committee dates have changed so we will be updating and recirculating the committee dates including nominated governors	**SA**
	Resolved: that the Governor Election Process and workshops be received for information	

CoG25/018	**Any other business**	
	None	
CoG25/019	**Date and Time of Next Meeting** The next meeting of the Dorset County Hospital NHS Foundation Trust Council of Governors will take place on 18 August 2025	

Signed by Chair …….. Date ……..

DCH GoG Action Tracker April 2025

Action No	Minute Reference & Name	Date of Meeting	Topic	Action	Lead	Deadline	Response	Status
1	CoG24/079	09.12.2024	CEO Report - waiting list data	Regarding different ways to express the waiting list data AT to pick up with JPL how to do this by adding caveats	AT	August 2025	This item is on the agenda today and Adam Savin will provide a presentation	Complete
		22.04.2025	Nominated Governor Observers	A list detailing who was the nominated governor observers to be circulated to all governors	JH	May 2025	sent out on the 15/05/2024 to some governors, resent to all governors 12/08/2025	Complete

Dorset County Hospital
NHS Foundation Trust

JOINT CHAIR REPORT TO COUNCIL OF GOVERNORS

22nd April to 18th August

David Clayton-Smith
Joint Chair
DCH & DHC NHS Foundations Trusts

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Dorset County Hospital

NHS
Dorset County Hospital
NHS Foundation Trust

23rd April, 28th May, 23rd June & 24th July	121 with Kathryn Harrison, Lead Governor
25th April	An Evening with Kate Adie in aid of the Emergency & Critical Care Appeal
28th April	Visit to Maternity/SCBU – Midwifery & Neonatal Services Team
27th May – 30th September	NED Appraisals
3rd June	Captain Michael Fulford-Dobson Memorial
5th June	High Sheriff (Callum Brenner) visit to The Hive – meet the volunteers (part of Volunteer week)
6th June	NHP Groundbreaking Ceremony

Dorset County Hospital

NHS
Dorset County Hospital
NHS Foundation Trust

10th June	Board of Directors (Part 1 & 2)
30th June	Annual FPPT submission made to NHSE – compliant with process. No areas of concern and all Board members deemed fit and proper
7th July	Quality Walkaround – Maternity Services
21st July	Quarterly Informal Staff Governor meeting
23rd July	Quality Walkaround – Eye Department
30th July	Quality Walkaround – Fortuneswell Ward & Unit

Dorset Healthcare

NHS
Dorset County Hospital
NHS Foundation Trust

24th April	Visit to Access to Wellbeing Hub, Boscombe
25th April	Nominations & Renumeration Committee
29th April	Visit to the Friendly Food Cooking Club, Weymouth
27th May – 30th September	NED Appraisals
30th May	121 with Becky Aldridge, Governor Co-ordinator
3rd June	Non-Medical Prescribing Conference
11th June	Board of Directors (Part 1 & 2)
30th June	Annual FPPT submission made to NHSE – compliant with process. No areas of concern and all Board members deemed fit and proper

Dorset Healthcare

NHS
Dorset County Hospital
NHS Foundation Trust

14th July	Nominations & Renumerations Committee
16th July	Council of Governors meeting
23rd July	Corporate Orientation
23rd July	Quarterly Informal Staff Governor meeting
31st July	Visit to Julia's House, Corfe Mullen
31st July	Visit to Herm Ward Conservatory, Alderney Hospital
4th August	Bournemouth Symphony Orchestra Herm & St Brelades Wards, Alderney Hospital
13th August	Board of Directors Part 1 & 2

Joint

Dorset County Hospital
NHS Foundation Trust

22nd April	Joint NED Interviews
23rd April	Strategy, Transformation & Partnership Committee in Common
23rd April	Quarterly informal Staff Governors meeting (DCH & DHC)
29th April	Extra-ordinary Finance & Performance Committee in Common
28th May & 28th July	Strategy, Transformation & Partnership Committee in Common (formal)
2nd June, 7th July & 4th August	Chair & Deputy Chairs catch up (DCH & DHC)
9th June	Subsidiary Company discussion with Unions
9th June, 14th July & 11th August	Monthly Combined NEDs (DCH & DHC) meeting
16th June	Joint Governor & NED Workshop

Joint

Dorset County Hospital
NHS Foundation Trust

23rd June	Joint Chair Appraisal
26th June	Extraordinary Board in Common
1st July	DiiS webinar – Effective prevention & protecting communities
2nd July	Joint Board Development Workshop
10th July	Committees in Common Chairs bi-monthly meeting
21st July	Joint RATOS/REMCOM Committee meeting
28th July	Joint CEO Appraisal
Ongoing	121s with NEDs

System

Dorset County Hospital
NHS Foundation Trust

23rd April & 23rd June	Bi-monthly 121 with Rob Whiteman, ICB Chair
24th April	Introductory meeting with Judy Gillow, UHD Chair
21st May	Bi-monthly CEO & Chair meeting (ICB, UHD, DCH/DHC)
27th May	Stakeholder Panel – Recruitment of BCP Council's new CEO
28th May	Board to Board to Board (collaboration) dinner
29th May	ICP Workshop
2nd June	Dorset Chair to Chair (UHD, ICB, DCH&DHC)

System

Dorset County Hospital
NHS Foundation Trust

5th June	Wholly Owned Subsidiaries Webinar
17th June	Chairs & NEDs Oversight Group (Our Provider Collaborative)
24th June	Health & Care Academy Opening, Bournemouth & Poole College
26th June	Visit to Health Sciences University, Bournemouth Campus
27th June	Attended Chairs Forum event in Birmingham
8th July	NHS Providers' Chair & CEO Network meeting
9th July	Quarterly call with Cllr Millie Earl, Leader of BCP Council
14th July	Bi-monthly Chair to Chair meeting – Judy Gillow (UHD Chair)

System

Dorset County Hospital
NHS Foundation Trust

14th July	Quarterly CEOs & Chairs meeting (UHD, DHC & DCH)
17th July	ICP meeting
17th July	Bi-monthly CEO/Chair meeting (UHD, ICB, DCH/DHC)
Ongoing	Bi- weekly CEO Escalation Meeting (Region)

Other

Dorset County Hospital
NHS Foundation Trust

16th April	Creative Health in Dorset Strategy progress meeting
6th June	Creative Health in Dorset Strategy – ICP Report progress meeting
15th June	Creative Health – funding for delivery of strategy meeting
17th July	Creative Health Strategy progress update paper to ICP meeting

Dorset County Hospital
NHS Foundation Trust

Council of Governors

Executive Update

18 August 2025

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ICB changes

Dorset County Hospital
NHS Foundation Trust

- On 20 May it was announced that Bath and North East Somerset, Swindon and Wiltshire ICB is also set to join with the boards operating in Somerset and Dorset. This would match a proposed reform in local government in which Dorset, Somerset and Wiltshire will be grouped together under a regional mayor.
- The broader document published regarding ICB mergers notes that mergers are planned to take effect from the start of the 2026-27 financial year should be agreed by the end of September 2025 to ensure there is enough time to implement the transition of “digital and data and finance” functions.
- The majority of remaining mergers should have been agreed by September 2026 before coming into force in April 2027. However, it is understood that some ICBs may be allowed to merge after April 2027 if it is deemed in the best interests of their area.
- Merging ICBs will involve abolishing the legacy bodies and establishing a “new successor ICB”. Staff assets and liabilities will be transferred and a new ICB board appointed. Finally, the ICB and its partner local authorities will form a new integrated care partnership.

Fit for the Future: 10 Year Plan

Dorset County Hospital
NHS Foundation Trust

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

- The main thrust of the plan is to bring the NHS closer to people's homes through neighbourhood health services and to shift care out of hospitals and into the community. The direction of travel is very aligned with our own vision of healthier lives, empowered citizens and thriving communities. In terms of neighbourhood healthcare, we have been doing considerable work to develop Integrated Neighbourhood Teams in Dorset in partnership with primary care colleagues, so we are now well placed to take this work forward with even greater pace.
-
- After all the months of anticipation it is good to be able to see this plan - and it feels like it will give a sense of coherency and direction to change in the NHS, with a long-term vision built around improving population health. As we work through the detail and start implementing it I'm sure there will be many challenges - and of course our financial challenges remain - but I feel optimistic about the opportunities the plan offers for us to make a difference for our population and lead the reshaping of the NHS to make it stronger and better for the future.

- You can find the full 10 Year Health Plan and a summary here.

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Board updates

Dorset County Hospital
NHS Foundation Trust

- In the autumn Nick Johnson will be leaving DCH and DHC to undertake a his new role as Managing Director at Salisbury FT.

- We will also be looking at the future arrangements for his portfolio of services. Due to the challenging financial situation we face we won't be making an immediate re-appointment so there will be some differences going forward.

- I would like to give huge congratulations to Nick on his success and thank him for all his continued work for our trusts. He has made a huge contribution in his time with us.

Trust Update

Dorset County Hospital
NHS Foundation Trust

- Dorset County Hospital's chemotherapy unit has been transformed following a £2million refurbishment.
- Patients undergoing chemotherapy on the Fortuneswell Unit will now receive their treatment in a vastly improved area with new facilities.
- The layout has been reconfigured to provide more space for patients, and a new outdoor courtyard area has been created to offer a calming escape from the clinical environment.
- It also features artwork by local artist Bethan Venn. Commissioned by the Arts in Hospital team, Bethan custom designed prints that feature within the unit. Inspired by nature, plants in the courtyard and the four seasons, the aim is to bring the outside in for patients on the unit.

People

Dorset County Hospital
NHS Foundation Trust

KPIs

	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25
Sickness	4.8%	4.4%	4.3%	4.1%	4.0%	4.1%
Turnover	9.4%	9.4%	9.5%	9.6%	9.5%	9.2%
Vacancy Rate	3.1%	3.1%	3.9%	4.2%	5.3%	5.9%
Appraisal Rate	78%	77%	78%	79%	79%	78%
Mandatory Training Compliance	88%	87%	87%	88%	88%	88%

Narrative

- The turnover and appraisal rates remain stable
- The vacancy rate is increasing, however this is expected with the focus on WTE Reduction
- Sickness absence reduced in Q1 and is following the usual seasonal pattern of absence
- Mandatory training compliance is at 88%. Recovery plans in place for the three subjects that are below the 80% lower threshold

Bull Henry
14/08/2025 18:18:56

Focus

Ongoing WTE reduction, SubCo, appraisal compliance, staff survey action plans, Year 1 priorities in Joint People Plan

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Dorset County Hospital
NHS Foundation Trust

Dorset County Hospital
Council of Governors

Finance Update to M4 2025/26

18th August 2025

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Dorset County - 2025/26 Financial Headlines to M4

NHS
Dorset County Hospital
NHS Foundation Trust

- **Overall Variance to Plan:** £0.011m better than planned deficit position of £11.1m YTD. In month delivery of a £3.4m deficit, being £0.004m better than plan, including £143k of Yeovil maternity costs offset by assumed income.

- **Pay:** Industrial Action costs c. £123k with no assumed income per national advice.

- **Agency** expenditure incurred in month of £0.4m, £0.1m better than M4 plan**.** Driving an achievement of **£0.5m better than YTD plan**, however **off framework cost £56k YTD** with daily break glass process in place. £50k increase seen in Medical agency due to Industrial Action cover.

- **Bank** expenditure £0.5m above plan in month - and **£1.6m above plan YTD** – internal enhanced bank controls pending. Increased use: **Urgent & Emergency Care:** ED, Ilchester and Gen Med staff. **Family & Surgical services:** Maternity, Theatres, SCBU, Kingfisher. **Corporate areas:** clinical coding, Estates & Facilities (E&F) areas incl catering and security. Drivers covering vacancies, sickness, maternities and operational pressures.

- **Efficiency delivery achieved £3.7m of the £3.8m planned target YTD, being £0.1m away from plan YTD. Of which 38% delivered recurrently (£1.4m) and 62% non recurrently (£2.3m)** – schemes undelivered in month are largely E&F (required to recover) and Divisional income generation and bank reduction schemes. Increased recurrent delivery essential to support recovery of underlying deficit position.

- **Currently £4.5m (15%) of the total efficiency target remains unidentified, with a further £11.4m (39%) classed as high risk; £5.5m (19%) medium risk and £4m (14%) low risk noting £3.7m (13%) delivered.**

- **Capital** £2.1m spend in month being £0.8m under plan and **£0.9m better than plan YTD** due to timing of equipment purchases, offset by Digital Electronic Health Record (EHR) and stroke works design fees. Excellent completion of Chemotherapy ward, well received.

- **Cash** – strong position of **£26m** due to M12 £13m receipt; ICB and HEE funding plus ongoing sound cash management practices. Risk area from H2 reliant on efficiency delivery, effective cost controls and careful timing of capital payments.

- **Executive led Delivery Group** focus with bi-weekly meetings in place to ensure oversight and delivery of the financial, workforce and operational position, recognising risks to full delivery.

Dorset County Hospital
NHS Foundation Trust

Federation's strategic alignment with the 10 Year Plan - Fit for the Future

Dorset County Hospital Council of Governors

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Aims

Dorset County Hospital
NHS Foundation Trust

- Share and discuss initial views of the 10 Year Plan in relation to the Federation's strategy

Aims

Dorset County Hospital
NHS Foundation Trust

- Share and discuss initial views of the 10 Year Plan in relation to the Federation's strategy

Initial findings

Dorset County Hospital
NHS Foundation Trust

- Broadly the Joint Strategy aligns well with the 10 Year Plan
- The Joint Strategy is broader in scope
- The 10 Year Plan is narrower and deeper in places
- The federation will be affected, and Dorset is relatively well-positioned to make the most of the opportunities
- There are missing links
- Invites further exploration as the details emerge

Strategic Alignment

Dorset County Hospital
NHS Foundation Trust

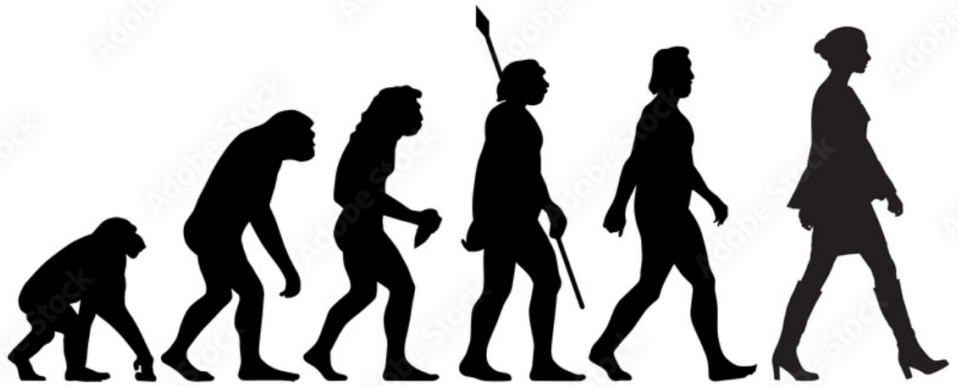
	Close	Neutral	Not close	Programmes
Long-term ambition				Strategy
Hospital to Community				INT, Future Care
Analogue to digital				EHR
Sickness to prevention				INT & Acess to wellbeing
New operating model				
Quality of care				Quality priorities
Workforce				People plan
Powering transformation				Improving Together
Productivity				Efficiency plan
Collaboration & integration				Federating

Subjective assessment of how closely the Federation is aligned to the 10 Year Plan – for discussion

Missing links

Dorset County Hospital
NHS Foundation Trust

- Limited focus on integrating mental healthcare within physical healthcare settings, and vice versa
- Health inequalities stated as a key goal without explicit a transformation programme or funding
- Acute services receive minimal attention, aside from noting that most outpatient care will shift outside hospitals by 2035
- No reference to “Improvement” as a strategy to inspire, empower, and enable ongoing progress
- There may be more



More to find out

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NHS Foundation Trust

- Integrated Neighbourhood Teams is a major programme that generally aligns well. Need further analysis to review the detail
- Electronic Health Record is a major programme for Dorset and Somerset. Need to review the scope to check if the digital ambitions are covered
- How the Future Care programme links with the ambitions for transformed urgent care
- If we need to refine the Strategy dashboard to consider some of the key metrics outlined
- What else do we need to know more about?

SWOT

Dorset County Hospital
NHS Foundation Trust

Strengths

- Strategically relatively well-aligned
- Uniquely positioned in Dorset
- Already federating
- Community assets
- Existing programmes well-aligned
- High-quality flexible workforce

Weaknesses

- Capacity & Capability to transform
- Financial sustainability
- Capital to invest
- Digitally limited in the short-term

Opportunities

- Earned autonomy
- More integrated care through Neighbourhood Health Services
- Lead/Collaborate patient activation
- Lead/Collaborate on Care Planning
- Review and refine existing programmes to better align
- Further develop relationship with UHD & Primary Care

Threats

- Failure regime
- Loss of focus on Mental Health and Acute services
- New entrants into the Dorset health and care economy
- Pace of regional change and decisions

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Summary

Dorset County Hospital
NHS Foundation Trust

- 10 Year Plan and Federation strategy are broadly well-aligned
- There are some missing links
- We have several relative strengths that create choices
- We need to be aware of a few relative weaknesses
- There are a range of opportunities and threats we need to be mindful of
- We will develop our collective understanding and position in the coming months

Change or Bust

Dorset County Hospital
NHS Foundation Trust

- Lord Darzi's Review
  - Critical condition – GP or Dental Appointment, waiting lists, morale, outcomes
  - Demographic changes – obesity & aging
  - Model is unsustainable
  - Transformational change
  - Engaged with hundreds of thousands
  - A change – keep free at point of delivery, paid via taxation
  - Utilise science and technology
  - Patient controlled
  - Address inequalities (working class, ethnic backgrounds)
  - Optimise and 3 changes

Hospital to Community

Dorset County Hospital
NHS Foundation Trust

- Not a coherent single organised service
- Move to accessible & integrated
- Neighbourhood health service – in communities
- Genomics & predictive and preventative care
- Supported by digital systems
- Shift investment to community
- Patient centred – self booking
- Establish neighbourhood health centres (12 hrs a day, 6 days a week)
- Access to dentistry
- Urgent care in people's homes
- End corridor care and back to constitutional standards

Analogue to Digital

Dorset County Hospital
NHS Foundation Trust

- Move to being a technological leader
- Utilise our data
- Have a Dr in your pocket
- Bricks to clicks - single secure account of data
- Build on NHS App
- Book appointments directly
- Manage medicines and LTC
- Manage children's healthcare

Sickness to Prevention

Dorset County Hospital
NHS Foundation Trust

- Live too long in ill health
- Discrepancy in life expectancy
- Obesity in childhood – junk food advertising
- Focus on prevention
- Healthy Start – expand free school meals
- Weight loss reduction
- Healthy reward scheme
- Alcohol consumption
- Support people to stay in work
- Mental Health support teams in schools
- HPV vaccination
- Genomic testing for newborns to allow early intervention

New Operating Model

Dorset County Hospital
NHS Foundation Trust

- More diverse and devolved health service
- **Power to patients and providers**
- ICBs being strategic commissioners
- Earned autonomy
- Re-invent Foundation Trust – retain and invest surplus with ability to borrow, hold health budgets as Integrated Health Organisation
- Higher standards for leaders
- Closer partnerships with local government
- New patient choice charter
- Patient Power Payments

Transparency & Quality of Care

Dorset County Hospital
NHS Foundation Trust

- Systematic & avoidable harm
- Easy to understand league tables
- Patients able to search and choose providers
- Patient Reported Outcome Measures
- National Independent review of Maternity/neonatal
- Reform complaints process
- Reform NQB and regulators
- Consistent poor care results in decommissioning

Report to	Council of Governors	
Date of Meeting	18th August 2025	
Report Title	DCH Non-NHS Activity/Income Compliance NHS Act 2006	
Prepared By	Claire Abraham, Deputy CFO DCH	
Accountable Executive	Chris Hearn, Chief Finance 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	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below	
Board Assurance Framework	Income compliance associated with NHS Act 2006	
Financial	NHS and non NHS income comparison	
Statutory & Regulatory	NHS Act 2006 compliance re NHS and non NHS income	
Equality, Diversity & Inclusion	n/a	
Co-production & Partnership	n/a	

Executive Summary

Executive Summary

One of the areas falling within the remit of the Council of Governors under the National Health Service Act 2006 (the **NHS Act 2006**) following the changes in the Health and Social Care Act 2012 relates to non-NHS activity and income.

Under the NHS Act 2006, NHS Foundation Trusts must ensure that the income they receive from providing goods and services for the health service in England (their principal purpose) is greater than their income from the provision of goods and services for any other purposes (non-NHS income). This is the case for Dorset County Hospital NHS Foundation Trust.

To support the Trust in achieving this where the Trust carries out any activity which is not providing goods and services for the purposes of the health service in England, the Council of Governors must decide whether it is satisfied that carrying out the activity will not to any significant extent interfere with the Trust's fulfilment of its principal purpose or the performance of its other functions and notify the Directors of its decision.

Reviewing non-NHS activity as part of the forward planning process also enables the Council of Governors to monitor when it may need to specifically approve an increase in non-NHS income under other provisions of the NHS Act 2006. This would apply to proposals to increase by 5% or more the proportion of 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.

The table below details the 2024/25 Trust non NHS activity and income:

Activity	Income	Income source(s)
Research and development	£1,190,000	NHS, Department of Health and Social Care (DHSC) and other external bodies (Pharmaceutical companies, Universities)
Education and training	£9,189,000	NHS, NHS England Local authorities and other external bodies (e.g. Pharmaceutical companies, Weymouth college)
Non-patient care services	£18,199,000	NHS, NHS England, Local authorities and other external bodies (e.g. Universities, Air Ambulance, Macmillan)
Other	£4,970,000	NHS, local authorities and other external bodies (e.g. Car parking, Catering, Accommodation)
	£33,548,000	

The Trust's income from healthcare activities in 2024/25 was **£319,740,000**.

Recommendation

The Council of Governors is recommended to:

1) Confirm that is satisfied that the Trust's non-NHS activity would not significantly interfere with its principal purpose, which is to provide goods and services for the health service in England, or the performance of its other functions; and

2) Authorise the Chair or Director of Corporate Affairs to inform the Directors of its decision.

Dorset County Hospital
NHS Foundation Trust

Patient Experience

Presentation to Council of Governors – 18 August 2025
Hannah Robinson – Head of Patient Experience / Armed Forces Lead

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Experience of care Framework

A person's experience starts from their very first contact with the health and care system, right through to their last, which may be years after their first treatment, and can include end-of-life care. In addition, it is also important to understand and learn from people who do not currently access services but who have a need to, ensuring that the service provided understands and meets the needs of the community as a whole.

https://www.england.nhs.uk/long-read/experience-of-care-improvement-framework/ Published Feb 2025

Focus on Patient Experience, Learning and Complaints response reforms.

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The Patient Experience Team

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- Head of Patient Experience — Hannah Robinson
  - Complaints / PALS Manager — Amy Dyson
    - Complaints/PALS Co-ordinator — Debbie McDermott
    - Complaints PALS Co-ordinator — Kiri Willsher
    - Patient Experience Officer — Nickie Shave
  - Patient Experience and Engagement Manager — Julia Woodhouse
    - Patient Experience Administration Assistant — Samia O'Leary
  - Volunteer Manager — Louisa Plant
    - Volunteer Co-ordinator — Sophie Charles
    - Volunteer Engagement and Administration Officer — Debbie Scammell

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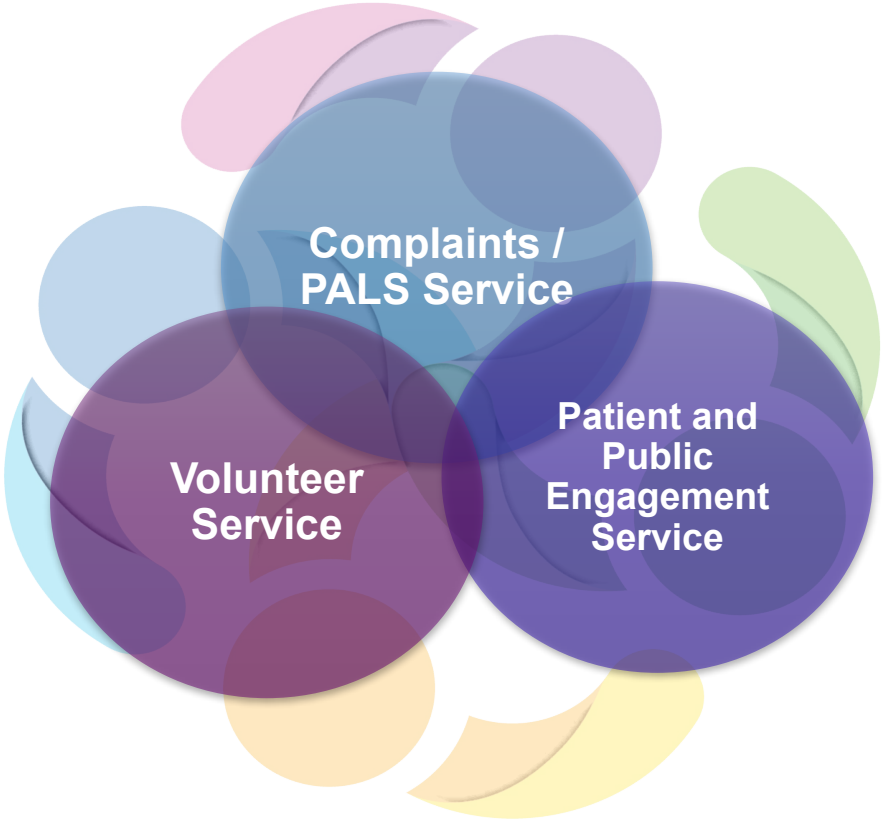
Patient Experience - Services

Dorset County Hospital
NHS Foundation Trust

- Armed Forces Community Support
- Carers Support
- Complaints
- Friends and Families Test (FFT)
- CQC National Surveys
- Patient Advice and Liaison Services (PALS)
- Patient and Public Engagement
- Patient and Public Voice Partners
- Patient Information Leaflets
- Volunteers
- Young Volunteer Programme



Service delivery

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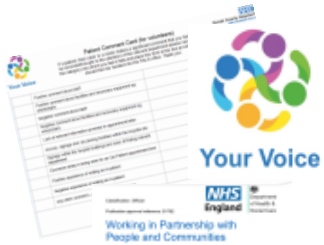

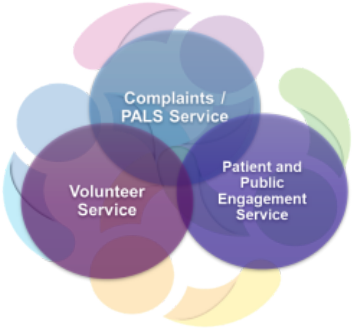

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Responding to a Complaint

Dorset County Hospital
NHS Foundation Trust

Quick Resolution

Responding and dealing with an issue raised verbally at the time the issue is raised.
(Usually within 24 hours)

Early Resolution

This means:

- Acknowledge of complaint within 3 working days (national standard)
- Making contact with the person making the complaint within 10 working days to try and resolve the complaint.

Closer Look Investigation

For issues that have not been resolved at the early resolution stage or that are complex, serious or 'high risk', a closer look investigation will take place. We will have six months to complete the investigation.

Independent External Review

For issues that have not been resolved the PHSO will assess whether there is evidence of service failure, maladministration and issues in respect of clinical judgement. The PHSO will also assess how the complaint has been handled by the Board/Service Provider.

Quality Priorities – Patient Experience

Dorset County Hospital
NHS Foundation Trust

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 and 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 Patient Groups

- 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.

Support and Signposting

Dorset County Hospital
NHS Foundation Trust

- Encourage to contact the Patient Experience team to share all feedback.
- Feedback – encourage people to complete FFT - signpost to QR code including Care Opinion.
- Promotion of our services and work – i.e. Carer / Veteran identification.
- Come and spend time with us in the Patient Experience Office / HIVE
- Collaboration on Governor / Patient Experience events.

Thank you

Dorset County Hospital
NHS Foundation Trust

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NHS Foundation Trust

Patient Experience

Presentation to Council of Governors – 18 August 2025
Hannah Robinson – Head of Patient Experience / Armed Forces Lead

Healthier lives Empowered citizens Thriving communities

Report to	Council of Governors	
Date of Meeting	*18 August 2025*	
Report Title	Membership Engagement Report	
Prepared By	Sarah Anton, Joint Governor and Membership Manager	
Approved by Accountable Executive	Jenny Horrabin, Joint Director of Corporate Affairs	
Previously Considered By	None	
Action Required	**Approval**	N
	Assurance	N
	Information	Y

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

Executive Summary

- A group of Dorset County Hospital Governors have been active in visiting community groups around the Weymouth and Portland area.
- The aim of the visits is for the governors to engage with the members of the public present at the groups, connect with and listen to them around their experiences with local healthcare.
- The governors record the feedback they hear into an anonymised report.
- If a person has a specific complaint about their care the governors encourage and direct this person to the patient experience team so this can be followed up appropriately.
- The governors attend the event with two display boards, (one with governor information and one with new hospital building information) patient experience leaflets, membership leaflets, as well as a few copies of the latest public press releases.
- The governors will promote membership to the people they talk to if they feel it is appropriate, although the main aim of the visit is to connect and engage with people rather than recruit more members.
- This will be the first of a new bi-annual report to summarise the governor activities. The full anonymised feedback document produced for each of the meetings listed below is available on request.

The governors have attended the following community groups since 8 October 2024

Date of Group	Name of group
8 October 2024	Meeting with a knitting group
30 October 2024	Mother and Baby Group
20 March 2025	Church Community Group
13 May 2025	Church Community Group
25 June 2025	Chat-a-Latte, Portland
10 July 2025	Women's Institute, Wyke Regis

Feedback Themes

Below is a summary of the themes identified from of the feedback collected from all of events to date. The below summary has been produced from the original reports, produced by Jean-Pierre Lambert for each event. The full reports have been shared with the Patient Experience Team and feeds into their wider collection of patients experience information. This is then tri-angulated with wider patient information and feeds into routine reporting through our governance structures.

Positive Themes

These reflect appreciation for specific services, staff, and facilities:

- **Exceptional Staff Care**: Repeated praise for staff across departments—especially in A&E, radiotherapy, chemotherapy, cardiology, and maternity. Words like “brilliant,” “amazing,” and “kind” are frequently used.
- **Special Units and Facilities**:
  - **Robert White Radiotherapy Unit**: Noted for its welcoming environment and community feel.
  - **South Walks House**: Appreciated for punctual appointments, parking, and ambiance.
  - **Damers Restaurant**: Valued for accessibility and service.
- **Efficiency and Responsiveness**: Quick referrals, timely diagnostics, and coordinated care (e.g., emergency helicopter transfers, rapid cancer treatment).
- **Community Spirit and Support**: Positive feedback from groups like knitting circles, baby groups, and church communities highlights the importance of social support in healthcare experiences.

2. Negative Themes

These highlight areas of concern or dissatisfaction:

- **Staffing Issues**:
  - Understaffing in ED, maternity, and isolation wards.
  - High staff turnover affecting continuity of care.
- **Communication Gaps**:
  - Between departments (e.g., Southampton and DCH).
  - Between hospitals and GPs.
  - Confusing service name changes.
- **Waiting Times and Delays**:
  - Long waits for appointments (e.g., ENT, ophthalmology, hearing services).
  - Delays in discharge due to medication processing.
- **Transport Challenges**:
  - Ambulance delays.
  - Poor patient transport coordination.
  - Inaccessibility for disabled or elderly patients.
- **Facilities and Environment**:
  - Cold rooms, lack of blankets, and poor cleanliness in some areas.
  - Lack of seating in courtyards and inadequate toilet facilities for stoma patients.
- **Mental Health Services**:

- Long waits and perceived lack of support, especially in crisis situations.

3. Suggestions for Improvement

These are practical ideas from patients and carers:

- **Enhanced Support for Vulnerable Groups**:
  - Better care for blind/partially sighted patients.
  - More breastfeeding support and continuity in maternity care.
  - Improved communication for patients with dementia or language barriers.
- **Facility Enhancements**:
  - Hooks and shelves in toilets for stoma patients.
  - Extended restaurant hours.
  - More accessible parking for elderly patients.
- **Process Improvements**:
  - Clearer discharge procedures.
  - Better follow-up systems.
  - Improved triage coordination between facilities.

4. Systemic and Structural Issues

These reflect broader concerns:

- **Access to Services**:
  - Difficulty navigating GP systems.
  - Lack of NHS dental services.
  - Long waiting lists for specialist care.

Recommendation

Members are requested to:

- **Note** the membership engagement report.

NHS
Dorset County Hospital
NHS Foundation Trust

Report to	Council of Governors	
Date of Meeting	*18 August 2025*	
Report Title	Dorset County Hospital Governor Position Update	
Prepared By	Sarah Anton, Governor and Membership Manager	
Approved by Accountable Executive	Jenny Horrabin, Joint Director of Corporate Affairs	
Previously Considered By	None	
Action Required	**Approval**	N
	Assurance	N
	Information	Y

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	No Implications	
Financial	No implications	
Statutory & Regulatory	Requirement to act in accordance with Constitution and to have a Council of Governors	
Equality, Diversity & Inclusion	We will consider this as part of approaching appointed organisations	
Co-production & Partnership	No Implications	

Executive Summary

This paper is to update on the progress of recruiting governor to the Dorset County Hospital (DCH) Council of Governor (CoG) seats. There are currently 20 governors in post at DCH Council of Governors from a potential of 28 seats.

We welcome new governors-

- Lynn Taylor, Public governor for North and East Dorset,
- Jan Wagner, Staff Governor both for a term until 2027.
- Kate Will, CEO for Kingston Maurward College has been become an appointed governor for a three-year term until 2028.
- Laura Kerr, Manager of People First Dorset has become appointed governor for a three-year term until 2028.
- Paul Kent has replaced Barabara Purnell as appointed governor for The Friends of Dorset County Hospital. Has become appointed governor for a three-year term until 2028.

Becky Aldridge, CEO of the Dorset Mental Health Forum will join the Dorset County hospital Council of Governors in November as appointed governor for a three-year term until 2028.

Recommendation

The Council is requested to

- NOTE the update of Governor positions

Council of Governor Position Update

1. Introduction

1.1. This paper is to update about the newly appointed governors to Dorset County Hospital (DCH) Council of Governor seats.

1.2. In April 2025 there were 16 governors in post at DCH Council of Governors from a potential of 28 seats.

1.3 It was proposed at the last Council of Governor meeting in April 2025 that we would concentrate on recruiting into the five appointed governor posts.

2. Changes since the last meeting

2.1 The following changes have occurred since the last meeting:

- Kate Will, CEO for Kingston Maurward College has been become an appointed governor for a three-year term until 2028.
- Laura Kerr, Manager of People First Dorset has become appointed governor for a three-year term until 2028.
- Becky Aldridge, CEO of the Dorset Mental Health Forum will join the Dorset County hospital Council of Governors in October as appointed governor for a three-year term until 2028.
- Paul Kent has replaced Barabara Purnell as appointed governor for The Friends of Dorset County Hospital.
- Lynn Taylor, Public governor for North and East Dorset, for a term until 2027.
- Jan Wagner, Staff Governor for a term until 2027.

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3. Appointed Governors

3.1 Table 1 outlines the current appointed governor seats and vacancies, there are currently five, soon to be six appointed governors in post from a potential eight seats. Discussions are continuing about which organisation should fill the final vacancy.

3.2 We have two new appointed governors and have another appointed governor due to start in October. This leaves a vacancy for an appointed governor from Weldmar and a vacant space for another partner organisation where we are exploring the possibility of a working partnership with Two Harbour Healthcare.

Table 1 - Appointed Governors

Partner Organisations	Term End	Terms Served
Terri Lewis - Age UK	2025	1
Paul Kent – Friends	2028	1
Cllr Rory Major - Dorset Council	2027	1
Kate Wills – Kingston and Maurward College and Weymouth Collage	2028	1
Laura Kerr - People First	2028	1
Becky Aldridge - Dorset Mental Health Forum (To start in November 2025)	2028	1
Vacancy - Weldmar		
Vacancy- for further national/regional healthcare charity		

4. Public Governors

4.1. Tables 2 shows the existing public Governors aligned to the three constituencies.

4.2. Due to the change in the Constitution in March 2025 we are now able to reach out to the next highest polling candidate to invite them to fill the vacant seat.

4.3. The constitution states regarding vacancies amongst governors - under 16.1 'To invite the next highest polling candidate for that seat at the most recent election to fill the seat until the next election or for the unexpired term of office of the vacant seat, whichever is the earlier, subject to a minimum term of six months, at which time the seat will fall vacant and subject to election.'

4.4. Therefore, we offered Lynn Taylor the vacant seat for North and East Dorset. Lynn accepted and will be Public Governor until the end of the term in 2027.

4.5. There are four public governor vacancies for West and South Dorset and one vacancy for South Somerset and the Rest of England, these vacancies will be carried until the next planned elections in September 2026.

Table 2 - Public governors seats for West and South Dorset

Public Governors		
West and South Dorset	**Term End**	**Terms Served**
Mike Byatt	2027	2
Alan Clark	2027	1
Jean-Pierre Lambert	2026	1
Anne Link	2027	1
Judy Crabb	2027	2
Kathryn Harrison	2026	2
David Taylor	2026	1
Vacancy		

Vacancy		
Vacancy		
Vacancy		
North and East Dorset	**Term End**	**Terms Served**
Maurice Perks	2027	3
Simon Bishop	2026	3
Carol Manton	2027	1
Lynn Taylor	2027	2
South Somerset & Rest of England	**Term End**	**Terms Served**
Vacancy		

5 Staff Governors

5.1. Due to clause 16.2 in the constitution, we approached Jan Wagner to offer the vacant post of staff governor. Jan accepted and will be Staff Governor until the end of the term in 2027.

5.2. Jack Welch will be stepping down from his staff governor post in September.

Table 3 – Staff Governors

Staff Governors	Term End	Terms Served
Max Deighton	2027	1
Midhun Paul	2026	1
Jack Welch	2026	1
Jan Wagner	2027	1

6. Conclusion

6.1. There are now twenty governors in post from a potential 28 seats.

6.2. We have appointed two new appointed governors and have another appointment due to start in October. This leaves a vacancy for an appointed governor from Weldmar and a vacant space for another partner organisation where we are exploring the possibility of a working partnership with Two Harbour Healthcare.

6.3 The Council of Governors is still carrying the following vacancies, which we will carry until the next planned elections in September 2026.

7. Recommendations

The Council is requested to

- Note the update on Governor Positions

Name and Title of Author: Sarah Anton, Governor and Membership Manager
Date 12 August 2025

NHS
Dorset County Hospital
NHS Foundation Trust

Report to	Council of Governors	
Date of Meeting	*18 August 2025*	
Report Title	Standing Orders (Annex 6) of the Constitution	
Prepared By	Sarah Anton, Governor and Membership Manager	
Approved by Accountable Executive	Jenny Horrabin, Joint Director of Corporate Affairs	
Previously Considered By	Council of Governors 22 April 2025	
Action Required	**Approval**	Y
	Assurance	N
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	No Implications	
Financial	No Implications	
Statutory & Regulatory	An up-to-date Constitution that reflects the system working expectations of the Health and Care Act 2022 (2022 Act) and the NHS Providers Code of Governance (2022 Code) provides a solid foundation for up-to-date governance arrangements in line with current requirements.	
Equality, Diversity & Inclusion	The Trust's commitment to EDI is strengthened by an up-to-date Constitution which upholds the best practice principles of governance	
Co-production & Partnership	The Constitution is required to be approved jointly by the Board and the Council. Governors have been directly involved in the production of the revised Constitution. There are clear expectations and frameworks within the document that support working in partnership and co-production	

Executive Summary

In March 2025 the Constitution Review and update including the revised standing orders for the Council of Governors were bought to the Dorset County Hospital (DCH) Council of Governors (CoG) for approval.

The Constitution Review and Update was approved as the required ten governors (one third of the CoG) were present to approve. However, for Annex 6, the standing orders of the Council of Governors, nineteen governors (two thirds of the CoG) were required to approve.

In March 2025 DCH CoG only had sixteen governors in post and therefore it was not possible to approve the changes to the standing orders.

In March 2025 fifteen governors approved the changes agreeing that once the required number of governors were in post the item would be brought back to CoG.

Due to recent governor recruitment to the Council of Governors there are now twenty governors in post so the standing orders have been brought back to CoG for approval.

1. The rationale for change

Annex 6 - paragraph	Standing Orders for Council of Governors
1.2	Primacy of constitution missing from the current version
2.1	Cross reference to Constitution and process for amendment missing in the current version
3.3	Appointment of SID as point of contact missing from the current version
4.1.5 (& 4.17.3)	Ability to hold virtual meetings using video or computer link added as missing in the current version.
4.1.6	Requiring an ED to attend a Council meeting missing from the current version
4.2.1	Provision to include the Secretary's right to call a council meeting missing from the current version
4.2.2	Decisions taken in good faith missing from the current version.
4.3.1	Schedule of dates, times and venues to be provided (Liverpool benchmark).
4.5	Clarity on chairing CoG meetings and conflicts included as missing from the current version. Right of a governor to chair COG has been removed as not allowed within the model constitution.
4.10	This is current custom and practice but the current version is silent. Update to support custom and practice
4.14	Clarity on process for amending Council's standing orders. This is missing in the current version. Approval changed from 2/3rds to a majority.
4.17	The Working Group recommended the quorum for Council meetings be reduced to ten governors from a third of all governors to help with quoracy due to vacancies being carried
5.1	Expands power of Council to appoint committees with governors and adds Directors and other persons
7.2, 7.5	Definition of material interests and the power to remove a governor who fails to disclose a material interest – both were missing in the current version
9.1 & 9.2	Compliance was missing Standards of business Conduct and the Standing Financial Instructions.
10.1 – 10.9	Process for resolving disputes between Board and Council was missing in the current version. This recommendation taken from the Liverpool benchmark
11	The requirement to annually review council performance was missing from the current version.

Conclusion

3.1. The recommended changes have been fully discussed and debated by the Council's Working Group.

The changes outlined in Annex 6, the Standing Orders, appended, fall into two categories :-
Yellow highlighted text – is required as the content was missing or inaccurate in the current version
Green highlighted text – recommended for alignment with DHC

Recommendation

Members are requested to:

- **APPROVE** the change in the standing orders.

Annex 6 – Standing Orders for the Practice and Procedure of the Council of Governors

(Paragraph 18)

Interpretation

1.1 Save as permitted by law, the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which they shall be advised by the Secretary).

1.2 If there is any conflict between these Standing Orders and the Constitution, the Constitution shall prevail.

1.3 Any expression to which a meaning is given in the 2006 Act shall have the same meaning in this interpretation and in addition:

Board of Directors shall mean the Chair and Non-Executive Directors and the Executive Directors.

Chair is the person appointed as Chair by the Council of Governors in accordance with this Constitution. The expression "the Chair" shall be deemed to include the Vice Chair or otherwise a Non-Executive Director appointed to preside for the time being over meetings.

Chief Executive shall mean the Chief Executive officer of the Trust.

Committee shall mean a committee appointed by the Council of Governors. Such committees shall be advisory only.

Committee members shall be persons formally appointed by the Council of Governors to sit on or to chair specific committees.

Constitution means the Constitution of the Trust and all annexes to it, as may be amended from time to time.

Council of Governors means the Council of Governors of the Trust

Director shall mean a person appointed to the Board of Directors in accordance with the Trust's Constitution and includes the Chair.

Executive Director means a Director appointed by the relevant Committee of the Board who is a full or part-time employee of the Trust or the holder of an executive office

Governor means a Governor on the Council of Governors.

Lead Governor means the person(s) appointed by the Council of Governors in accordance with Annex 4 paragraphs 3 and 4 of the Constitution to be Lead Governor of the Council of Governors.

Meeting means a duly convened meeting of the Council of Governors;

Motion means a formal proposition to be discussed and voted on during the course of a meeting.

Nominated Officer means an Officer charged with the responsibility for discharging specific tasks within Standing Orders.

Non-Executive Director means a Director appointed by the Council of Governors who is not a full or part-time employee of the Trust or the holder of an executive office

Officer means an employee of the Trust.

Question on Notice means a question from a Governor (notice of which has been given pursuant to Standing Order 4.7.2) about a matter over which the Council has powers or duties or which affects the services provided by the Trust;

Secretary means the Secretary of the Trust or any other person appointed to perform the duties of the Secretary, including a joint assistant or deputy secretary.

Senior Independent Director means one of the Non-Executive Directors who is appointed to be available to Governors if they have concerns that contact through the usual channels has failed to resolve. The Senior Independent Director could be the Vice Chair

SOs means Standing Orders.

General Information

2.1. These Standing Orders for the practice and procedure of the Council of Governors are the standing orders referred to in paragraph 18 of the Constitution. They may be amended in accordance with the procedure set out in Standing Order 4.14 below.

2.2. The purpose of the Council of Governors' Standing Orders is to ensure that the highest standards of corporate governance and conduct are applied to all meetings of the Council of Governors and associated deliberations. The Council shall always seek to comply with the Trust's Code of Conduct for Governors.

2.3. All business shall be conducted in the name of the Trust.

2.4. A Governor who has acted honestly and in good faith will not have to meet out of their own personal resources any personal civil liability which is incurred in the execution or purported execution of their functions as a Governor save where the Governor has acted recklessly. Any costs arising in this way will be met by the Trust. On behalf of the Council of Governors, and as part of the Trust's overall insurance arrangements, the Board of Directors shall put in place appropriate insurance provision to cover such indemnity.

Composition of the Council of Governors

3.1. The composition of the Council of Governors shall be in accordance with paragraph 12 and Annex 3 of the Constitution.

3.2. If the person presiding at any meeting of the Council of Governors has a conflict of interest in relation to the business being discussed, a Non-Executive Director will chair that part of the meeting.

3.3. A Senior Independent Director will be appointed to act as a further point of contact with the Council of Governors in accordance with paragraph 27 of the Constitution.

Meetings of the Council of Governors

4.1. Admission to meetings

4.1.1 Meetings of the Council of Governors must be open to the public (which, for the avoidance of doubt, includes representatives of the press), subject to 4.1.2 and 4.1.3 below.

4.1.2 The Council of Governors may resolve to exclude members of the public or a representative from the press from any meeting or part of a meeting for reasons of commercial confidentiality or for other special reasons.

4.1.3 The Chair may exclude any member of the public or representative from the press from the meeting of the Council of Governors if they consider that that member of the public or representative from the press is interfering with or preventing the proper conduct of the meeting or for other special reasons.

4.1.4 Meetings of the Council of Governors shall be held at least four times each financial year at such times and places that the Chair may determine.

4.1.5 In exceptional circumstances, a member of the Council who is not present at the meeting may participate in the meeting and count towards the quorum if the absent member can hear the voices of the other members and they can hear the voice and see the absent member director by video or computer link.

4.1.6 Without prejudice to the power of the Council of Governors to require one or more of the Directors to attend a meeting of the Council of Governors for the purposes of obtaining information about the Trust's performance of its functions or the Directors' performance of their duties (and decide whether to propose a vote on the Trust's or Directors' performance) at paragraph 17.3 of the Constitution, the Council of Governors may invite the Chief Executive, one or more Directors or a representative of the auditor or other advisors, as appropriate, to attend any meeting of the Council of Governors to enable Governors to raise questions about the Trust's affairs.

4.2. Calling Meetings

4.2.1 Meetings of the Council of Governors may be called by the Secretary or the Chair or ten Governors (including at least five elected Governors and one appointed Governor) who give written notice to the Secretary specifying the business to be carried out. The Secretary shall send a written notice to all Governors as soon as possible after receipt of such a request. The Secretary shall call a meeting on at least fourteen but not more than twenty-eight days' notice to discuss the specified business. If upon receipt of such a request, the Secretary fails to call such a meeting, the Chair or four Governors, whichever is the case, shall call the meeting.

4.2.2 All decisions taken in good faith at a meeting of the Council of Governors shall be valid even if it is discovered subsequently that there was a defect in the calling of the meeting or the appointment or election of the Governors attending the meeting.

4.3. Notice of Meetings

4.3.1 The Secretary shall deliver a schedule of the dates, times and venues of meetings of the Council of Governors for each financial year, three months in advance of the first meeting of the Council of Governors to be called, duly signed by the Chair or by an Officer of the Trust authorised by the Chair to sign on their behalf, to every Governor, or send such schedule by post to the usual place of residence of such Governor. The Council will meet no less than four times in a financial year. Lack of service of the notice on any Governor shall not affect the validity of a meeting, subject to 4.3.4 below.

4.3.2 Notwithstanding 4.3.1, and subject to 4.3.3, should an additional meeting of the Council of Governors be called pursuant to 4.2, the Secretary shall, as soon as possible, deliver written notice of the date, time and venue of the meeting to every Governor, or send by post to the usual place of residence of such Governor, so as to be available to them at least fourteen days but not more than twenty-eight days' notice before the meeting. Such notice will also be published on the Trust's website.

4.3.3 The Chair may waive the notice required pursuant to 4.3.2 in the case of emergencies or in the case of the need to conduct urgent business.

4.3.4 Subject to 4.3.3, failure to serve notice on more than three quarters of Council of Governors will invalidate any meeting. A notice will be presumed to have been served 48 hours after the envelope containing it was posted or, in the case of a notice contained in an electronic communication, 48 hours after it was sent.

4.3.5 Before each meeting of the Council of Governors, the Secretary shall ensure that every Governor is provided with reasonable notice of the details of the business to be transacted in it. In the case of a meeting called by Governors in default of the Chair, no business shall be transacted at the meeting other than that specified in the notice.

4.4. Setting the Agenda

4.4.1 The Secretary shall ensure an agenda, minutes of the previous meeting of the Council of Governors, copies of any questions on notice and/or motions on notice to be considered at the relevant meeting of the Council of Governors. Supporting papers are circulated to every Governor via electronic means, or made available in paper copy, as required, normally at least five days in advance of the meeting.

4.4.2 Approval of the minutes of the previous meeting of the Council of Governors will be a specific item on each agenda.

4.4.3 In the case of a meeting called by the Chair, a Governor desiring a matter to be included on an agenda shall make their request in writing to the Chair at least ten working days before the meeting. Requests made less than ten days before a meeting may be included on the agenda at the discretion of the Chair.

4.5. Chair of Meeting

4.5.1. At any meeting of the Council of Governors, the person presiding shall be determined in accordance with paragraph 17.1 of the Constitution.

4.5.2. At any meeting of the Council of Governors, the Chair, if present, shall preside. If the Chair is absent from the meeting or the Council of Governors is meeting to appoint or remove the Chair or decide their remuneration and allowances and other terms and conditions of office or outcome of annual appraisal, the Vice Chair shall preside.

4.5.3. If the Vice Chair is absent from the meeting, or the Council of Governors is meeting to appoint or remove the Vice Chair or decide their remuneration and allowances and other terms and conditions of office, the Senior Independent Director shall preside.

4.5.4. If the person presiding at any meeting of the Council of Governors has a conflict of interest in relation to the business being discussed, a Non-Executive Director will chair that part of the meeting.

4.6. Notices of Motions

4.6.1 Motions by the Council of Governors may only concern matters for which the Council of Governors has a responsibility or which affect the services provided by the Trust.

4.6.2 Notice of motion to amend or rescind any resolution (or the general substance of any resolution), which has been passed within the preceding six calendar months, shall bear the signature of the Governor who gave it and the signature of four other Governors. When any such motion has been disposed of by the Council of Governors it shall not be competent for any Governor to propose a motion to the same effect within six months; however the Chair may do so if they consider it appropriate.

4.6.3 Subject to 4.6.5 and except in the circumstances covered by 4.8, Governors desiring to move or amend a motion shall send a written notice thereof at least ten working days before the meeting at which it is proposed to be considered to the Secretary, such written notice to be signed or transmitted by at least two Governors. For the purposes of this 4.6, receipt of such motions by electronic means is acceptable.

4.6.4 Upon receipt of a motion, the Secretary shall:

4.6.4.1 acknowledge receipt in writing to each of the Governors who signed or transmitted it; and

4.6.4.2 insert this in the agenda for that meeting, together with any relevant papers.

4.6.5 The following motions may be moved at any meeting without notice:
- 4.6.5.1 To amend the minutes of the previous meeting of the Council of Governors in order to ensure accuracy;
- 4.6.5.2 To change the order of business in the agenda for the meeting;
- 4.6.5.3 To refer a matter discussed at a meeting to an appropriate body or individual;
- 4.6.5.4 To appoint a working group arising from an item on the agenda for the meeting;
- 4.6.5.5 To receive reports or adopt recommendations made by the Board of Directors;
- 4.6.5.6 To withdraw a motion;
- 4.6.5.7 To amend a motion;
- 4.6.5.8 To proceed to the next business on the agenda;
- 4.6.5.9 That the question be now put;
- 4.6.5.10 To adjourn a debate;
- 4.6.5.11 To adjourn a meeting;
- 4.6.5.12 To exclude the public and press from the meeting in question pursuant to 4.1.2 (in which case, the motion shall state on what grounds such exclusion is appropriate).
- 4.6.5.13 To not hear further from a Governor, or to exclude them from the meeting in question (if a member persistently disregards the ruling of the Chair or behaves improperly or offensively or deliberately obstructs business, the Chair, in their absolute discretion, may move that the Governor in question will not be heard further at that meeting and, if seconded, the motion will be voted on without discussion. If the Governor continues to behave improperly after such a motion is carried, the Chair may move that either the Governor leaves the meeting room or that the meeting is adjourned for a specific period. If seconded, that motion will be voted on without discussion.)
- 4.6.5.14 To give the consent of the Council of Governors to any matter on which its consent is required pursuant to the Constitution.

4.6.6 The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

4.7. Questions on Notice at Meetings

4.7.1 Subject to 4.7.2, a Governor may ask a Question on Notice of:
- 4.7.1.1 the Chair;
- 4.7.1.2 another Governor;
- 4.7.1.3 an Executive Director; or
- 4.7.1.4 the chair of any sub-committee or working group of the Council.

4.7.2 Except in the circumstances covered by 4.8, notice of a Question on Notice must be given in writing to the Secretary at least ten days prior to the relevant meeting. For the purposes of this Standing Order 4.7, receipt of any such Questions on Notice via electronic means is acceptable.

4.7.3 A response to a Question on Notice may take the form of:
- 4.7.3.1 A direct oral answer at the relevant meeting (which may, where the desired information is in a publication of the Trust or other published work, take the form of a reference to that publication);
- 4.7.3.2 Where a direct oral answer cannot be given, a written answer which will be circulated as soon as reasonably practicable to the questioner and circulated to the remaining Governors with the agenda for the next meeting.

4.7.4 Supplementary questions for the purpose of clarification of a reply to a Question on Notice may be asked at the absolute discretion of the Chair.

4.8. Urgent motions or questions

4.8.1 The Chair may, in their opinion, table an urgent motion or question.

4.8.2 A Governor may submit an urgent motion or question in writing to the Secretary before the commencement of the meeting at which it is proposed it should be considered.

4.9. Reports from the Executive Directors

4.9.1 At any meeting, a Governor may ask any question on any report by an Executive Director or another Officer through the Chair without notice, after that report has been received by or while such report is under consideration by the Council of Governors at the meeting.

4.9.2 Unless the Chair decides otherwise, no statements will be made by a Governor other than those which are strictly necessary to define or clarify any questions posed pursuant to 4.9.1 and, in any event, no such statement may last longer than three minutes each.

4.9.3 A Governor who has asked a question pursuant to 4.9.1 may ask a supplementary question if the supplementary question arises directly out of the reply given to the initial question.

4.9.4 The Chair may, in their absolute discretion, reject any question from any Governor if, in the opinion of the Chair, the question is substantially the same and relates to the same topic as a question which has already been put to the meeting or a previous meeting.

4.9.5 At the absolute discretion of the Chair, questions may, at any meeting which is held in public, be asked of the Executive Directors present by members of the Trust or any other members of the public present at the meeting.

4.10. Speaking

This Standing Order applies to all forms of speech/debate by Governors or members of the Trust and public in relation to a motion or question under discussion at a meeting of the Council of Governors.

4.10.1 Any approval to speak must be given by the Chair.

4.10.2 Speeches must be directed to the matter, motion or question under discussion or to a point of order.

4.10.3 Unless in the opinion of the Chair it would not be desirable or appropriate to time limit speeches on any topic to be discussed having regard to its nature, complexity or importance, no proposal, speech nor any reply may exceed three minutes.

4.10.4 The Chair may, in their absolute discretion, limit the number of replies, questions or speeches which are heard at any one meeting.

4.10.5 A person who has already spoken on a matter at a meeting may not speak again at that same meeting in respect of that matter unless exercising a right of reply or speaking on a point of order.

4.11. Chair's Ruling

Statements of Governors made at meetings of the Council of Governors shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

4.12. Voting

4.12.1 Subject to the provisions of this Constitution, decisions at meetings shall be determined by a majority of the votes of the Governors present and voting.

4.12.2 All decisions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Governors present so request or if the Chair so directs.

4.12.3 If at least one-third of the Governors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Governor present voted or abstained.

4.12.4 If a Governor so requests, their vote shall be recorded by name upon any vote (other than by paper ballot).

4.12.5 In no circumstances may an absent Governor vote by proxy. Subject to paragraph 4.17.3, absence is defined as being absent at the time of the vote.

4.12.6 An elected Governor may not vote at a meeting of the Council of Governors unless, before attending the meeting, they have made a declaration in the form specified by the Council of Governors of the particulars of their qualification to vote as a member of the Trust and that they are not prevented from being a Governor on the Council of Governors. An elected Governor shall be deemed to have confirmed the declaration upon attending any subsequent meeting of the Council of Governors and every agenda for meetings of the Council of Governors shall draw this to the attention of the elected Governors.

4.13. Suspension of Standing Orders (SOs)

4.13.1 Except where this would contravene any statutory provision or a direction made by the Secretary of State, any one or more of these Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Council of Governors are present and that a majority of those present vote in favour of suspension.

4.13.2 A decision to suspend SOs shall be recorded in the minutes of the meeting.

4.13.3 A separate record of matters discussed during the suspension of SOs shall be made and shall be available to the Directors.

4.13.4 No formal business may be transacted while SOs are suspended.

4.13.5 The Trust's Audit Committee shall review every decision to suspend SOs.

4.14. Variation and Amendment of Standing Orders

These Standing Orders shall be amended only in accordance with the procedure set out in paragraph 44 of the Constitution and only if:

4.14.1 a motion to amend the Standing Orders is signed by five Governors (including at least three elected Governors and two appointed Governors) and submitted to the Secretary in writing at least 21 days before the meeting at which the motion is intended to be proposed; and

4.14.2 the majority of the Governors present and voting vote in favour of the amendment.

4.15. Record of Attendance

4.15.1 The names of the Governors present at the meeting (including when present pursuant to paragraph 4.17.3) shall be recorded in the minutes.

4.15.2 Governors who are unable to attend a meeting shall notify the Secretary in writing in advance of the meeting in question in order that their apologies are submitted.

4.16. Minutes

4.16.1 The minutes of the proceedings of the meeting shall be drawn up and maintained as a public record. They will be submitted for agreement at the next meeting.

4.16.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

4.16.3 The minutes of the meeting shall be made available to the public except for minutes relating to business conducted when members of the public and press are excluded pursuant to 4.1.2 unless otherwise required by law.

4.17. Quorum

4.17.1 Ten Governors shall form a quorum including not less than five elected Governors, and not less than one appointed Governor.

4.17.2 If a Governor has been disqualified from participating in the discussion on any matter and from voting on any resolution by reason of the declaration of a conflict of interest they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

4.17.3 The Council of Governors may agree that its members can participate in its meetings by live and uninterrupted video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

Arrangements for the Exercise of Functions by Delegation

5.1 The Council of Governors may not delegate any of its powers to a committee or sub-committee, although it may appoint committees consisting of its members, Directors and other persons to assist the Council of Governors in carrying out its functions. The Council of Governors may, through the through the Secretary, request that advisors assist them or any committee they appoint in carrying out its duties. Secretary, request that advisors assist them or any committee they appoint in carrying out its duties.

Confidentiality

6.1 A Governor on the Council of Governors shall not disclose a matter dealt with by, or brought before, the Council of Governors without its permission unless:

6.1.1 it is reported to the Council of Governors; or

6.1.2 the matter is in the public domain; or

6.1.3 disclosure is required by law.

6.2 Members of the Nominations and Remuneration Committee shall not disclose any matter dealt with by the Committee, notwithstanding that the matter has been reported or action has been concluded, if the Council of Governors or the Committee resolves that it is confidential.

Declaration of Interests and Register of Interests

7.1. Governors are required to comply with the Trust's Standards of Business Conduct and to declare interests to the Council in accordance with paragraph 20 of the Constitution and any other material interest as defined below. All Governors should declare such interests on appointment and on any subsequent occasion that a conflict arises.

7.2. Subject to the exceptions in 7.3, a "material interest" is:

7.2.1 any Directorship of a company;

7.2.2 any interest or position in any firm, company, business or organisation (including any charitable or voluntary organisation) which has or is likely to have a trading or commercial relationship with the Trust;

7.2.3 any interest in an organisation providing health and social care services to the National Health Service;

7.2.4 a position of authority in a charity or voluntary organisation in the field of health and social care;

7.2.5 any connection with any organisation, entity or company considering entering into a financial arrangement with the Trust including but not limited to lenders or banks.

7.3. The exceptions which shall not be treated as material interests for the purposes of these provisions are as follows:
- 7.3.1 shares not exceeding 2% of the total shares in issue held in any company whose shares are listed on any public exchange;
- 7.3.2 an employment contract with the Trust held by a Staff Governor;
- 7.3.3 an employment contract with a local authority held by a Local Authority Governor;
- 7.3.4 an employment contract with or other position of authority within an appointing organisation held by an Appointed Governor.

7.4. Any Governor who has an interest in a matter to be considered by the Council of Governors (whether because the matter involves a firm, company, business or organisation in which the Governor or their spouse or partner has a material interest or otherwise) shall declare such interest to the Council of Governors and:
- 7.4.1 shall withdraw from the meeting;
- 7.4.2 play no part in the relevant discussion or decision; and
- 7.4.3 shall not vote on the issue (and if by inadvertence they do remain and vote, their vote shall not be counted).

7.5. Any Governor who fails to disclose any interest or material interest required to be disclosed under these provisions must permanently vacate their office if required to do so by a majority of the remaining Governors.

7.6. If a Governor has any doubt about the relevance of an interest, they should discuss it with the Chair who shall advise them whether or not to disclose the interest.

7.7. At the time a Governor's interests are declared, they should be recorded in the Council of Governors' minutes and entered on a Register of Interests of Governors to be maintained by the Secretary. Any changes in interests should be declared at the next meeting of the Council of Governors following the change occurring.

7.8. Governors' Directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's annual report.

Register of Interests

8.1. The Secretary will ensure that a Register of Interests is established to record formally declarations of interests of Governors.

8.2. Details of the Register will be kept up to date and reviewed annually.

8.3. The Register will be available to the public.

Compliance - Other Matters

9.1 All Governors shall comply with the Standards of Business Conduct set by the Board of Directors for the guidance of all staff employed by the Trust.

9.2 All Governors of the Trust shall comply with Standing Financial Instructions prepared by the Chief Finance Officer and approved by the Board of Directors for the guidance of all staff employed by the Trust.

9.3 All Governors must behave in accordance with the Trust's Code of Conduct for Governors as amended from time to time and the seven Nolan principles of behaviour in Public Life: -
- Selflessness;
- Integrity;
- Objectivity;
- Accountability;
- Openness;
- Honesty, and
- Leadership.

Resolution of Disputes with Board of Directors

10.1 Should a dispute arise between the Council of Governors and the Board of Directors, then the disputes resolution procedure set out below shall be followed.

10.2 The Chair, or Vice Chair (if the dispute involves the Chair), shall first endeavour, through discussion with Governors and Directors or, to achieve the earliest possible conclusion, appropriate representatives of them, to resolve the matter to the reasonable satisfaction of both parties.

10.3 Failing resolution under 10.2 above, then the Board of Directors or the Council of Governors, as appropriate, shall at its next formal meeting approve the precise wording of a Disputes Statement setting out clearly and concisely the issue or issues giving rise to the dispute.

10.4 The Chair shall ensure that the Disputes Statement, without amendment or abbreviation in any way, shall be an agenda item and agenda paper at the next formal meeting of the Board of Directors or Council of Governors as appropriate. That meeting shall agree the precise wording of a Response to Disputes Statement.

10.5 The Chair or Vice Chair (if the dispute involves the Chair) shall immediately, or as soon as is practical, communicate the outcome to the other party and deliver the written Response to Disputes Statement. If the matter remains unresolved or only partially resolved then the procedure outlined in 10.2 above shall be repeated. The Disputes Statement must this time set out whether the referral of matter to independent mediation has been considered and if the option of independent mediation has been rejected or has proven unsuccessful in facilitating a resolution.

10.6 If, in the opinion of the Chair or Vice Chair (if the dispute involves the Chair) and following the further discussions/independent mediation prescribed in 10.5 above, there is no further prospect of a full resolution or, if at any stage in the whole process, in the opinion of the Chair or Vice Chair, as the case may be, there is no prospect of a resolution (partial or otherwise) then they shall advise the Council of Governors and Board of Directors accordingly.

10.7 On the satisfactory completion of this disputes process, the Board of Directors shall implement agreed changes.

10.8 On the unsatisfactory completion of this disputes process, the view of the Board of Directors shall prevail.

10.9 Nothing in this procedure shall prevent the Council of Governors, if it so desires and acting through the Lead Governor, from informing NHS England that, in the Council of Governors' opinion, the Board of Directors has not responded constructively to concerns of the Council of Governors that the Trust is not acting in accordance with the terms of its Constitution or not complying with the terms of the 2006 Act.

Council Performance

11.1 The Chair shall, at least annually, lead a performance assessment process for the Council of Governors to enable the Council of Governors to review its roles, structure and composition, and procedures, taking into account emerging best practice.

11.2 The performance assessment process shall include a review of the input into the Council of Governors of each appointing organisation.

Dorset County Hospital
NHS Foundation Trust

Dorset County Hospital NHS Foundation Trust Annual Report and Accounts 2024 – 2025

Healthier lives Empowered citizens Thriving communities

Dorset County Hospital NHS Foundation Trust

Annual Report and Accounts 2024 – 2025

Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

Contents

Statement from the Chair and Chief Executive

Chair's Statement

Welcome to our Annual Report for 2024/25. The landscape of the NHS is changing nationally and it's clear that the way we operate in future will look very different. As we move into that new phase, we will need to navigate new relationships – for example, with the Department for Health and Social Care as NHS England becomes part of that organisation, and relationships may change with significantly reduced Integrated Care Boards, like NHS Dorset.

At the same time, we must still operate effectively in the present, delivering quality care for our communities with an ever-increasing focus on productivity, efficiency and with careful scrutiny of our finances. While these are difficult waters to navigate, the principle of ensuring that as much resource as possible is directed to frontline patient care is, of course, the right one and where our priorities lie.

Our relationship and partnership with our communities is reflected throughout our new joint strategy, with its focus on improving population health, helping people to take care of themselves and helping them to stay well, whilst playing our part in supporting our communities to flourish and thrive.

We have continued to develop the way we work with partners over the last year, and this is a cornerstone in building the health and care services of the future. In our federation between Dorset HealthCare and Dorset County Hospital, we have developed a programme of joint Board workshops which allow directors to work through problems together. Our two Councils of Governors have also been meeting, sharing the valuable perspectives they have from our communities to help inform the way we plan and deliver care.

Our voluntary and community sector is increasingly working alongside us, bringing the considerable knowledge, capability and capacity of thousands of active organisations to work alongside public sector partners for the benefit of communities. A special mention must go to our hospital charity – they offer their energy and passion to fundraising and have made a huge difference. Their Emergency and Critical Care Appeal has reached its first major milestone of £500,000 and they are continuing to support a host of local fundraising events and initiatives to reach their £2.5million appeal target. The appeal will fund significant enhancements to the new Emergency Department and Critical Care Unit that is being built on the old Damers School site.

More broadly across our system, we have also organised three-way Board workshops with our own two trusts and University Hospitals Dorset. While the urban and rural populations of these two areas may be different, it's incredibly important that we strive for equity of access

and outcomes for everyone living in our county, whatever their needs and situation.

The Our Dorset Provider Collaborative includes these three NHS providers as well as our primary care colleagues, working in GP practices at local level. These are also incredibly important relationships and the progress already being made to improve the flow of patients through urgent and emergency care is testament to what can be achieved by working more closely together. I look forward to seeing this work come to fruition and make a real difference in our communities.

At the heart of any NHS organisation is its people and our staff have continued to do a fantastic job, even as things have felt much harder than in the past. Our NHS Staff Survey results are a useful temperature check, and I am pleased to say that we are above our benchmark average in five of the seven People Promise elements. It's been a real pleasure to meet colleagues on visits to our sites - Dorset County Hospital teams have a strong focus on our communities and are working hard to adapt to some big changes and take charge of our destiny. I'd like to thank everyone for their commitment to our patients and for their kindness, compassion and support for each other.

We have already begun to build the foundations for the new NHS the Government is looking to create. In some cases that will be literal such as the foundations of the new development for which we've won funding through the New Hospital Programme being laid. But it's also more than that, it's the opportunity for all of us to rethink our relationship with our own health and wellbeing and build the resilience and capacity of our communities to better support themselves.

I'd like to thank our committed Council of Governors for their useful input through the year and I'm also grateful to our executive and non-executive directors for their ongoing efforts through the many changes we face.

While the current financial challenges are difficult and concerning, they do open the door and give us permission to try something radically different which we might not otherwise have dared to do. There are many opportunities and I'm confident that colleagues will grasp the nettle and make the most of them to do the best we can for our communities. At every Board meeting we hear an inspiring patient story that demonstrates the difference we are making for people and how we can improve. I know we will continue to keep both those things in mind in all we do.

Signed

David Clayton-Smith
Trust Chair

Chief Executive's Statement

At its heart the NHS is all about people – those who need our support and their carers and loved ones, those who provide care, and those we work with in our own and other organisations. At Dorset County Hospital the relationships between these people are central to our commitment to provide high quality, person-centred care.

Throughout the year we have heard many patient stories illustrating the impact our services make for them, as well as the improvements we could make. Working in partnership with people and communities is crucial as we move into a new period of change and build the NHS of the future.

That major transformation in the NHS began this year as the new Government set out its plans to make our health service fit for the future. With a backdrop of ongoing economic challenges and reduced resources available across public sector, we have begun a journey which will see the most significant changes to the NHS in well over a decade.

Informed by a national engagement exercise, we will soon have a 10-year plan for the health service which will deliver a shift from care in hospitals to the community, analogue delivery to digital wherever possible and treatment to prevention. This last shift is particularly important as we work together with partners to support our communities to thrive and individuals to look after themselves and stay well for longer.

This is reflected in our new joint strategy for Dorset HealthCare and Dorset County Hospital – Working together, improving lives. The strategy was approved by the Board in July 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. We must do this in the context of significant financial challenges as a health and care system in Dorset and the need to ensure we make the most of our limited resources.

We continue to strive for the difficult balance between providing services today and planning for what is needed tomorrow. This puts considerable pressure on colleagues and so holding to our strategic direction and to our values is particularly important for us in this time of change.

We have continued this year to use a range of measures that help us to carefully scrutinise and manage our spend whilst focussing on delivering safe, effective care and improving outcomes and experience for the people we serve. We know we will need to go further, with requirements to reduce our spend on corporate services well as transforming our clinical services.

We have further developed our federation with Dorset HealthCare, with some support and

corporate services now being delivered as one team and more planned for the coming year. Clinical services such as stroke have also benefited from the federated approach, simplifying pathways for our patients and improving health outcomes.

Our ongoing work with wider partners is central to making this work and some major transformation programmes have got underway this year which will help us shape the future. These include Integrated Neighbourhood Teams (INTs), which will be the vehicle for providing the community health service aspirations set out in the Government's plans. This is being led by Dorset HealthCare and the General Practice Alliance, strengthening our work with primary care colleagues. The teams will work together to improve the health of the population in their neighbourhood area and ultimately reduce the demand on our acute hospitals.

The FutureCare programme works alongside the development of INTs to improve the flow of people who need urgent and emergency care. This way of working puts a focus on avoiding admission to hospital wherever possible and safely discharging people as quickly as possible. We know that people recover better in their own environment. FutureCare will help reduce the pressure on our acute hospitals so that they can focus on those in most need.

Through the Our Dorset Provider Collaborative we are looking at opportunities for joint working across all providers, including University Hospitals Dorset and primary care. This includes exploring new ways of working, such as the establishment of a subsidiary company which could provide some support services like procurement and estates management. This is a direction of travel being recommended by NHS England for all trusts and we are in the midst of developing an approach for our three provider trusts.

Central to these programmes, and to all our work, is a clear commitment to working with people and communities to identify and respond to their needs and preferences in the way they access services. Our voluntary and community sector partners play a particularly important role here, representing a wide range of groups and communities and, increasingly, taking on the delivery of some services where it makes more sense for them to do so.

The challenges we have been tackling have inevitably had an impact on colleagues and we continue to place a strong emphasis on supporting health and wellbeing and developing colleagues to manage change. Our NHS National Staff Survey results have remained above the average in our benchmark group for five of the seven People Promise elements. Kindness and compassion will continue to be crucial as we go into what we know will be another tough year.

What I have found particularly inspiring is the way colleagues have continued to innovate, improve and develop despite the difficulties. We have shared numerous successes this year including:

- We opened a new CT scanner at Weymouth Community Hospital to offer tests closer to home and an operating theatre was also upgraded at the hospital to enable DCH to perform a range of elective surgeries and reduce waiting lists.
- We opened a new unit for people having orthopaedic surgery including a new admissions lounge and therapy suite.

- We started a £2million refurbishment project on the Fortuneswell Unit for patients undergoing chemotherapy, funded by the Trust and the DCH Charity's Chemotherapy Appeal.
- We changed the public access to the Emergency Department to enable construction work on the New Hospital Programme-funded ED and critical care unit project. Our charity's appeal to support enhancements to the new facilities hit £500,000 in its £2.5million appeal.
- A £2million project transformed a procedure room into an operating theatre for special care dentistry and other surgeries.

The hard work and resilience of colleagues makes this progress possible, alongside their team spirit, compassion for everyone around them and their ability to adapt and find new ways to work and deliver services. I am confident that we have the vision and the capability we need to help shape healthcare services for the future.

Signed

Matthew Bryant
Chief Executive

Performance Report

Overview of the Trust

Purpose of the Overview

The purpose of the overview is to provide the reader with sufficient information to gain an understanding of Dorset County Hospital NHS Foundation Trust, our purpose, the key risks to the achievement of our objectives and how we have performed during the financial year 2024/25. This Annual Report should be read in conjunction with the 2024/25 Quality Account.

About the Trust

Dorset County Hospital NHS Foundation Trust has a joint strategy as part of the federation with Dorset HealthCare. Their mission is to work in partnership to provide high quality, compassionate services and to nurture an environment where people can be at their best. Dorset County Hospital NHS Foundation Trust achieved Foundation Trust status on 1 June 2007 under the Health and Social Care (Community Health and Standards Act 2003). It 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 Trust serves a population of approximately 250,000 people but provides specialist services including Renal Services to the whole of Dorset and South Somerset. The population served has a proportion of older patients much greater than the national average (over 65 years representing 30% of the total population vs 19% for England and Wales). Dorset continues to experience an increasing total population, with 0.4% per annum forecast in the coming years, and the older population growing around 2% per annum. The main hospital opened on its current site in 1987, with major additions in 1996, and is situated centrally in the county town of Dorchester. 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. As a Foundation Trust, Dorset County Hospital is accountable to Parliament, rather than the Department of Health, and is regulated by NHS England. We are part of the NHS and are committed to meet the national standards and targets set us. Our governors and members ensure that we are accountable and listen to the needs and views of our patients.

The Trust provides the following services for patients:

- Full Emergency Department services;
- Emergency assessment and treatment services, including critical care (the hospital has trauma unit status);

- Acute and elective (planned) surgery and medical treatments, including day surgery and endoscopy, outpatient services, older persons services, acute stroke care, cancer services and pharmacy services;
- Comprehensive maternity services including a midwife-led birthing service, community midwifery support, antenatal care, postnatal care and home births. We have a Special Care Baby Unit;
- Children's services including emergency assessment, inpatient and outpatient services;
- Diagnostic services such as fully accredited pathology, liquid based cytology, CT scanning, MRI scanning, ultrasound, cardiac angiography and interventional radiology;
- Renal services to all of Dorset and parts of Somerset;
- A wide range of therapy services, including physiotherapy, occupational therapy and dietetics;
- An integrated service with social services to provide a virtual ward enabling patients to be treated in their own homes.

The Trust is organised internally into two Divisions - the Urgent and Integrated Care Division and the Family and Surgical Services Division. Each Division has responsibility for general business: workforce, education, access and flow, space utilisation, budget and capital and strategic planning. The Divisions are further split into Care Groups according to specialties, and have responsibility for governance: safety, clinical effectiveness, safeguarding and patient experience.

The Divisions report into the Trust Board Committees formally on a bi-monthly basis. Informal committee meetings are held in the intervening months. The Committees and their remits are as follows:

- Finance and Performance Committee provides finance and access assurance
- Quality Committee provides quality assurance
- Audit Committee has a corporate governance responsibility to provide Board Assurance Framework, corporate risks, internal and external audit assurance
- People and Culture Committee oversees the Trust's People Strategy, monitors standard workforce metrics, and recruitment strategies and approaches.
- Strategy, Transformation and Partnership Committee oversees delivery of the Trust's strategic objectives and priorities, and all collaborative and partnership arrangements.

The Board of Directors meets bi-monthly and is supported by the assurance and performance sub-committees, with the Board Assurance Framework capturing the risks to delivery of Trust strategy. The Board and sub committees have formal minutes, and the Senior Management Team provides strategic and operational support to the Board of Directors and its sub-committees.

Dorset was one of the first regions to signal the intention to form an Integrated Care System (ICS) in 2018. 'Our Dorset' was formed in 2021 as a new partnership of two local councils, NHS services and the voluntary sector, and obtained final legal standing in July 2022 when

the Integrated Care Board (ICB) began operations. The ICB published its Five Year Plan in January 2023, the Strategic Objectives within which the Trust is committed to supporting.

As part of the collaborative working across the Dorset System, there are several key groups to ensure that there is an aligned approach to meeting the needs of the Dorset population. These groups are cross-cutting across the breadth of the services provided.

Highlights of the Year

May 2024
We opened a new CT scanner suite at Weymouth Community Hospital as part of a national drive to offer tests closer to home and help shorten waiting lists. The new suite was introduced as part of NHS England's Community Diagnostics Centre (CDC) programme and the Targeted Lung Health Check (TLHC) programme and was carried out in collaboration with Dorset HealthCare and University Hospitals Dorset.

May 2024
Patients and staff met (the then) Secretary of State for Health and Social Care Victoria Atkins when she visited our Outpatient Assessment Centre at South Walks House in Dorchester and the construction site of our new Emergency Department and Critical Care Unit.

August 2024
A new dedicated unit for people having orthopaedic surgery officially opened. Existing ward space was transformed into the Ridgeway Elective Orthopaedic Unit, which includes a new admissions lounge for people coming in for orthopaedic surgery and a therapy suite to support patients with their recovery.

September 2024
An operating theatre at Weymouth Community Hospital was upgraded to allow Dorset County Hospital to perform a range of elective surgeries and reduce waiting lists. Dorset HealthCare, which manages Weymouth Community Hospital, refurbished and upgraded the theatre.

October 2024
An initiative to support patients who are unexpectedly admitted to hospital hit a milestone. The Friends of Dorset County Hospital have been donating comfort bags, filled with essential toiletries, to patients in ED and families in the Special Care Baby Unit. The charity donated more than 1,000 comfort bags to patients since launching the initiative in May 2023.

October 2024
Works to transform Fortuneswell Unit for patients undergoing chemotherapy treatment started. Funded by the Trust and money raised from Dorset County Hospital Charity's Chemotherapy Appeal, the £2million refurbishment will include a revised layout with more space, better facilities and an outdoor courtyard space.

November 2024
A procedure room at Dorset County Hospital was transformed into a full operating theatre for Special Care Dentistry and other surgeries. The £2million project was jointly funded between DCH and NHS Dorset, which commissions the Special Care Dentistry service provided by Somerset NHS Foundation Trust at the main hospital site.

November 2024
The latest Urgent and Emergency Care Survey results were issued. The positive results highlighted how Dorset County Hospital continues to provide good urgent and emergency care, despite the ongoing pressures faced by Emergency Departments throughout the country. DCH scored 'better than expected' in overall patient experience in comparison with other trusts, with 82% rating their experience highly.

November 2024
Our Endoscopy Department achieved their JAG accreditation. This is only awarded to high-quality gastrointestinal endoscopy services and was a huge achievement.

January 2025
Dorset County Hospital Charity's Emergency and Critical Care Appeal reached £500,000, its first major milestone. The £2.5million appeal will fund significant enhancements to the new Emergency Department and Critical Care Unit that is being built on the old Damers School site.

February 2025
We changed the names of some of our outpatient areas at the Dorset County Hospital site so they are no longer specialty-specific. Orthopaedic Outpatients became Sandsfoot Outpatients; Women's Health became Maumbury Outpatients and the middle area of what was previously Medical and Surgical Outpatients became Fleet Outpatients.

March 2025
In order to keep emergency services running smoothly during the construction work of the Trust's new Emergency Department and Critical Care Unit, the way the public accesses the hospital's existing ED changed in March 2025. People arriving at the current ED on foot or by car now access the department via South Wing, Entrance 1.

Strategy and Objectives

After a thorough process of development, engagement and refinement, the Joint Strategy was approved in July 2024. This strategy is titled **Working together, Improving lives** and runs from 2024 – 2029. It is the first to encompass both Dorset County Hospital and Dorset HealthCare NHS Foundation Trusts, creating a joint vision, mission and strategic objectives.

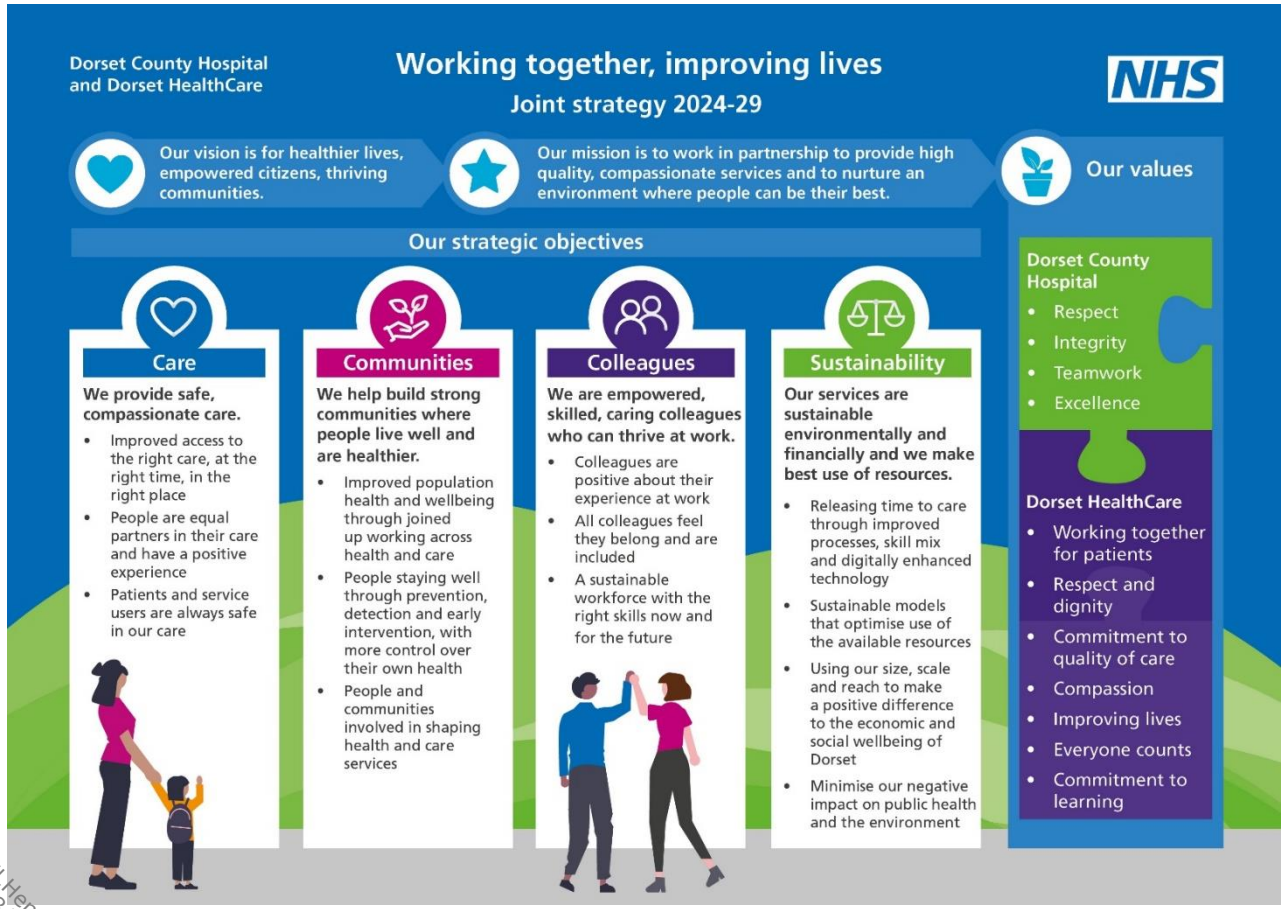
We are very grateful to the support and contributions from all our stakeholders that we worked with to shape the strategy in ways that are meaningful to them. This includes the people and communities we serve, patients and service users, staff, health, care and Voluntary Community and Social Enterprise partners.

As part of our engagement work, we consistently heard the words below and they form part of the strategy.

Compassion	*Kindness*	*Together*	*Integrated*	*Quality*
Respect	*Empowering*	*Excellence*	*Community*	*Thriving*

The strategy was developed to align with the ambitions of the Dorset's Integrated Care System (ICS) Joint Forward Plan. It also aligns well with the Dorset Integrated Care Partnership Strategy. This ensures we are positively contributing to the health and wellbeing of the Dorset population and those we serve.

Further detail about the strategy is available on the Trust website.



Performance Overview

The performance report is based on the requirements of a Strategic Report as set out in with sections 414A, 414C and 414D(6) of the Companies Act 2006, except for sections 414A(5) and (6) and 414D(2) which are not relevant.

Summary of operational performance

The Trust's Emergency Department has seen strong performance against the four-hour standard, which has been sustained throughout the year, with expected seasonal variation.

Through effective system working with other partner organisations, and with tried and tested surge plans, the fluctuations in demand, seen because of seasonal variation has been managed safely. There was a continued mismatch between capacity and demand for ongoing care packages that support the safe discharge of patients. This results in patients staying in acute hospital beds when they are medically fit for discharge, causing a backlog in the Emergency Department for patients that require beds on the wards. Patient safety remains the top priority and has been maintained.

The waiting times for planned surgery have reduced in year, with the Trust eradicating the number of patients waiting over 65 weeks for treatment, except for one patient due to complex care needs, with treatment planned for April 2025. Waiting times at the end of the COVID-19 pandemic had increased to over 104 weeks. The Trust is expected to reduce the proportion of the waiting list that is waiting over 52 weeks to 1% by March 2026.

Improvements in productivity have been made with the return to operating in Weymouth Hospital and the development of Theatre 8 at Dorchester, which has enabled the Trust to deliver 12.3% more elective activity (volume) that the pre-COVID baseline year of 2019/20. This has meant, that despite a growth in elective demand, the Trust has been able to reduce the total incomplete Referral to Treatment waiting list size from 21,836 to 20,761.

The Trust has performed well against cancer waiting time standards compared to previous years and whilst not all national performance standards have been achieved every month, the Trust has benchmarked well against other providers of a similar size and demographic. Performance of the 28 days to diagnosis against the operating plan has been achieved for seven out of 12 months and cancer 62-day treatment standard has been achieved for nine out of 12 months. The waiting list size has fluctuated month on month, but compared to previous year it has not grown, despite an increase in referral demand.

Referral demand has increased by 7% compared to 2023/24 and to keep up with this demand, the Trust has responded by increasing activity using established insourcing partners and improved productivity.

Performance against the six-week diagnostic standard has been challenging throughout the year, ending with 82.83% of patients having their diagnostic test within six weeks, compared to 81.52% at the start of the year. Diagnostic services have seen an increase in demand via the emergency and elective pathways because of increased demand at the front door, increase in cancer two- week wait referrals and an increase in elective activity. The increase in demand has been managed with additional capacity through insourcing providers and a

new workforce model in cardiology.

The Trust recognises that maintaining and improving performance standards in 2025/26 will present ongoing challenges due to rising demand and the challenging financial climate. Focus on efficiency and productivity will increase further, to ensure the maximum level of activity can be delivered with every pound spent. Teams remain committed to reducing waiting times for elective pathways and to improving patient flow throughout the hospital. Work through the Dorset Provider Collaborative, will deliver greater collaboration between Dorset County Hospital, Dorset HealthCare and University Hospitals Dorset, to utilise the capacity and available resources at a system level rather than an organisational one.

Going Concern Statement

International Accounting Standard 1 (IAS1) requires the board to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. In the context of non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The financial statements should be prepared on a going concern basis unless there are plans for, or no realistic alternative other than, the dissolution of the Trust without the transfer of its services to another entity within the public sector.

After making enquiries, the directors have a reasonable expectation that the services provided by the NHS Foundation Trust will continue to be provided by the public sector for the going concern period, being 12 months from the date of signing this Annual Report.

In preparing the financial statements, the Board of Directors have considered the Trust's overall financial position against the requirements of IAS1.

The Trust is reporting a surplus of £13million for the year ended 31 March 2025. As at 31 March the Trust had a closing cash position of £25.2million.

The Trust has submitted a planned deficit before technical adjustments of £9.7million for 2025/26 and a closing cash position of £7.2million.

The Trust has contracts with national and local commissioners for 2025/26 and is planning to deliver services for the going concern period, and the Board of Directors have made no decision to discontinue any operations, transfer services or significantly restructure the organisation. The regulator (NHS England) has not issued any communications that impact the Trust's going concern requirements.

The Directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual

Financial Performance

In 2024/25, the Trust's financial plan recognised the increased demand for NHS services, bringing with it further financial pressures due to the need to address the ongoing recovery of elective service waiting lists experienced across the country. The Dorset Integrated Care System submitted a breakeven plan with the Trust also submitting a breakeven plan against

the adjusted control total position and after technical adjustments with a challenging £14.4million efficiency target.

Following the receipt of an additional £13.0 million structural deficit support funding from NHS England in March 2025, the Trust delivered a surplus of £13.0 million before technical accounting adjustments, effectively achieving the planned breakeven position before recognition of the deficit support. The support was provided to recognise likely underfunding in DCH allocations, however due to the late notification of this funding significant and non-recurrent mitigations had already been established to compensate resulting in the final surplus position. The £13.0 million surplus equates to approximately 3.68% of the Trust's turnover. The position before and after technical adjustments is shown in Table 1 below. The adjusted surplus position removes donated capital assets and impairment movements in year from the operating surplus these figures offset, in line with accounting guidance.

Table 1 : Financial Performance against Plan	2024/25 Plan £ millions	2024/25 Actual £ millions	Variance £ millions
Total income	303.8	354.2	50.4
Total expenses	(303.8)	(341.2)	(37.4)
Operating (deficit)/surplus	0.0	13.0	(13.0)
Capital donations	(0.5)	(0.5)	0.0
Donated depreciation	0.5	0.5	0.0
Impairments	0.0	0.0	0.0
Adjusted (deficit)/surplus	0.0	13.0	13.0

Performance Against Plan

Income exceeded planned levels to the value of £50.4million. The Trust earned £11million of Elective Recovery Funding above plan following overachievement against planned activity levels. There was significant improvement on all areas with 65 week waiting lists and within cardiology. In addition to the £13million of structural deficit support, a further £14million of System Support was received throughout the year. Other areas of income improvement included funding to support Community Diagnostic Centres, Virtual Wards, Targeted Lung Health Check and additional staff posts.

Expenditure was £37.4million above plan. There was significant pressure on expenditure budgets relating to: increased quantity and inflation on drugs, insourcing costs to drive the improved elective service activity, hyperinflation, nationally mandated pay awards and underachievement of efficiency plans.

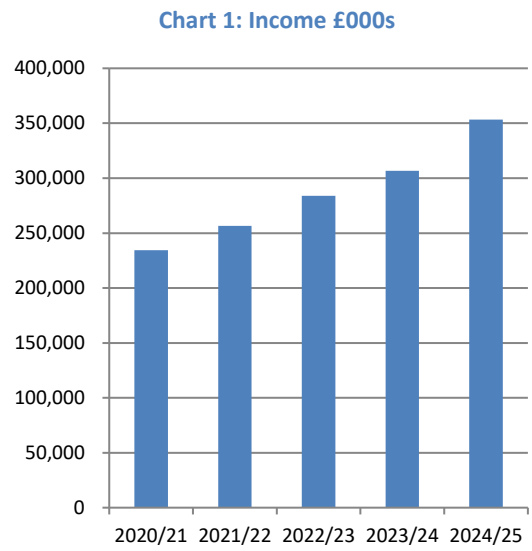
Revaluation of Land and Buildings

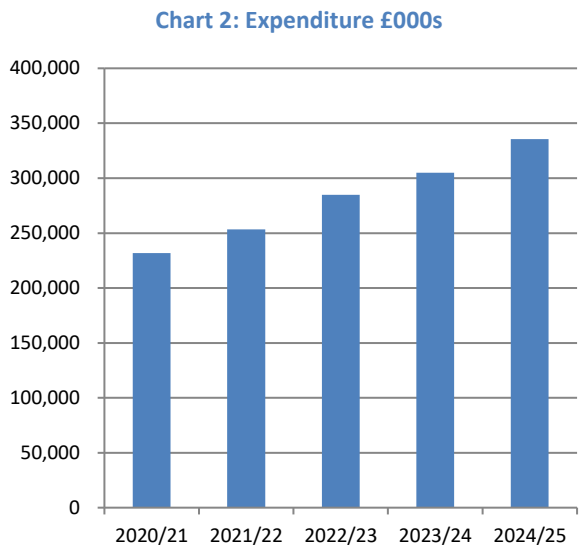
As part of the preparation of the annual accounts, the Trust is required to assess the value of its land and buildings. This exercise is carried out at the end of the financial year. This year, the Trust had a desktop valuation by Avison Young. Overall, there was a decrease in valuation of land and buildings of £1.3million. This included a charge to the Revaluation Reserve of £1.4million for impairments and a charge to other operating expenses in the

Consolidated Statement of Comprehensive Income for impairments of £0.4million and reversals of impairments of £0.4million.

Trends in Income and Expenditure

The charts below show the trends in income and expenditure over the five-year period from 2020/21 to 2024/25.





Trends

Chart 1 shows the growth in income over the five-year period from April 2020 to March 2025. This growth in income is at an average rate of 51% per year over the five-year period. From 2020/21, this is primarily the result of the non-recurrent funding received to support the growing impact of rising inflation, increased activity levels, high cost of drugs in order to deliver elective recovery of services.

Chart 2 shows the growth in expenditure over the five-year period. Expenditure has increased at an average rate of 9% per year. This is primarily the result of challenging costs linked to rising inflation, increased activity levels, heightened operational pressures, high cost of drugs and under delivery of recurrent efficiency targets.

Cost Improvement Programme

The Trust delivered £9.6 million of cost improvements in 2024/25, against a challenging £14.4 million efficiency target. While the Trust did not reach the full target, the delivery of £9.6 million was double the levels achieved by the Trust in previous years. The Trust delivered significant cost reduction associated with agency savings, savings as a result of contract negotiation, pay savings resulting from restructure and vacancies and also improvement from income generation including bank interest.

Cash Flow

The Trust ended the year with £25.2 million cash. This was an increase of £16.4million during the year. The increase in the cash position is due to the surplus achieved relating to the £13.0 million cash support, plus national revenue support in the form of additional Public Capital Dividend and an increase in the working capital position.

Charitable Funding
The Trust is fortunate to be supported by Dorset County Hospital Charity and a number of other local charities. All Dorset County Hospital Charity funds benefit the Trust. In 2024/25, the Trust received charitable grants for capital projects from the Charity of £0.5million.

Capital Expenditure
Capital expenditure during 2024/25 was focused on completion of the elective recovery project for Ridgeway Ward, Fortuneswell Chemotherapy Unit refurbishment, conversion of a Procedure Room into a fully-fledged Operating Theatre, backlog maintenance, medical equipment, investment in digital projects and enabling works for the New Hospital Programme with main construction works commencing in March 2025. The Trust's capital plan is set through a risk-based approach to ensure continuity of patient care. The Trust set its capital plan at £30.0million and incurred expenditure of £22.5million. The underspend was due to an agreed updated project phasing of the New Hospital Programme with NHS England.

Performance Analysis

Monitoring Trust Performance
Dorset County Hospital NHS Foundation Trust is committed to the principles of good governance, and this includes a robust approach to performance management and performance improvement. The Board aspires to providing the best services within the resources available, ensuring patient safety and experience are prioritised.

The Board monitors Trust performance against a range of key national and local objectives and targets as agreed with Dorset system partners. The Board Assurance Framework ensures that the Board's focus is on the key risks to delivery of the organisation's principal objectives. This is in turn is linked to the Corporate Risk Register to ensure that all necessary mitigations are in place to reduce risk wherever possible.

This process seeks to encompass the achievement of the broader strategic objectives agreed by the Foundation Trust Board and other enabling strategies to ensure a clear line between national requirements, contractual obligations, and strategic business priorities of the Trust.

The Trust recognises that health inequalities are at risk of widening with the ongoing economic challenges facing the country. Economic instability impacts rural communities such as the west of Dorset disproportionately and those from ethnic minority groups, individuals with learning disabilities, those that are from areas of deprivation and/or are suffering from mental health conditions are most likely to experience further widening of health inequalities. Waiting list performance by ethnicity, learning disability and deprivation has been reported via the Trust's Finance and Performance Committee. The Trust continues to offer virtual appointments where clinically appropriate, reducing travel costs for patients and offering a more flexible approach, which may better support family life and those with dependants. Increasing activity in the community, with increased capacity in the Hospital at Home team, the introduction of virtual wards and a return of some outpatient clinics in community locations, has increased the accessibility of hospital services.

Staffing levels across the Trust have much improved, with a record low vacancy rate thanks to the success of various recruitment strategies, particularly in nursing. This has meant the use of agencies has reduced, saving money and improving the consistency of care. Some key specialist areas such as ophthalmology and trained theatre staff continue to be challenged, something which is seen nationally. Work with the Provider Collaborative is mitigating some of these risks, exploring all options to move to a more shared workforce approach, across Dorset.

Moving into 2025/26, the Elective Recovery Fund (ERF) will continue but with amended guidance from NHS England. The amount of money allocated to spend on elective recovery has reduced, which means to deliver the activity targets and performance standards, the gap will need to be delivered with further efficiency and productivity improvements. However, the good performance seen in 2024/25 has put the Trust in a good starting position and as such, the 2025/26 performance trajectories are all set to deliver against the national ask.

The Trust's performance trajectories were agreed as part of the 2024/25 contracting round

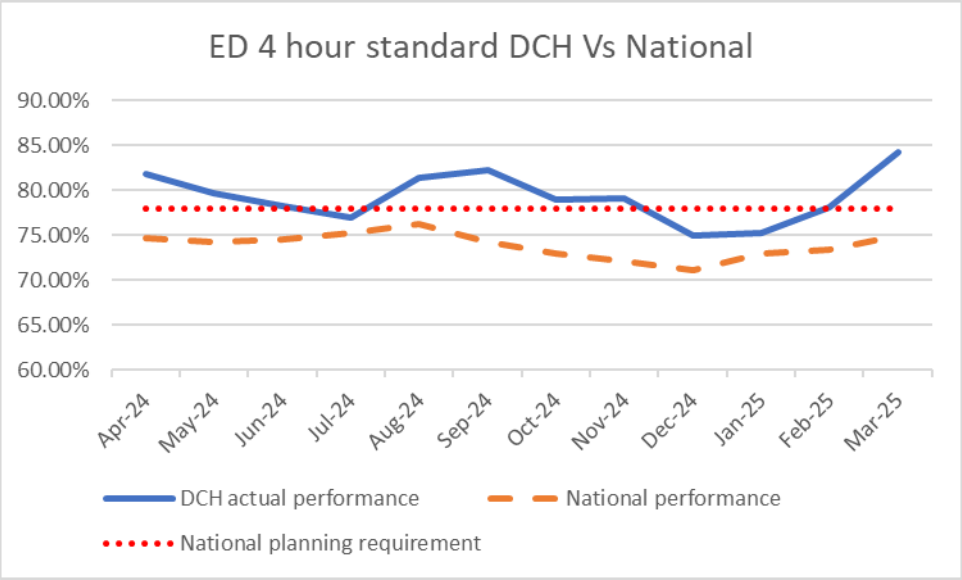
and included the following five key performance indicators:

- Emergency Department waiting times,
- Referral to Treatment waiting times,
- Elective activity volumes,
- Diagnostic waiting times and
- Cancer waiting times.

Operational Performance: The Emergency Department
In 2024/25 the Emergency Department experienced 2% fewer attendances than the previous year but 8.19% more when compared to the pre-COVID comparable year (2019/20). The drop in the number of ED attendances in 2024/25 compared to 2023/24 is not being caused by a drop in demand, but rather a change in the pathway. Same day emergency care (SDEC) activity is recorded nationally as an admission. SDEC capacity was increased during 2024/25, as it enables a reduction in length of stay (LoS) by preventing admission to a ward. SDEC activity increased by 21%.

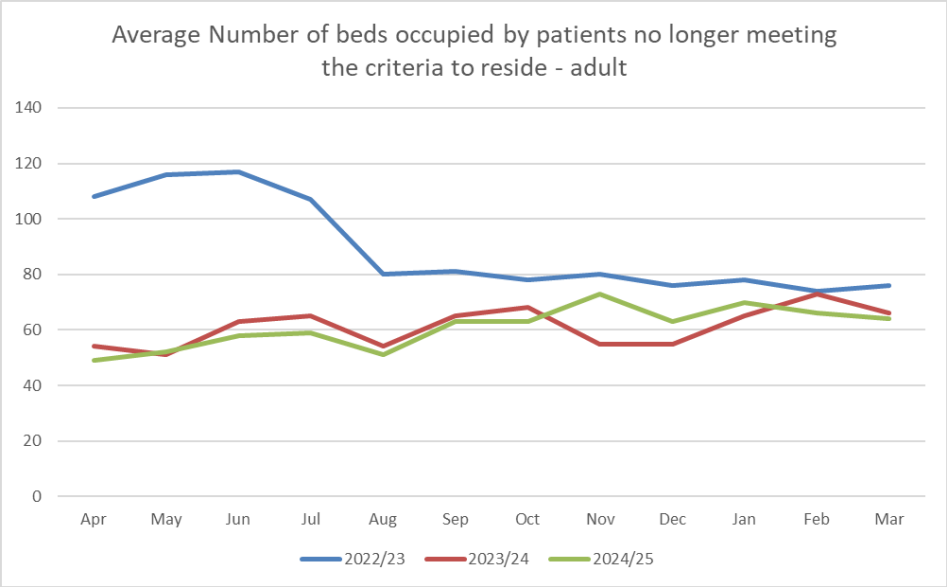
The percentage of patients that have been admitted from an ED attendance remained static between 36% and 38%, apart from during peak times of seasonal variation (winter) where it hit 44%. This is no notable change in the proportion of patients admitted than the previous year.

The combined Type 1 and Type 3 performance (Emergency Department and Urgent Care Centre) did achieve the national ask of 78%, nine out of 12 months. Performance all year tracked above the national performance. This performance was achieved against the operational challenges that restricts on hospital flow due to the continued high levels of patients with no reason to reside.



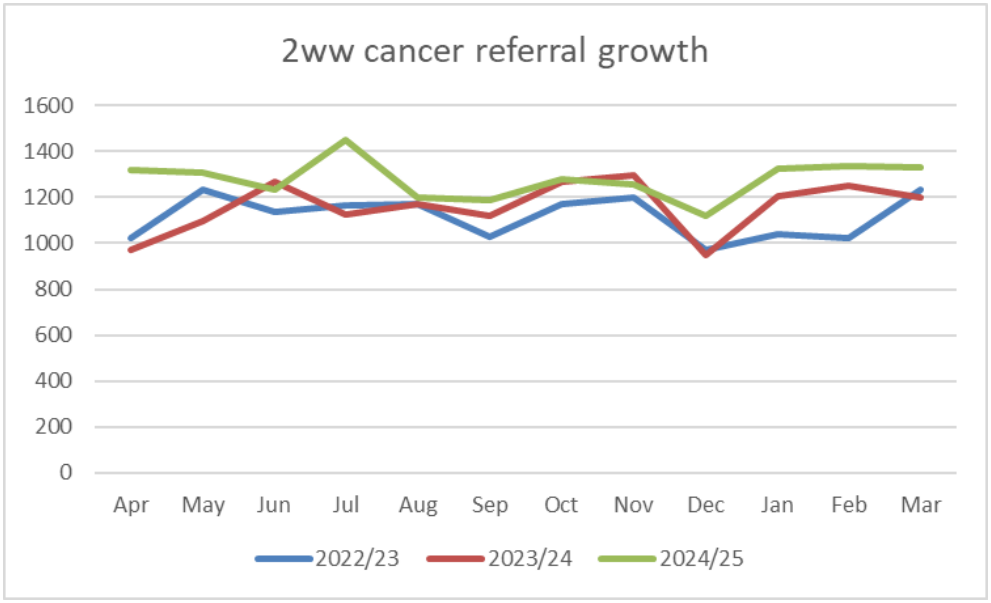
For 2024/25 the Trust continued to see the percentage of beds that were occupied by patients with 'no reason to reside' to be lower than the peak of 2022/23 but tracked at a similar level to that of 2023/24. These are patients that are medically fit for discharge but are

waiting on a care package to enable them to go home or return to an out of hospital care setting. This continuation of performance, with an aging population, is a positive outcome and follows a multiple stranded plan, working with system partners and the Council in a multidisciplinary way. However, the Trust and its partners recognises that if A&E waits are to be improved to the constitutional standard, more needs to be done.



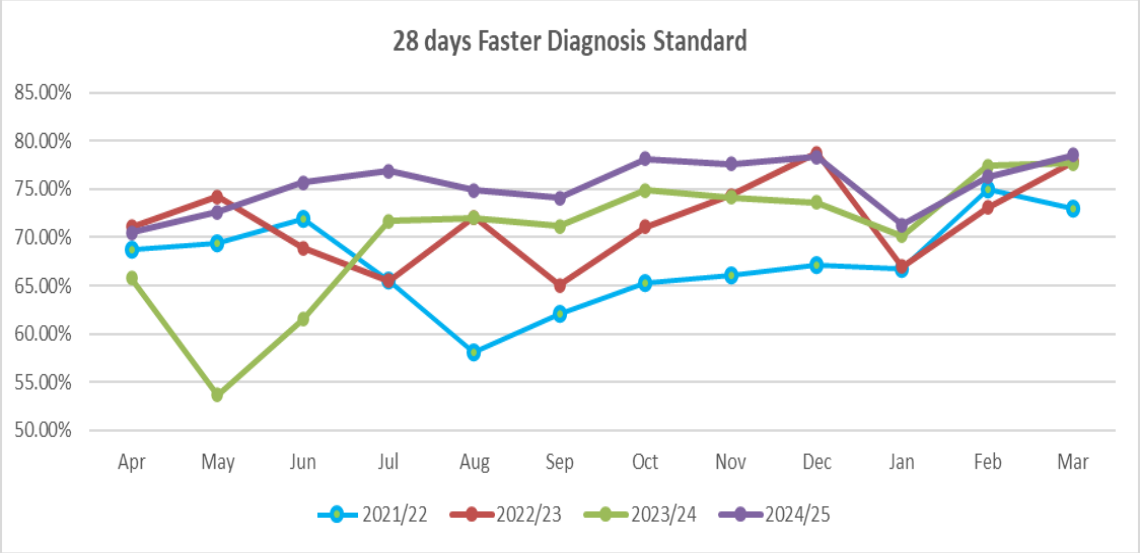
Operational Performance: Cancer Waiting Times

The Trust has experienced another year of increases in the demand for cancer services. The number of referrals to the two-week referral pathway increased by 10.18% compared to 2023/26 and 50.18% compared to 2019/20, the pre-COVID comparable year.

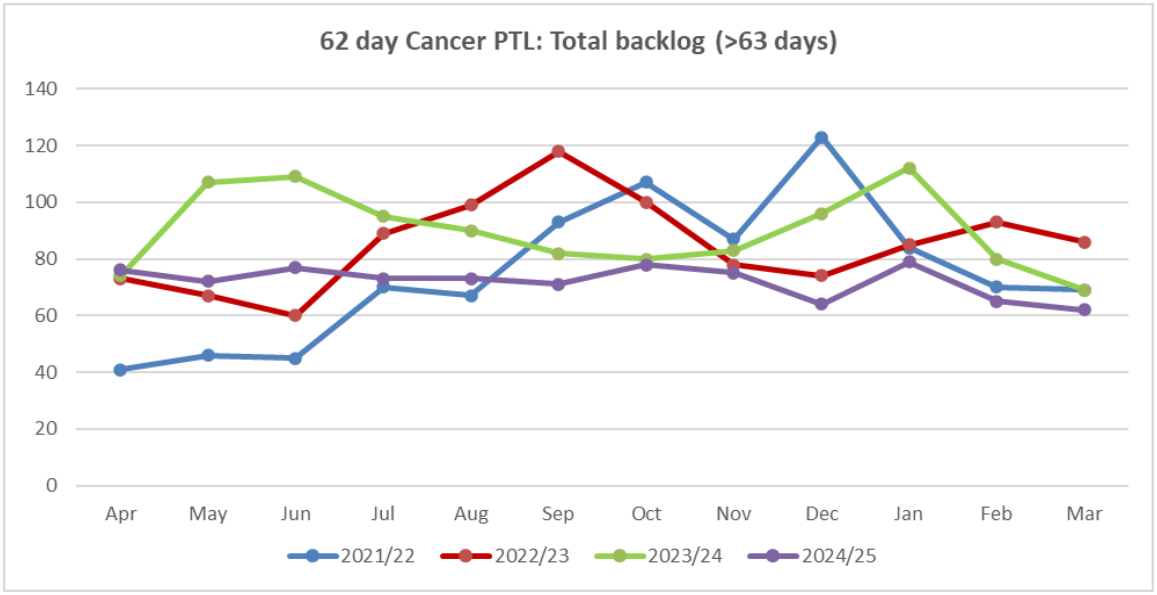


Performance against the cancer waiting time standards was not impacted because of the increase in demand. The Trust increased capacity and performed well against the cancer waiting time standard.

Performance against the 28-day standard, which required the Trust to get to 77% of patients to be diagnosed and informed of their cancer, or non-cancer diagnosis, within 28 days of referral was an improved position on all previous years this metric has been measured. The Trust achieved 77.9% by March 2025.



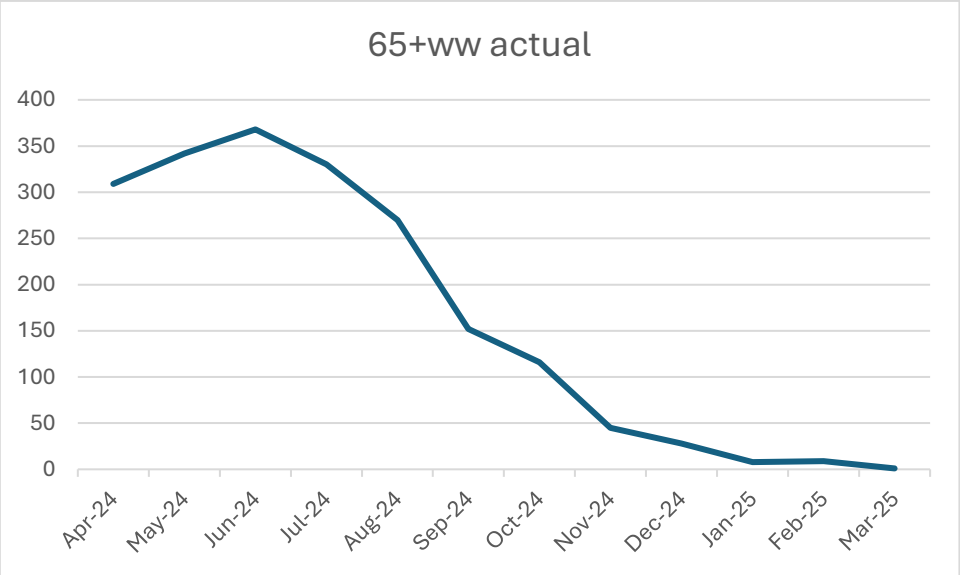
Despite the increase in demand, the Trust has seen an overall reduction in the size of the cancer 62-day backlog. The backlog as not only relatively static throughout the year, from August 2024, it was lower every month than the previous four years. Achievement of this has been due to the commitment of the clinical and administrative workforce, which supports cancer patients through their pathway in a timely manner, which supports the best clinical outcome and additional capacity.



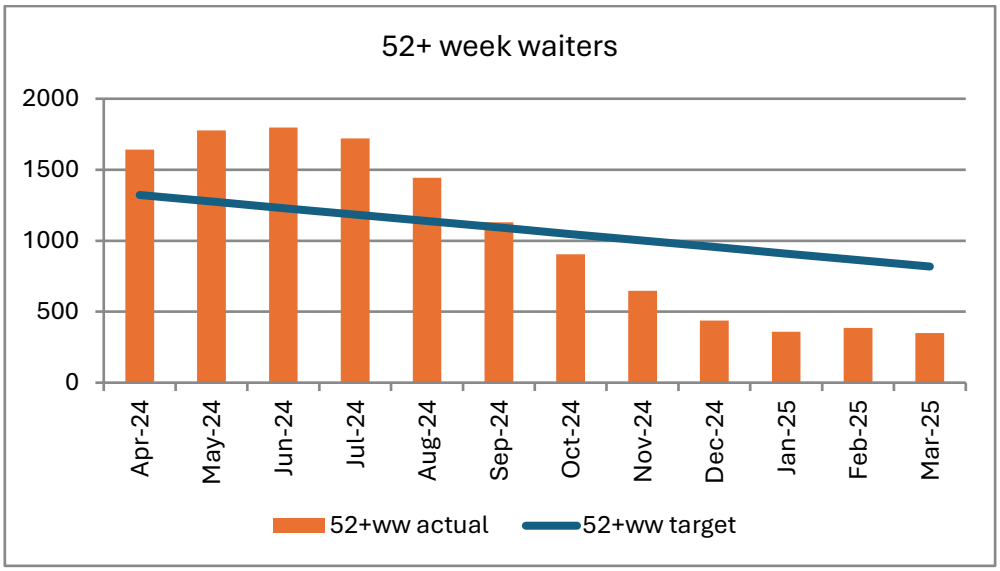
For the 2024/25 Operating Plan, there was a return to a focus on the 62-day referral to treatment standard, with Trusts required to achieve 70% by March 2025. DCH hit 70% or more, for nine months out of 12.

Operational Performance: Referral to Treatment Times

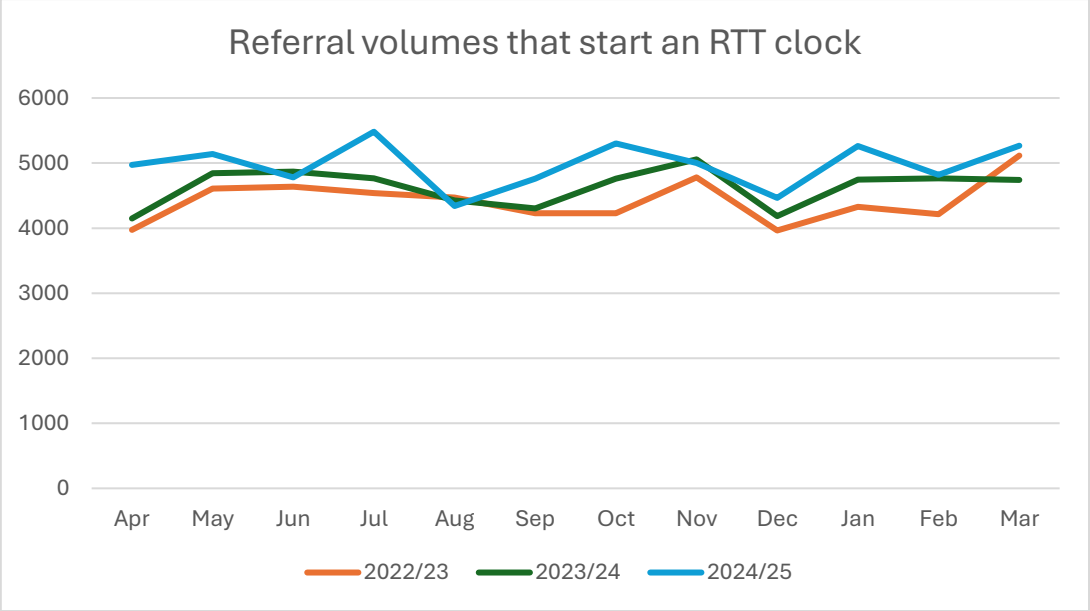
In response to the national elective care waiting list recovery programme, the focus was on irradicating the longest waits. At the end of 2024/25, the Trust had treated all patients waiting over 65 weeks, apart from one complex patient with a planned treatment date in April 2025.



The Trust also made significant process in reducing the number of patients waiting over 52 weeks, going further than the trajectory and reducing the over 52 week waiting list by 468 more than forecasted. This was possible with additional income earnt from over delivering against the Elective Recovery Fund, which enabled additional activity to be delivered.



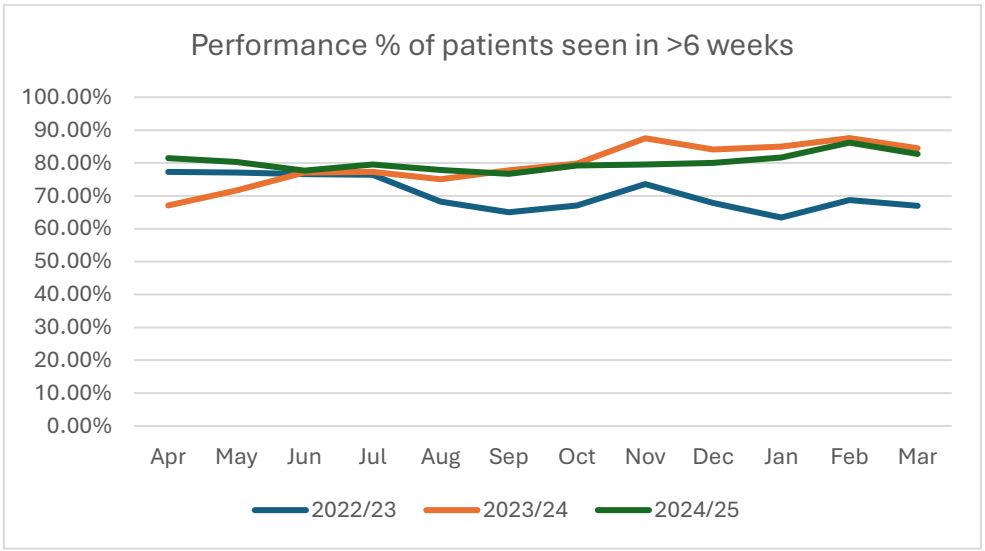
Referral volumes for the financial year 2023/24 were 7.17% up when compared to 2023/24. However, activity kept pace with demand and as a result, the total waiting list size decreased, from 21,836 to 21,135.



Although this growth put further pressure on services, the Trust was pleased to see that patients were accessing the care and treatment they needed. The Trust has responded by increasing capacity within the constraints of available resources.

Operational Performance: Diagnostic Waiting Times

Diagnostic performance against the six-week waiting time standard has not performed as well when compared to the previous year, with performance below that of last year, every month since October. The demand increases for both elective and non-elective pathways has put considerable pressure on diagnostic services and achievement of 95% within six weeks by March 2025 was not achieved. The Trust acknowledges that additional capacity will be required to achieve this.



Pathway re-design is critical to managing the high levels of demand and the Trust is working with system partners to maximise the use of the new Community Diagnostic Centres. The Trust is committed to bringing down the diagnostic waiting times as it is an imperative enabler for the delivery of all non-elective and elective pathways.

Environmental Performance

Introduction

This section aims to show the delivery over the past 12 months of the Sustainable Development Goals that combine to deliver Net Zero Carbon (NZC)[1] progress, to meet the requirements of the Task force on climate-related Disclosures (TCFD) and demonstrate good corporate responsibility with respect to environmental and social sustainability and where this concurs with economic sustainability.

Task force on climate-related Disclosures

TCFD Compliance statement

The TFCD guidance determines the topics and content of the sustainable pages supported by extracts of supporting data. The requirements for phases 1 and 2 are met as far as practicable at this time of year when month 12 energy data is not available. The Trust is at a developing stage of maturity in its sustainability reporting. Plans for future reporting improvements include developing intensity carbon reporting e.g. tCO_2e[2] per m2 and setting carbon reduction targets in measurable tCO_2e. With the need to be concise and respond to TFCD further information will be developed into an online sustainability report for all stakeholders, with targets, challenges and achievement in more detail.

Workforce and System Leadership

Board oversight

The Board's oversight of climate-related issues stems from representation by, and reporting lines of, the Sustainability Working Group with assurance reports to the Strategy, Transformation and Partnerships (STP) Committee in Common. The STP Committee in Common has a remit for NZC and the Sustainability Manager updates the Director and Deputy Head of Estates and Facilities via one-to-one monthly meetings and ad hoc discussions. Further sustainability actions are reported via the IMPACT Social Value tool, Business Intelligence dashboard, internal bulletin communications and the Chief Executive Brief.

Monitoring sustainability-related issues

The Chief Financial Officer has sign-off for sustainability funding applications, including a Heat Network Development Unit part-funded techno-economic and feasibility study into Geothermal and Ground Source heat. The Chief Financial Officer and Energy Efficiency team with officers from estates had oversight of the Decarbonisation Plan and Energy Strategy. The DCH Green Plan is tracked for progress in the bi-monthly Sustainability Working Group. The decarbonisation plan and energy strategy set out return on investment on different time horizons although these are not funded and reliant on identification of grant funding or private investor partnerships.

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[1] net zero means that total greenhouse gas emissions are equal to the carbon removed from the atmosphere.

[2] TCO2e A **carbon dioxide equivalent** or **CO_2 equivalent**, abbreviated as **CO_2e** is a metric measure used to compare the emissions from various greenhouse gases based on their climate change potential equivalent to the same amount of carbon dioxide with that climate change potential. This is commonly in Tonnes (T).

Materiality
Within the NHS Statutory Guidance 'Delivering a Net Zero NHS' materiality themes were set nationally, as is the NHS carbon footprint. DCHFT has calculated its carbon footprint and from this materiality was determined for projects within the themes with decarbonisation of energy as a large focus. Further aspects such as procurement/supply chain and medicines have significant materiality. Actions in these areas have included removing the nitrous manifold and changing from desflurane anaesthesia. Some areas of materiality, such as medicines, are a significant area that needs to be considered at national level. Within the Green Plan refresh guidance materiality themes, DCH theme leads identify projects and priorities such as measuring food waste, delivering outpatient appointments remotely, and seeking to identify things that are relatively easy that we were not doing, such as low carbon travel options on StaffNet, the staff intranet.

Identifying and Managing Sustainability-related risks and integrating into DCH's overall risk management
The Sustainability Policy was agreed by the Sustainability Working Group and identifies the commitment to Net Zero. A range of sustainability-related risks were identified as part of Joint Working and fed into this process with oversight by the Joint Director of Estates and Facilities. Sustainability risks are highlighted in the assurance report each quarter and requested to add the NZC target as at risk for delivery. The Green Plan Review will consider sustainability-related risks and data collected on the NZC and Green Plan theme targets.

Identifying and responding to climate risk Green Plan (2022/3-2024/5) Adaptation theme actions:

ACTION	Ensure our Business Continuity Plans include ways to mitigate the effects of flooding, heatwaves and snowstorms on our infrastructure, patients and staff by March 2025
PROGRESS	The Adaptation Plan was completed and runs to 2026; Business Continuity Plans include extreme weather events. Discussions take place with Sustainability Manager and Head of Emergency Planning and Security Specialist
ACTION	Develop an action plan to improve our green spaces for the health and wellbeing of staff, patients and visitors by March 2025
PROGRESS	A Green Spaces and Gardens Group have a working action plan and the scope for a green space plan is drafted with a CSH Recovery Ranger commencing summer 2025 to progress this

Net zero carbon (NZC) progress

Metrics
The Trust uses the following metrics to assess climate-related risks and opportunities in line with its Green Plan and Delivering a Net Zero NHS reported to the Sustainability Working Group

- Green Plan tracker (collated from theme leads and Sustainability Manager) progress against material theme actions and targets
- Greener NHS quarterly tracker (fleet, catering, transport, procurement and supply

chain, recycling, energy and sustainability)

- Carbon footprint, updated locally with information from ERIC returns on energy, greener NHS dashboard and local data on volatile anaesthetic gases.
- NHS Clinical Waste Strategy target (60:20:20)
- EcoEarn staff sustainability pledge and actions platform, memberships and activity

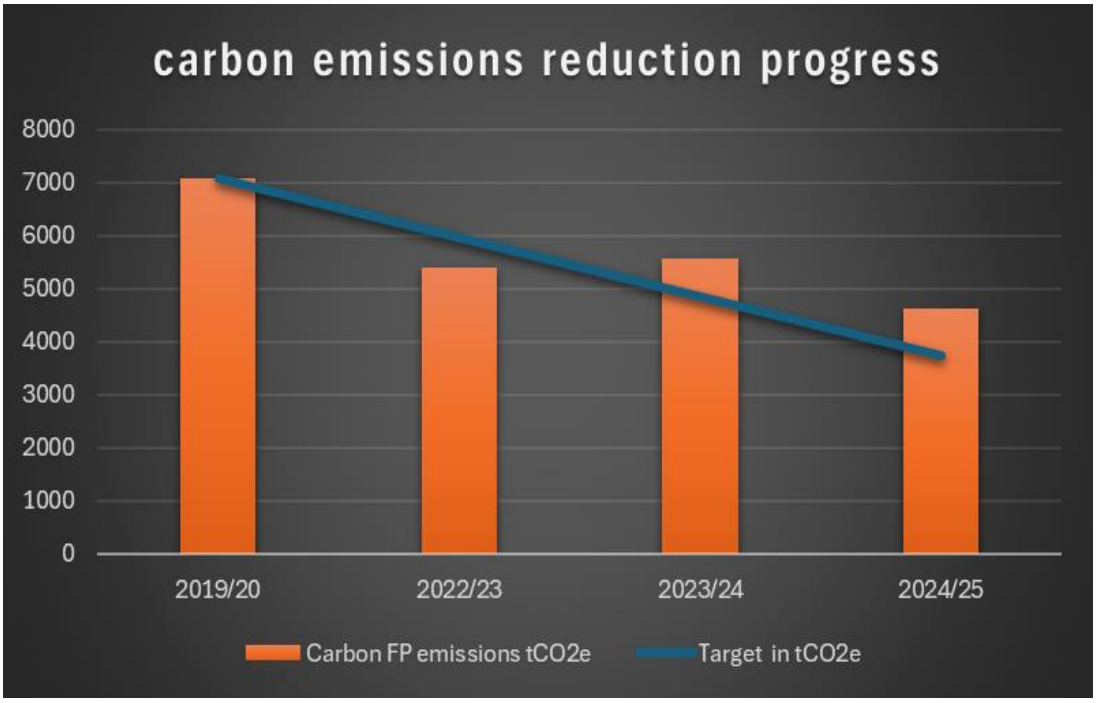
Targets

While there is a risk of not achieving the targets, the Trust has pledged to meet the NHS Net Zero Carbon targets - these have been adjusted to 2019/20 baseline:

- Net Zero Carbon Footprint by 2040, reducing emissions by 47% by 2028-2032 (Scope 1 and2)
- Net Zero Carbon Footprint Plus by 2045, reducing emissions by at least 73% by 2036-2038 (Scope 3)

Progress to Net Zero against the National Health Service England midway targets since 2019/20 baseline.

Graph 1: Carbon Footprint Emissions 2019/20 to 2024/5 against the NHS Target



Progress on the metrics include:

- Green Plan Progress: Achieved 21 of 29 actions, 72% (March 2025)
- Greener NHS returns: 80% achieved, working towards major challenges in catering like digital meal ordering and ‘guardians of grub’ approach
- Carbon footprint: remains rising this year, most likely due to energy (heating and power) use
- Clinical Waste Strategy targets: Achieved January 2025, new target to maintain
- EcoEarn membership and activity: 213 total participants and 101 activities in website for staff to participate

Further targets include:

- Reducing single occupancy car journeys e.g. Dorset NHS lift share signups and validated journeys
- Progress against the Estates Technical Annexe Roadmap targets, this will be included in a separate sustainability report and revised in the Green Plan refresh
- Net Zero Supplier Roadmap implemented as far as relevant after government changes, including 10% weighting of tenders on Social Value and Sustainability
- Social value and sustainability projects include horticultural college in sensory garden, construction partners support to small to medium enterprise suppliers, and food and nutrition increasing local and small to medium enterprise suppliers (please refer to social value and procurement sections)

Environmental Performance

Responsible use of resources

Electricity

The Trust is supplied by grid electricity by EDF. Total consumption across various meters equate to 2.32 GWh compared to 3.06 GWh of FY 23/24. Data limited to 11 months (until February 2025), (Table 1)

There are 20 electricity meters supplying to various buildings on the site and Albany Court accommodation, six British Gas meters supplying electricity to the buildings in Charlton Down.

Table 1: Total Consumption of Electricity (kWh) consumption 20222/23-2024/5

	KWH consumed
FY 22/23	2,511,724
FY 23/24	3,060,098
FY24/25	2,321,320

Gas

Out of 20 gas meters in total, eight of them belong to bronze service from Total energies and does have automatic meter reading, the rest are standard non-half hourly meters. Gas prices vary monthly and is not constant throughout the financial year like electricity. (Graph 1)

Gas consumption of the site was lower at 18.66 GWh for FY 24/25 compared to 25.18GWh of FY 23/24. Data limited to 11 months (until February 2025). Gas consumption is related to electricity use, heating and cooling, with a combined heat and power system.

Graph 1: Gas pricing for the main site:

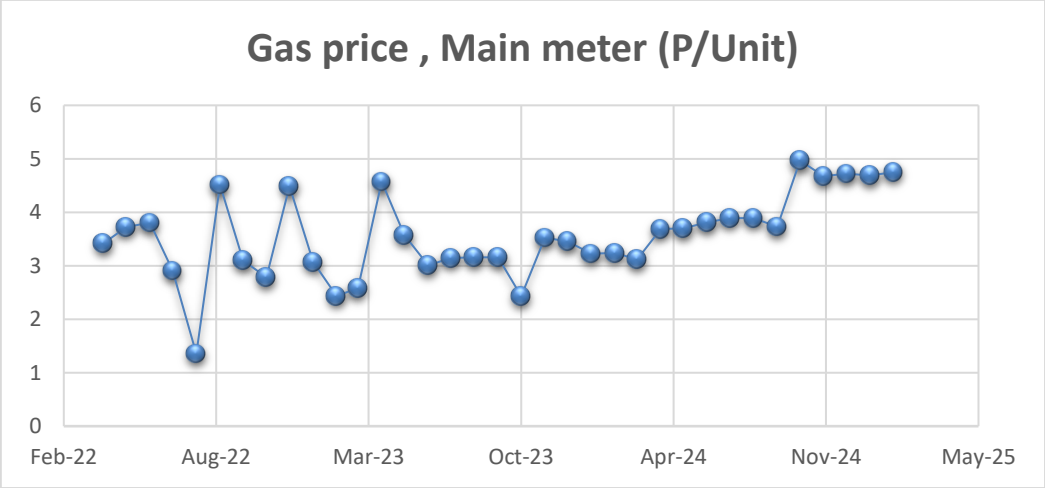


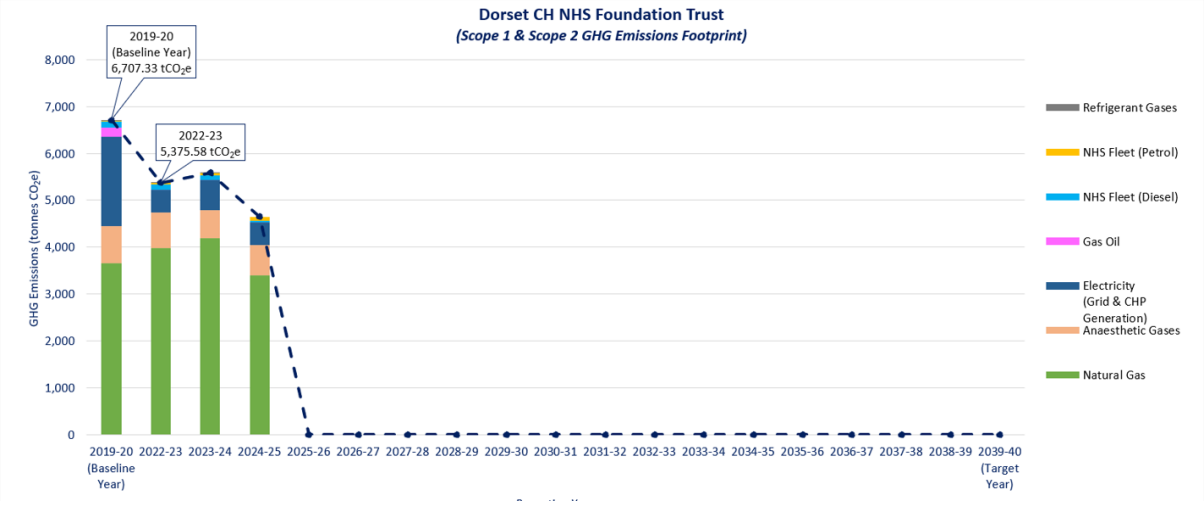
Table 2: kWh and Gas cost 2023/4-2024/5

	kWh	Cost
Annual usage FY23/24	25,182,682	£997,809.86
Annual usage FY24/25	18,664,832	£928,268.50

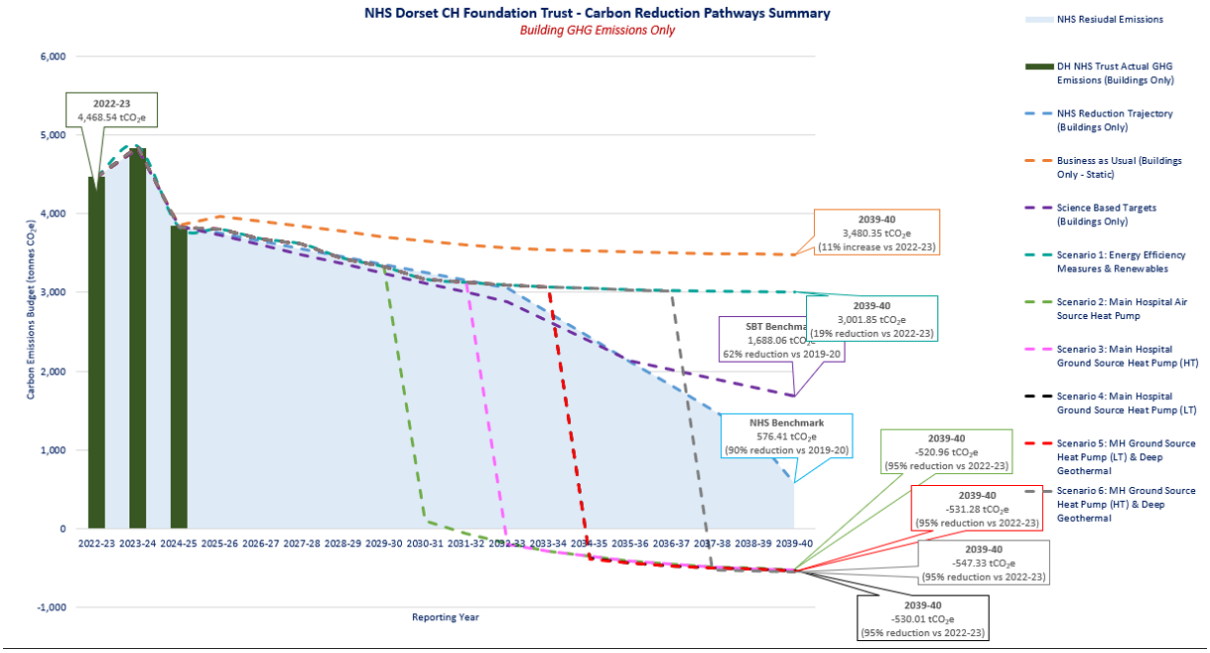
DCH Carbon emissions ($tC0_2e$)

- Carbon emissions from natural gas equates to 3,395.05 tC02e.
- Grid supplied electricity is 448.01 tC02e.
- Combined heat and power carbon emissions are included in the natural gas emissions.
- Anaesthetics are at 580.1 tC02e.

Graph 2: Carbon emissions footprint tool extract of Decarbonisation Plan (completed to 2024/25 only)



Graph 3: Extract of Decarbonisation Plan – Carbon Reduction Pathways



Waste

The Trust has achieved the Clinical Waste Strategy targets (Chart 1) in February 2025, with a slight decrease in March (Chart 2).

Chart 1: Clinical Waste Targets

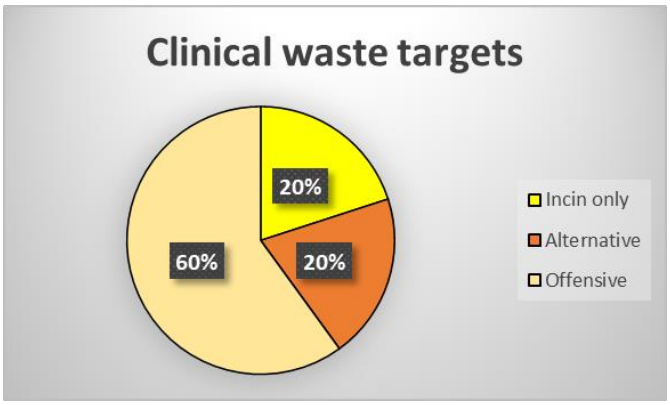
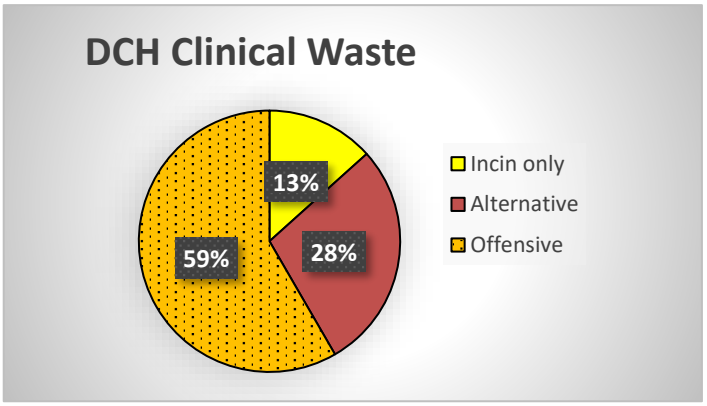


Chart 2: DCHFT Clinical Waste March 2025



The rehoming scheme has saved disposal costs of £5,968.90 and 15.78 tCO_2e[3], equivalent to of 7,890 litres diesel[4]. It is estimated the value of the 17 tonnes of items rehomed in the Trust is £252,000.

Recycling initiatives include a recycling station in Damers Restaurant and an initiative to increase recycling in theatres. The Waste Co-ordinator and Sustainability Manager are working with a training manager in education to improve correct waste stream knowledge and knowing the correct recycling items forms part of the staff induction.

An Environmental Agency (EA) Waste Audit on 27 September 2024 was broadly positive, with a waste action tracker set up and all actions completed, recommendations in progress and notified to the EA within the deadline.

Food and nutrition

Improvements to Damers Restaurant with stakeholders, including a recycling station, review of chemicals and disposable serviceware, looking at eco and recyclable options. Measuring food waste and a baseline was established, a staff scheme for those who need support can access discounted unused but useable meals. Discussions with the Soil Association accreditation schemes took place. The Hotel Manager, Catering Manager and wards pilot of ward housekeepers and reusable serviceware was successful. The Catering Manager and team took steps to increase local supply of fresh produce, reducing food miles and adding social value.

Water

[3] Based on disposal of wood to landfill from Government Greenhouse Gas conversion factors converted to tonnes of Carbon Dioxide equivalent emissions (for landfill wood this is likely to be methane) https://www.gov.uk/government/publications/greenhouse-gas-reporting-conversion-factors-2023

[4] https://www.edenseven.co.uk/what-does-a-tonne-of-co2-look-like#:~:text=Carbon%20Visuals&text=One%20unit%20is%20equal%20to,tonnes%20of%20CO2%20per%20annum

Staff can report water leaks through EcoEarn and claim their green points. We have sensor taps which help minimise consumption, and greener theatres actions include use of hand sanitiser after initial scrubbing, rather than repeat scrubbing. Details about the Trust's total water consumption and costs for 2024/25 are in the below table.

Dorset County Hospital NHS Foundation Trust - Summary (Apr 2024 to Mar 2025)

Water Consumption m³	Sewerage Consumption m³	Total Consumption m³
88669	11709.7	100378.7

Water Cost £	Sewerage Cost £	Total Cost £
£196,279.97	£26,750.87	**£223,030.84**

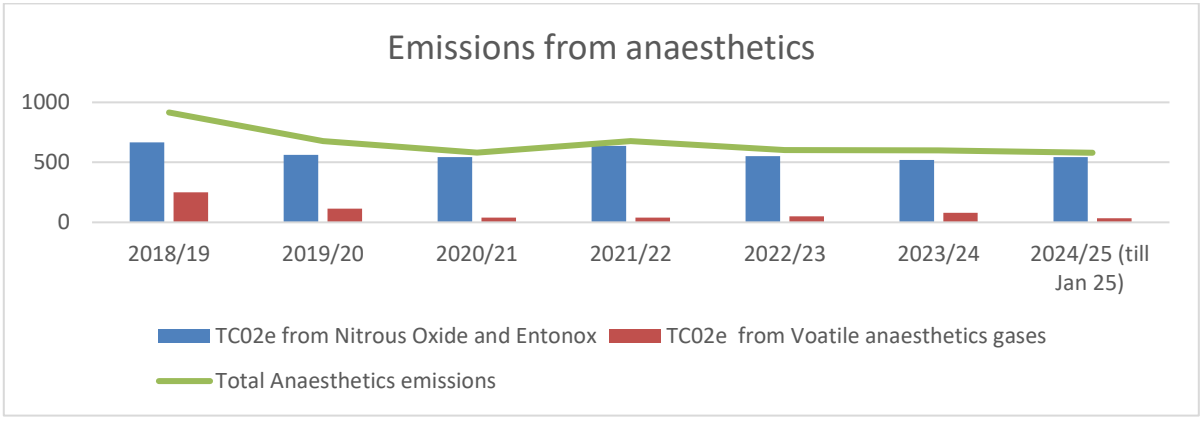
Greener theatres and anaesthetics

Data acquired from Greener NHS dashboard; details limited to 10 months (to January 2025). In line with the guidelines and standards from NHS England, we have moved completely from desflurane and decommissioned the manifolds for nitrous oxide. The anaesthetic gas emissions are at 580.1 tCo2e compared to that of 599.1 tC02e of last financial year (Table 3)

Table 3: Volatile gases tCO2e emissions

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25 (till Jan 25)
$tC0_2e$ from Nitrous Oxide and Entonox	562.3	543.3	638.5	552.1	520.8	544.7
$tC0_2e$ from Volatile anaesthetics gases	115.3	38.7	38.6	51.1	78.3	35.4
Total Anaesthetics emissions	677.6	582	677.1	603.2	599.1	580.1

Graph 4: Volatile Gas Emissions



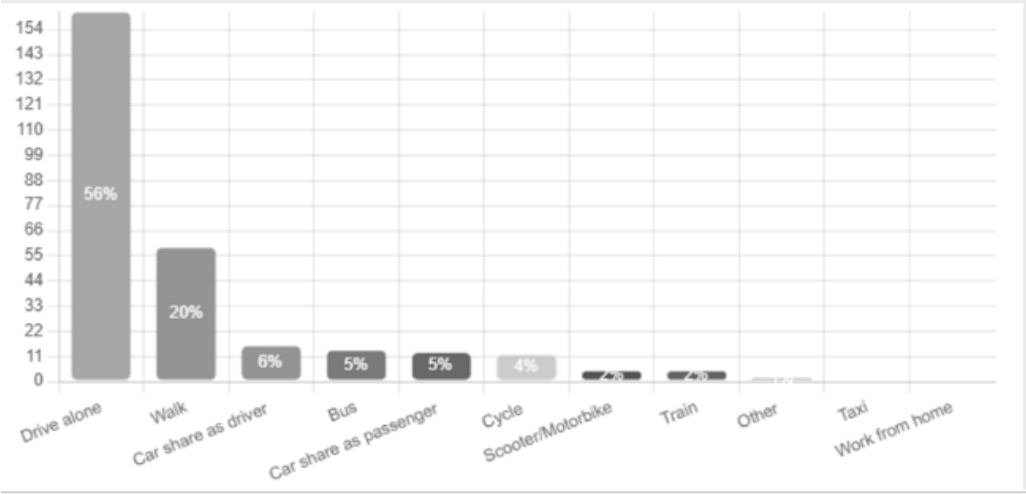
Green travel plans

The NHS England Green Plan refresh guidance, available from 5 February 2025, states that Green Travel Plans should be integrated to Green Plans from December 2026. Green Travel

Plan actions to date include;

- South Walks House (SWH) Travel Plan completed and in delivery, part of the BREEAM achievement of 'Very Good'.
- Main site Green Travel Plan scope in development
- Staff Travel Survey June-July 2024, 288 responses, setting a benchmark (graph 5)
- Travel survey to take place annually in line with Greener NHS
- Working closely with Dorset Council Transport planner with Beryl e-Bikes roll out in Weymouth and Dorchester to include spaces near SWH and DCH main site.
- Low carbon travel options are available on the internal StaffNet and being adapted for the main Trust website.

Graph 5: DCHFT Staff Travel Survey July 2024



Carbon Reduction Projects

The Trust has submitted various funding applications to the National energy efficiency fund and has been awarded £42,000 for the replacement of Emergency LEDs with new and optimised ones, which reflects 40,479 KWH annual energy savings and 425kgco2e annual carbon savings, also successful in the submetering application for £25,000 for making the site energy efficient and to help monitor the resources. In 2023/24 the Trust was awarded with £20,000 for replacing the old lights with newer energy efficient LED ones and that is estimated to save 1,535 kgC02 of carbon and annual energy savings of 146,200 KWH per year from completion in April 2025.

Submitted various expression of interest forms for the Solar PV for Damers Court accommodation and fleet EV charging facilities, altogether worth around £420,000.

Funding was achieved from Heat Network Delivery Unit for a feasibility assessment of the ground source / geothermal potential, with fortnightly meetings between DCH and consultants to find out if these are the best and feasible option to decarbonise heat network.

The refurbishment of South Walks House led by Strategic Estates achieved the Code for a Sustainable Built Environment 'BREEAM' Very Good, 62.9%.

IPC initiatives – reduce and save energy, money and carbon

- Reuseable tourniquets
- Gloves off initiative, including for ward rounds
- IV to oral switch
- Early intervention removal of devices
- Sterilising facilities in Special Care Baby Unit
- Theatre ventilation down time

Green spaces and biodiversity

The Trust is working to improve its green spaces for health and wellbeing benefits and a Greenspaces and a Gardens Group, led by the Director of Nursing, are working to achieve these aims.

- A Greener Communities, Hubbub and Starbucks Charity Award of £50,226 to develop a Sensory Courtyard Garden broke ground in March 2025 with hard landscaping features due to complete in June 2025
- The Centre for Sustainable HealthCare 'Healthy by Nature' project and National Lotteries Community Fund. DCH are one of 9 trusts successful to start a CSH Recovery Ranger from summer 2025
- Staff gardens group are meeting monthly with tasks of planting NHSForest hedgerow whips, collect wildflower seeds, cutting back, weeding, planting donated snowdrop and daffodil bulbs
- Organised across Dorset Biodiversity Net Gain training with the NHS Dorset Green leads participants across strategic projects, sustainability, estates and fabric teams.
- Installed interpretation board and gate sign for Mark's Meadow funded by DCH Charity
- Regular wildlife sightings by staff added to a repurposed whiteboard in Mark's Meadow.

Communication/Engagement of sustainability

EcoEarn

- 213 total number of participants
- Main events include big garden bird watch, Health Bioblitz, Pantry Challenge.
- Attended 23 staff induction coffee breaks for promoting EcoEarn and Liftshare, altogether 250 engagements with staff.
- 112,562kg C02e avoided, 249,450 Green points collected by staff and approximately 36,038 coffee cups and bottles avoided: stats considering DCH, DHC, UHD and SWAST. Relates to scope three with some tailoring to NHS roles.

Sustainability Champions

Sustainability champions drop-in session promoting big garden bird watch was held at Damers Restaurant in January 2025; 30 engagements and 12 signed for the sustainability champions bimonthly e-newsletter, four signed in for the gardening club.

Dorset NHS Liftshare

- 90 members liftsharing
- Historic savings are £28,657, 21.65 Tonnes of C02 and 98,175 miles saved as a part

of liftsharing.
- Forecasted 12-month savings figures are £11,694, eight Tonnes of C02 and 40,063 miles to be expected to be saved in next 12 months.

Social, Community and Human Rights Issues

The Trust takes its responsibilities towards the community it serves very seriously and recognises the responsibility it has to:

- meet the needs of the population it serves as safely, effectively and efficiently as possible.
- ensure that services are designed and delivered taking into account the views and opinions of patients.
- improving the wider economic, social and environmental wellbeing of the local population, through its social value commitments as an anchor institution.
- take into account its status as a large employer and that decisions it makes may impact on the local economy and the health and wellbeing not only of staff but their families as well.
- consider the impact it has on the environment. As set out in the Sustainability Report, the Trust is committed to reducing its environmental impact.
- take into account its responsibility to respect human rights and to ensure that actions and decisions do not have an adverse impact on human rights.
- ensure that staff feel motivated, empowered and are clear about the difference they are making to patient care and the achievement of the Trust's strategic objectives.
- ensure that the Trust is a positive place to work.

Social Value

Dorset County Hospital NHS Foundation Trust, as an anchor institution, commits to maximise the positive social value impact we have on our local communities, contributing to improving the economic, social and environmental wellbeing of the local population. Through our approach to delivering social value as an acute trust, we aim to reduce avoidable inequalities and improve health and wellbeing across our community.

Social Value Pledge

The Dorset County Hospital NHSFT Social Value Pledge is available on the hospital's website https://www.dchft.nhs.uk/about-us/social-value/ and presents the Trust's commitments to helping to improve the overall wellbeing of the community.

The Trust is committed to:

Maximising Local Investment

Maximising local investment, recognising the social, economic and environmental benefits of buying locally when procuring goods and services.

Increasing Local Employment

Increasing employment and training opportunities for local people, especially from areas of high deprivation and unemployment.

Being Recognised as a Good Employer
Providing outstanding careers, ensuring that employees have a positive and fulfilling experience – empowering staff to deliver outstanding services, sustainably, every day.

Championing Equality, Diversity, Inclusion and Belonging
Championing equality, diversity, inclusion and belonging, recognising people from different backgrounds and experience make a valuable contribution to the way in which we work.

Being Greener and Sustainable
Recognising the impact the Trust has on the environment and our responsibility to improve the Trust's sustainability and contributing to better health and wellbeing of the local community.

Involving our Community
We will play an active role in engaging with our local community by listening to them, involving them and acknowledging their contributions to our social value commitments.

Promoting Civic Partnerships
Promoting partnerships between Dorset County Hospital and the civic community, implementing local activities which contribute to reducing inequalities and improving health and wellbeing for all.

Social Value Action Plan
The Trust's Social Value Programme Group has developed Dorset County Hospital NHS Foundation Trust's Social Value Action Plan, aligned to the Trust's strategy. The Social Value Programme Group is focused on embedding delivery of social value across the Trust. This involves aligning to the Trust strategy and enabling plans and embedding social value impact assessment in Trust policies and business planning processes. The group have implemented methodologies for measuring and reporting social value delivered by the Trust. This forms the basis for social value reporting, internally and externally, including to the Trust Board.

Dorset Anchors Network
Dorset County Hospital is a member of the Dorset Anchors Network. The ambition of the network, which is in development, is outlined in the Dorset Anchors Charter which aims to improve the social, economic and environmental wellbeing of the communities across Dorset.

Charitable Activities
Dorset County Hospital Charity
The Charity's purpose is to raise funds to enhance patient care and staff welfare at Dorset County Hospital; providing support that is above and beyond the NHS budget. Dorset County Hospital Charity's Business Plan details fundraising plans, budgets and opportunities. These include a major £2.5million capital appeal supporting enhancements to

the new Emergency Department and Critical Care Unit and a focus on building the charity's income to improve the charity's financial sustainability and the contribution it makes to enhance patient care and staff welfare.

Friends of Dorset County Hospital
The Friends of Dorset County Hospital fundraise in support of the hospital, providing funds which benefit patient care. Their ongoing funding support is greatly valued by the hospital.

Volunteering and Community involvement
The Volunteer Service at Dorset County Hospital is part of the Patient Experience Team supporting a positive patient experience. We support approximately 200 volunteers who give up their time to support the hospital in a range of roles. Our focus over the last year has been on the expansion and development of our Activity Volunteer Team. We have been working closely with the Dementia Team and the Arts in Hospital Team to train and support volunteers to deliver therapeutic activity to patients. This work has supported our quality priorities for 2024/25 and will continue into 2025/26. Volunteer-led activities have included a wide range from cooking sessions on the Stroke Unit to arts and crafts sessions in day rooms and fun with bingo and other games in ward bays. Volunteers made a positive impact on the health and wellbeing of patients across the hospital. Alongside the activity volunteers we now have six therapy dogs who provide regular visits to the hospital, brightening up the day for patients and staff alike, and a volunteer musician to entertain patients on our wards.

Our Healthy Stay volunteers continue to provide support to wards with tasks including hydration rounds and mealtime help, and our Greet and Guide Volunteers continue to provide wayfinding support to patients and visitors as they arrive for appointments both on the main site and at our Outpatient Assessment Centre. Our Young Volunteer Programme continues to thrive, though with reduced numbers for our autumn volunteer intake, enabling us to better manage and support the new volunteers into successful roles linked to individual wards. As part of our commitment to the original funded Young Volunteer Programme and our Power of Youth Pledge with the #iWill Movement, we have also continued to work with schools and youth organisations to support Youth Social Action. Examples of this has included delivery of the NHS Young People's Health Challenge with Junior Sea Cadets and ongoing support with the Employability Diploma healthcare challenges at Budmouth Academy sixth form in Weymouth.

We have continued to work closely with the Friends of DCH and the YFW Blood Bikes supporting them with the recruitment and training of new volunteers and we continue to work closely with both NHS voluntary sector partners and the wider voluntary sector. 2024/25 saw the introduction of the NHSE mandatory data collection for volunteers which requires us to submit quarterly data on numbers of volunteers we have, the hours worked and EDI information. This data is helping to form a national picture of volunteering and will help to inform future development of voluntary services in the NHS.

Human Rights
The Human Rights Act is integrated into the Trust's day to day operations and implemented through policies, procedures and strategy. It is essential that staff and service users are aware of the specific requirements of the Act and its application in a human rights-based approach to healthcare. The principles of Human Rights are integrated within the Trust

training programme and communicated to patients via the Patient Charter.

Anti-Bribery
The Bribery Act 2010 which came into force on 1 July 2011 aims to tackle bribery and corruption in both the public and private sectors.
Bribery can be defined as "giving someone a financial or other advantage to encourage them to perform their functions or activities improperly or reward them for having done so".

Dorset County Hospital NHS Foundation Trust is committed to applying the highest standards of ethical conduct, following good NHS business practice and having robust controls in place to prevent bribery. As an organisation, the Trust cannot afford to be complacent and under no circumstances is the giving, offering, receiving or soliciting of a bribe acceptable. The Trust's zero tolerance approach to bribery and corruption is set out in further detail within the Trust's Anti Bribery Policy and across a range of other Trust policies and procedural documentation.

The Trust is committed to ensuring that all staff are aware of their responsibilities in relation to the prevention of bribery and corruption and that the risk of Trust exposure to acts of bribery is mitigated.

Modern Slavery Act 2015
Slavery is a violation of a person's human rights. It can take the form of human trafficking, forced labour, bonded labour, forced or servile marriage, descent-based slavery and domestic slavery. This can include people being forced to work through mental or physical threat, owned or controlled by an ‘employer’ usually through mental or physical abuse, dehumanised, treated as a commodity or sold and bought as ‘property’, physically constrained or having restrictions placed on their freedom of movement.

Typically, the products bought nowadays have passed through a long chain of producers, manufacturers, distributors and retailers who have all participated in its production, delivery and sale. It can therefore be very difficult to certify that a product has or has not been produced using slavery. However, the way in which we operate and manage our supply chain can affect the likelihood of slavery being a part of the final product. The Modern Slavery Act gives responsibility to companies for ensuring that no slavery has occurred, and this applies not only to the products they sell or the services they provide themselves but also to their suppliers, and the suppliers of their suppliers, all the way down the supply chain.

Primarily our requirements relate to section 54 of the Act "Transparency in the supply chain". Under the Act, any company with a turnover of more than £36million must produce a statement for each financial year listing the steps it is taking to ensure that slavery and human trafficking is not taking place in any of its supply chains or in any part of its business. This statement is published on our website and is visible to staff, suppliers, customers and investors. The trickle-down effect of the Act was felt this year as businesses began to ask more searching questions of their suppliers to seek assurance that they are also taking steps to ensure that their supply chains are free from slavery

Dorset County Hospital requires the contractors to agree to the NHS Terms and Conditions of Contract for the provision of goods or services. By doing so they are confirming that they

comply with all relevant Law and Guidance and shall use Good Industry Practice to ensure that there is no slavery or human trafficking in their supply chains.

Overseas Operations
The Trust has no overseas operations.

Events After the Reporting Period
There have not been any significant events requiring disclosure after the reporting period to the date of this report.

Signed

Matthew Bryant
Chief Executive
26 June 2025

Accountability Report

The Board of Directors, collectively and individually, are required to act with a view to promoting the success of the organisation to maximise the benefits for its members and the public. Paragraph 18A of Schedule 7 of the National Health Service Act (NHS Act 2006) (as inserted by the Health and Social Care Act (HSCA) 2012. The Foundation Trust Code states that 'Every Foundation Trust should be headed by an effective Board of Directors. The Board of Directors is collectively responsible for the performance of the trust'.

Directors' Report

Board of Directors Profiles

Chair
David Clayton-Smith – first term 01/05/2023 – 30/04/2026
David is a vastly experienced chair and non-executive director, working in a broad range of non-executive roles in both the public and private sectors, most recently focusing heavily on health.

David has held non-executive director roles at Frimley Health NHS Foundation Trust and has been Chair at East Sussex Healthcare NHS Trust, as well as the NHS Sussex and NHS Surrey Primary Care Trusts.

From 2019-22, David was Independent Chair at the Buckinghamshire, Oxfordshire, Berkshire West Integrated Care System. He was also an Independent Chair at Epsom and St Helier NHS Trust. David's executive career was spent in marketing roles across the retail and hospitality sector.

Chief Executive Officer
Matthew Bryant – appointed 01/04/2023
Matthew joined Dorset County Hospital and Dorset HealthCare Trusts in March 2023 (and took up the substantive role in April 2023).

Matthew previously worked for Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust where he was Chief Operating Officer for hospital services.

He led the Somerset health and care system boards for planned and unplanned care and previously led surgical and medical services at the Royal Devon and Exeter NHS Foundation Trust, as well as redesigning care for frail older people. Over a 25-year career in the NHS he has worked with hospital, community and mental health services, and helped to establish the Peninsula Medical School in the South West.

He is passionate about empowering NHS staff and working in partnership across organisations to improve health outcomes for local people. Matthew is also Senior Independent Trustee at Hospiscare, the palliative care provider based in Exeter.

Non-Executive Directors

Margaret Blankson – first term 01/01/2021 – 31/12/2023, second term 01/01/2023 – 31/12/2026

Promoting issues of diversity and inclusion have been core tenets throughout Margaret's personal life and professional career. Following a career in local government, Margaret established her own consultancy providing strategic advice on transformation, regeneration and Corporate Social Responsibility programmes, with a focus on embedding issues of diversity inclusion into 64 mainstream delivery. Margaret's clients extend across all three sectors and have included Nike UK, Unilever, Lloyds Banking and the Football Association. Margaret spent several years involved in training Metropolitan Police Service officers in diversity and inclusion. She has held a number of advisory roles including Chair for the charity IMPACT and advisory Board member for Choice FM Radio. Margaret is currently a Trustee of Over the Wall, a charity providing breaks for children facing serious health challenges and is the founder of the Foodbank DoorSteppers, an organisation she established in response to COVID-19. Margaret is currently undertaking an MA in Consulting and Leadership in Psychodynamic and Systemic Approaches at the Tavistock Institute, London.

Eiri Jones – first term 01/01/2022 – 31/12/2024, second term 01/01/2025 – 31/12/2027 Deputy Chair from 01/09/2022. Joint NED with Dorset HealthCare University NHS Foundation Trust from 23/09/2024.

Eiri Jones joined the Trust in January 2022. Eiri is a Registered Adult and Children's Nurse; has an MA in Professional Development; and is a QI practitioner supporting several Trusts with improvement work. Eiri has clinical, managerial and executive leadership knowledge and skills gained during a career spanning over 45 years. Eiri has held senior and board positions in a range of Trusts in England and Wales and has also held regional (Trust Development Authority), national (Welsh Government and State of Qatar) and regulatory (Nursing and Midwifery Council) appointments. Her most recent full-time role was as the Regional Director for Getting it Right First Time (GIRFT) in the South West region. She is a Clinical Non-Executive Director in Salisbury Foundation Trust and has recently moved to Dorset.

Claire Lehman – first term 18/07/2023 – 17/07/2026

Claire joined Dorset County Hospital NHS Foundation Trust Board in July 2023.

As a GP and Public Health Consultant, Claire brings a holistic perspective in understanding needs of the changing demographic of our local communities. She is a keen advocate of empowering individuals to direct their own health trajectories.

Her previous leadership experience includes roles as Health Protection lead consultant during the COVID-19 pandemic in local authority, as a GP partner, as GP clinical lead for quality, and as an LMC Medical Director and 18 months as Medical Officer for the British Antarctic Survey.

Claire is strongly motivated to positively influence the health and social care services of those served by the Trust.

Stuart Parsons – first term 01/12/2021 – 30/11/2024, second term 01/12/2024 – 30/11/2027
Stuart is a fellow of the Association of Chartered Certified Accountants, having qualified whilst working at Eldridge-Pope Brewery in the centre of Dorchester. He has more than 30 years of experience in commercial finance and has held senior positions in a number of sectors including telecoms, logistics, equipment rental, asset management and engineering services. Before retirement he held the position of Group Commercial and Finance Director for Briggs Equipment UK Limited based in Staffordshire. His roles have included international businesses across Northern Europe and Russia. His experience demonstrates a strong collaborative approach, whilst improving governance and control, along with the critical challenge to improve performance and efficiency. He has a keen love of sport and music and returned to Dorset in 2022 after moving to the Midlands more than 23 years ago.

Stephen Tilton – first term 01/06/2020 – 31/05/2023, second term 01/06/2023 – 31/05/2026
Stephen qualified as a Chartered Accountant with Price Waterhouse and is a Fellow of the ICAEW. He has held a series of senior executive roles in the financial services sector specialising in regulation, risk and governance, including over 10 years as director of legal and compliance at a global private equity firm. He joined DCH having spent nearly four years as a Non-Executive Director at Worcestershire Health and Care NHS Trust where he chaired the Audit and Charitable Funds committees and was a member of the Quality and Safety committee. Stephen is also an accomplished musician, and for 10 years was Master of Music at the Chapels Royal, HM Tower of London, having been a choral scholar at King's College, Cambridge from where he graduated with a degree in Classics.

David Underwood – first term 01/03/2020 – 28/02/2023, second term 01/03/2023 – 28/02/2026. Senior Independent Director from 01/09/2022. Joint NED with Dorset HealthCare University NHS Foundation Trust from 23/09/2024.
Dave is an experienced senior leader having worked first at the Civil Aviation Authority as an Air Traffic Control Scientist and Research Manager before joining the Met Office, in 1998, to lead their Civil Aviation Business. Over 20 years with the Met Office Dave undertook a range of senior executive roles including Group Head of Public Sector Business, Deputy Director of Technology and Information Systems and latterly Deputy Director of High-Performance Computing. In addition to his executive roles Dave has more than 10 years non-executive leadership experience gained in the fields of Environmental Business, Further Education (serving on the Board of Exeter College) and most recently as a Non-Executive Independent Advisor to the Royal Devon & Exeter NHS Foundation Trust with regard to their MyCare Technology enabled Transformation Programme. Dave is passionate about delivering effective leadership of change and promoting the benefits of careers in science, technology, engineering, mathematics and medicine.

Frances West – first term 23/09/2024 – 31/08/2025 (running co-terminus with her NED role at Dorset HealthCare University NHS Foundation Trust)
Frances brings a varied career experience to her non-executive role. She started her civilian working life in 2008 after more than 20 years in the army where she was a lieutenant colonel in the Royal Military Police.

She moved into local government with Purbeck District Council initially, as the Head of Legal and Democratic services and then went on to run their public health and housing services.

More recently, Frances has worked in the charity sector with senior roles with Help for Heroes, Age UK and EDP Drug and Alcohol Services. She is also the Senior Independent Director on the Board of Westward Housing Group and was a Non-Executive Director for Tricuro Ltd until May 2023.

Executive Directors

Joint Chief Financial Officer: Chris Hearn – appointed 01/02/2024 (Chief Finance Officer from 03/10/2022)

Chris joined DCHFT in October 2022 from Dorset HealthCare University NHS Foundation Trust, where he was Director of Operational Finance. During his time in the NHS, Chris has worked in a number of senior finance roles within acute, mental health and community trusts, and prior to this has experience across a variety of technical and commercial finance roles within a large FMCG organisation. Chris is a Fellow of the Institute of Chartered Accountants in England and Wales (ICAEW), having qualified with PwC London where he was involved in the audit of a number of FTSE 100 companies.

Joint Chief Nursing Officer: Dawn Dawson – appointed 01/04/2024

Dawn is a nurse with an extensive clinical background having worked in acute, community and the mental health sector; most recently she has held a number of senior positions in an integrated mental health and community trust.

Dawn has a broad academic background, which includes psychology, law, and post-compulsory education. Her focus on high quality patient care combined with workforce development led to Dawn working strategically across an STP footprint successfully heading up a national test site for the Nurse Associate Programme.

Joint Director of Corporate Affairs: Jenny Horrabin – appointed 11/03/2024 (non-voting)

Jenny was appointed Joint Executive Director of Corporate Affairs for Dorset HealthCare and Dorset County Hospital on 11 March 2024.

She is a qualified accountant and chartered company secretary. She worked in audit and assurance for over 20 years in the public and private sector, before moving into a Company Secretary role in the NHS in 2012.

She joined the Trusts from Coventry and Warwickshire Partnership Trust, having previously worked in senior governance and corporate affairs roles in two clinical commissioning groups.

Jenny has a passion for continuous improvement and excellence in practice and is an active member of the NHS Company Secretaries Network and a member of the HFMA Audit and Governance Committee. She is also a trustee of a charity and an Audit Committee Member at Citizen Housing.

Chief Medical Officer: Professor Alastair Hutchison – appointed 01/07/2018 – retired 31/03/2025
Alastair joined DCH in July 2018 from Manchester Royal Infirmary, where he was Clinical Head of Division for Specialist Medicine and Clinical Professor of Kidney Medicine (University of Manchester). He has worked in clinical leadership roles in Manchester for over 15 years, including being Clinical Director for Renal Medicine, the Royal College Tutor in Medicine, Associate Clinical Head of the Division of Medicine, and most recently the Clinical Head for Specialist Medicine. He has clinically supervised the development and introduction of new IT systems as well as having a major interest in infection control. Alastair has wide-ranging experience in managing complex clinical services and is actively involved in research into acute and chronic kidney disease with around 100 publications in peer-reviewed journal and books. He has written chapters for both the Oxford Textbook of Medicine and the Oxford Textbook of Clinical Nephrology.

Joint Chief Strategy, Transformation and Partnerships Officer: Nick Johnson – appointed 01/02/2024. Deputy Chief Executive from 01/04/2023. (Director of Strategy, Transformation and Partnerships from 01/02/2016).
Nick joined DCHFT in 2016 from University Hospital Southampton NHS Foundation Trust where he was responsible for strategy and commercial development projects, including establishing an innovative commercial development joint venture, for which he was a Board Member.

Nick became the Trust's Deputy Chief Executive in 2020 and since joining the Trust Nick's portfolio has expanded to include strategy and corporate planning, transformation, commercial, the DCH Charity and strategic estates developments, including the New Hospital Programme. Nick is also the executive lead for health inequalities and one of the Dorset Integrated Care System board member representatives for the Wessex Academic Health Science Network, as well as executive lead for the Trust's Subsidiary Company and Dorset Estates Partnership.

Prior to that he was responsible for business development and bid management at a large, multi-national infrastructure and support services provider focussing on strategic public private partnerships. Nick has also worked in a number of local authorities delivering innovative strategic partnerships, contract management and service transformation. Nick has a MSc from Warwick Business School and started his career on the National Graduate Management Scheme for Local Government.

Joint Chief People Officer: Nicola Plumb – appointed 01/02/2024. (Interim Joint Chief People Officer from 01/05/2023).
Nicola is passionate about the NHS and has spent her career in the public sector since graduating from Durham University with a Politics degree in 2000.

Nicola has held a variety of communications and development roles in the NHS and Department of Health including working at NHS Bournemouth and Poole, Communications Advisor to the NHS Chief Executive and working as Head of Brand for NHS England.

Chief Operating Officer: Anita Thomas – appointed 04/10/2021
Anita joined DCHFT in 2000 as an Administration Manager. Since then, she has worked in a variety of roles across the Trust including Head of Health Records, Transport and Waste, Head of Access and Administration, Associate Director for Cancer and Access Services, Deputy Chief Operating Officer, Head of Transformation and Performance Improvement and Divisional Manager for Urgent and Integrated Care. Anita has a degree in History (Warwick), Masters in Developing and Leading Services (School of Health and Social Care, Bournemouth University), completed the 2015 NHS Leadership Academy Nye Bevan Programme - NHS Leadership Academy Award in Executive Healthcare Leadership as well as Quality Improvement and Service Redesign (NHSI QSIR Programme) and has been a Teaching Faculty Member Associate since 2017. She has a passion for quality improvement led by staff and patient/carer co-design, use of data, user experience and intelligence to drive improvement and support teams to deliver high quality care for all.

Interim Chief Medical Officer: Rachel Wharton – appointed designate from 06/01/2025, substantive from 01/04/2025
Rachel has been working as an Emergency Medicine Consultant at DCH since 2009. As well as her Emergency Medicine training, Rachel also spent time in Australia doing paediatric and neonatal retrieval and worked in prehospital care with the London HEMS service.

Since settling down with her family in Dorset, Rachel has enjoyed several leadership positions within the Trust – most notably as the first Lead for Locally Employed Doctors. Rachel has supplemented her leadership experience with academic studies at Masters Level. Rachel was appointed as the CMO in January 2025.

Board of Directors' Register of Interests
Dorset County Hospital NHS Foundation Trust is required to maintain a record of the details of company directorships and other significant interests held by Directors which may conflict with their management responsibilities. The Trust maintains a Register of Interests for Executive Directors, Non-Executive Directors, Governors and senior members of staff. The Register of Declarations of Interest for our Board members is available on the hospital website https://www.dchft.nhs.uk/about-us/freedom-of-information/publication-scheme/ or on request from the Director of Corporate Affairs.

Council of Governors Register of Interests
Information about the Council of Governors Register of Interests can be found in the Corporate Governance Report.

HM Treasury Compliance
Dorset County Hospital NHS Foundation Trust has complied with the cost allocation and charging guidance issued by HM Treasury.

Political Donations
Dorset County Hospital NHS Foundation Trust has not made any political donations during 2024/25.

Better Payment Practice Code Compliance
The Trust has adopted the Better Payment Practice Code, which requires all undisputed invoices to be paid by their due date, or within 30 days of receipt of goods or a valid invoice. The application of this policy resulted in a supplier payment period of 50 days for the Trust's trade payables as at 31 March 2025 (2024: 28 days). The Trust incurred interest and compensation charges of £879 during 2024/25 (2023/24 £916) under the Late Payment of Commercial Debt (Interest) Act 1998. The performance of the Trust in complying with the Code were as follows:

	2024/25		2023/24	
	Number	Value £000	Number	Value £000
Trade payables				
Total bills paid in year	**60,000**	**126,382**	63,939	128,204
Total bills paid within target	**57,501**	**118,938**	58,465	116,876
Percentage of bills paid within target	**96%**	**94%**	91%	91%
NHS payables				
Total bills paid in year	**1,456**	**12,749**	1,363	10,160
Total bills paid within target	**1,204**	**11,106**	1,141	8,921
Percentage of bills paid within target	**83%**	**87%**	84%	88%

Income Disclosure
The Trust has met the requirement of Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012), by ensuring the income from the provision of goods and services for the purposes of the health service in England are greater than income from

the provision of goods and services for any other purposes. The income from provision of goods and services for any other purpose was £1.3million which represents 0.36% of total Trust income. The Trust's financial planning process ensures the requirement is maintained in the future and that any income for other purposes is contributing a profit for reinvestment into health services in England.

Disclosure relating to the CQC and NHS England Well Led Framework
Information relating to the Trust's Well Led inspection can be found in the Corporate Governance Report and the Annual Governance Statement sections of this report.

Patient Care
The Patient Experience Team comprises the Complaints Service, Patient Advice and Liaison Service(PALS), Volunteer Service and the Patient and Public Engagement Service. Joint and cross working across the team is key to ensuring all aspects of patient experience functions and demands on the service are met. Restructure in the team over the last 12 months has allowed us to deliver our services more effectively.

The team strive to provide support in line with the Trust's mission – to work in partnership to provide high quality, compassionate services and to nurture an environment where people can be at their best. We do this by providing both a central point for patients, families, carers, and the public to raise concerns, get advice and provide feedback to us and through provision of our support and services which includes our team of over 200 volunteers.

We monitor performance throughout the year through our Patient Experience and Public Engagement Committee (PEPEC) and Quality Committee, reporting on the numbers of complaints and concerns, compliments and Friends and Family Test (FFT) feedback. We look for any themes in this data which could indicate where areas of improvement and learning are required or where best practice can be shared and adopted. PEPEC also receives standard reports from our volunteer service, patient and public engagement services (which also incorporates, carers, armed forces, and youth engagement reports), our Your Voice – patient voice group and Healthwatch Dorset. Alongside our Your Voice group the newly launched Accessible Information Standards Group sits as a sub-group to PEPEC with plans in 2025/26 to launch the new Patient Experience Learning Network (PELN) and relaunch the Armed Forces Community Steering Group.

Working closely with our Business Intelligence Team, we oversee the NHS Patient Surveys each year. During 2024/25 we completed the National Inpatient Survey, Maternity Survey, Children and Young People Survey and Urgent and Emergency Care Survey. Results from these surveys are reported at PEPEC and action plans are put in place to address areas for improvement. In 2024, this included focus on ensuring we increased ways for people to feed back to us around the quality of their care. Posters around the Trust now encourage people to leave their feedback via Care Opinion. Feedback and stories left via this method are shared with us anonymously and we then reply to the feedback to thank people and where we might feel more information is needed, invite the writer to contact us directly to discuss. Feedback is also shared with relevant staff and departments.

Complaints concerning patient care are handled centrally. Our dedicated complaints and PALS team work to ensure that complaints and enquiries are responded to within set

timeframes. Complaints are recorded on the Trust incident reporting system and appropriate staff directly involved are allocated to the complaint to investigate and engage with the person raising the complaint. This year our new Patient Experience Policy covering our Complaints and PALS services has been published. This has seen us adopt the Parliamentary and Health Service Ombudsman, (PHSO), NHS Complaint Standards.

We began implementation of the new policy and standards in December 2024 focusing firstly on the new Early Resolution process. Early resolution shifts the focus from what can be a lengthy response time to complaints to engaging with the person making the complaint within a few days by phone(or preferred method of contact) to discuss and where possible resolve any issues or concerns in a more timely way. As part of the implementation, we are developing a package of training for staff, have restructured the Complaints and PALS Team to deliver the service more efficiently and will be continuing to work through our plan to reach a point of full implementation to incorporate robust processes for Closer Look Investigations by the start of Q3 2025/26.

Patient information continues to be supported through the Patient Experience Team. 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. The process for patient information leaflets has now been amalgamated into the new Communication with Patients Policy which brings together policy around translation and interpretation services, health literacy and Accessible Information Standards.

We have continued to promote the Carer's Passport across the Trust and this year have worked closely with voluntary and community sector 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 primary care network 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 2025/26 so that we can develop co-designed improvements.

In line with the statutory guidance for Working in Partnership with People and Communities, 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. 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 2025 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 2025/26 with continued engagement with the deaf community.

Our work with the Armed Forces Community was recognised through reaccreditation as a Veteran Aware trust with the Veterans Covenant Healthcare Alliance in October 2024. 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 more easily which in turn can aid delivery of care and potential post discharge support.

Our volunteer service continues to thrive. Our volunteers have given over 15,000 hours of their time this year to support the Trust(this figure is for our direct volunteers only and does not currently include our Friends of DCH or the YFW Blood Bikes). Our volunteers deliver core roles including 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. Our team also includes our fantastic therapy dogs and their owners who never fail to bring a smile to anyone they meet. This year has seen us develop new volunteer roles supporting the community based pulmonary rehabilitation workshops and with the orthodontics team supporting with patient calls ahead of appointments.

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.

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.

Quality priorities for the coming year include:

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, and 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.

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 of funding from the DCH Charity, is now on track for opening in May 2025. 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.

Stakeholder Relations

Our approach to stakeholder relations is built on a deep commitment to partnership and collaboration, recognising that collective effort is essential for achieving lasting improvements in the health and wellbeing of the Dorset community. This is exemplified by our evolving and significant partnership with Dorset HealthCare, where we now operate as federated Trusts under a joint Chair and Chief Executive, guided by our first unified strategy and a shared executive management team. This strengthened relationship forms the bedrock of our engagement across all stakeholders, ensuring a cohesive approach to delivering improved care.

Central to shaping our strategic direction was extensive engagement with a diverse range of stakeholders, including staff from both Trusts, patients and carers, partner organisations, and the public. This inclusive process, conducted over three months through various channels, ensured our priorities reflect the needs and insights of those we serve and those who deliver our services. Key themes such as patient safety, access, co-designing services with communities, staff support, and partnership working directly informed our strategic objectives. We remain committed to ongoing dialogue to keep the voices of our community at the heart of our work.

We are guided by the principle of placing patients, service users, carers, and communities at the core of our activities, treating them as equal partners in the planning and delivery of care, aligning with the Integrated Care System's (ICS) principles. This includes actively involving individuals in shaping services and empowering them in their own health and wellbeing. Our valued partnerships with the voluntary and community sector and the contributions of volunteers, such as within our Outpatient Assessment Centre's Live Well initiative, are integral to this commitment.

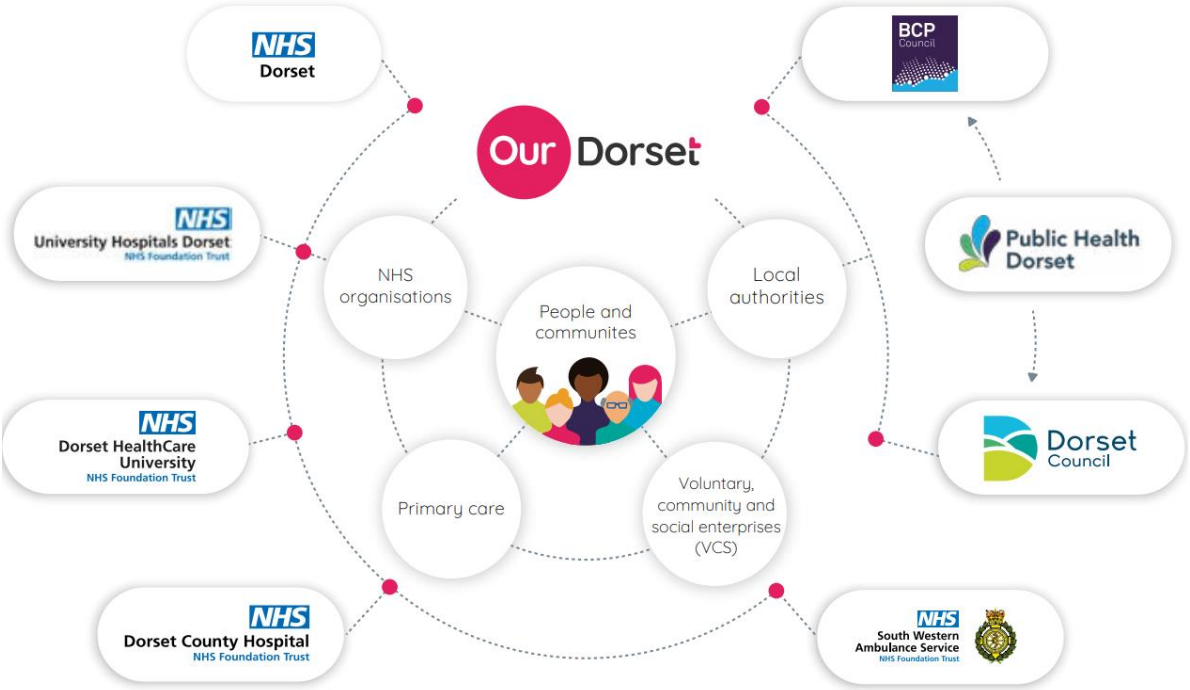
Our collaborative reach extends formally through active participation in the Our Dorset Integrated Care Partnership (ICP) and the Our Dorset Provider Collaborative (ODPC). These vital structures facilitate collective decision-making with NHS organisations, local councils, emergency services, and the voluntary sector to improve care integration, access, and address health inequalities across Dorset. Our close working relationships with University Hospitals Dorset (UHD) and primary care partners are crucial for ensuring seamless service delivery.

Recognising our colleagues as our greatest asset, we are dedicated to fostering an

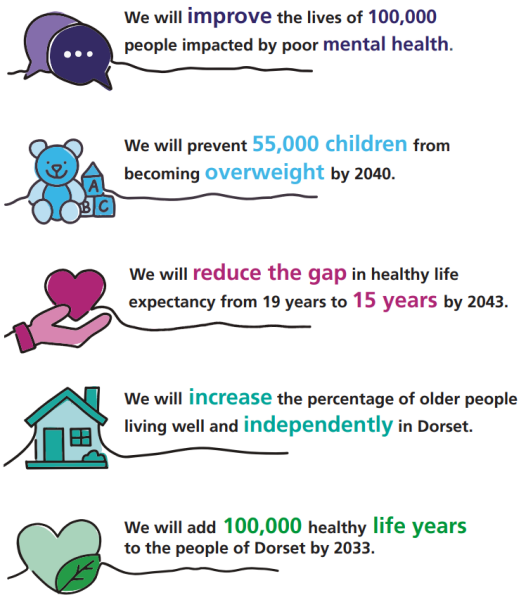
environment where they feel empowered, valued, skilled, and able to thrive. Our People Plan, a key enabler of our strategy, prioritises colleague engagement, diversity, and inclusion. Effective communication and engagement with our staff are paramount to the successful implementation of our joint strategy, ensuring a shared understanding of our direction and its impact on their roles.

Collaboration is rapidly becoming the cornerstone of the way we work. Building on previous efforts, we now view co-designed, integrated services as the expected norm, aligning with the 'Partnership' theme of our strategy.

The Trust's approach to collaboration is underpinned by our commitment to collaborate with our partners to make Dorset the healthiest place to live, captured in the Joint Forward Plan 2023-28, see the figure below.



The plan focuses on five specific goals: mental health, overweight children, life expectancy inequalities, independent living, and healthy lives, see below.



The Our Dorset Provider Collaborative (ODPC)

It was mandated (but not set in statue) when ICBs were formed in 2022 that all NHS Provider organisations should be part of at least one collaborative. The Our Dorset Provider Collaborative was first established in August 2022 and is formed of Dorset HealthCare University NHS Foundation Trust, Dorset County Hospital NHS Foundation Trust, University Hospitals Dorset NHS Foundation Trust and the General Practice Alliance (whose membership includes all GP practices in Dorset).

There are monthly Executive led Board meetings of the ODPC. The role of the Chair has been held by the UHD CEO during 2024/25 and will continue to be for 2025/26. The Board currently has no delegated decision-making authority from any of the Trust Boards or the ICB.

The ODPC Board reports for information to the System Executive Group and reports progress to each of the Boards of the member organisations. The Terms of Reference are due for review in June 2025; it is not expected that there will be radical change, rather that some of the TOR are strengthened – such as the establishment of the Chairs and NEDs oversight group.

During 2024/25 the ODPC has overseen a number of programmes of work agreed and aligned to the national ask of provider collaboratives:

The programmes of work for 2024/25 achieved:

- significant reduction in the reliance on bank and agency nursing staff across Dorset, reducing the cost of services and improving recruitment to substantive posts through the nursing bank workforce programme;
- improvements in collaborative working and alignment of clinical policies and pathways in several services meeting across Dorset as a network (for example urology and orthopaedics);
- move to providing two services county-wide due to fragility in the service model, which means rheumatology and orthodontics are now provided by a single leadership and clinical team across Dorset;
- Implementation and oversight of One Dorset Pathology services and the Clinical Diagnostic Centre programmes giving patients faster access to diagnostic tests closer to home;
- Consideration of an approach to shared services which for 2025/26 has led to a business case proposal for single shared services in Dorset for Estates, Facilities and Procurement services (not yet approved), this will enable more of the NHS funds to be spent on estates and facilities locally and support retaining our staff as well as reducing variation in clinical equipment making it easier for clinical teams to work across the county.

Integrated Neighbourhood and Community Teams

Both Trusts are actively collaborating with residents and all ICS partners in a new programme called Integrated Neighbourhood and Community Teams. This programme aims to improve outcomes for communities with high deprivation, focusing on the wider determinants of health and in turn, preventing the need for secondary care. The first pilot communities are located within Weymouth and Portland, with the programme expanding to include other communities and their individual needs as it progresses.

Routine Collaboration with Primary Care

The Trust maintains regular operational communication through weekly calls with the Clinical Directors of the local Primary Care Networks as part of the West Dorset Clinical Collaborative. This fosters greater understanding and facilitates targeted support where needed.

Patient and Public Engagement

The Trust has an active Patient Advice and Liaison Service (PALS) and a vibrant volunteering team with excellent links to local residents, schools, and colleges. Furthermore, DCH has established a voluntary Your Voice forum, a patient voice group who are regularly engaged with. We are now also benefitting from liaison with the DHC Experts by Experience.

Remuneration Report

The Remuneration Report has been prepared in accordance with the following legislative requirements:

- Sections 420 to 422 of the Companies Act 2006 (section 420(2) and (3), section 421(3) and (4) and section 422(2) and (3) do not apply to NHS foundation trusts)
- Regulation 11 and Parts 3 and 5 of Schedule 8[15] of the Large and Medium-sized Companies and Groups (Accounts and Reports) Regulations 2008 (SI 2008/410) ("the Regulations")
- Parts 2 and 4 of Schedule 8 of the Regulations as adopted by this Manual and
- elements of the Code of governance for NHS provider trusts.

Annual Statement on Remuneration
As Chair of the Remuneration and Terms of Service Committee, I am pleased to present the Remuneration Report for 2024/25.

The purpose of the Remuneration and Terms of Service Committee is to make recommendations to the Board of Directors in relation to the appointment and remuneration of the Chief Executive Officer and Executive Directors. The Committee also reviews and makes recommendations regarding the Board of Directors' skill mix and balance, taking into account future challenges, risks and opportunities facing the Trust and the skills and expertise that the Board of Directors requires in order to meet these. The Remuneration and Terms of Service Committee also ensures adequate succession planning arrangements for the executive team are in place.

In the reporting year the Remuneration and Terms of Service Committee met on three occasions and discussed the following:

- Appointment of the Director of Nursing (Acute) post; a deputy role which reports into the Joint Chief Nursing Officer
- Pay award for very senior managers (VSM). This was a committee in common meeting with Dorset HealthCare University NHS Foundation Trust
- Appointment of the interim Chief Medical Officer following the announcement of the retirement of the incumbent Chief Medical Officer.

The decisions made at those meetings were taken within the context of the Trust's federated working with Dorset HealthCare University NHS Foundation Trust although no joint posts were required to be recruited to in the reporting period.

David Clayton-Smith
Trust Chair and Remuneration and Terms of Service Committee Chair

Policy on Remunerations of Senior Managers
The Trust's senior management remuneration policy requires the use of benchmark information, and the Trust makes reference to the Foundation Trust Network Annual Salary Comparison Report.

With the exception of Executive Directors, the remuneration of all staff is set nationally in accordance with the NHS Agenda for Change (for non-medical staff) conditions or Pay and Conditions of Service for Doctors and Dentists. Performance Related Pay is not applicable for any Trust staff, including Executive Directors. Future policy on senior manager remuneration will remain in line with national terms and conditions.

Senior managers are employed on contracts of service and are substantive employees of the Trust. Their contracts are open ended employment contracts which can be terminated by either party with six months' notice. The Trust's normal disciplinary policies apply to senior managers, including the sanction of instant dismissal for gross misconduct. The Trust's redundancy policy is consistent with NHS redundancy terms for all staff. Total remuneration for each of the Trust's Executive Directors comprises the following elements:

Salary + Pension and Benefits = Total Remuneration

Entitlement to payment for outstanding annual leave in accordance with the contract provisions for Executive Directors can also apply. In compliance with the General Condition 4(3) of NHS England's provider licence, contracts for all Directors contain a provision permitting summary termination in the event of a Director being or becoming an unfit person.

Future Policy Table
The Trust's remuneration policy in respect of each of the above is outlined in the tables on the next page.

Salary – (Fees and Salary)

Purpose and Link to Strategy

- Helps to recruit, reward and retain
- Reflects competitive market level, role, skills, experience and individual contribution

Operation

Base salaries are set to provide the appropriate rate of remuneration for the job, taking into account relevant recruitment markets, business sectors and geographical regions.
The Remuneration Committee considers the following parameters when reviewing base salary levels:

- Pay increases for other employees across the Trust
- Economic conditions and governance trends
- The individual's performance, skill and responsibilities through appraisals
- Base salaries at NHS organisations of similar size are benchmarked against Dorset County Hospital NHS Foundation Trust
- Base salaries are paid in 12 equal monthly instalments via the regular monthly employee payroll
- The Executive Directors do not receive performance related pay.

Opportunity

The Remuneration Committee ensures levels of remuneration are sufficient to attract, retain and motivate directors of the quality needed to run the organisation successfully but avoid paying more than is necessary though using benchmarking.

National and local benchmarking data was reviewed by the Remuneration Committee who reviewed the relative position of each Executive.

Performance Conditions

None, although performance of both the Trust and the individual are taken into account when determining whether there is a base salary increase each year. The individual receives an annual appraisal to review performance and set objectives.

Performance Period

Annual Appraisal covers a 12-month period

Pension and Benefits

Purpose and Link to Strategy

- Help to recruit and retain
- NHS Pension scheme arrangements provide a competitive level of retirement income

Operation

Executive Directors are eligible to receive pension and benefits in line with the policy for other employees.

Executive Directors are entitled to join the NHS Pension Scheme, which from April 2015 is a Career Average Revalued Earnings scheme.

Where an individual is a member of a legacy NHS defined benefit pension scheme section (1995 or 2008) and is subsequently appointed to the Board, they retain the benefits accrued from these schemes.

The principal features and benefits of the NHS Pension Scheme are set out in a table in the Remuneration Report.

Pension related benefit is the annual increase in pension entitlement accrued during the current financial year from total NHS career service.

Opportunity

The maximum Employers' contribution to NHS Pension Scheme is 20.68% (14.38% paid by the Trust and 6.3% is paid by NHS England) of base salary for all employees including Executive.

Performance Conditions

None

Performance Period

None

Differences in Remuneration for Other Employees

The remuneration approach for Executive Directors is consistent with the UK Corporate Governance Code, Code of Governance for NHS Provider Trusts and NHS Policy. This guidance requires that remuneration committees ensure levels of remuneration are sufficient to attract, retain and motivate directors of the quality needed to run the organisation successfully.

The structure of the reward package for the wider employee population is based on the national NHS remuneration frameworks for Medical, Dental and Non-Medical Staff. Non-Medical Staff remuneration is in line with the Agenda for Change Framework, which assesses remuneration in line with the framework for Medical and Dental Staff remuneration. All staff are eligible to join and participate in the NHS Pension Scheme.

Where one or more senior managers are paid more than £150,000, the committee is required to ensure this remuneration is reasonable. The Trust has two senior managers paid more than £150,000. The committee is satisfied the salary of the individual is reasonable when compared to the benchmarking provided in setting the senior managers' salaries.

The Trust's policy for equality, diversity and inclusion defines the approach that will be taken to promoting and championing a culture of diversity and equality of opportunity, access, dignity, respect, and fairness in the services the Trust provides and in employment practices.

The activities and decisions of the Remuneration and Terms of Service Committee are in accordance with the Trust's Equality, Diversity, and Inclusion Policy.

Policy on Remuneration of Non-Executive Directors

Element	Purpose and link to strategy	Overview
Fees	To provide an inclusive flat rate fee that is competitive with those paid by other NHS organisations of equivalent size and complexity	The remuneration and expenses for the Trust Chairman and Non-Executives are determined by the Council of Governors.
Appointment		The Council of Governors appoint the Non-Executive Directors in accordance with the Trust's constitution which allows them to serve two three-year terms. Any term beyond six years is subject to rigorous review and takes into account the need for progressive refreshing of the board and their independence. This is subject to annual re-appointment approved by the Council of Governors.

Annual Report on Remuneration

The following sections of the Remuneration Report are not subject to audit.

Senior Managers Service Contracts

The table below contains contract information on the Trust's senior managers for the financial year 2024/25.

Name	Title	Current Tenure	Notice Period
Non- Executive Directors			
David Clayton-Smith	Chair	01/05/2023 – 30/04/2026	3 months
Eiri Jones	NED, Deputy Chair	01/01/25 – 31/12/27 (second term)	3 months
Margaret Blankson	NED	01/01/24 – 31/12/26 (second term)	3 months
Claire Lehman	NED	18/07/23 – 17/07/26	3 months
Stuart Parsons	NED	01/12/24 – 30/11/27 (second term)	3 months
Stephen Tilton	NED	01/06/23 – 31/05/26 (second term)	3 months
David Underwood	NED	01/03/23 – 28/02/26 (second term)	3 months
Frances West	NED	23/09/24 – 31/08/2025 (running co-terminus with her NED role at Dorset HealthCare University NHS Foundation Trust)	3 months
Executive Directors			
Matthew Bryant	Chief Executive	Commenced 01/04/23	6 months
Dawn Dawson	Joint Chief Nursing Officer	Commenced 01/04/24	6 months
Chris Hearn	Joint Chief Financial Officer	Commenced 03/10/22	6 months
Jennifer Horrabin	Joint Director of Corporate Affairs	Commenced 11/03/24	6 months
Alastair Hutchison	Chief Medical Officer	02/07/18 – 31/03/25	6 months
Nick Johnson	Deputy Chief Executive/Joint Chief Strategy, Transformation and Partnerships Officer	Commenced 01/02/16	6 months
Nicola Plumb	Joint Chief People Officer	Commenced 01/05/23	6 months
Anita Thomas	Chief Operating Officer	Commenced 04/10/21	6 months
Rachel Wharton	Interim Chief Medical Officer	Designate from 06/01/25 Substantive from 01/04/25	6 months

Remuneration and Terms of Service Committee

Remuneration and Terms of Service for the Chief Executive and Executive Directors is considered by a Remuneration and Terms of Service Committee consisting of the Chair and Non-Executive Directors. The Chief Executive Officer and Chief People Officer or an appropriate deputy are invited to attend the committee as and when required. Secretariat support is provided to the committee by the Joint Director of Corporate Affairs.

The committee's attendance record is set out in the table below:

Name	Attendance/Meetings eligible to attend
David Clayton-Smith (Trust Chair) (Chair)	3/3
Margaret Blankson	1/3
Eiri Jones (Deputy Chair)	2/3
Claire Lehman	2/3
Stuart Parsons	2/3
Stephen Tilton	3/3
David Underwood	3/3
Frances West (from 23 09 24)	2/2

Expenses of Governors and Directors

The expenses incurred or reimbursed by the Trust relating to Governors and Directors were:

	2024/25 Number receiving expenses / total	£	2023/24 Number Receiving Expenses / total	£
Governors	**2 / 28**	**129**	**0 / 23**	**0**
Chairman and non-executive directors	**2 / 9**	**299**	**3 / 9**	**690**
Executive directors	**8 / 9**	**3,073**	**3 / 8**	**2,563**
Total expenses		**3,501**		**3,253**

The following sections of the Remuneration Report are subject to audit

The total remuneration of Directors and senior managers for 2024/25 was £877,400 (2023/24: £958,900).

Total Remuneration of Directors 2024/25	Note	Salary	Taxable Benefits	Pension Related Benefits	Total Remuneration	Recharges Salary	Recharges Taxable Benefits	Recharges Pension	Remuneration net of Recharges
Name and Title		(Bands of £5,000)	(To nearest £100)	(Bands of £2,500)	(Bands of £5,000)	(Bands of £5,000)	(To the nearest £100)	(Bands of £2,500)	(Bands of £5,000)
		£000'	£	£000'	£000'	£000'	£	£000'	£000'
David Clayton-Smith, Joint Chairman		35 - 40	-	-	35 - 40	-	-	-	35 – 40
David Underwood, Non-Executive Director	1	15 - 20	-	-	15 – 20	(5 -10)	-	-	10 – 15
Stephen Tilton, Non-Executive Director		10 - 15	-	-	10 – 15	-	-	-	10 - 15
Margaret Blankson, Non-Executive Director		10 - 15	-	-	10 – 15	-	-	-	10 - 15
Stuart Parsons, Joint Non-Executive Director		10 - 15	-	-	10 – 15	-	-	-	10 - 15
Claire Lehman, Non-Executive Director		10 - 15	-	-	10 – 15	-	-	-	10 - 15
Frances West, Joint Non-Executive Director*	2	-	-	-	-	5 – 10	100	-	5 - 10
Eiri Jones, Joint Non-Executive Director	3	25 - 30	-	-	25 – 30	(5 – 10)	-	-	20 - 25
Matthew Bryant, Joint Chief Executive Officer*	4	-	-	-	-	105 - 110	-	20.0 - 22.5	130 - 135
Nick Johnson, Joint Chief Strategy, Transformation and Partnerships Officer / Deputy CEO	5	165 - 170	-	42.5 - 45.0	210 - 215	(80 - 85)	-	(20.0 - 22.5)	105 - 110

Total Remuneration of Directors 2024/25 (continued)	Note	Salary	Taxable Benefits	Pension Related Benefits	Total Remuneration	Recharges Salary	Recharges Taxable Benefits	Recharges Pension	Remuneration net of Recharges
Name and Title		(Bands of £5,000)	(To nearest £100)	(Bands of £2,500)	(Bands of £5,000)	(Bands of £5,000)	(To the nearest £100)	(Bands of £2,500)	(Bands of £5,000)
		£000'	£	£000'	£000'	£000'	£	£000'	£000'
Prof Alastair Hutchison, Chief Medical Officer	6	195 - 200	-	-	195 - 200	-	-	-	195 - 200
Rachel Wharton, Interim Chief Medical Officer	7	40 - 45	-	42.5 – 45.0	85 - 90	-	-	-	85 – 90
Chris Hearn, Joint Chief Financial Officer	8	165 - 170	-	45.0 - 47.5	210 - 215	(80 - 85)	-	(22.5 - 25.0)	105 - 110
Anita Thomas, Chief Operating Officer		140 - 145	-	97.5 - 100.0	240 - 245	-	-	-	240 – 245
Dawn Dawson, Joint Chief Nursing Officer*	9	-	-	-	-	80 – 85	-	75.0 – 77.5	160 - 165
Nicola Plumb, Joint Chief People Officer*	10	-	-	-	-	80 - 85	700	22.5 - 25.0	105 – 110
Jennifer Horrabin, Joint Director of Corporate Affairs*	11	-	-	-	-	65 – 70	500	77.5 – 80.0	140 - 145

The individuals with an asterisk (*) are shared posts with Dorset Healthcare University Hospital NHS Foundation Trust (DHUFT) which reflects the Joint Board arrangement between Dorset Healthcare University Hospital NHS Foundation Trust and Dorset County Hospital NHS FT (DCHFT). The recharge columns on the above table show the amounts recharged between the two Trust's.

Notes

1 - Appointed Joint Non-Executive Director on 23 September 2024 for DCHFT and DHUFT
2 - Appointed Joint Non-Executive Director on 23 September 2024 for DCHFT and DHUFT
3 - Appointed Joint Non-Executive Director on 23 September 2024 for DCHFT and DHUFT
4 - Postholder as Joint Chief Executive Officer for DCHFT and DHUFT and post is shared on 50:50 basis full salary banding £215,000 – £220,000.
5 - Postholder as Joint Chief Strategy, Transformation and Partnerships Officer / Deputy CEO for DCHFT and DHUFT and post is shared on 50:50 basis.
6 - Until 31 March 2025
7 - Appointed Interim Chief Medical Officer designate on 6 January 2025 and commenced as Chief Medical Officer on the 1 April 2025.
8 - Postholder as Joint Chief Financial Officer for DCHFT and DHUFT and post is shared on 50:50 basis.
9 - Postholder became Joint Chief Nursing Officer for DCHFT and DHUFT from 1 April 2024 and post is shared on 50:50 basis full salary banding £165,000 - £170,000.
10 - Postholder appointed as Joint Chief People Officer for DCHFT and DHUFT and post is shared on 50:50 basis full salary banding £160,000 - £165,000.
11 - Postholder appointed as Joint Director of Corporate Affairs for DCHFT and DHUFT and post is shared on 50:50 basis full salary banding £130,000 - £135,000.

Total Remuneration of Directors 2023/24	Note	Salary	Taxable Benefits	Pension Related Benefits	Total Remuneration	Recharges Salary	Recharges Taxable Benefits	Recharges Pension	Remuneration net of Recharges
Name and Title		(Bands of £5,000)	(To nearest £100)	(Bands of £2,500)	(Bands of £5,000)	(Bands of £5,000)	(To the nearest £100)	(Bands of £2,500)	(Bands of £5,000)
		£000'	£	£000'	£000'	£000'	£	£000'	£000'
David Clayton-Smith, Joint Chairman	1	30 - 35	-	-	30 - 35	(15 - 20)	-	-	15 - 20
Mark Addison, Chairman	2	0 - 5	-	-	0 - 5		-	-	0 - 5
David Underwood, Non-Executive Director		10 - 15	-	-	10 - 15		-	-	10 - 15
Prof Sue Atkinson, Non-Executive Director	3	0 - 5	-	-	0 - 5		-	-	0 - 5
Stephen Tilton, Non-Executive Director		10 - 15	-	-	10 - 15		-	-	10 - 15
Margaret Blankson, Non-Executive Director		10 - 15	-	-	10 - 15		-	-	10 - 15
Stuart Parsons, Non-Executive Director		10 - 15	-	-	10 - 15		-	-	10 - 15
Claire Lehman, Non-Executive Director	4	5 - 10	-	-	5 - 10		-	-	5 - 10
Eiri Jones, Non-Executive Director		15 - 20	-	-	15 - 20		-	-	15 - 20
Matthew Bryant, Joint Chief Executive Officer	5	205 - 210	-	380 - 382.5	585 - 590	(100 - 105)	-	(190.0 - 192.5)	290 - 295
Nick Johnson, Joint Chief Strategy, Transformation and Partnerships Officer / Deputy CEO	6	150 - 155	-	37.5 - 40.0	190 - 195	(10 - 15)	-	(2.5 - 5.0)	175 - 180
Prof Alastair Hutchison, Chief Medical Officer		235 - 240	-	-	235 - 240	-	-	-	235 - 240
Chris Hearn, Joint Chief Financial Officer	7	130 - 135	-	35.0 - 37.5	165 - 170	(10 - 15)	-	(2.5 - 5.0)	150 - 155

Total Remuneration of Directors 2023/24 (continued)	Note	Salary	Taxable Benefits	Pension Related Benefits	Total Remuneration	Recharges Salary	Recharges Taxable Benefits	Recharges Pension	Remuneration net of Recharges
Name and Title		(Bands of £5,000)	(To nearest £100)	(Bands of £2,500)	(Bands of £5,000)	(Bands of £5,000)	(To the nearest £100)	(Bands of £2,500)	(Bands of £5,000)
		£000'	£	£000'	£000'	£000'	£	£000'	£000'
Anita Thomas, Chief Operating Officer		125 - 130	-	27.5 - 30.0	155 - 160	-	-	-	155 - 160
Jo Howarth, Chief Nursing Officer	8	145 - 150	-	-	145 - 150	-	-	-	145 - 150
Nicola Plumb, Joint Chief People Officer	9	135 - 140	-	42.5 - 45.0	180 - 185	(65 - 70)	-	(20.0 - 22.5)	90 - 95
Emma Hallett, Interim Chief People Officer	10	5 - 10	-	0.0 - 2.5	10 - 15	-	-	-	10 - 15
Jennifer Horrabin, Joint Director of Corporate Affairs	11	5 - 10	-	0.0 - 2.5	5 - 10	(0 – 5)	-	(0.0 – 2.5)	0 - 5

Notes
1 - Appointed as Joint Chairman for Dorset County Hospital NHS FT and Dorset HealthCare University NHS FT on 1 May 2023.
2 - Until 30 April 2023.
3 - Until 31 May 2023.
4 - Appointed on 18 July 2023.
5 - Postholder as Joint Chief Executive Officer for Dorset County Hospital NHS FT and Dorset HealthCare University NHS FT and post is shared on 50:50 basis.
6 - Postholder became Joint Chief Strategy, Transformation and Partnerships Officer / Deputy CEO for Dorset County Hospital NHS FT and Dorset HealthCare University NHS FT from 1 February 2024 and post is shared on 50:50 basis.
7 - Postholder became Joint Chief Financial Officer for Dorset County Hospital NHS FT and Dorset HealthCare University NHS FT from 1 February 2024 and post is shared on 50:50 basis.
8 - Postholder appointed between 28 November 2022 and 31 March 2024 into interim post on secondment from NHS England.
9 - Postholder appointed on 1 May 2023 as Joint Chief People Officer for Dorset County Hospital NHS FT and Dorset Healthcare University NHS FT and post is shared on 50:50 basis.
10 - Postholder appointed interim on 13 July 2022 until 30 April 2023.
11 - Postholder appointed on 11 March 2024.

NHS Pensions are using pension and lump sum data from their systems without any adjustment for a potential future legal remedy required as a result of the McCloud judgement (this is a legal case concerning age discrimination over the manner in which UK public service pension schemes introduced a CARE benefit design in 2015 for all but the oldest members who retained a Final Salary design). We believe this approach is appropriate given that there is still considerable uncertainty on how the affected benefits within the new NHS 2015 Scheme would be adjusted in future once legal proceedings are completed.

There have been no annual performance related or long-term performance related bonuses paid during the year 2024/25 or 2023/24.

There is provision for pay in lieu of notice when appropriate, where there is a contractual provision for this. Notice periods for all grades of staff, including Executive Directors, have been subject to consultation and agreement with trade union representatives. In cases of redundancy of Executive Directors, the Trust will apply provisions equivalent to Agenda for Change national conditions of service, including the application of any salary caps, and payments will not be expected to exceed contractual entitlements.

In cases of capability arising from performance concerns, the Trust will seek to apply the provisions of the Performance Management Policy and Procedures to support a return to full performance wherever possible. Where continued performance issues do not support continuation in the senior post, this may involve redeployment to an alternative post at the same or a lower pay grade, or a managed exit from the organisation which may include the exercise of discretion in respect of notice and garden leave within contractual provisions. In the event of gross misconduct, the Trust may summarily terminate a Director's employment (subject to investigation and in accordance with the Disciplinary Policy). Notice pay will not normally apply where termination of employment arises in connection with the fit and proper person provisions. Assessment of the continued fitness of Directors to perform their duties and responsibilities is undertaken annually through the appraisal process."

There have been no payments for loss of office during 2024/25 or 2023/24.

There have been no payments to past senior managers during 2024/25 or 2023/24.

Fair Pay Multiple Statement

Fair Pay Multiple Statement Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their Trust against the 25th percentile, median (50th) and 75th percentile of remuneration of the Trust's workforce.

The banded remuneration of the highest-paid director in the Trust in the financial year 2024/25 was £185,001 – £190,000 (2023/24, £235,001 - £240,000). The change between years saw a 21% reduction; this relates to Chief Medical Officer reducing their working days in line with the appointment of the Interim Chief Medical Officer - designate on 6 January 2025.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

For employees of the Trust as a whole, the range of remuneration in 2024/25 was from £290,001 - £295,000 to £10,001-£15,000 (2023-24 £290,001 - £295,000 to £10,001 - £15,000). The percentage change in average employee remuneration (based on total for all

employees on an annualised basis divided by full time equivalent number of employees) between years is a reduction of 4.0%. In 2024/25, 24 (2023/24: 3) employees received remuneration in excess of the highest-paid director. Remuneration was in the banding range of £290,000 to £295,000 (2023/24: £290,000 to £295,000).

The remuneration of the employee at the 25th percentile, median (50th) and 75th percentile is set out in the table below. The pay ratio in the table below shows the relationship between the total pay and benefits of the highest paid director (excluding pension benefits) and each point in the remuneration range for the Trust's workforce.

	25th Percentile		**Median**		**75th Percentile**	
Year	**24/25**	23/24	**24/25**	23/24	**24/25**	23/24
Salary Component of pay	**£24,071.00**	£22,816.00	**£32,324.00**	£28,407.00	**£44,962.00**	£42,618.00
Salary Component: pay ratio for highest paid director	**7.86**	10.51	**5.85**	8.45	**4.21**	5.63
Total Pay and Benefits excluding Pension benefits	**£25,674.00**	£24,515.16	**£32,334.14**	£34,485.65	**£45,535.32**	£45,943.58
Pay and benefits excluding pension: pay ratio for highest paid director	**7.37**	9.79	**5.85**	6.96	**4.15**	5.22

Pension Arrangements

All Executive Directors of the Trust are eligible to join the NHS Pension Scheme. The Trust Chair and non-executive directors are not eligible to join the scheme and are not accruing any retirement benefits in respect of their services to the Trust. The Trust did not make any contributions to any other pension arrangements for directors and senior managers during the year.

The principal features and benefits of the NHS Pension Scheme are set out in the table below:

	1995 section	2008 section	2015 section
Member contributions	5% - 13.3% depending on rate of pensionable pay		
Pension	A pension worth 1/80th of final year's pensionable pay per year of membership	A pension worth 1/60th of reckonable pay per year of membership	A pension worth 1/54th of Career Average Re-valued Earnings of pensionable pay per year of membership
Retirement lump sum	3 x pension. Option to exchange part of pension for more cash up to 25% of capital value	Option to exchange part of pension for cash at retirement, up to 25% of capital value. Some members may have a compulsory amount of lump sum	Option to exchange part of pension for a lump sum up to 25% of capital value
Normal retirement age	60	65	Equal to an individuals' State Pension Age or age 65 if that is later
Death in membership lump sum	2 x final years' pensionable pay (actual pensionable pay for part-time workers)	2 x reckonable pay (actual reckonable pay for part-time workers)	The higher of (2 x the relevant earnings in the last 12 months of pensionable service) or (2 x the revalued pensionable earnings for the Scheme year up to 10 years earlier with the highest revalued pensionable earnings
Pensionable pay	Normal pay and certain regular allowances		

The tables below set out details of the retirement benefits that Executive Directors have accrued as members of the NHS Pension Scheme. All the Executive Directors that are accruing benefits under these schemes with their normal retirement age in line with the table above.

	Real Increase in pension at retirement (bands of £2,500) £000	Real Increase in lump sum at retirement (bands of £2,500) £000	Total accrued pension at retirement at 31/03/2025 (bands of £5,000) £000	Related lump sum at retirement at 31/03/2025 (bands of £5,000) £000
Matthew Bryant, Chief Executive*	2.5 – 5.0	0	80 – 85	215 – 220
Nick Johnson, Deputy Chief Executive/Director of Strategy, Transformation and Partnerships	2.5 – 5.0	0	15 – 20	0
Anita Thomas, Chief Operating Officer*	5 – 7.5	7.5 – 10.0	45 – 50	120 – 125
Chris Hearn, Chief Financial Officer	2.5 – 5	0	20 – 25	0
Nicola Plumb, Chief People Officer*	2.5 – 5.0	0 – 2.5	50 – 55	15 – 20
Rachel Wharton, Interim Chief Medical Director	0 – 2.5	2.5 - 5	45 - 50	120 – 125
Dawn Dawson, Joint Chief Nursing Officer	7.5 – 10.0	12.5 – 15.0	55 - 60	145 – 150
Jennifer Horrabin, Joint Chief Director of Corporate Affairs*	7.5 – 10.0	15 – 17.5	35 – 40	100 – 105
Prof Alastair Hutchison, Chief Medical Director	0	0	85 - 90	255 - 260

	Cash Equivalent Transfer Value at 01/04/2024 £000	Cash Equivalent Transfer Value at 31/03/2025 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension £000s
Matthew Bryant, Chief Executive*	1613	1798	43	-
Nick Johnson, Deputy Chief Executive/Director of Strategy, Transformation and Partnerships	179	235	23	-
Anita Thomas, Chief Operating Officer*	873	1049	100	-
Chris Hearn, Chief Financial Officer*	207	264	22	-
Nicola Plumb, Chief People Officer*	707	814	40	-
Rachel Wharton, Interim Chief Medical Director*	781	1043	44	-
Dawn Dawson, Joint Chief Nursing Officer*	1128	1397	172	-
Jennifer Horrabin, Joint Chief Director of Corporate Affairs*	689	919	168	-
Prof Alastair Hutchison, Chief Medical Director	-	-	0	-

* is affected by the Public Service Pensions Remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted with a zero.

Cash equivalent transfer value (CETV) figures are calculated using the guidance on discount rates for calculating unfunded public service contribution rates that was extant on 31 March 2023. HM Treasury published updated guidance on 27 April 2023. The factors used to calculate a CETV increased, following this guidance and will affect the calculation of the real increase in CETV. This guidance will be used in the calculation of 2024/25 CETV figures.

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries. CETVs are not disclosed for scheme members who have reached their normal retirement date.

The pension figures shown relate to the benefits that the individual has accrued as a

consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and the other pension details, include the value of any pension benefits in another scheme or arrangement that the individual has transferred to the NHS Pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost.

The real increase in CETV represents the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the year.

Matthew Bryant
Chief Executive

Staff Report

People Strategy
Between Dorset HealthCare (DHC) and Dorset County Hospital (DCH), we employ over 10,000 staff in a huge variety of roles and with a wealth of knowledge and expertise. Attracting, developing and retaining a highly engaged workforce is essential to delivering high quality care and support for all the communities of Dorset.

We are operating in an exceptionally challenging financial environment and our People Plan must focus on the key areas that will enable us to maintain a sustainable workforce and at the same time support service and workforce transformation. Essential to achieving this ambition is ensuring we have joined up, effective and modernised People services across both Trusts and the joint People Plan presents an opportunity to strengthen our support services by working collaboratively.

Our Joint People Plan 2025-28 forms one of five enabling strategies that support our joint strategy, Working Together, Improving Lives.

As well as supporting the other four enabling plans, the Joint People Plan works specifically towards the 'Colleagues' objective in the joint strategy, which aims to ensure:

- Colleagues are positive about their experience at work
- All colleagues feel they belong and are included
- A sustainable workforce with the right skills now and for the future

Extensive engagement across a range of stakeholder groups was undertaken to inform the priorities set out in the plan and year 1 priorities outlined in the Joint People Plan are focused on building and strengthening our core:

- Improving wellbeing at work and belonging and inclusion
- Equipping our leaders and managers
- Workforce planning and development and support for transformation
- Modernising the people directorate

A lot has been achieved across both Trusts in the post-COVID period, and the year one priorities are designed to build and strengthen our foundations. The respective Heads of Service and professional leads are already working very closely together to share resources where appropriate and reduce duplication, as well as working with wider health and care partners.

Recruitment
The past 12 months have seen ongoing pressures on recruitment with national shortages of professionally qualified staff. However, despite these challenges the overall vacancy rate has remained below the Trust target and is sitting at 3.11%.

Recruitment of clinical staff has been high priority to reduce the need for agency and bank worker expenditure. This focus has now moved to medical recruitment to reduce the use of high-cost agencies.

Working in collaboration is a key pillar for the People Plan and the Trust has continued to work closely with other NHS Trust colleagues in the Dorset Integrated Care System to enhance recruitment and selection activity and promote Dorset as a place to live and work.

Employment Policies
The Trust has 55 employment policies in place which have been designed to provide guidance to our staff and to ensure we meet our legal obligations to them. The effectiveness of each policy is reviewed in conjunction with staff side representatives. During 2024/25, 21 of our employment policies were reviewed to ensure effectiveness and adherence to legal requirements and recommendations made by professional bodies such as the British Medical Association and NHS Employers.

The Trust is dedicated to collaborative working with Dorset HealthCare and during 2024/25 have created joint Organisational Change, Death in Service and Pension Policies and have adopted the same principles with our relaunched flexible working policy.

Appraisal Process
The simplified 'appraisal-on-a-page' form and policy, accompanied by the 'Meaningful Appraisals' workshops which form part of our Management Matters Programme, has ensured our managers have the confidence to hold effective and regular wellbeing, career development and performance conversations with every individual in their team.

Staff Gender Analysis (at 31 March 2024)
A full report on the Trust's gender pay gap statistics was provided to the People and Culture Committee in March 2024, and formal submission made via the government portal the same month. The current DCH Gender Pay Gap Report is available to view here:

Gender-Pay-Gap-Report-2024.pdf

The Gender Pay Gap is not the same as unequal pay. The Gender Pay Gap can be simplified by understanding that we have more men than women in higher paid roles. Our Gender profile in Dorset County Hospital on 31March 2024, shows that the workforce consisted of 2,939 women and 1,011 men inclusive of bank workers.

Dorset County Hospital's Median Gender Pay Gap in 2023/24 was -1.43% in favour of women. This represents an improvement on last year's reported figure of 7.65% in favour of men for the period 2022/23. It is also the lowest reported figure over the last six years.

Overall, like many organisations Dorset County Hospital still has a gender pay gap in favour of men in some pay bands. As a Trust we will continue to look at ways in which we can close the gap through the actions that are outlined in our People Plan.

Our gender pay gap results (based on the hourly pay rates our employees received on 31 March 2024) are as follows:

- Our mean gender pay gap is 18.95%
- Our median gender pay gap is -1.43%

- Our mean bonus gender pay gap is 1.92%
- Our median bonus gender pay gap is 48.46%
- Our proportion of males within whole Trust receiving a bonus payment is 3.40%
- Our proportion of females within whole Trust receiving a bonus payment is 0.35%

For Gender Pay Gap calculations, our bonus payments relate to Clinical Excellence Awards only. Traditionally, these award Consultants who perform 'over and above' the standard expected of their role. It's worth noting CEAs have now been incorporated into overall pay so cease to exist. However, a few contractual CEAs will remain in place for some longstanding consultants across the NHS which may see a continuation of the disparity in medics pay.

Continued work underpinned by our People Plan and our goal to be recognised as a highly attractive place to develop a long term clinical and non-clinical career aligns with are continued work to address the barriers for female employees.

A Gender breakdown report by headcount for our Executive and Non-Executive Directors (Senior Leaders) is as follows:

Male	Female
8	7

Staff Sickness

Source: NHS Digital - Sickness Absence and Workforce Publications - based on data from the ESR Data Warehouse

Period covered: January to December 2024

Data items: ESR does not hold details of the planned working/non-working days for employees so days lost and days available are reported based upon a 365-day year. For the Annual Report and Accounts the following figures are used:

The number of FTE-days available has been taken directly from ESR. This has been converted to FTE years in the first column by dividing by 365.

The number of FTE-days lost to sickness absence has been taken directly from ESR. The adjusted FTE days lost has been calculated by multiplying by 225/365 to give the Cabinet Office measure.

The average number of sick days per FTE has been estimated by dividing the FTE Days by the FTE days lost and multiplying by 225/365 to give the Cabinet Office measure. This figure is replicated on returns by dividing the adjusted FTE days lost by Average FTE.

Figures converted by DH to Best Estimates of Required Data Items			Statistics Produced by NHS Digital from ESR Data Warehouse	
Average FTE 2024	Adjusted FTE days lost to Cabinet Office definitions	Average Sick Days per FTE	FTE-Days Available	FTE-Days Lost to Sickness Absence
3,347	32,167	9.6	1,221,651	52,182

Turnover
The Trust's turnover rate for 01 April 2024 – 31 March 2025 was 9.51% (based on a rolling 12-month period). Turnover has remained stable and within the Trust's acceptable range of 8% - 10%.

We have seen a reduction in turnover in all staff groups except for Allied Health Professionals and Medical and Dental (although this remains low). A system-wide workforce plan for the Allied Health Professions (AHP) staff group has been developed, outlining the resourcing pipelines and optimal staffing numbers required to ensure that the AHP workforce remains at an optimal capacity to meet projected demand.

We continued to see a significant reduction in turnover in the Additional Professional Scientific and Technical staff group (which includes Pharmacy). Several initiatives have been implemented to support the recruitment and retention of staff within this service, and this is having a positive impact on recruitment and retention.

Turnover in Estates and Facilities remains high relative to other staff groups. This is being addressed by the implementation of Recruitment and Retention premia which offers a competitive and enhanced benefits and reward package, within the remit of AfC Terms and Conditions, to attract and retain skilled workers with the staff group.

Turnover data is reported to the Board (via the balanced scorecard) and the People and Culture Committee in Common.

Staff Group	LTR Headcount %	LTR FTE %
Add Prof Scientific and Technic	6.35%	5.31%
Additional Clinical Services	9.00%	8.83%
Administrative and Clerical	13.67%	13.38%
Allied Health Professionals	12.83%	12.73%
Estates and Ancillary	13.89%	14.06%
Healthcare Scientists	5.92%	5.95%
Medical and Dental	6.71%	6.44%
Nursing and Midwifery Registered	6.64%	6.61%
Students	0.00%	0.00%

Equity, Diversity, Inclusion and Belonging (EDIB)
At Dorset County Hospital, our commitment to equity, diversity, inclusion and belonging (EDIB) remains central to how we support staff and shape our organisational culture. In collaboration with Dorset HealthCare, we have launched a Joint Inclusion and Belonging Strategy (2024–2026) which sets a shared direction of travel for inclusive practice across the colleague lifecycle—from recruitment and onboarding to progression and transition.

Our work continues to be guided by national and legal frameworks, including the Equality Act 2010, Public Sector Equality Duty, Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), and the Equality Delivery System (EDS2). These

frameworks help ensure we meet our obligations—but our ambition is to build a culture where inclusion is not a requirement, but a lived and shared value.

Significant progress has been made in areas such as data-led strategy development, inclusive training design, and network collaboration. Conscious Inclusion Training, developed in partnership with DHC, continues to lay important groundwork for leadership accountability and awareness. Work is also underway to further embed Equality Impact Assessments (EIAs) into strategic planning and policy development. These assessments now include revised guidance and are increasingly used to identify how decisions may impact different groups—an essential step in ensuring equitable outcomes.

Staff Networks remain central to our EDIB ambitions. Over the past year, their influence has grown through closer engagement with policy reviews and strategic forums. Alongside this, the introduction of an anonymous reporting tool for freedom to speak up and sexual safety issues marks a tangible step toward improving psychological safety and colleague trust.

As part of the wider inclusion and belonging agenda, we continue to explore how Trust infrastructure and staff experience align. Issues such as affordable staff accommodation are recognised as material to equity and retention, and work is ongoing with Strategic Estates and People teams to ensure that belonging is not only about values, but also about access and practical support.

We know that culture change does not happen overnight and our EDIB work is not about visibility alone. It is about ensuring that the systems we build, the decisions we make, and the behaviours we reinforce reflect the diversity and dignity of all who work here.

Consultation, Partnership Working and Staff Engagement

We have several established mechanisms of communicating information to staff across the Trust, including a weekly e-bulletin shared via email and our staff app, a weekly briefing from the Chief Executive (via email and staff app), monthly online Team Brief sessions open to all staff and posters for staff noticeboards. There are also regular e-bulletins from the organisational development and education teams, and a weekly bulletin which highlights staff successes and thank you messages. In addition to these corporate channels, line managers have their own staff communications channels for circulating key messages, including WhatsApp groups. The staff intranet (StaffNet) is accessible to staff via their own devices, and the Trust communicates with both the public and staff via social media channels, our public website and local media.

Our established consulting and negotiating bodies, the Partnership Forum (for non-medical staff) and Local Negotiating Committee (for medical staff), continue to make an important contribution to promoting effective staff engagement and partnership working and in ensuring these are underpinned by a commitment to: promoting the success of the organisation; recognising the respective parties' legitimate interests; operating in an honest and transparent manner; focusing on the quality of working life and its benefit to the quality of patient care; maintaining, as far as possible, employment security.

Trade Union Facility Time

Relevant union officials

Number of employees who were relevant union officials during the relevant period	FTE employee number
11	2927

Percentage of time spent on facility time

Percentage of time	Number of employees
0%	-
1-50%	11
51%-99%	-
100%	-

Percentage of pay bill spent on facility time

	Figures
Provide the total cost of facility time	£3802
Provide the total pay bill	£219,974,639.63
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.001%

Paid trade union activities

Time spent on paid TU activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid TU activities by TU representatives during the relevant period ÷ total paid facility time hours) x 100	80%

Workforce Planning

Our Workforce Business Partners deliver workforce planning training to managers across the Trust, supporting managers to develop workforce plans that inform recruitment, retention and safe staffing strategies. This includes opportunities for new operating models, role re-redesign, skill mix reviews and new apprenticeships.

Nursing Apprenticeship pipelines continue through the system Registered Nurse Degree Apprenticeship scheme (RNDA) alongside other Pan Dorset system recruitment approaches e.g. Occupational Therapy and Physiotherapy.

Workforce plans continue to be refined supporting delivery of a new services such as ED and Critical Care Unit (NHP) Acute Hospital at Home expansion, Stroke Expansion, Working Better Together and other schemes to support flow and admission avoidance.

Workforce Business Partners work alongside the Business Intelligence (BI) Team to develop and improve workforce data and dashboards which track key workforce metrics such as turnover, exit interview data, vacancies and workforce demographics. These dashboards assist in the development of workforce plans and in monitoring changes to Whole Time Equivalents (WTE) over time. Additionally, these dashboards form a key part of the Trust overall governance processes, ensuring that workforce decisions, plans and solutions remain data driven.

Health and Wellbeing

The focus for Health and Wellbeing (HWB) has been to continue embedding our HWB offer across the Trust, aligning to our joint strategy, raising awareness and usage, and encouraging local ownership from line managers in supporting their teams.

Our EAP provision from Vivup continues to be available to staff 24/7, 365 days per year.

The community of Health and Wellbeing Coaches (HWCs) has grown to a community of 80, with ongoing interest in the role. Quarterly Community of Practice sessions are being conducted to support our coaches. Surveys conducted with HWB coaches show the key themes of conversations they are having is work-based stress and working relationships.

Staff have access to a peer-delivered assessment tool (TRiM) if affected by a potentially traumatic incident, and to ascertain whether they would benefit from further support.

Financial support for staff has continued to be a priority due to the cost-of-living. We work closely with the Money and Pensions service and our credit union Serve & Protect. Staff can be referred confidentially to foodbanks, and we offer shopping voucher support to these staff members as well as free food which would otherwise go to waste from our Damers Restaurant.

We have seven Menopause Advocates (who have completed relevant e-learning), who supply information around the menopause to staff. There is ongoing interest in becoming Menopause Advocates.

The 150 hard back folders with Health and Wellbeing information, are being used by HWB coaches and line managers to signpost staff to relevant support.

Livewell Dorset have conducted five events of staff health checks and will continue with this offer in the coming year. These and other activities have improved staff knowledge around the wellbeing support available with a goal to impact on staff sickness, retention and cognitive ability whilst at work.

Countering Fraud and Corruption

The Trust's Counter Fraud Policy sets out the standards of honesty and propriety expected of staff and encourages employees to report any suspicious activity that might indicate fraud or corruption promptly.

The Trust's counter fraud service during 2024/25 was provided by TIAA who report directly to

the Chief Financial Officer and report regularly to the Audit Committee throughout the year. Raising awareness of counter fraud and corruption and ensures that it is taken seriously by the Trust and is communicated via a variety of methods, including leaflets, counter fraud newsletters and notices, staff bulletins, staff awareness presentations, induction training and the Trust's intranet. TIAA undertook several proactive work streams throughout the year to support the Trust's commitment to this area and have in the last year attended site for awareness sessions and swiftly responded to requests for the Trust for specialist investigations.

The Trust's Freedom to Speak Up Guardian (FTSUG) is supported by a network of Freedom to Speak Up Champions. The FTSUG has a regular meeting with the Chief People Officer and Senior Independent Officer, to discuss and raise any concerns. An annual Freedom to Speak Up report is submitted to the People and Culture Committee in Common.

The Trust's Senior Independent Officer (SIO) and Whistleblowing Lead is one of our Joint Non-Executive Board members. This role is in place to ensure there is a direct point of contact on the Board, and to provide Board level visibility of any potential issues.

What our Staff Say

Staff experience and engagement

The Trust recognises the important link between staff engagement and improved patient care. Understanding how staff experience their work environment is critical to the success of any organisation, and the annual NHS National Staff Survey provides an important insight into how our staff experience work at DCH.

The most critical part of this process is not just about reviewing the results but being clear about where we want to be as an organisation, and what needs to be done differently to ensure we are.

Since 2021/22, the questions in the NHS Staff Survey have been aligned to the People Promise and are made up of seven People Promise elements and two themes (Staff Engagement and Morale).

For 2024/25, a response rate of 46.4% was achieved (1,747 employees). This is an improvement of 5.4% from last year. The median response rate for our benchmarking group (Acute and Acute and Community Trusts) was 49%.

2024/25 results

Out of the seven People Promise elements, five have improved and two have declined (although none of the differences in scores are statistically significant). Five of the People Promise elements are significantly better than the sector average. Just one People Promise element (We are safe and healthy) scored lower than average (by 0.04%) with declining scores relating to work pressures.

The Employee Engagement index continues to have a score out of 10. Our score has declined since last year from 7.07 to 7.03 but is not considered statistically significant. A score of 7.0 or more is considered excellent. The DCH Staff Engagement score is

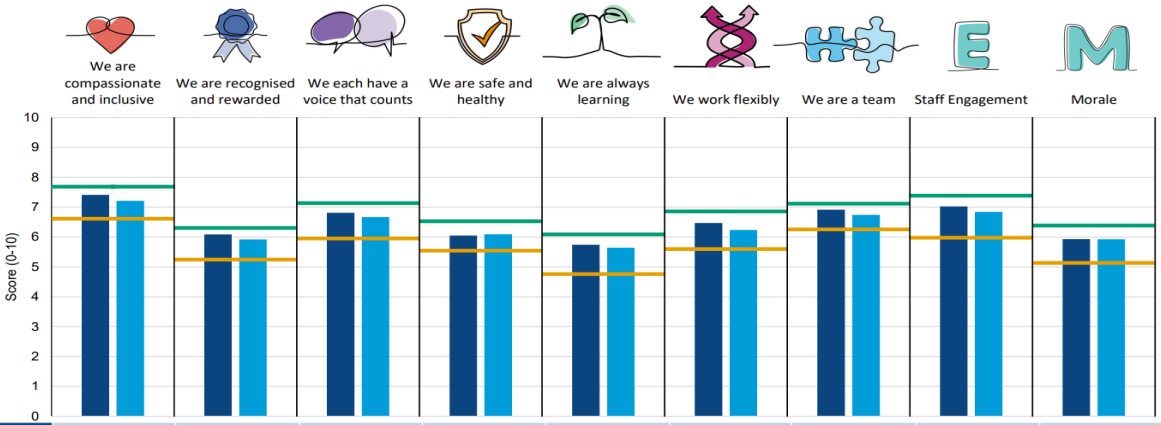
significantly better than the sector average. The theme of 'Morale' has declined since last year from 6.0 to 5.9 but again this is not considered statistically significant.

Drilling down further, there are some encouraging results in relation to flexible working, line management and reasonable adjustments for disabled staff, reflecting our focus in these areas over the past 18 months. It is also great to see an overall increase in those recommending the Trust as a place to work (67.6%) and we were also proud to see this score rank us third in the South-West Region as a recommended place to work.

We continue to utilise the results to identify positive outcomes, areas to improve and any trends worthy of note. At a local level, divisional and team leaders will be cascading results using a newly created NSS Results Toolkit and Action Plan template to encourage consistent approaches.

The summary scores of People Promise Themes and the two elements of Engagement and Morale are shown in the table below:

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.41	6.09	6.81	6.05	5.74	6.47	6.92	7.03	5.93
Best result	7.69	6.30	7.14	6.53	6.09	6.86	7.12	7.39	6.38
Average result	7.21	5.92	6.67	6.09	5.64	6.24	6.74	6.84	5.93
Worst result	6.61	5.24	5.95	5.54	4.76	5.60	6.26	5.98	5.13
Responses	1743	1740	1713	1719	1650	1724	1739	1746	1745

Celebrating Success

Every day, individuals and teams within the Trust go above and beyond the call of duty; and throughout 2024/25 this was again evident. Our quarterly Hospital Hero scheme has been replaced by a weekly Celebrating Success bulletin.

We have changed our Long Service Awards to move towards the Dorset Healthcare approach. 52 staff who reached the milestone of 25 years of NHS service have been awarded with a commemorative pin badge and certificate.

We are reviewing our reward and recognition offers (to include long service) and this will form part of our year one People Plan priorities.

Leadership Development

The Management Matters Programme (MMP) continues to be delivered, evaluated and valued by participants. The programme adopts a blended approach, offering face-to-face workshops, virtual workshops, e-learning and on-line resources.

New Workshops for 2024/25 included: Performance Management, Managing Risk, Quality Improvement, Introduction to Budgets and Finance, Capital and Charitable Funds, Income, Costings and Productivity, Procurement, Inventory Management and Business Case Development.

A Clinical Leadership Programme was piloted using Michael West's book on Compassionate Leadership as a foundation. This programme is being developed further for a multidisciplinary group of leaders for 2025/26.

Organisational Development
The OD work portfolio areas are wide reaching and have significant impact for the organisation: Equality, Diversity and Inclusion, Health and Wellbeing and Leadership and Management Development.

Key work programmes during 2024/25 included the Management Matters Programme, Dignity and Respect at Work Programme and the new Clinical Leadership Programme. These programmes of work are central to driving culture change and improving the staff experience at the Trust.

The Team has started to implement the TED tool (team engagement and development) across the Trust. It is a toolkit that helps teams understand how effectively they work together and engage team members in creating actions to improve their effectiveness.

Throughout the year the OD Team has supported individuals and teams through coaching, facilitated conversations, team development sessions and key work programmes. A consultancy approach is taken to team development requests, and this has led to successful tailored interventions involving a mix of bespoke sessions and existing core resources.

Education, Learning and Development
The Education, Learning and Development department provides training, continuing professional development and pastoral education support to the whole workforce at Dorset County Hospital to improve their knowledge, skills, and capabilities regardless of role. The organisation is committed to ensuring that education and training is a key priority, investing in the development of the current and future workforce to deliver and contribute to safe, high quality, evidenced based patient care.

We have a purpose-built education centre with lecturing and training rooms including an IT training suite, a clinical skills simulation suite and a well-resourced library. We deliver education and training using a blended approach of face to face, e-learning, and simulation. We actively seek new opportunities to collaborate with partner organisations to innovate and improve access to education, learning and development for all staff and learners.

In 2024 we supported over 2,000 staff and learners to undertake training and education.

Corporate and Mandatory training
In 2024 the Corporate and Mandatory Training team have welcomed 746 new staff, delivering up to three corporate induction sessions each month. Feedback from attendees

has been overwhelmingly positive, with 89% saying they would recommend the training to others.

1,207 inter-authority transfers from 105 NHS organisations were processed in 2024 allowing staff to passport training completed with a previous employer. Additionally, tools like paperless digital registration, automated compliance reporting, and a digital competency check form have been introduced to help speed up processes and allow staff to focus on relevant training.

The team's ongoing efforts to improve and optimise underscore our dedication to supporting staff amid continued challenges that have occurred, including the increasing burden of additional statutory and mandatory training topics, which has contributed to essential skills training currently being 2% below the 90% compliance target (-5% change year on year.) Despite these pressures, the team is committed to minimising the impact on staff. Efforts include aligning Fire Safety training with the Core Skills Training Framework standards to halve training time over two years, optimising Moving and Handling Level 2 training to cut refresher time by one hour per session and revising Dementia Awareness and Safeguarding training to introduce shorter online pathways. These initiatives aim to streamline training while awaiting NHS England's national review of statutory and mandatory training for further recommended improvements.

Library and Knowledge services

NHS Library and Knowledge services exist to provide all staff and learners with high-quality resources and the expertise of knowledge and library staff to help inform decision making.

Demand for library and knowledge services have continued to increase throughout 2024. In the past 12 months library user registrations have increased by 22% and we have seen an increase of 24% in requests for articles, both print and electronic, via our Inter Library Document Supply Service. Requests for literature searches have increased too, by 57% over a two-year period.

Our Library User Education training and workshops continue to be popular. These have covered a range of topics, including academic writing, study skills, Health Literacy, searching the healthcare databases, referencing and critical appraisal; and bookings for these have increased by 65%.

Our Health Literacy awareness workshops are reaching increasing numbers of staff (delivered to 119 people in 2023 and 276 in 2024) and we are proud to have 25 Health Literacy Champions at the Trust supporting this work.

Our Knowledge Mobilisation offer has grown, and we have facilitated three Knowledge Café events and one Randomised Coffee Trial this year.

Medical Education

The Medical Education Team has successfully inducted 128 Resident Doctors (previously doctors in training), provided 68 Medical Students and seven Trainee Physician Associates with clinical placements and supervision and supported 10 international doctors with a Clinical Attachment.

As the lead employer for GP trainees, we have collaborated with local GP practices and the GP School to address placement shortages in Dorset. Additional hospital placements were provided to minimise disruption to GP training.

We continue to invest in doctors not on formal training programmes, employing 61 Locally Employed Doctors (LEDs) and 82 Specialty and Associate Specialty (SAS) doctors. We run a monthly ‘Professional Skills Development Programme’ for doctors pursuing consultant status outside traditional training routes, through the Portfolio Pathway.

In December, the University of Southampton Medical Faculty conducted a Quality Assurance visit, praising our high standard of medical education and student-centred culture.

We successfully ran the "Introduction to Medicine" programme in July in conjunction with the Duke of Edinburgh Gold Award, delivering a five-day residential programme to 30 young people aged 16-19. Dorset County Hospital continues to be the only NHS organisation in England to offer this opportunity. We also run a local Introduction to Medicine programme during October half-term for sixth form students from local schools.

Widening Participation

Vocational Scholarships
Introduced in 2022, the Vocational Scholarship is a two-week programme which runs twice a year and accommodates up to 15 people. The programme introduces people to Support Worker roles through training and supervision and giving them employability skills, with a guaranteed interview at the end of the programme. To date, 89% of the individuals who have undertaken the programme have been successfully appointed into posts at DCH.

Supported Internships
We continue to offer supported internship placements in conjunction with Weymouth College and have now expanded our offering to include The South West Regional Assessment Centre (SWRAC). This programme provides a work placement for young people who have a physical, mental, or learning difficulty and who would otherwise may not be able to enter the world of work. We have been able to offer six placements lasting 32 weeks to young people this year and have supported four individuals into full employment with the organisation or one of our ICB partners.

Functional Skills
At DCH we strive to develop an individual’s educational achievements to expand opportunities to pursue their chosen career pathway. To assist staff to reach their full potential we are pleased to offer free functional skills. Functional skills are practical skills in English, Digital Skills and Maths which provide learners with the skills, knowledge and understanding required to help them progress in their role, boost their confidence, and support their ongoing education. We are currently supporting 54 staff within the organisation in completing their functional skills qualifications and obtaining a formal qualification.

Work Experience Placements
During 2024 we have continued to build upon the relaunch of the work experience placement programme of 2023. Work experience placements are offered in several services across the organisation, including clerical and administrative roles, medical and dentistry, IT, pharmacy, healthcare sciences and allied health professions, and insight and support is offered to individuals in understanding different career pathways within the organisation and the wider NHS. During 2024 we have welcomed 132 individuals on placements, marking a huge increase of 257% from 2023. Alongside these career exposure programmes we have welcomed an additional 207 young people into the organisation on work experience.

Healthcare Support Worker development
The nationally recognised Care Certificate programme continues to be implemented for all new Healthcare Support Workers employed by the Trust. Our robust and engaging six-day education programme is now embedded and offers excellent support to staff at the point of joining and throughout their first 12 months in post. During 2024/25 we have supported 133 individuals through the Care Certificate programme.

We have a high completion rate and are successful in supporting staff who choose to continue their education journey and progress to Level 2 or 3 health care apprenticeships.

We continue to see an increase in numbers of staff progressing to professional careers in Nursing, Midwifery, Therapies and Medicine, and in collaboration with the Widening Participation Team and federation partners, launched our three-day Introduction to Nursing programme in February. This event was incredibly popular and significantly oversubscribed.

Non-Medical Undergraduate education
Clinical placement capacity for non-medical undergraduate students continues to increase to meet demand, with particular focus on analysis and action to increase Allied Health Professional placement capacity. Highlights this year include piloting an innovative approach to pre-registration nurse practice placement learning on Ridgeway Ward, increasing their student nurse capacity to 19 with up to 12 on shift running the ward under supervision of a registered nurse. The National Education and Training Survey results reflect the commitment of the non-medical undergraduate practice education team on providing high quality placements across the organisation. High level results were higher than all national education quality indicator averages, except from sexual safety which fell just below. An action plan is in place to address this. Only 3% of learners would not recommend DCH to their friends and family for care (a decrease of 3% from 2023) and 5% would not recommend DCH for training (a decrease of 5% from 2023)

Preceptorship
The Preceptorship Programme is a 12-month development programme for all non-medical newly qualified registered health care professionals. This year has seen a significant review to ensure the programme is aligned to the National Frameworks for Nurses, AHPs and Midwives. Over the last year we have delivered five programmes to 139 newly registered staff. The programme continues to advocate the Edward Jenner programme as a leadership development package at the end of year one. We continue to maintain the standards of the National Preceptorship Interim Quality Mark we achieved in February 2024.

The following sections of the Staff Report are not subject to audit.

Consultancy

The NHS has additional controls for spending on consultancy contracts over the value of £50,000 to ensure value for money. The Trust did not have any contracts which exceeded the £50,000 limit.

	2024/25 £000s
Finance	24
Strategy	15
Technical	23
Total	**61**

Reporting High Paid Off-payroll Arrangements

The Trust has a policy on the engagement of staff off-payroll to ensure compliance with employment law, tax law and HM Treasury guidance for government bodies. This contains a procedure to ensure appointees give assurances to the Trust that they are meeting their Income tax and National Insurance obligations.

The policy includes controls for highly paid staff including board members and senior officials, individuals under these sections require Accounting Officer approval and should only last longer than six months in exceptional circumstances.

For any off-payroll engagements as at 31 March 2025, for more than £245 per day and that last for longer than six months	Number of engagements
Number of existing engagements as of 31 March 2025	1
Of which, the number that have existed:	
For less than on year at time of reporting	1
For between two and three years at the time of reporting	Nil
For between three and four years at the time of reporting	Nil

All off-payroll workers engaged at any point during the year ended 31 March 2025, for more than £245 per day	Number of engagements
Number of new engagements during the year ended 31 March 2025	630
Of which…	
Not subject to off-payroll legislation	625
Subject to off-payroll legislation and determined as in-scope of IR35	5
Subject to off-payroll legislation and determined as out-of-scope of IR35	Nil
Number of engagement reassessed for compliance or assurance purposes during the year	Nil
Of which; No of engagements that saw a change to IR35 status following review	Nil

For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2024 and 31 March 2025	Number of engagements
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year	Nil
Number of individuals that have been deemed "board members and/or senior officials with significant financial responsibility" during the financial year. This figure includes both off-payroll and on-payroll engagements	18

The Trust has made no payments for off payroll arrangements to individuals through their own companies during 2024/25.

The following sections of the Staff Report are subject to audit.

Average number of employees (WTE basis)

	Average for year ended 31 March 2025		
	Total number	Permanent number	Other number
Medical and dental	462	448	14
Administration and estates	575	573	2
Healthcare assistants and other support staff	1,020	1,020	-
Nursing, midwifery and health visiting staff	1,091	1,045	46
Nursing, midwifery and health visiting learners	42	42	-
Scientific, therapeutic and technical staff	275	271	4
Healthcare science staff	89	86	3
Social care and staff	-	-	-
Other	-	-	-
Total	3,554	3,485	69
Of which: Engaged on capital projects	59	59	-

The average number of employees is calculated on the basis of the number of worked hours reported. This means that the reporting of staff numbers and staff costs incurred are on a more consistent basis.

Employee Expenses

	Total £000	Permanent employed £000	Other total £000
Salaries and Wages	166,121	164,029	2,092
Social security costs	17,272	17,272	-
Apprenticeship levy	839	839	-
Pension cost – NHS pensions	19,731	19,731	-
Pension cost – Employer contributions paid by NHSE	12,905	12,905	-
Pension cost – other	33	33	-
Termination benefits	478	478	-
Temporary staff – Agency/contract staff	6,459	-	6,459
Total Gross Staff Costs	**223,838**	**215,287**	**8,551**
Included within; costs capitalised as part of assets	3,667	3,667	-

Exit Packages

2024/25 Exit package cost band	Number of Compulsory redundancies	Number of Other departures agreed	Total number of exit packages by cost band
< £10,000	-	22	22
£10,001 - £25,000	-	3	3
£25,001 - £50,000	1	2	3
£50,001 - £100,000	-	1	1
> £200,000	1	-	1
Total number of exit packages by type	2	28	30
Total resource cost (£000)	242	236	478

2023/24 Exit package cost band	Number of Compulsory redundancies	Number of Other departures agreed	Total number of exit packages by cost band
< £10,000	-	29	29
£10,001 - £25,000	-	4	4
£50,001 - £100,000	-	1	1
Total number of exit packages by type	-	34	34
Total resource cost (£000)	-	216	216

The payments included in ‘Other departures’ agreed for 2024/25 are 25 in respect of contractual payments made in lieu of notice and three Mutually agreed resignations (MARS) contractual costs (2023/24 33 payments for lieu of notice and one payment for voluntary redundancy). Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pension scheme. Ill-health retirement costs are met by the NHS pension scheme and are not included in this table.

Corporate Governance Report

Code of Governance for NHS Provider Trusts

The ***Code of Governance for NHS Provider Trusts*** (the *Code of Governance*) was published in October 2022 and has been applicable since 1 April 2023. It replaces the previous NHS Foundation Trust Code of Governance issued by Monitor.

The *Code of Governance* sets out a common overarching framework for the corporate governance of NHS providers reflecting developments in UK corporate governance and the development of integrated care systems. Providers must comply with each of the provisions of the code or, where appropriate, explain in each case why the provider has departed from the code.

Compliance with the Code

NHS foundation trusts are required to provide some disclosures in their annual report to meet the requirements of the Code of Governance. Dorset County Hospital NHS Foundation Trust has applied the principles of the Code of Governance for NHS Provider Trusts on a comply or explain basis.

The Board of Directors implements the Code of Governance through a number of key governance documents which include:

- The Constitution
- Standing Orders and Standing Financial Instructions
- Scheme of Delegation and Matters Reserved to the Board
- Code of Conduct – Board of Directors and Council of Governors
- Board and Committee governance structure.

The Trust undertook a comprehensive self-assessment of compliance with the code in April 2025 in preparation for the production of the Annual Report and the Annual Governance Statement.

The Trust is fully compliant with the Code of Governance. In terms of new developments during the year, we have appointed to Non-Executive Director posts across Dorset County Hospital NHS Foundation Trust and Dorset HealthCare University NHS Foundation Trusts, and the skills matrix was used to inform this recruitment. A succession plan across both Trusts has now been developed and this will be shared with the Council of Governors Nominations and Remuneration Committee in the coming year.

There are no areas where the Trust expects to be non-compliant (in these cases the Trust would be required to 'explain' this non-compliance under the 'comply or explain' requirement, as detailed in Section 4 of the code).

Three of the provisions relate to making information publicly available. The Trust is fully compliant with these requirements.

Compliance with the NHS Provider Licence

NHS England undertook a review of the NHS Foundation Trust Licence conditions in 2023 and extended the provisions of the licence to all NHS providers, updating the conditions to reflect the wider system compliance requirements also. The Trust undertook comprehensive reviews of compliance with the revised Provider Licence conditions in Quarter 4 to ensure compliance with the revised requirements.

The Trust is compliant with the NHS Provider Licence conditions.

Board of Directors

The Board of Directors is responsible for establishing the strategy of the Trust and for the operation of the Trust's business, ensuring compliance with the Trust's Constitution, NHS Provider Licence, statutory requirements and contractual obligations. Details of the composition of the Board can be found in the Directors' Report above. Terms of office and remuneration details are contained within the Remuneration Report.

Individual members of the Board of Directors undertake annual appraisal in order to establish performance objectives for the coming year. The process includes self-assessment, peer review and feedback from Governors and external stakeholders. The Trust Chair's appraisal is undertaken by the Senior Independent Director and submitted to NHS England. The Board has considered the skills, expertise and experience needed to ensure appropriate balance and completeness to meet the ongoing requirements of the Trust and has reflected these requirements in the appropriateness of appointments made to the Board of Directors during the year.

Attendance at Trust Board Meetings 2024/25

* indicates extra-ordinary meetings

P1 = Public P2 = Private	01 May 24*		29 May 24		31 July 24		09 Oct 24		10 Dec 24		11 Feb 25		24 Mar 25*
	P2	P1	P2	P1	P2	P1	P2	P1	P2	P1	P2	P2
Non-Executives													
David Clayton-Smith	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Margaret Blankson	✓	✓	✓	✓	✓	A	A	✓	A	✓	✓	✓
Eiri Jones	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Claire Lehman	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Stuart Parsons	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	A
Stephen Tilton	A	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dave Underwood	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Frances West (from 23 09 24)						✓	A	✓	✓	✓	✓	✓
Executives													
Matthew Bryant	✓	✓	✓	✓	✓	✓	✓	✓	✓	A	A	✓
Dawn Dawson	✓	✓	✓	✓	✓	✓	✓	✓	✓	A	A	A
Chris Hearn	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Jenny Horrabin	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Alastair Hutchison	✓	A	A	✓	✓	✓	✓	✓	✓	✓	✓	A
Nick Johnson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nicola Plumb	✓	A	A	✓	✓	✓	✓	✓	✓	✓	✓	✓
Anita Thomas	✓	A	A	✓	✓	A	A	✓	✓	✓	✓	✓
Rachel Wharton (from 06 01 25)										A	A	✓

Attendance at committees

Remuneration and Terms of Service Committee

Information about this committee and its activities can be found in the Remuneration Report.

Audit Committee

During the year the Audit Committee Terms of Reference were reviewed in accordance with the 2024 Healthcare Financial Managers Association NHS Audit Committee Handbook. The Committee, formerly known as the Risk and Audit Committee was renamed the Audit Committee from 9 October 2024.

The Audit Committee comprises a Non-Executive Chair with accounting experience and two other Non-Executive Director members. The Chief Finance Officer and Director of Corporate Affairs are not members of the committee but normally attend meetings. Other executives are invited to attend the committee as required, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director. The Committee is supported by Internal and External Auditors and representation from the Counter Fraud Authority. The work of the committee is regularly observed by members of the Council of Governors.

The purpose of the committee is to maintain oversight of the Trust's systems of internal control, governance and quality safety on behalf of the Board of Directors, seeking assurances from non-executive Committee chairs, supported by executive directors.
The internal audit function is provided by a third-party provider of internal audit services, BDO LLP, which reports to the Audit Committee. The Audit Committee monitors the internal audit work programme and receives regular reports and assurances on the adequacy of controls in place. The Audit Programme facilitates and informs the Head of Internal Audit Opinion that is included within the Trust's annual report each year.
External auditors review the plan of work, risks and mitigations and provide recommendations on areas where further mitigations or improvement could be made. They undertake a formal audit of the Trust's accounts and annual report each year which includes scrutiny of: Management Override of Controls, Valuation of Land and Buildings and Fraudulent recognition of non-pay expenditure. External auditors have not provided any non-audit services in year.

The committee considered the Annual Report and Audited Accounts for 2024-25 at a meeting held on 2 June 2025 and concluded that there were no significant risks requiring action pursuant to the Corporate Governance Code.

Non-Executive Director Members Attendance at the Audit Committee 2024/25

Name	Attendance/Meetings eligible to attend*
Claire Lehman	4/5
Stuart Parsons (Committee Chair)	5/5
Stephen Tilton	5/5
Dave Underwood	4/5

* Meetings of the Audit Committee took place in June, September, December, February and March.

Quality Committee

The purpose of the Committee is to maintain oversight of the clinical strategies; scrutinising delivery of quality care and strategy outcomes in order to provide assurance to the Audit Committee and to the Board that risks to delivery of the clinical strategies are being managed appropriately. This would support the signing of the Annual Governance Statement and Quality Accounts. The Committee will ensure that all aspects of quality governance, patient safety and experience are subject to scrutiny in order to provide assurance to the Board.

Name	Attendance/Meetings eligible to attend*
Dawn Dawson	9/11
Alastair Hutchison	10/11
Eiri Jones (Committee deputy chair)	10/11
Claire Lehman (Committee Chair)	10/11
Stuart Parsons	10/11
Anita Thomas	8/11
Rachel Wharton	3/3

Finance and Performance Committee

The Finance and Performance Committee operated as a Trust-specific committee until September 2024. From September 2024 onwards the Trust's Finance and Performance Committee operated as a committee in common with the same Committee from Dorset HealthCare University NHS Foundation Trust.

The Finance and Performance CiC advises, supports and assures the Board of Dorset HealthCare and Dorset County Hospital on matters related to:

- Reviewing financial and operational performance. This includes operational performance against both internal and external (agreed local, regional, national, regulatory, commissioning and contractual) indicators and reviewing financial performance and delivery of the Trust's financial efficiency/cost improvement plans;
- Scrutinising and approving enabling strategies, business cases, expenditure, procurement and financial plans in line with the Standing Financial Instructions and Scheme of Delegation;

- Oversight of compliance in respect of estates, health and safety (including fire and water) and Emergency Preparedness, Response and Resilience, Subsidiary Companies and Joint Ventures.

Finance and Performance Committee attendance to September 2024

Name	Attendance/Meetings eligible to attend*
Margaret Blankson	3/4
Dawn Dawson	3/4
Chris Hearn	4/4
Alastair Hutchison	1/4
Nick Johnson	3/4
Eiri Jones	4/4
Claire Lehman	4/4
Stuart Parsons	4/4
Nicola Plumb	0/4
Anita Thomas	4/4
Stephen Tilton (Committee chair)	4/4
Dave Underwood	3/4

Finance and Performance Committee attendance from September 2024 (operating as a committee in common)

Name	Attendance/Meetings eligible to attend*
Chris Hearn	5/5
Alastair Hutchison	1/3
Nick Johnson	4/5
Anita Thomas	5/5
Stephen Tilton	5/5
David Underwood (Committee chair)	5/5
Frances West	5/5
Rachel Wharton	2/2

People and Culture Committee

The People and Culture Committee operated as a Trust-specific committee until September 2024. From September 2024 onwards the Trust's People and Culture Committee operated as a committee in common with the same committee from Dorset HealthCare University NHS Foundation Trust.

The People and Culture CiC advises, supports and assures the Board of Dorset HealthCare and Dorset County Hospital on matters related to:

- The production and delivery of strategies and plans related to people, culture and organisational development;

- To oversee key performance indicators relevant to the scope of the work of the Committee;
- The scope of the Committee will include matters related to equality, diversity and inclusion, annual reporting and compliance with regulatory and legislative requirements.

People and Culture Committee attendance to September 2024

Name	Attendance/Meetings eligible to attend*
Margaret Blankson (Committee chair)	3/4
Dawn Dawson	4/4
Alastair Hutchison	0/4
Nick Johnson	4/4
Eiri Jones	1/2
Stuart Parsons	4/4
Nicola Plumb	4/4
Anita Thomas	1/4
Dave Underwood	3/4

People and Culture Committee attendance from September 2024 (operating as a committee in common)

Name	Attendance/Meetings eligible to attend*
Margaret Blankson	2/4
Dawn Dawson	4/4
Alastair Hutchison	2/4
Eiri Jones	4/4
Nicola Plumb	4/4
Frances West (Committee chair)	4/4
Rachel Wharton	1/4

Working Together Programme Committee (to September 2024, operating as a committee in common)

The Working Together Programme (operating as a committee in common) was a formally constituted committee of the Board until September 2024, at which time the Strategy, Transformation and Partnerships Committee (operating as a committee in common) was formally constituted and took over the same remit and responsibility of the Working Together Programme Committee.

The Committee was established in order to strengthen collaboration, promote integration and to simplify decision-making relating to the collaboration and integration programme (the Working Together Programme) for the benefit of patient care and experience and population health.

The purpose of the Committee was to maintain oversight of the Working Together

Programme; scrutinising delivery of programme aims, objectives, strategy outcomes and expected patient and organisational benefits in order to provide assurance to the DCH and DHC Boards that risks to delivery of the programme are being managed appropriately and goals are being achieved.

Name	Attendance/Meetings eligible to attend*
David Clayton-Smith (Committee chair)	2/3
Dawn Dawson	3/3
Alastair Hutchison	3/3
Nick Johnson	3/3
Eiri Jones	3/3
Dave Underwood	3/3

Strategy, Transformation and Partnerships Committee (from September 2024, operating as a committee in common)

From September 2024 the Trust's Strategy, Transformation and Partnerships Committee operated as a committee in common with the same committee from Dorset HealthCare University NHS Foundation Trust, taking over similar responsibilities to the former Working Together Programme Committee.
The Strategy, Transformation and Partnerships CiC advises, supports and assures the Board of Dorset HealthCare and Dorset County Hospital on matters related to:

- Oversight of delivery of the Trust's strategic objectives and priorities and the One Transformation Approach (consisting of four portfolios: Place and Neighbourhood; Sustainable Services; Mental Health; and Working Together);
- Ensuring that addressing health inequalities is embedded in the One Transformation Approach;
- Maintaining oversight of the programmes of work in respect of digital; net zero; New Hospital Programme and quality improvement and ensuring alignment with the strategic objectives and priorities and the One Transformation Approach;
- Maintaining oversight of all collaboratives and partnership arrangements, ensuring alignment with the strategic objectives and priorities and the One Transformation Approach.

Name	Attendance/Meetings eligible to attend*
David Clayton-Smith (Committee chair)	5/5
Dawn Dawson	4/5
Chris Hearn	3/5
Nick Johnson	5/5
Claire Lehman	4/5
Nicola Plumb	5/5
Dave Underwood	4/5
Frances West	5/5

Effectiveness Evaluation
The Board of Directors has a programme of staff and patient stories at each formal Board meeting, and this has been maintained throughout the year. These stories provide direct feedback from staff, patients and their carers.

The Board has undertaken a comprehensive review of its sub-committee performance in order to ensure delivery of respective committee work programmes and assurances and effective cross committee communication and escalation of matters to the Board.

This review was used to inform the governance across the federation between DCH and DHC and three 'Committees in Common' have been established (as referenced earlier) from September 2024. There were clear transition plans in place as we moved to the new Committee structure. Shared annual work plans were established, clearly denoting the joint and individual trust items, and these have been kept under ongoing review as the new arrangements were embedded. As we have come to the end of the year, we have undertaken a Committee Evaluation and reviewed the Terms of Reference and annual work plan for 2025/26 for each Committee, and these will be reported to Committees and Board in May and June 2025 respectively. Further work is now in progress to review the underlying governance structures to ensure they are aligned to the Committees.

During the year we have moved from monthly to bi-monthly formal Committee meetings as we moved to the new Committees in Common. The exception to this is the Quality Committee which maintained monthly meetings throughout the year (and will move to a Committee in Common with DHC from 2025/26), and Audit Committee which continued to meet quarterly. To manage the transition from monthly to bi-monthly Committee meetings we have introduced informal sessions to allow for subject specific briefings and development sessions to be held. Board has met publicly in alternate months, with joint Board Development Workshops with DHC and DCH held in the intervening months.

A review of strategic risks contained within the Board Assurance Framework (BAF) was undertaken following approval of the Joint Strategy in July 2024. A joint set of strategic risks was approved. A new Board Assurance Framework template was developed for each trust, recognising the differences in controls and assurances and level of risk in each organisation. Each risk was assigned to a committee who reviewed the controls and assurance and mitigations on a quarterly basis, with the full Board Assurance Framework reviewed by the Audit Committee and Board.

Well Led Review
NHS foundation trusts are required to undertake an independent external review against the Care Quality Commission's Well Led Framework every three to five years. Dorset County Hospital NHS Foundation Trust last underwent formal external review of its compliance with the requirements in 2021, and the development and improvement actions identified at that time have been completed. Following recruitment to several jointly appointed executive and non-executive roles in 2023 and 2024 and a review of the shared governance framework during 2024/25 we will now consider the most appropriate timing for an independent external well led review during 2025/26. Some preparatory work has been undertaken with our senior leaders to support this review.

Further details about how the trust is well led can be found in the Directors' Report section of this report and the Annual Governance Statement.

Care Quality Commission
The Trust is required to register with the Care Quality Commission (CQC) under section 10 of the Health and Social Care Act 2008.

Following the CQC inspection of maternity services at Dorset County Hospital in 2023/24 which resulted in the Trust receiving a rating of Requires Improvement. The Trust commissioned an independent Maternity Improvement Advisor to complete a full diagnostic assessment. This assessment delivered recommendations to improve leadership structures, governance and oversight and compliance with the Maternity Incentive Scheme (MIS). The Trust is committed to ensuring safe effective and patient centred care for our patients and in response to the inspection report, and independent diagnostic, the Trust has progressed with identified areas for improvement and is fully compliant with the Maternity Incentive Scheme.

During this reporting period, the CQC has undergone leadership changes and also began roll-out of their new regulatory approach. The Single Assessment Framework has retained the five key questions and the four-point rating system. Services are to be assessed against Quality Statements which replace the Key Lines of Enquiry.

The Trust continues to engage with the CQC inspection team, report on progress with action plans and respond to enquiries as and when received.

The CQC continues with a risk-based approach to regulation through their Single Assessment Framework, which is driven through a regular review of data and information available to the CQC through national and regional reporting, engagement with people who use the services and engagement meetings with the Trust. Throughout the year, the Trust has continued to be monitored under 'routine surveillance', meaning that no concerns were raised or escalated prompting additional inspection.

The Trust has a current overall rating of 'Good' with a location rating of 'Requires Improvement'.

Information Governance
Significant work has continued in year to maintain information governance compliance requirements across the Trust and to ensure compliance with the Data Security and Protection Toolkit requirements. Further discussion of information governance activity throughout the year can be found in the Annual Governance Statement.

Council of Governors

The Council of Governors represents the interests of the populations and communities served by the Trust and partner organisations. The Council of Governors has a duty to hold non-executive directors to account individually and collectively for the performance of the Board of Directors, providing feedback on the Trust's performance to stakeholder organisations and members. The Chair of the Council of Governors is also the Chair of the Board of Directors and is responsible for the performance of non-executive directors.

The Council of Governors received the Annual Report and Accounts and has responsibility for conducting an Annual Members' Meeting, which is held jointly each year with the Annual General Meeting.

Members of the Council of Governors and the constituencies they represent are outlined below.

Governor contact details are available on the Trust's website www.dchft.nhs.uk or correspondence can be sent to the Joint Director of Corporate Affairs, Dorset County Hospital NHS Foundation Trust, Trust Headquarters, Williams Avenue, Dorchester, DT1 2JY.

Governors Terms of Office and Attendance at Council of Governors' meetings 2024/25

ELECTED GOVERNORS

Name	Constituency	Current Tenure	Attendance at Council of Governors meetings/Meetings eligible to attend* x/x
Simon Bishop	East Dorset	01/10/23 – 30/09/26 (third term)	7/7
Maurice Perks	North Dorset	09/07/24 – 08/07/27 (third term)	5/7
Carol Manton	North Dorset	09/07/24 – 08/07/27 (first term)	4/5
Judy Crabb	West Dorset	09/07/24 – 08/07/27 (second term)	6/7
Kathryn Harrison (Lead Governor)	West Dorset	01/10/23 – 30/09/26 (second term)	7/7
David Taylor	West Dorset	01/10/23 – 30/09/26 (first term)	3/7
Anne Link	Weymouth and Portland	09/07/24 – 08/07/27 (first term)	4/5
Alan Clark	Weymouth and Portland	09/07/24 – 08/07/27 (first term)	5/5
Mike Byatt	Weymouth and Portland	09/07/24 – 08/07/27 (second term)	4/5
Jean-Pierre Lambert	Weymouth and Portland	09/07/2024 – 08/07/2027 (first term) (Apptd gov for Weldmar from 13/02/2023 08/07/2024)	6/7

Midhun Paul	Staff	01/10/23 – 30/09/26 (first term)	4/7
Max Deighton	Staff	08/07/2024 – 08/07/2027 (first term)	5/5
Jack Welch	Staff	01/10/23 – 30/09/26 (first term)	5/7
VACANCIES (Elected Governors)			
1 VACANCY	East Dorset	-	-
1 VACANCY	South Somerset and Rest of England	-	-
3 VACANCIES	West Dorset		
1 VACANCY	Weymouth and Portland	-	-
1 VACANCY	Staff	-	-

APPOINTED GOVERNORS

Name	Organisation	Current Term Ends	Attendance at Council of Governors meetings/Meetings eligible to attend*
Terri Lewis	Age UK	11/09/2025 (first term)	0/7
Rory Major	Dorset Council	04/07/2025 (second term)	3/7
Barbara Purnell	Friends of DCH	16/10/2025 (first term)	2/7
VACANCIES (Appointed Governors)			
	Weldmar Hospice Care Trust	-	-
	Weymouth College		

GOVERNORS WHO LEFT DURING THE YEAR

Name	Constituency/Organisation	Leaving Date	Attendance at Council of Governors meetings/Meetings eligible to attend*
Lynn Taylor	North Dorset	09/07/21 – 08/07/24 (first term)	2/2
Robin Armstrong	Staff	0807/2024 - 28/02/2025 (first term)	2/4
Sarah Carney	West Dorset	09/07/21 – 08/07/24 (second term)	1/1
Steve Hussey	West Dorset	09/07/21 – 08/07/24 (first term)	1/1
Kevin Perry	West Dorset	01/10/23 – 01/10/2024 (first term)	2/4
Stephen Mason	Weymouth and Portland	09/07/21 – 08/07/24 (second term)	2/2
Tim Nicholls	Weymouth and Portland	01/10/23 – 08/12/2024 (first term)	0/2
Dave Stebbing	Weymouth and Portland	09/07/21 – 08/07/24 (second term – non-	0/2

		consecutive)	
Tony Petrou	Staff	09/07/21 – 08/07/24 (first term)	1/2
Tim Limbach	West Dorset	08/07/2024 – 20/02/2025 (first term)	3/4
Tony Alford	Dorset Council	04/07/2024 (second term)	1/2
Mike Wood	Weymouth College	21/02/2025 (first term)	0/6

* The Council of Governors met on the following dates in 2024/25: 08 April, 10 June, 12 August, 12 September, 14 October, 09 December, 03 March.

Governor Activities

Council of Governors meetings and committee meetings are held in person, with the option of virtual attendance when required. As part of the Trust's federation with Dorset HealthCare University NHS Foundation Trust governors were active in the Joint Non-Executive Director recruitment, along with their counterparts from Dorset HealthCare. Governors have been active in engagement activities around local communities with the intention of connecting with the public and developing the Trust membership.

In the latter part of the year, Governors were instrumental in the review of the Trust Constitution, which will become effective during 2025. The Trust's Constitution underwent a fundamental review to bring it, and the Dorset HealthCare Constitution, into alignment with each other, with a joint working group comprising Governors from both Trusts. There continue to be nominated governor observers allocated to observe Board sub-committees, including the new committees in common of Dorset County Hospital and Dorset HealthCare. Governors are also invited to observe at public Board meetings.

Throughout the year Governors have continued to meet regularly. Each regular meeting of the Council of Governors was attended by two Non-Executive Directors, who provided updates on key topics for the Governors, as well as updates from the Joint Chief Executive Officer, Joint Chief Finance Officer and other members of the Executive Team. The Governors also received the auditor's report on the annual report and accounts. The Trust's NHS staff survey results were presented to the Governors as well as the Trust quality priorities. The Governors received a presentation from the Freedom to Speak Up Guardian and were given the opportunity to attend a Joint Strategy engagement session to input into the new Joint Trust Strategy between Dorset County Hospital and Dorset HealthCare. Following the launch of the new joint strategy, Governors have been presented with the enabling plans which will implement the new strategy.

A joint Governor and Non-Executive Director workshop conducted jointly with the Dorset HealthCare University NHS Foundation Trust Council of Governors took place to further strengthen the two Councils of Governors working relationships, as part of the broader federated working between the two Trusts. The Governors also participated in a pan-Dorset Governor workshop in collaboration with Dorset HealthCare University NHS Foundation Trust and University Hospitals Dorset NHS Foundation Trust with the focus on public engagement and how the Council of Governors from all three Trusts can work together to effectively and efficiently serve the population of Dorset.

Details of the activity of the Governors' Nominations and Remunerations Committee are

given below.

Nomination and Remuneration Committee (Council of Governors' sub-committee)
The Nomination and Remuneration Committee is a subcommittee of the Council of Governors and is responsible for the appointment of Non-Executive Directors and determining the rate of remuneration for Non-Executive Directors. The Committee has met on three occasions in the reporting year.

The Committee met on one occasion to receive the recommendation for re-appointment of two Non-Executive Directors. The recommendation was made by the Committee to the Council of Governors in September 2024 to reappoint Eiri Jones and Stuart Parsons for their second term as Non-Executive Directors; the recommendation was approved by the Council of Governors.

The Committee met on another occasion to approve a process to appoint joint Non-Executive Directors across Dorset County Hospital and Dorset HealthCare University NHS Foundation Trust. The Committee then met again as a Committee in Common with Dorset HealthCare University NHS Foundation Trust to consider the appointment of three joint Non-Executive Director roles. David Underwood and Eiri Jones were already appointed to Dorset County Hospital Board and became joint Non-Executive Directors across the two Trusts. Frances West was previously appointed by Dorset HealthCare and was appointed at Dorset County Hospital to become a joint Non-Executive at both Trusts. Members of the committee were involved at all stages of the recruitment process.

Attendance at Nomination and Remuneration Committee 2024/25

Name	Title	Attendance/ Meetings invited to or required to attend
David Clayton-Smith (Chair)	Trust Chair	3/3
Dave Underwood	Non-Executive Director, Senior Independent Director	1/1
Simon Bishop	Public Governor	3/3
Judy Crabb	Public Governor	2/3
Kathryn Harrison	Lead Governor	3/3
Jean-Pierre Lambert	Appointed Governor	3/3
David Taylor	Public Governor	0/2
Carol Manton	Public Governor	1/2
Jack Welch	Staff Governor	2/2

Council of Governors Register of Interests
Dorset County Hospital NHS Foundation Trust is required to maintain a record of the details of company directorships and other significant interests held by Governors which may conflict with their responsibilities.

The Trust maintains a Register of Interests for Executive Directors, Non-Executive Directors, Governors and senior members of staff. The Register of Declarations of Interest for our Board members is available on the hospital website https://www.dchft.nhs.uk/about-us/freedom-of-information/publication-scheme/ or on request from the Joint Director of Corporate Affairs.

How the Board and Governors Work Together
There are a number of mechanisms in place to enable the Board and Governors to work together. The Board and Governors maintain contact via Governors observing Board sub-committee meetings, executive and non-executive attendance at Council of Governors meetings, and an open invitation for Governor attendance at part one board meetings. Additionally, a standing invitation to Confidential (part 2) Board of Directors meetings has been extended to the Lead Governor as part of the Trust's focus on being open and transparent to the Council of Governors.

Governors have continued to be able to ask questions of the Board via the Governor Matters item at Council of Governors' meetings, at part one Board meetings and via the Corporate Governance team as required.

Governors are also able to ask questions as part of any agenda item presented to them at Council of Governors meetings. Executive attendance at Council meetings has enhanced the dialogue between the Board and the Governors. A joint Governor and Non-Executive Director workshop in collaboration with Dorset HealthCare took place to further develop and strengthen the working relationships between Governors and Non-Executive Directors. Governors have regularly joined a small group made up from Executive and Non-Executive Directors to carry out walk arounds in various wards and areas around Dorset County Hospital.

In the event of a disagreement between the Council of Governors and the Board of Directors, the Dispute Resolution process referred to in the Trust's constitution (annex 8) will be invoked. This process has not been invoked during the year.

Director Attendance at Public Council of Governor Meetings during 2024-25

Date of Public Council of Governors' Meeting	Executive Attendance*	Non-Executive Attendance**
08 April 2024	Joint Chief Nursing Officer Joint Director of Corporate Affairs Joint Chief People Officer Joint Chief Financial Officer Deputy CEO and Director of Strategy Transformation and Partnerships Chief Medical Officer Chief Operating Officer	Eiri Jones (Chair) Claire Lehman
10 June 2024	Joint Chief Executive Officer Joint Chief People Officer Joint Chief Financial Officer Deputy CEO and Joint Director of Strategy Transformation and Partnerships Joint Chief Nursing Officer Joint Director of Corporate Affairs Chief Operating Officer	David Clayton-Smith (Chair) Eiri Jones Dave Underwood
12 August 2024	Joint Chief Financial Officer Joint Chief Nursing Officer Deputy CEO and Joint Director of Strategy Transformation and Partnerships Chief Operating Officer Joint Chief People Officer Chief Medical Officer Joint Director of Corporate Affairs	David Clayton-Smith (Chair) Claire Lehman Stuart Parsons
12 September 2024	Joint Chief Executive Officer Joint Chief Financial Officer Joint Chief Nursing Officer Deputy CEO and Joint Director of Strategy Transformation and Partnerships Chief Operating Officer Joint Chief People Officer	David Clayton-Smith (Chair) Stuart Parsons
14 October 2024	Joint Chief Executive Officer Joint Chief Nursing Officer Deputy CEO and Joint Director of Strategy Transformation and Partnerships Joint Chief People Officer Joint Director of Corporate Affairs	David Clayton-Smith (Chair) Margaret Blackson Stephen Tilton
09 December 2024	Joint Chief Financial Officer Joint Chief Nursing Officer Deputy CEO and Joint Director of Strategy Transformation and Partnerships Joint Chief People Officer	David Clayton-Smith (Chair) Claire Lehman
03 March 2025	Joint Chief Financial Officer Deputy CEO and Joint Director of Strategy Transformation and Partnerships Chief Operating Officer Joint Chief People Officer	David Clayton-Smith (Chair) Eiri Jones Claire Lehman Frances West

* Executives are invited to the Council of Governors on a routine basis and attend the Council of Governors as requested to present relevant reports. Governors also have the right to request members of the executive team

attend the meetings, but the Council of Governors has not exercised this right during 2024/25.
** In addition to the Chair's attendance, Non-Executive Directors are invited to attend Part One Council of Governor meetings on a routine basis and present to the Council of Governors on a rota basis.

Governor Elections

In 2024/25, the trust held Governor elections in North Dorset, West Dorset, Weymouth and Portland, and the Staff constituency. There was an election with contested seats in North Dorset, and Staff constituency with Governors in West Dorset, East Dorset, Weymouth and Portland, Governors elected unopposed. The election turnout was 13.45% in North Dorset and 3.1% turn out for the Staff constituency. The following results were announced on 3 July 2024.

North Dorset

Carol Manton (elected)
Maurice Perks (re-elected)

West Dorset

Judy Crabb (re-elected)
Tim Limbach (elected)

Weymouth and Portland

Mike Byatt (re-elected, non-consecutive second term)
Alan Clark (elected)
Jean-Pierre Lambert (elected)
Anne Link(elected)

Staff Governors

Midhun Paul (elected)
Max Deighton (elected)

The following governors left the Council of Governors at the end of the election process:

Sarah Carney
Steven Hussey
Stephen Mason
Dave Stebbing
Tony Petrou
Lynn Taylor

Membership
Foundation trusts have a responsibility to engage with the communities that they serve and listen to community views when planning services.

The Trust has two types of membership: public and staff. The Trust encourages people who live within its constituency boundaries to register as public members. Being a member demonstrates support for the hospital and the services it provides and gives the opportunity to share views with the Trust to help it best meet patient needs.

Membership is open to people ages 16+ years who are resident in England. Registration as a member can be via a membership application form, online at www.dchft.nhs.uk, via email to foundation@dchft.nhs.uk, or by phoning 01305 255419.

The Council of Governors has established a Membership Development Committee which meets on a quarterly basis to keep the membership development strategy under review and to oversee membership communications, events and recruitment. The Trust membership numbers have declined slightly throughout 2024/25. Governors have continued to engage with the Trust membership and with members of the public by holding pop-up stands within the hospital to meet staff, patients, and visitors, and with the Governors holding informal engagement events in public spaces in the community. The Governors have also attended, by appointment, other organised groups to engage with the people in attendance. The Trust has also continued to keep in contact with its members via the Trust's website, social media and the publication of the bi-annual Governor Bulletin; an e-newsletter to enable to Governors to communicate directly with the membership. Through these mechanisms the Governors are able to update the membership and constituents on how they have discharged their responsibilities.

Constituency	2024/25	2023/24
East Dorset	201	203
North Dorset	226	220
South Somerset and the Rest of England	87	85
West Dorset	1,046	1,061
Weymouth and Portland	602	616
Total Public Members	2,162	2,185
Staff Members	3,950	4,488
Total	6,112	6,673

NHS Oversight Framework

NHS England's NHS Oversight Framework provides the framework for overseeing systems including providers and identifying potential support needs. NHS organisations are allocated to one of four 'segments'.

A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4). A segment does not determine specific support requirements. By default, all NHS organisations are allocated to segment 2 unless the criteria for moving into another segment are met. These criteria have two components:

a) objective and measurable eligibility criteria based on performance against the six oversight themes using the relevant oversight metrics (the themes are: quality of care, access and outcomes; people; preventing ill-health and reducing inequalities; leadership and capability; finance and use of resources; local strategic priorities)
b) additional considerations focused on the assessment of system leadership and behaviours, and improvement capability and capacity.

An NHS Foundation Trust will be in segment 3 or 4 only where it has been found to be in breach or suspected breach of its licence conditions.

The Trust maintained its position in segment 3 for the full year. Performance against the operational planning standards was strong, but due to the challenging financial performance, movement from segment 3 was not attainable.

This segmentation information is the Trusts position as at 31 March 2025.

Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS England website: https://www.england.nhs.uk/publication/nhs-system-oversight-framework-segmentation/

Statement of Accounting Officer's Responsibilities

Statement of the Chief Executive's responsibilities as the Accounting Officer of Dorset County Hospital NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS England.

NHS England has given Accounts Directions which require Dorset County Hospital NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Dorset County Hospital NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the *Department of Health and Social Care Group Accounting Manual* and in particular to:

- observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* (and the *Department of Health and Social Care Group Accounting Manual*) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable them to ensure that the accounts comply with requirements outlined in the above-mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the Foundation Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make

myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

Matthew Bryant
Chief Executive

Annual Governance Statement 2024/25

Scope of Responsibility
As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum.*

Purpose of the System of Internal Control
The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.
The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Dorset County Hospital NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Dorset County Hospital NHS Foundation Trust for the year ended 31 March 2025 and up to the date of approval of the annual report and accounts.

Capacity to Handle Risk

Leadership of Risk Management
The Trust has continued to develop risk management processes within the organisation. These processes are overseen by coherent and comprehensive management structures and roles. The Trust's risk management strategy outlines the Trust's approach to risk management throughout the organisation, including identifying the accountability arrangements and the tools and resources to manage these. Successful risk management starts with the setting of Trust's objectives to direct the safe delivery of services and care to patients, promote and deliver sustainable population health, protect the business and reputation of the Trust and make the Trust a place that staff want to work.

The Board of Directors determines the balance required between achieving the Trust's objectives and avoiding risk altogether. This is reflected in the risk appetite statement agreed by the Board. The achievement of the Trust's strategic objectives is subject to uncertainty, which gives rise to both opportunities (desirable risk) and threats (undesirable risk). The Trust aims to mitigate those risks to acceptable levels through risk management policies and processes by making the most of opportunities and reducing the impact of threats.

Non-Executive Directors are aware of their responsibilities in relation to risk management and chair all Board committees, applying independent judgement in relation to risk management issues and satisfying themselves that the Trust's systems of risk management are robust and defensible. All Board committees have defined terms of reference setting out responsibilities for risk management where appropriate.

The Chief Executive Officer has overall responsibility for effective risk management in the Trust. High level operational responsibility for risk management has been delegated to the Chief Nursing Officer. All executive leads have a specific responsibility for the identification and prudent management of risks within their sphere of accountability and are responsible, where required, for the provision of specialist advice to the Board. This recognises that all Executive Directors are subject matter experts and have specific responsibilities for interpreting and applying national policy, legislation and regulations in their specific areas of responsibility and expertise.

The Chief Nursing Officer has designated staff responsible for:

- the risk management process (the development of risk management strategy and policy, administration of risk management systems and oversight of clinical risk exposures facing the Trust, ensuring the provision of risk management training, supporting divisions and localities, carrying out checks within and across divisions and localities to monitor the management of risk and triangulating lessons for learning from clinical risks ensuring defects alerts or changes in practice are conveyed to frontline teams promptly)
- monitoring the quality of services against Care Quality Commission standards and progress against the Trust's quality priorities, advising on and escalating risks relating to regulatory standards and patients.

The Director of Corporate Governance has responsibility for the Board Assurance Framework, working with executive leads assigned to each identified strategic risk. Quarterly updates are provided to Committees and Board.

Risk Management Training

Effective implementation of the strategy facilitates the delivery of a quality service and, alongside staff training and support, provides an improved awareness of the measures needed to prevent, control and contain risk. To achieve this, the Trust:

- ensures all staff and stakeholders have access to a copy of the Risk Management Framework.
- produces a register of risks across the Trust that is subject to regular review at Divisional level, by the Senior Management Team, Safety Group, Board sub-committees and the Board.
- communicates to staff any action to be taken in respect of risk issues.
- has developed policies, procedures and guidelines based on the results of assessments and identified risks.
- ensures that training programmes raise and sustain awareness throughout the trust of the importance of individual responsibility in identifying and managing risk.
- ensures that staff have the knowledge, skills, support and access to expert advice necessary to implement the policies, procedures and guidelines associated with the strategy; and
- monitors and reviews the performance of the Trust in relation to the management of risk and the continuing suitability and effectiveness of the systems and processes in place to manage risk.

- Corporate risks are linked to the Board Assurance Framework, and they are also linked to any supporting information to evidence where and how the risk has arisen and how the risk score has been determined.

Risk training forms part of the Trust Induction programme for clinical and non-clinical staff and is also included in preceptorship and junior doctor training. Specific training in Risk Management and Human Factors has been provided with an option for staff to be supported with statement writing and investigations provided by the Risk Management team.

The Risk and Control Framework

The Trust acknowledges that effective risk management is a key enabler to ensuring continuous improvement in the quality of care delivered and that all members of staff have an important role to play in identifying, assessing and managing risk.
This is achieved, through proactive risk assessment, or reactively, through review of adverse events, complaints, inquests and legal claims. To support staff in this role, the Trust provides a fair, consistent environment that encourages a culture of openness and willingness to acknowledge mistakes.

The Trust has in place clear policies and systems for identifying, evaluating and monitoring risk. These include:

- The Risk Management Framework
- Trust policies and procedures
- Service, Care Group, Divisional and Corporate Risk Registers that contain both clinical and non-clinical risks together with the Board Assurance Framework
- Designated appointments to support the Board and staff in the management of risk.

Trust-wide risk profiling is undertaken on an on-going basis and managers are required to ensure that risk assessment and audit is undertaken within their areas of responsibility. Outcomes are recorded within the Trust's risk management system and managers are responsible for ensuring that findings are acted upon and adequately monitored. Audit of the centralised system ensures that managers review assessments as required.
The Trust's Incident Management and Review Policy requires staff to report all adverse incidents, both actual and potential (near misses), and sets out the methodology and responsibilities for assessing and evaluating the risks. The impact of a risk will dictate at which level of the organisation the risk event is investigated and reported, with the lowest category (green) being managed at a local level and the highest (red) managed at executive level with reports being made to the Board and statutory external agencies.

Governance framework

The Trust has a robust governance framework in place, which ensures that there are clear reporting lines from operational areas through to the Board. The structures that are in place ensure that the responsibilities of the Board as a corporate body are effectively executed and that the Board conducts its business with openness and transparency.

The Standing Orders, in conjunction with the associated Scheme of Delegation and Reservation of Powers to the Board and Standing Financial Instructions, form the core part of the governance framework. The Scheme of Delegation, as set out in the Standing Orders,

sets out the responsibilities reserved for the Board and those delegated to the Committees. The Standing Financial Instructions are part of the Trust's control environment for managing the Trust's financial affairs. These policies contribute to good corporate governance, internal control and the management of risk. They also enable sound administration, reduce the risk of irregularities and support the delivery of safe, effective, and efficient services. The Standing Orders have been reviewed as part of the review of the Constitution, with updated Standing Orders approved in April 2025. Due to the non-quoracy of the Council of Governors (due to vacant positions) the Standing Orders have not yet been formally approved by the Council of Governors.

The Board has an ongoing role in reviewing the governance arrangements to ensure that the Trust continues to reflect the principles of good governance. The effectiveness of the system of internal control has been subject to ongoing review by the Board against the measures detailed within this section. Membership and attendance of the Board and the committees is routinely monitored and attendance for the period is included in the Directors' Report.

The Board held six meetings in public during the year. Governors routinely attended and members of the public were invited to attend.

During the year, the agendas for the Board have been focused on the key areas of Safety and Quality, Strategy, People and Culture and Performance and Governance. The Board hears a staff or patient story at each public Board meeting.

Dorset HealthCare University NHS Trust (DHC) and Dorset County Hospital NHS Foundation Trust (DCH) Boards approved the establishment of a federated model of collaboration during 2023/24. The aims of this approach include improving quality of care and population health for patients, and providing a better experience, including new development opportunities, for staff. Where appropriate reference is made to the collaborative approach within the Annual Governance Statement.

In addition to the Joint Chair, Chief Executive and other Executive Director posts established during 2023/24 we have developed this further during 2024/25 with the establishment of some 'Committees-in-Common' and shared Non-Executive Director (NED) posts.
From September 2024 we formed three 'Committees in Common' between the two Trusts:

- People and Culture Committee in Common
- Finance and Performance Committee in Common
- Strategy, Transformation and Partnerships Committee in Common

There were clear transition plans in place for the transition to the new Committees.

The Terms of Reference for the Audit Committee were aligned across the two Trusts. There are plans to move to a Quality Committee in Common at the beginning of 2025/26 and there has been a working group in place to ensure the smooth transition.

From a NED perspective there has been one appointment (to a held vacant post) during the year. This was a joint appointment with DHC (with one DHC NED appointed into DHC and two DCH NEDS appointed in DHC). The appointments were made by considering the skills,

experience and diversity required to maximise Board effectiveness. The appointments during the year demonstrate our commitment to collaborative working.

The NED skills matrix has been reviewed and updated and is used to inform recruitment and succession planning.

There were no changes to the Executive Directors during the year. The Chief Medical Officer retired with effect from 31 March 2025 and an interim appointment has been made. There was a period of shadowing between January and March 2025. The role of Chief Medical Officer is not a joint role, with individual roles retained in the respective organisations.

There have, therefore, been no gaps in Board capacity throughout the year. The smooth transition plan during the change of Chief Medical Officer has ensured that Board capacity and effectiveness has not been compromised as we move into 2025/26.

All Board members receive an annual appraisal undertaken by the Chief Executive or the Chair as appropriate. During 2024/25 the Leadership Competency Framework was used as the framework for these appraisals.

Throughout the year, the Board has participated in a programme of Board Development, which provided the opportunity to focus on issues of strategic importance including strategy development, risk management and the Board Assurance Framework, partnership working and the provision of high-quality safe services. Since September 2023 the joint Board Development sessions have been held between the DHC and DCH together and we continue to review and refresh the Board Development programme to respond to national developments and emerging issues.

The work of the Board is supported by the following formal committees that it has established (see table). Each committee is chaired by a Non-Executive Director, with the duties and responsibilities of each committee clearly articulated in the Terms of Reference that include explicit accountability arrangements and reporting relationships. All Committees in Common (as at 31 March 2025) are chaired by Joint Non-Executive Directors (prior to the establishment of joint Non-Executive Director roles the Chair and Vice Chair for each Committee in Common were from the two Trusts).

An annual evaluation of effectiveness of each committee has been completed, with the results reported to the committee and the Board.

Committees	Chair as at 31 March 2025
Audit Committee*	Stuart Parsons
Remuneration and Terms of Service Committee *	David Clayton-Smith
Finance and Performance Committee **	David Underwood
Strategy, Transformation and Partnerships Committee **	David Clayton-Smith
People and Culture Committee**	Frances West
Quality Committee	Claire Lehman

*Denotes statutory Committee
**Established from September 2024 as a Committee in Common with DHC

These and other committees keep the Board informed of significant risks and provide both the Board and me with necessary assurance, playing a critical role in ensuring that risk management systems and processes are in place and are effective.

Following each meeting the Chair of each committee reports to the Board and outlines the most important aspects of the agenda, and any issues that need to be brought to the attention of the Board and providing assurance on the discharge of the responsibilities delegated to the committee.

Assessment against the CQC and NHS England Well Led Framework is undertaken through the work of the Quality Committee (via the Quality Governance Group) and the Senior Leadership Group. In addition, BDO LLP (the Trust's Internal Audit provider) were commissioned to undertake a review of preparedness on the well led framework with coaching sessions held with senior leaders during 2024/25. This works continues in 2025/26.

The Board considers statements relating to compliance with this condition of the NHS Provider Licence on an annual basis as part of a self-certification process. Annual compliance with the principles of the Code of Governance for NHS Providers is reviewed as part of the required disclosure which appears in this annual report. The principal risks to compliance with the NHS Provider Licence Section 4 (governance) relate to the oversight metrics set out in the appendices to the NHS Oversight Framework. These metrics are monitored by the Board of Directors through its Balanced Scorecard and finance reports.

Compliance with the Code of Governance for NHS Providers.
The Board of Directors implements the Code of Governance for NHS providers through a number of key governance documents which include:

- The NHS Constitution
- Standing Orders and Standing Financial Instructions
- Scheme of Delegation and Matters Reserved for the Board
- Code of Conduct – Board of Directors and Council of Governors.

A self-assessment has been completed to provide assurance on compliance with the NHS Code of Governance for 2024/25. The Trust is fully compliant. We continue to strengthen our governance arrangement, particularly as we further develop our shared governance arrangements across DCH and DHC.

Compliance with the new NHS Provider Licence
NHS England undertook a review of the NHS Foundation Trust Licence conditions in 2023, and extended provisions of the licence to all NHS providers, updating the conditions to reflect the wider system compliance requirements. The Trust undertook comprehensive revies of compliance with the revised Provider Licence conditions in quarter 4, to ensure compliance with the revised standards.

The Trust can assure itself of compliance with NHS Licence section 4 requirements through the following mechanisms that have been deployed during 2024/25:

- the Board has maintained a strong emphasis on quality and safety in its meeting agendas to ensure that these remain the focus of decision making and planning.
- the Board has an executive lead for quality and clear accountability structures are in place for a quality agenda that is integrated into all aspects of the organisation's work.
- The Board has continued to undertake visits to wards to meet with staff and gain feedback. Governor participation in these visits has continued and governors have continued to observe Board and committee meetings where feedback has been shared.
- The Board has maintained appropriate oversight of regulatory and compliance regimes through robust incident management arrangements in line with regional and national guidance and support.

The Trust is compliant with the NHS Provider Licence conditions.

The Trust must also review whether their Governors receive enough training and guidance to carry out their roles. The Governors receive:

- Induction training
- Regular development events each year
- Regular updates and information on key areas
- Training provided through the NHS Providers GovernWell Programme.

Governors also have access to specialist expertise to provide appropriate and objective guidance including the corporate governance team, communications team in relation to membership and engagement and human resources and external support for the Council of Governors' Nominations and Remuneration Committee.

This year the Governors have also taken part in joint workshops with the NEDs and Governors from Dorset HealthCare, and a joint Governor workshop to look at increasing membership with Dorset HealthCare and University Hospitals Dorset.

Strategic Risks

The Joint Strategy 'Working together, improving lives' was approved by the Board of Directors of Dorset County Hospital and Dorset HealthCare 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 took place.

A joint set of strategic risks were approved by each Board of Directors in July/August 2024. Whilst there is a set of joint strategic risks, there is a separate Board Assurance Framework for each Trust as the score (likelihood and consequence) and the controls, assurance and actions are different across the two Trusts.

The full Board Assurance Frameworks were approved by the respective Boards in September/October 2024 and have been reported quarterly thereafter. Each risk is assigned to an Executive Director and a Committee. Individual risks are reviewed by the Committee and the full Board Assurance Framework is reviewed by the Audit Committee and the Board of Directors on a quarterly basis.

The Board Assurance Framework (BAF) sets out the strategic risks facing the Trust and the action being taken to manage them. It is based on the identification of the Trust's strategic objectives and the principal risks to delivering these and the key controls to minimise the risks, with the key assurances of these controls identified.

The strategic risks as at 31 March 2025 are shown in the table below:

Reference	Strategic Risk
SR1: Safety and Quality	If we are not able to deliver the fundamental standards of care in all of our services we will not be providing consistently safe, effective and compassionate care
SR2: Culture	If we do not achieve a culture of compassion and empowerment and engagement, we will not have a motivated workforce with the required capacity and skills to improve patient outcomes and deliver safe care.
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
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
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
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
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.
SR8: Transformation and Improvement	If we do not seek and respond to the views of our communities to co-produce and continuously improve and transform our services, we will not contribute to the reduction of health inequalities within our communities.
SR9: Digital Infrastructure	If we do not advance our digital and technological capabilities, including achieving our EHR ambitions, we will not deliver the innovative and sustainable services and the delivery of safe services could be compromised.
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

Quality Governance

The Chief Nursing Officer is the executive lead for quality and safety governance, supported by the Chief Medical Officer and the Chief Operating Officer. The Trust has maintained oversight of key quality performance and activity metrics throughout the year. The Quality Committee has continued to scrutinise quality governance arrangements and performance in the Trust and provide assurance to the Board. The Quality Committee met monthly during the year and maintained oversight of CQC registration requirements through routine reporting. During the year the Quality Governance Group, reporting to the Quality Committee, was established to provide greater oversight of the breadth of quality governance reporting and in preparation for a move to a Committee in Common with DHC from April 2025. Quality performance is also monitored by NHS Dorset Integrated Care Board at regular relationship and system level meetings.

The Quality Committee has delegated responsibility to oversee the Trust's clinical and quality governance arrangements. It provides a clear vision for clinical governance within the Trust. It sets clear performance standards and holds the divisions, corporate functions and, where relevant, other Trust-wide groups to account for the delivery of the clinical and quality governance agenda.

The Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC).

The annual quality account for 2024/25 has been developed in accordance with The National Health Service (Quality Accounts) Regulations 2010 and national guidance, led by the Chief Nursing Officer. Stakeholders receive a draft version of the report for comment, with feedback received included in the final version. These include the Council of Governors, the Health Oversight and Scrutiny Committees of Dorset Council, Healthwatch Dorset and NHS Dorset Integrated Care Board.

The Trust's quality priorities underpin quality governance and are reviewed and updated annually. They outline the Trust's priority areas of focus for quality and progress is monitored 'from ward to board'. Data included within the quality account is based on the descriptors set out in national guidance and is subject to data quality checks as part of the Trust's data quality assurance process. The Board's Quality Committee and the Quality Governance Group have a key role in monitoring the content of the quality account, the determination of quality priorities, and the ongoing monitoring thereof, and in providing assurance to the Board of Directors.

All Trust policies and procedures are produced in line with best practice. The effectiveness of policies in ensuring quality of care provided is monitored through a variety of mechanisms including:

- as part of the Patient Safety Incident Response Framework
- by undertaking audit
- by monitoring incident, coroners, complaints and clinical litigation data.

Should the Trust wish to explore a particular aspect in the quality of care in more detail a focussed 'deep dive' review will be undertaken. The Trust-wide clinical audit programme

includes topics from priority areas such as regulatory inspection reports, NICE guidance and contractual requirements.

The Trust uses an online incident management system (Datix) for reporting all types of incidents (clinical and non-clinical). The system enables real-time notifications of incidents to be sent to identified members of staff. The notification and distribution rules are co-ordinated and disseminated using incident type and severity to ensure that the correct people are made aware when an incident has occurred and its potential significance.

All staff are encouraged to report when things have, or could have, gone wrong. At the heart of the Trust's Risk Management Framework is the desire to learn from incidents and near misses, complaints, inquests and claims, to continuously improve management processes and clinical practice. The primary focus is to achieve a culture that gives staff the confidence to speak honestly about something that didn't go to plan and to report issues.

The Patient Safety Incident Response Framework (PSIRF) was introduced from autumn 2023. It sets out a fundamentally different approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

The Trust is in dialogue to actively manage risks with key public stakeholders. Examples of this dialogue include:

- participation in the Dorset Integrated Care Partnership, the Dorset Health and Care Partnership
- working collaboratively with NHS Dorset Integrated Care Board
- engaging with Healthwatch Dorset
- consulting the Council of Governors on key issues and risks
- holding public engagement events, including an annual members' meeting
- interaction at various levels with Higher Education institutions
- membership of clinical networks
- membership of research networks
- regular relationship meetings with the Care Quality Commission.

Safe Staffing

The Trust completes an annual workforce plan as part of the wider operational and financial planning process. The Trust has a wide range of actions and initiatives in place to tackle our immediate and medium-term workforce pressures and a comprehensive plan in place that details the actions and initiatives we will take to deliver our four key strategic objectives. Focusing on recruitment, retention, staff well-being and workforce planning is essential for us to meet these challenges.

Assurance is provided to the Board, via the People and Culture Committee and Quality Committee, that short, medium, and long-term workforce strategies and safe staffing systems are in place. Progress against the three-year People Plan is also reviewed at this committee.

In order to ensure safe staffing, daily safe staffing meetings are held with the Divisional

Heads of Nursing, Matrons of the Day, the Safer Staffing Lead and the Temporary Staffing Team. These are held in conjunction with fortnightly Safe Staffing Meetings chaired by the Director of Nursing; use of Allocate Safe care to monitor patient acuity, dependency and staffing levels, bi-annual audit of staffing levels using the Safer Nursing Care Tool (SCNT), quarterly audits of Neonatal staffing levels, and use of Birth Rate Plus to monitor staffing levels in Maternity Services. The Trust has completed a self-assessment and is assured that it complies with the *Developing Workforce Safeguard* recommendations through:

- Formal adoption of the NQB 2016 guidance in Safe Staffing policies and procedures.
- Bi-annual audit of safe staffing levels using the Safer Nursing Care Tool and subsequent reporting to the Trust Board.
- Development of the Safe Staffing governance framework to ensure evidence of compliance with professional judgement, triangulation with quality and safety risks, and daily decision making with clear lines of escalation, as well as describing the ward to board safeguards in place.
- Monthly review of ESR people performance, workforce modelling, establishments and clinical models of care to inform strategic plans and ensure operational delivery.
- Leadership from the Associate Director, Allied Health Professions and a Safe Staffing Fellow, and the appointment of a Joint Head of Nursing, Professional Practice and Workforce, to strengthen the leadership of workforce planning, development and delivery of priorities.
- Development of Ward level dashboards detailing key nursing, quality and staffing metrics to inform local and Trust-wide areas for improvement.

Other Areas of Internal Control

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past 12 months, as required by the Managing Conflicts of Interest in the NHS guidance. During the year we have reviewed our processes and policies, and these will be re-launched for 2025/26 with reporting of compliance to the Audit Committee on an annual basis.

As an employer with staff entitled to membership of the NHS pension scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations. Under the pensions automatic enrolment legislation, the Trust uses the National Employment Savings Trust (NEST) as an alternative scheme for those not eligible to access the NHS pension scheme.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. The Trust reports annually on its compliance and progress through its annual report to the Board as well as externally through its Workforce Race Equality Standard and Workforce Disability Equality Standard, Equality Delivery System (EDS) and Gender Pay Gap reporting.

The Trust has undertaken risk assessments on the effects of climate change and severe

weather and have developed a Green Plan following the guidance of the Greener NHS programme. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of economy, efficiency and effectiveness and the use of resources
Each member of the Board is aware of their responsibility to spend public money effectively. All budget managers have a responsibility to manage their budgets and systems of internal control effectively and efficiently. This message has also been communicated throughout the organisation so that all staff are aware of their responsibilities.

The Audit Committee receives reports from internal and external audit and counter fraud, on the work undertaken to review the Trust's systems of control including economy, efficiency and effectiveness of the use of resources. Action plans are agreed from these reports to improve controls where necessary.

The Trust's internal auditors have undertaken a programme of work to provide independent assurance on the adequacy and effectiveness of systems of control across a range of financial and organisational areas including those identified in the Board Assurance Framework. All internal audit reports have been reported to the Audit Committee throughout the year and are reflected in the Head of Internal Audit's 'Annual Opinion', which is included within this report.

The Head of Internal Audit's 'Annual Opinion' has concluded that: "Overall, we provide Moderate Assurance that there is a sound system of internal controls, designed to meet the Trust's objectives, that controls are being applied consistently across various services."

Under the Code of Audit Practice published by the National Audit Office, the external auditors are required to assess the Trust's arrangements for securing economy, efficiency and effectiveness (value for money) and report if they have identified a significant weakness in the arrangements in place. The external auditors have not identified any significant risks or weaknesses following their assessment.

Information Governance
The Board is actively engaged in quality improvement and is assured that quality governance is subject to rigorous challenge through Non-Executive Director engagement and chairmanship of the key board committees. The Chief Information Officer reports directly to an Executive Director and the Chief Finance Officer is the accountable Senior Information and Reporting Officer. Oversight of the digital and data quality agendas is through the Digital Transformation and Assurance Group and the Information Governance Group which report to the Strategy, Transformation and Partnership Committee. The Information Governance Manager/Data Protection Officer leads the operational delivery of the Data Security and Protection Toolkit (DSPT) and works closely with the Information Assurance Manager to support the requirements of the DSPT and other regulatory requirements across the trust.

Staff are encouraged to report all information security incidents, whether suspected or actual so that they can be investigated, appropriate actions taken to address the incident and lessons learnt to prevent reoccurrence. They are reported using an electronic system, with the risks being graded in accordance with the Trust's risk matrix. The Data Protection

Officer and Information Governance Manager, Senior Information Risk Owner and Caldicott Guardian and deputies are alerted of all serious data security incidents. This is done within 24 hours of the incident and investigated, with the aim of closing the incident within five days. All level two incidents will be reported using the Data Security and Protection Toolkit (DSPT) incident reporting tool which informs the Department of Health and Social Care, the Information Commissioner's Office (ICO), and NHS England of data breaches.

The Trust Information Governance Group (IGG) promotes a consistent approach to information governance. It is responsible for developing and sharing good practice across the Trust and ensuring that information governance standards are included in other work programmes and projects. It co-ordinates the review of the Trust's information governance management and accountability arrangements and produces and monitors the annual information governance work programme. Any matters of concern are escalated to the Strategy, Transformation and Partnership Committee. The Trust will, under its duty of candour, inform service users if there has been a breach in respect of their personal information.

During the financial year 2024/25 the Trust had two incidents that were escalated to the ICO via the NHS England DSPT incident reporting system, both were caused by technical issues and neither required reporting any further.

Data Quality and Governance
Work to strengthen the existing processes around data quality is ongoing throughout the year, building on the data quality processes and procedures that have been in place for some time in the trust. Current processes and procedures, as well as recent initiatives to improve data quality, include the following:

- **Data Quality:** The Trust monitors and reports on data quality using the CDS Data Quality Dashboards published by NHS England. The Information Assurance Manager reports the Trust's performance at the bi-monthly meetings of the Information Governance Group. A variety of tools is used both by the Data Quality team and by staff Trust-wide to improve these figures including targeted queries and Power BI reports designed by the Business Intelligence Team. This work has resulted in the overall percentage for all Emergency Care, Outpatient and Inpatient activity to be above the national average in the Dashboards. The emphasis is on continuous improvement and data quality being the responsibility of all staff.

- **Information Assurance:** In line with the changes to the requirements of Data Security and Protection Toolkit (DSPT) considerable work is underway to ensure the new Information Asset and Flows Register is populated accurately and comprehensively. The wider value to the organisation of the information recorded in the Register has been recognised and consequently a secure way of sharing some of the data is underway. Training and support in the roles of the Information Asset Administrators (IAA), System Administrators (SA) and Information Asset Owners (IAO) is provided and new ways of delivering this training are being explored. These are key roles across the trust in supporting a robust mechanism to monitor and control data quality measures for all trust information systems, this has included more emphasis on non-clinical information assets.

- **Governance:** Information assurance, incorporating data quality, is reported through the Information Governance Group, chaired by the SIRO with escalation to the Finance and Performance Committee. The Digital Transformation and Assurance Group (DTAG), chaired by the Joint Chief Strategy, Transformation and Partnership also receives key performance indicators (KPI) relating to key data quality metrics as part of the broader and regular KPI reporting across all digital services.

- **Information Dashboards.** The performance dashboards have been kept under review and a process of continual development and improvement has been implemented. Increasingly, the committees of the Board have been receiving performance dashboards in SPC format. Specific dashboards are available for respective Board committees and divisional services.

- **Ownership.** Improving ownership of data quality issues is a long-term objective for the trust. The Trust conducts an annual DSPT audit to ensure compliance, this requires information asset ownership and responsibilities are agreed and supported at executive level and cascaded through divisional directors and managers who hold staff accountable.

- **Regular audit and external assurance**. In addition to the annual DSPT audit, other data quality audits are conducted in a number of areas including: mortality; specialist clinical coding areas (on a regular, randomly selected basis as per national best practice recommendations); in addition to departmental clinical audits. Key issues are discussed at the Clinical Effectiveness Group to ensure a culture of continuous data quality improvement.

- **Information Systems**: As more information is captured in our information systems and business processes change accordingly, it is important to understand the data quality implications from any systems change. In recognition of this the Information Assurance Team of three, including the Information Assurance Manager, continue to work closely with system managers and key business users to address any data quality issues. Where data quality issues are identified, they are rectified quickly with feedback to users of source systems to reinforce the importance of accuracy and completeness in recording of patient data.

Review of Effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the Audit Committee and the Quality Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board of Directors has overall responsibility for the activity, integrity and strategy of the Trust and receives reports from the chairs of each of the Board committees, including the Audit Committee and Quality Committee.

The role of the Audit Committee is to provide the Trust Board with independent assurance that adequate processes of financial and corporate governance, risk management, audit and internal control are in place and working effectively. The Terms of Reference were reviewed and updated during the year in line with the Healthcare Financial Managers Association NHS Audit Committee Handbook. It oversees the establishment and maintenance of an effective system of governance, risk management and internal control throughout the organisation. The Committee is chaired by a Non-Executive Director and all members of the Committee are independent Non-Executive Directors. The Committee agrees the annual plans for internal and external audit and reviews the work and findings of internal audit and external audit and provides a conduit through which their findings can be considered by the Board of Directors. Internal audit during 2024/25 was undertaken by BDO LLP who produce an annual internal audit plan, produced in discussion with the Trust to enable high level scrutiny of the effectiveness of the processes and procedures that the Trust has in place. The Committee also maintains oversight of the Trust's counter fraud arrangements.

The Quality Committee is chaired by a Non-Executive Director. The Committee usually meets monthly and receives reports related to quality governance arrangements underpinning the planning and delivery of care and the management of clinical risks and risks relating to the delivery of the Trust's strategic objectives addressing the quality of services. This included monitoring ongoing compliance with the CQC's fundamental standards for quality and safety and clinical outcomes and effectiveness.

Clinical audit is primarily a quality improvement tool but is also used to provide assurance of compliance with best practice standards and contractual requirements. The Trust's clinical audit plan is built on the rolling programme of audits already in place and incorporated all statutory and mandatory requirements for clinical audit.

Based upon these inspections, reviews, and the opinions issued by our auditors on the system of internal control, I can confirm that the arrangements the Trust has in place for the discharge of statutory functions are effective.

Conclusion

The Trust has experienced a number of challenges during the year which, with the required focus, have improved by the end of year:

- There were significant financial challenges during the year and in response to this the executive team introduced a Recovery Group to increase the focus on delivery of the required cost improvements and workforce reduction targets. Whilst during the year the Trust was forecasting that it would not achieve its financial target, by the year end the Trust was on track to deliver a balanced position. Additional cash support then became available to the system, and it was agreed that this would come to DCH to support the underlying cash position in the Trust, therefore following the receipt of an additional £13.0million cash support funding from NHS England in March 2025, the Trust delivered a surplus of £13.0million before technical accounting adjustments,

effectively achieving the planned breakeven position before recognition of the cash support. The £13.0million surplus equates to approximately 3.68% of the Trust's turnover.

- At the beginning of the year the Trust had a significant backlog of Freedom of Information (FOI) requests, which was a continuation of challenges experienced in 2023/24. The matter was escalated to the Board and proactively reported to the Information Commissioner's Office (ICO) who issued an Enforcement Notice to the Trust. We take our obligations under the FOI Act seriously and recognise that we did not to respond to requests received within the statutory time limit. We have reviewed and changed our processes and are now working with our partner Trust, Dorset HealthCare University NHS Foundation Trust, to manage these requests. We now have the staffing capacity and resource to respond to all FOI requests in a timely manner, and a robust system is in place to make sure we fully comply with all aspects of the FOI Act. As a result we have made significant progress in tackling the backlog and at the end of the year there were 10 requests in breach. By 22 April 2025 the backlog had been cleared in full and 90% of all new requests are being responded to within 20 days.
- In November 2024 Dorset County Hospital, in line with NHS England regional intention to hold systems to account, Dorset was placed in 'Tiering' due to the volume of patients over 65 weeks and the requirement for further assurance that all would be treated within the financial year. The tiering programme is a key pillar of the NHS England national oversight and support infrastructure for elective recovery, cancer and diagnostics. This meant that regular meetings were held with NHS England discuss progress, identify additional support requirements and agree the performance criteria for escalation. A clear plan was established, and demonstrable progress was made to improve performance. Further details are provided in the Performance Analysis section of the Annual Report. On 3 February 2025 due to the progress made in reducing waiting times we receive notification that the Trust had been removed from NHSE 'tiering for elective' with immediate effect.

No significant internal control issues have been identified by the Trust during the course of the year through its own or external reviews.

Matthew Bryant
Chief Executive
26 June 2025

The Accountability Report was approved by the Board of Directors on 26 June 2025 and signed on its behalf by Matthew Bryant, Chief Executive.

Matthew Bryant
Chief Executive
26 June 2025

Independent Auditors Report

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Dorset County Hospital NHS Foundation Trust ("the Trust") for the year ended 31 March 2025 which comprise the Group and Trust Statements of Comprehensive Income, Group and Trust Statements of Financial Position, Group and Trust Statements of Changes in Taxpayers' Equity and Group and Trust Statements of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Group and the Trust as at 31 March 2025 and of the Group's and the Trust's income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State in February 2025 as being relevant to NHS Foundation Trusts and included in the Department of Health and Social Care Group Accounting Manual 2024/25; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Group in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The Accounting Officer has prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to either cease the Group and the Trust's services or dissolve the Group and the Trust without the transfer of their services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over their ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Accounting Officer's conclusions, we considered the inherent risks associated with the continuity of services provided by the Group and the Trust over the going concern period.

Our conclusions based on this work:

- we consider that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified and concur with the Accounting Officer's assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Group's and the Trust's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the Group and the Trust will continue in operation. As at the date of this audit report, we are unable to confirm that we have completed our work in respect of the trust accounts consolidation pack of the Trust for the year ended 31 March 2025 because we have not received confirmation from the NAO that the NAO's audit of the Department of Health and Social Care accounts is complete.

Until we have completed this work, we are unable to certify that we have completed the audit of Dorset County Hospital NHS Foundation Trust for the year ended 31 March 2025 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the NAO Code of Audit Practice.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal audit and inspection of policy documentation as to the Group's high-level policies and procedures to prevent and detect fraud including the internal audit function, and the Group's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected, or alleged fraud.
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, we performed procedures to address the risk of management override of controls in particular the risk that Group management may be in a position to make inappropriate accounting entries. On this audit we did not identify a fraud risk related to revenue recognition due to the non-complex nature of the funding provided to the Trust during the year. We therefore assessed that there was limited opportunity for the Group and the Trust to manipulate the income that was reported.

In line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we also recognised a fraud risk related to expenditure recognition, particularly in relation to year-end accruals. We consider this risk to be applicable to non-payroll and non-depreciation expenditure.

We performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included unexpected pairings with revenue, expenditure, capital and cash.
- For a selection of cash payments and expenditure transactions in the period post 31 March 2025, verifying that the expenditure had been recognised in the correct accounting period to which the expenditure related.

Identifying and responding to risks of material misstatement related to compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the Accounting Officer and other management (as required by auditing standards), and from inspection of the Trust's regulatory and legal correspondence and discussed with the Accounting Officer and other management the policies and procedures regarding compliance with laws and regulations.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

Firstly, the Group is subject to laws and regulations that directly affect the financial statements, including the financial reporting aspects of NHS legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Secondly, the Group is subject to many other laws and regulations where the consequences of non-compliance could have a material effect on amounts or disclosures in the financial statements, for instance through the imposition of fines or litigation. We did not identify any laws and regulations that are likely to have a material impact on the financial statements recognising the nature of the Trust's activities. Auditing standards limit the required audit procedures to identify non-compliance with laws and regulations to enquiry of the Accounting Officer and inspection of regulatory and legal correspondence, if any. Therefore, if a breach of operational regulations is not disclosed to us or evident from relevant correspondence, an audit will not detect that breach.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

The Accounting Officer is responsible for the other information, which comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared, in all material respects, in accordance with the NHS Foundation Trust Annual Reporting Manual 2024/25.

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 106, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Group's and the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to either cease the services provided by the Group and the Trust or dissolve the Group and the Trust without the transfer of their services to another public sector entity.

The Audit Committee is responsible for overseeing the Trust's financial reporting process.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the Trust to secure economy, efficiency and effectiveness in its use of resources.
We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on page 121, the Accounting Officer is responsible for ensuring that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Under Section 62(1) and paragraph 1(d) of Schedule 10 of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We are also not required to satisfy ourselves that the Trust has achieved value for money during the year.

We planned our work and undertook our review in accordance with the Code of Audit Practice and related statutory guidance, having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if:

- we issue a report in the public interest under paragraph 3 of Schedule 10 of the National Health Service Act 2006; or
- we make a referral to the Regulator under paragraph 6 of Schedule 10 of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of expenditure which is unlawful, or is about to take, or has taken, a course of action which, if pursued to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in these respects.

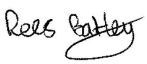
THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

DELAY IN CERTIFICATION OF COMPLETION OF THE AUDIT

As at the date of this audit report, we are unable to confirm that we have completed our work in respect of the trust accounts consolidation pack of the Trust for the year ended 31 March 2025 because we have not received confirmation from the NAO that the NAO's audit of the Department of Health and Social Care accounts is complete.

Until we have completed this work, we are unable to certify that we have completed the audit of Dorset County Hospital NHS Foundation Trust for the year ended 31 March 2025 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the NAO Code of Audit Practice.



Rees Batley
for and on behalf of KPMG LLP
Chartered Accountants
66 Queen Square
Bristol
BS1 4BE
27 June 2025

Foreword to the Accounts

Dorset County Hospital NHS Foundations Trust

These accounts, for the year ended 31st March 2025 have been prepared by Dorset County Hospital NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 within the National Health Service Act 2006.

Matthew Bryant
Chief Executive
26 June 2025

Statement of Comprehensive Income for the year ended 31st March 2025

	Note	Group 2024/25 £000	Group 2023/24 £000	Trust 2024/25 £000	Trust 2023/24 £000
Operating income from patient care activities	3	319,740	275,583	319,740	275,583
Other operating income	4	33,548	31,170	33,636	31,239
Operating expenses	6	(335,581)	(304,916)	(335,782)	(305,105)
Operating surplus/(deficit)		**17,707**	**1,837**	**17,594**	**1,717**
Finance costs:					
Finance income	10	874	938	856	910
Finance expenses	11	(755)	(675)	(755)	(675)
PDC dividends charge		(4,829)	(4,403)	(4,829)	(4,403)
Net finance costs		**(4,710)**	**(4,140)**	**(4,728)**	**(4,168)**
Gains/(losses) on disposal of assets	12	20	7	20	7
Corporation tax expense		(31)	(35)	-	-
Surplus/(deficit) for the year		**12,986**	**(2,331)**	**12,886**	**(2,444)**
Other comprehensive income will not be reclassified to income and expenditure:					
Impairment of property, plant & equipment		(1,447)	(5,358)	(1,447)	(5,358)
Revaluation gains on property, plant & equipment		109	162	109	162
Total comprehensive expense for the year		**11,648**	**(7,527)**	**11,548**	**(7,640)**

The notes on pages 136 to 175 form part of these accounts.

Statement of Financial Position as at 31st March 2025

		Group		Trust	
		31 March 2025	31 March 2024	**31 March 2025**	31 March 2024
	Note	**£000**	£000	**£000**	£000
Non-current assets					
Intangible assets	14	17,158	15,800	17,158	15,800
Property, plant and equipment	15.3	168,587	161,065	168,587	161,065
Right of use assets	16	20,167	20,384	20,167	20,384
Trade and other receivables	18.1	591	684	591	684
Total non-current assets		**206,503**	**197,933**	**206,503**	**197,933**
Current assets					
Inventories	17	5,090	3,778	4,810	3,544
Trade and other receivables	18.1	21,491	21,204	21,387	21,183
Cash and cash equivalents	19	25,165	8,805	24,410	8,609
Total current assets		**51,746**	**33,787**	**50,607**	**33,336**
Current liabilities					
Trade and other payables	20	(34,209)	(32,539)	(33,696)	(32,614)
Borrowings	21	(6,676)	(1,753)	(6,676)	(1,753)
Provisions	22	(51)	(36)	(51)	(36)
Other liabilities	23	(1,669)	(2,007)	(1,669)	(2,007)
Total current liabilities		**(42,605)**	**(36,335)**	**(42,092)**	**(36,410)**
Total assets less current liabilities		**215,644**	**195,385**	**215,018**	**194,859**
Non-current liabilities					
Borrowings	21	(25,496)	(30,271)	(25,496)	(30,271)
Provisions	22	(249)	(241)	(249)	(241)
Total non-current liabilities		**(25,745)**	**(30,512)**	**(25,745)**	**(30,512)**
Total assets employed		**189,899**	**164,873**	**189,273**	**164,347**
Financed by taxpayers' equity:					
Public dividend capital		167,356	153,978	167,356	153,978
Revaluation reserve		48,189	49,546	48,189	49,546
Income and expenditure reserve		(25,646)	(38,651)	(26,272)	(39,177)
Total taxpayers' equity:		**189,899**	**164,873**	**189,273**	**164,347**

The financial statements on pages 131 to 175 were approved by the Board on 26 June 2025 and signed on its behalf by:

Matthew Bryant
Chief Executive
26 June 2025

Statement of Changes in Taxpayers' Equity

Group	Total	Public Dividend Capital (PDC)	Revaluation Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2024	**164,873**	**153,978**	**49,546**	**(38,651)**
Surplus for the year	**12,986**	-	-	12,986
Net impairments on property, plant and equipment	**(1,447)**	-	(1,447)	-
Revaluations on property, plant and equipment	**103**	-	103	-
Revaluations on right of use assets	**6**	-	6	-
Transfer to retained earnings on disposal of assets	**-**	-	(19)	19
Public Dividend Capital received	**13,378**	13,378	-	-
Taxpayers' equity at 31 March 2025	**189,899**	**167,356**	**48,189**	**(25,646)**
Taxpayers' equity at 1 April 2023	**155,667**	137,245	54,742	(36,320)
Deficit for the year	**(2,331)**	-	-	(2,331)
Net impairments on property, plant and equipment	**(5,358)**	-	(5,358)	-
Revaluations on property, plant and equipment	**162**	-	162	-
Public Dividend Capital	**16,733**	16,733	-	-
Taxpayers' equity at 31 March 2024	**164,873**	**153,978**	**49,546**	**(38,651)**

Trust	Total	Public Dividend Capital (PDC)	Revaluation Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2024	**164,347**	**153,978**	**49,546**	**(39,177)**
Surplus for the year	**12,886**	-	-	12,886
Net impairments on property, plant and equipment	**(1,447)**	-	(1,447)	-
Revaluations on property, plant and equipment	**103**	-	103	-
Revaluations on right of use assets	**6**	-	6	-
Transfer to retained earnings on disposal of assets	**-**	-	(19)	19
Public Dividend Capital	**13,378**	13,378	-	-
Taxpayers' equity at 31 March 2025	**189,273**	**167,356**	**48,189**	**(26,272)**
Taxpayers' equity at 1 April 2023	**155,254**	137,245	54,742	(36,733)
Deficit for the year	**(2,444)**	-	-	(2,444)
Revaluations on right of use assets	**(5,358)**	-	(5,358)	-
Revaluations on property, plant and equipment	**162**	-	162	-
Public Dividend Capital	**16,733**	16,733	-	-
Taxpayers' equity at 31 March 2024	**164,347**	**153,978**	**49,546**	**(39,177)**

The Revaluation Reserve consists of £48,175k (£49,524k at 31 March 2024) relating to property, plant and equipment and £14k (£22k at 31 March 2024) relating to right of use assets.

Information on reserves

Public Dividend Capital
Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the Public Dividend Capital dividend.

Revaluation Reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and Expenditure Reserve
The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Statement of Cash Flows for the year ended 31st March 2025

	Group		Trust	
	2024/25	2023/24	**2024/25**	2023/24
	£000	£000	**£000**	£000
Cash flows from operating activities				
Operating surplus	17,707	1,837	17,594	1,717
Depreciation and amortisation	12,418	11,105	12,418	11,105
Impairments and reversals	22	2,025	22	2,025
Income recognised in respect of capital donations (cash and non-cash)	(473)	(194)	(473)	(194)
Increase in trade and other receivables	(160)	(6,994)	(79)	(6,885)
Increase in inventories	(1,312)	(253)	(1,265)	(182)
Increase/(decrease) in trade and other payables	3,709	(1,472)	3,117	(1,124)
Increase/(decrease) in other liabilities	(338)	(2,538)	(338)	(2,538)
Increase/(decrease) in provisions	21	(48)	21	(48)
Corporation tax paid	(35)	(35)	-	-
Net cash generated from operations	**31,559**	**3,433**	**31,017**	**3,876**
Cash flows from investing activities				
Interest received	836	967	819	940
Purchase of intangible assets	(3,652)	(4,202)	(3,652)	(4,202)
Purchase of property, plant and equipment	(19,231)	(20,401)	(19,231)	(20,401)
Sales of property, plant and equipment	7	9	7	9
Receipt of cash donations to purchase capital assets	473	194	473	194
Net cash used in investing activities	**(21,567)**	**(23,433)**	**(21,584)**	**(23,460)**
Cash flows from financing activities				
Public Dividend Capital received	13,378	16,733	13,378	16,733
Capital element of lease liability repayments	(1,498)	(1,656)	(1,498)	(1,656)
Interest paid	(97)	(97)	(97)	(97)
Other interest	(1)	(1)	(1)	(1)
Interest element of lease liability repayments	(589)	(578)	(589)	(578)
Public Dividend Capital paid	(4,825)	(4,510)	(4,825)	(4,510)
Net cash used in financing activities	**6,368**	**9,891**	**6,368**	**9,891**
Increase/(decrease) in cash and cash equivalents	**16,360**	**(10,109)**	**15,801**	**(9,693)**
Cash and cash equivalents at 1 April	8,805	18,914	8,609	18,302
Cash and cash equivalents at 31 March	**25,165**	**8,805**	**24,410**	**8,609**

Notes to the Financial Statements

1 Accounting policies and other information

NHS England has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2024/25 issued by the Department of Health and Social Care. The accounting policies contained in the DHSC GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the DHSC GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below.

These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting Convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.1 Critical accounting judgements and key sources of estimation uncertainty

In the preparation of the financial statements, the Trust is required to make estimates and assumptions that affect the application of accounting policies and the carrying amounts of assets and liabilities. These estimates and assumptions are based on historical experience and other factors that are considered to be relevant. Actual outcomes may differ from prior estimates and the estimates and underlying assumptions are continually reviewed.

The key sources of estimation uncertainty which have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities are:

Valuation of land and buildings
Land and buildings are included in the Trust's statement of financial position at current value in existing use. The assessment of current value represents a key source of uncertainty. The Trust uses an external professional valuer to determine current value in existing use, using modern equivalent asset value methodology and market value for existing use for non-specialised buildings.

Of the £149.8 million net book value of land and buildings subject to valuation, £117.2 million relates to specialised assets valued on a depreciated replacement cost basis. Here the valuer bases their assessment on the cost to the Trust of replacing the service potential of the assets. The uncertainty explained above relates to the estimated cost of replacing the service potential, rather than the extent of the service potential to be replaced.

It is possible that the inflation will affect the Trust's future assessment of what would be required in a modern equivalent asset, but as yet there is insufficient information to indicate what the impact of this will be.

Depreciation of property, plant and equipment and amortisation of computer software
The Trust exercises judgement to determine the useful lives and residual values of property, plant and equipment and computer software. Depreciation and amortisation is provided so as to write down the value of these assets to their residual value over their estimated useful lives.

1.2 Consolidation

1.2.1 Subsidiaries

Subsidiary entities are those over which the Trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of the subsidiary are consolidated in full into the appropriate financial statement lines. The capital and reserves of the subsidiary are included as a separate item in the Statement of Financial Position.

DCH appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the Trust (including where they report under UK FRS 102) or where the subsidiary's accounting

date is not coterminous. The amounts consolidated are drawn from the financial statements of DCH SubCo Ltd. Intra-entity balances, transactions and gains/losses are eliminated in full on consolidation.

The Trust wholly owns DCH SubCo Ltd which forms part of the consolidated accounts. DCH SubCo Ltd provides outpatient pharmacy services. Its turnover for the period ended 31st March 2025 was £5.8m and its gross assets at 31 March 2025 totalled £1.2m.

The Trust has established that, as it is the corporate trustee of Dorset County Hospital NHS Foundation Trust Charitable Fund, it effectively has the power to exercise control of this charity so as to obtain economic benefits. However the assets, liabilities and transactions are immaterial in the context of the Trust and therefore it has not been consolidated. Details of balances and transactions between the Trust and the charity are included in the related parties' notes.

1.2.2 Joint Ventures

Arrangements over which the Trust has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

Joint operations are arrangements in which the Trust has joint control with one or more other parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement. The Trust includes within its financial statements its share of the assets, liabilities, income and expenses.

Joint ventures are arrangements in which the Trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. Joint ventures are accounted for using the equity method.

The Trust has one joint venture DCH Estates Partnership LLP OC418519, which is a commercial partnership with Partnering Solutions (Dorset) Ltd (Interserve Prime) creating a Strategic Estates Partnership. No assets or transactions have taken place during 2024/25.

1.3 Income

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The DHSC GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or service is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS) which sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare in the form of fixed payments to fund an agreed level of activity.

Aligned payment and incentive contracts form the main payment mechanism under the NHSPS. API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

High costs drugs and devices excluded from the calculation of national prices are reimbursed by NHS England based on actual usage or at a fixed baseline in addition to the price of the related service.

The Trust also receives income from commissioners under Commissioning for Quality Innovation (CQUIN) and Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such CQUIN and BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and are accounted for as variable consideration under IFRS 15. Payment for CQUIN and BTP on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed. In 2024/25 payment under these schemes is included in fixed payments from commissioners based on assumed achievement of criteria.

Elective recovery funding provides additional funding to integrated care boards to fund the commissioning of elective services within their systems. Trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements as explained above. The level of activity delivered by the Trust contributes to system performance and therefore the availability of funding to the Trust's commissioners.

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure, it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's apprenticeship service account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1.4 Expenditure on employee benefits

1.4.1 Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.4.2 Pension costs

Payments to defined contribution pension schemes (including defined benefit schemes that are accounted for as if they were a defined contribution scheme) are recognised as an expense as they fall due.

NHS Pension Scheme:

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both

are unfunded defined benefit schemes that cover NHS employer, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the employer's pension contributions payable to that scheme for the accounting period.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill health. The full amount of the liability for the additional costs are charged to operating expenses at the time the Trust commits itself to the retirement regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

The Foundation Trust does not have any employees that are members of the Local Government Superannuation Scheme and therefore, does not pay employer contributions into this scheme.

1.4.3 Termination Benefits

Staff termination benefits are provided for in full when there is a detailed formal termination plan and there is no realistic possibility of withdrawal by either party.

The Trust ran a Mutually Agreed Resignation Scheme (MARS) during 2024/25. The MARS payment is fixed at ½ month's salary for each full year of reckonable service up to a cap of 12 month's salary. Furthermore, there is a minimum payment of 3 month's salary for 1 – 5 years reckonable service and a salary cap of £80,000 for high earners (pro-rata for part time staff).

1.5 Expenditure on other goods and services

Expenditure on goods and services is recognised to the extent that they have been received and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except when it results in the creation of a non-current asset such as property, plant and equipment.

1.6 Property, plant and equipment

1.6.1 Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- individually it cost at least £5,000; or
- collectively has a cost of at least £5,000 and individually a cost of more than £250;
- the assets are functionally interdependent, with broadly simultaneous purchase dates, which are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building, or refurbishment of a ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building includes a number of components with significantly different asset lives, e.g. hospital wings, then these components are treated as separate assets and depreciated over their own useful economic lives (UEL).

The component parts of each significant Trust building are depreciated as a group, as permitted by IAS 16, unless a component has a significantly different UEL and is deemed by the Trust to be significant, in which case it is depreciated separately over its own economic useful life.

1.6.2 Measurement

Valuation: All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at valuation.

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their re-valued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses.

Fair values are determined as follows:

- Non-specialised buildings – market value for existing use
- land and specialised buildings – Modern equivalent asset value

All land and buildings are revalued using professional valuations in accordance with accounting standard IAS 16 Property, Plant and Equipment every five years. A three-year interim valuation is also carried out. Additional valuations are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period.

Professional valuations are carried out by the Trust's external valuer (Avison Young). The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23 borrowings costs. Assets are re-valued and depreciation commences when they are brought into use.

Until 31st March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. Indexation ceased from 1st April 2008. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An item of property, plant and equipment, which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5. The last full valuation survey was assessed by the valuer of Avison Young at 31 March 2024 with a Desktop Valuation 31 March 2025.

<u>The Key factors impacting on the land and property valuation</u>

The valuation involves estimation techniques and in arriving at their opinion of the useful economic life and value of a building, the Trust's property valuation takes into account the following aspects:

- Physical obsolescence - the age, condition and the probable costs of future maintenance.
- Functional obsolescence - the suitability of the properties for their present use and the prospect of continuance or use for an alternative purpose. Another potential cause of functional obsolescence is legislative change, for example, statutory and regulatory compliance, including compliance with sustainability and energy legislation.
- Economic obsolescence - the extent of any loss in value resulting from external economic factors.
- Environmental Factors - where the existing use has been considered in relation to the present and future characteristics of the surrounding area, local and national planning policies and restrictions likely to be imposed by the planning authority on the continuation of the use.
- Change of use - any identified present of future change of use of a building.

The valuation has been prepared in accordance with International Financial Reporting Standards (IFRS) as interpreted and applied by the HMT Treasury Financial Reporting Manual (FReM), compliant DHSC Group Accounting Manual (GAM), and to comply with IFRS, specifically with regard to IAS 16 'Property, Plant and Equipment'.

The valuer's opinion of Fair Value was primarily derived using the Depreciated Replacement Cost (DRC) approach to value the specialised operational assets, and for non-specialised assets an Existing Use Value (EUV) basis as defined in the RICS Valuation – Professional Standards at UK VPGA 6.

Where assets are "specialised" the DRC for the Modern Equivalent Asset (MEA) methodology has been employed. An MEA has been determined based upon a single build programme on a cleared site to modern design and arrangement/adjacencies. The valuer has applied information provided by the Trust during consultation as to how a new MEA might be designed. Moreover, the valuer has analysed similar modern facilities presently being developed, where site densities, building arrangement, number of stories and bed

provision can be analysed and adjusted as appropriate to the subject Trust.

In arriving at the replacement build cost rates used in the DRC valuations, the Valuer relies on BCIS and other published costs data supplemented where available by knowledge of recent build costs incurred by the Trust of constructing general and specialised healthcare accommodation. The indices are shown in the table below:

Indices	2023/24	2024/25	Change
BCIS (TPI)	390	399	+9
Location Factor	106	106	0

Floor areas
The Trust uses a MICAD database/repository for its estate data, including plans and floor areas. The system is updated on an ongoing basis to reflect new build and disposals and other updates reflecting remeasurement to maintain data quality. Floor areas are supplied by the Trust to the valuer to inform the valuation. Differences between the floor areas held by the Trust and the valuer are investigated and resolved to a de minimums of no impact on the value.

Land Values
Land has been assessed to Current Value, interpreted as EUV, having regard to the cost of purchasing a notional replacement site in the same locality, equally suitable for the existing use and of the same size, with normally the same physical and locational characteristics as the actual site, other than characteristics of the actual site that are irrelevant, or of no value, to the existing use. Where the use is too specialised to categorise in market terms, the land has been valued assuming the benefit of planning permission for development for a use, or a range of uses, prevailing in the vicinity of the actual site.

Sensitivity of Assumptions
A sensitivity analysis of these assumptions allows the Trust to understand the impact on materiality, given the estimation uncertainty implicit in the valuation. The table below setting out at a high level the sensitivity of the valuation of the main hospital site to movements in each of these key assumptions, using a 5% tolerance. 31 March 2024 balances have been used as the baseline to derive these values, as the valuation indices were applied to these balances in arriving at the 31 March 2025 valuation.

	Build Cost Index	Obsole-scence Factor	Land Value /Acre
Baseline Adjustment Factor	1.023	(1.015)	1.00
Assumption value (£m)	2.4	(13.3)	0
Sensitivity (+5%) (£m)	5.1	0.7	0.2
Sensitivity (-5%) (£m)	(5.1)	(0.7)	(0.2)

Revaluation gains and losses: Revaluation gains are recognised in the revaluation reserve, except where; and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenses.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned; and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of other comprehensive income.

Impairments: In accordance with the DHSC GAM, impairments that arise from a clear consumption of economic benefits, or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) impairment charged to operating expenses; (ii) the balance in the revaluation reserve attributable to that asset before impairment.

An impairment that arises from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss are reversed. Reversals are recognised in operating expenses to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is

transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of other impairments are treated as revaluation gains.

At each reporting period end, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

1.6.3 Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that the future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

1.7 Intangible assets

1.7.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; and where the cost of the asset can be measured reliably.

Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset.

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred.

Expenditure on development is capitalised only where all of the following have been demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset is identified;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

1.7.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that is capable of operating in the manner intended by management.

Subsequently, intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment.

An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the definitions of IAS 40 Investment Properties or IFRS 5 Assets Held for Sale. Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell".

1.8 Depreciation and amortisation

Freehold land is considered to have an infinite life and is not depreciated. Properties under construction are not depreciated until brought into use.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives or, where shorter, the lease term.

The following table details the useful economic lives currently used for the main classes of assets:

Asset class	Min Life Years	Max Life Years
Buildings exc. dwellings	5	84
Dwellings	5	79
Plant & machinery	3	15
Information technology	3	15
Furniture & fittings	5	15
Intangible assets	3	19

Property, plant and equipment which have been re-classified as 'held for sale' cease to be depreciated upon the re-classification.

Right-of-use assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

1.9 Donated assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

This includes assets donated to the Trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the DHSC GAM, the Trust applies the principle of donated asset accounting to assets that the Trust controls and is obtaining economic benefits from at the year end.

1.10 De-recognition

Assets intended for disposal are reclassified as 'Held for sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;

- the sale must be highly probable i.e.:
  - management are committed to a plan to sell the asset;
  - an active programme has begun to find a buyer and complete the sale;
  - the asset is being actively marketed at a reasonable price;
  - the sale is expected to be completed within 12 months of the date of classification as 'Held for sale'; and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.11 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The Trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

1.11.1 Trust as lessee

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.72% applied to new leases commencing in 2024 and 4.81% to new leases commencing in 2025.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

1.11.2 Trust as lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying

amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

1.12 Inventories

Inventories are valued at the lower of cost and net realisable value using the 'first-in first-out' formula. These are considered to be a reasonable approximation to fair value due to the high turnover of stocks.

The Trust receives inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

1.13 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

1.14 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of that amount. The amount recognised in the Statement of Financial Position is the best estimate of the expenditure required to settle the obligation.

Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2025:

Term	Years	Nominal rate	Prior year rate
Short	Up to 5	4.03%	4.26%
Medium	After 5 up to 10	4.07%	4.03%
Long	After 10 up to 40	4.81%	4.72%
Very long	Exceeding 40	4.55%	4.40%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2025:

	Inflation rate	Prior year rate
Year 1	2.60%	3.60%
Year 2	2.30%	1.80%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of 2.40% in real terms (prior year: 2.45%).

1.15 Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 22.2 but is not recognised in the Trust's accounts.

1.16 Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk-pooling schemes under which the Trust pays an annual contribution to NHS Resolution and, in return, receives assistance with the costs of any claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses as and when the liability arises.

1.17 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, these are disclosed where an inflow of economic benefits is

probable. The Trust currently has no contingent assets to disclose.

Contingent liabilities are not recognised, but are disclosed in note 25 unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- Possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- Present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.18 Public dividend capital

Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as Public Dividend Capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) average daily cash balances held with the Government Banking Services (GBS) 111 and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, (iii) approved expenditure on current year COVID-19 capital assets, (iv) assets under construction for nationally directed schemes and (v) any PDC dividend balance receivable or payable.

The average relevant net assets is calculated as a simple average of opening and closing net relevant assets.

In accordance with the requirement laid down by the DHSC (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.19 Financial assets and financial liabilities

1.20.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The DHSC GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

1.20.2 Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets and financial liabilities are classified as subsequently measured at amortised cost.

1.20.3 Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income as a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

1.20.4 Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

1.20.5 De-recognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

1.20 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable.

Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.21 Corporation Tax

Section 148 of the Finance Act in 2004 amended S519A of the Income and Corporation Taxes Act 1988 to provide power to the Treasury to make certain non-core activities of Foundation Trusts potentially subject to corporation tax. This legislation became effective in the 2005/06 financial year. In determining whether or not an activity is likely to be taxable a three-stage test may be employed:

- The provision of goods and services for purposes related to the provision of healthcare authorised under section 14(1) of the Health and Social Care Act 2003 (HSCA) is not treated as a commercial activity and is therefore tax exempt;
- Trading activities undertaken in house which are ancillary to core healthcare activities are not entrepreneurial in nature and not subject to tax. A trading activity that is capable of being in competition with the wider private sector will be subject to tax;
- Only significant trading is subject to tax. Significant is defined as annual taxable profits of £50,000 per trading activity.

The majority of the Trusts activities are related to core healthcare and are not subject to tax.

Private patient activities are covered by section 14(1) of the Health and Social Care (Community Health and Standards) Act 2003 and not treated as a commercial activity and are therefore tax exempt; and

Other trading activities (including car parking and staff canteens) are ancillary to the core activities and are not deemed to be entrepreneurial in nature.

However, the Trust's commercial subsidiary is subject to corporation tax, and this has been included in the group accounts.

1.22 Foreign currencies

The Trust's functional currency and presentational currency is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of transaction.

Exchange gains and losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

1.23 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However they are disclosed in Note 29 to the accounts in accordance with the requirements of the HM Treasury's Financial Reporting Manual.

1.24 IFRS Standards that have been issued but have not yet been adopted

The DHSC GAM does not require the following standards to be applied in 2024/25:

IFRS 17 Insurance Contracts – The Standard is effective for accounting periods beginning on or after 1 January 2023. IFRS 17 has been adopted by the FReM from 1 April 2025. Adoption of the Standard for NHS bodies will therefore be in 2025/26. The Standard revises the accounting for insurance contracts for the issuers of insurance.

IFRS 18 Presentation and Disclosure in Financial Statements – The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

Changes to non-investment asset valuation – Following a thematic review of non-current asset valuations for financial reporting in the public sector, HM Treasury has made a number of changes to valuation frequency, valuation methodology and classification which are effective in the public sector from 1 April 2025 with a 5 year transition period. NHS bodies are adopting these changes to an alternative timeline.

Changes to subsequent measurement of intangible assets and PPE classification / terminology to be implemented for NHS bodies from 1 April 2025:

- Withdrawal of the revaluation model for intangible assets. Carrying values of existing intangible assets measured under a previous revaluation will be taken forward as deemed historic cost.
- Removal of the distinction between specialised and non-specialised assets held for their service potential. Assets will be classified according to whether they are held for their operational capacity.

Changes to valuation cycles and methodology to be implemented for NHS bodies in later periods:

- A mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years.
- Removal of the alternative site assumption for buildings valued at depreciated replacement cost on a modern equivalent asset basis. The approach for land has not yet been finalised by HM Treasury.

The Trust has considered the above new standards, interpretations and amendments to published standards that are not yet effective and concluded that they are not relevant to the Trust or that they would not have a significant impact on the Trust's financial statements, apart from some additional disclosures.

The Trust has not early adopted any new accounting standards, amendments or interpretations, which is in line with guidance contained in the DHSC GAM 2024/25.

1.25 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with general payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.26 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.27 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

1.28 Going concern

International Accounting Standard 1 (IAS1) requires the board to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. In the context of non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The financial statements should be prepared on a going concern basis unless there are plans for, or no realistic alternative other than, the dissolution of the Trust without the transfer of its services to another entity within the public sector.

After making enquiries, the directors have a reasonable expectation that the services provided by the NHS Foundation Trust and revenue support will continue to be provided by the public sector for the going concern period, being 12 months from the date of signing this Annual Report.

In preparing the financial statements, the Board of Directors have considered the Trust's overall financial position against the requirements of IAS1.

The Trust is reporting a surplus of £13.0 million for the year ended 31 March 2025. As at 31st March the Trust had a closing cash position of £25.2 million.

The Trust has submitted a planned deficit of £9.7m for 2025/26 and a closing cash position of £7.2 million.

The Trust has contracts with national and local commissioners for 2025/26 and is planning to deliver services for the going concern period, Board of Directors have made no decision to discontinue any operations, transfer services or significantly restructure the organisation. The regulator (NHS England) have not issued any communications that impact the Trust's going concern requirements.

The directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

2. Segment analysis

The Trust has considered the requirements in IFRS 8 for segmental analysis. Having reviewed the operating segments reported internally to the Board, the Trust is satisfied that it is appropriate to aggregate these as, in accordance with IFRS 8: Operating Segments, they are similar in each of the following respects:

- The nature of the products and services;
- The nature of the production processes;
- The type of customer for their products and services;
- The methods used to distribute their products or provide their services; and
- The nature of the regulatory environment.

The Trust therefore has just one segment, "healthcare". Analysis of income by different activity types and sources is provided in note 3.

3. Income from patient care activities

3.1 Analysis by activity

	Group		Trust	
	Year ended 31 March 2025	Year ended 31 March 2024	**Year ended 31 March 2025**	Year ended 31 March 2024
	£000	£000	**£000**	£000
Aligned payment & incentive (API) income - Variable*	60,580	54,579	60,580	54,579
Aligned payment & incentive (API) income - Fixed*	227,603	196,719	227,603	196,719
High costs drugs income from commissioners	12,516	11,913	12,516	11,913
Other NHS clinical income	3,941	3,220	3,941	3,220
Private patient income	1,299	1,274	1,299	1,274
Additional pension contribution central funding**	12,905	7,473	12,905	7,473
Other clinical income***	896	405	896	405
Total	**319,740**	275,583	**319,740**	275,583
Income commissioner requested services	317,545	273,904	317,545	273,904
Income non-commissioner requested services	2,195	1,679	2,195	1,679
Total	**319,740**	275,583	**319,740**	275,583

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the NHS Payment system documentation. https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/

**The employer contribution rate for NHS pensions increased from 20.6% to 23.7% (excluding administration charge) from 1 April 2024. Since 2019/20, NHS providers continued to pay over contributions at the rate of 14.3% with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

***Additional funding was made available by NHS England in 2024/25 and 2023/24 for implementing the backdated element of pay awards where government offers were made at the end of the financial year. 2024/25: In September 2024, the government announced a pay deal for resident doctors (formerly described as junior doctors) which included reforms to the resident doctor pay scales backdated to 1 April 2023 (2023/24): In March 2024, the government announced a revised pay offer for consultants, reforming consultant pay scales with an effective date of 1 March 2024. Trade Unions representing consultant doctors accepted the offer in April 2024.

Commissioner-requested services are services which local commissioners believe should continue to be provided locally if any individual provider is at risk of failing financially. Any organisation providing a commissioner-requested service must continue offering the service unless it can obtain agreement from NHS Improvement and the commissioners to stop. It cannot dispose of relevant assets used to provide the service without NHS Improvement consent and it must pay into a risk pool that will fund services in the event of financial failure.

3.2 Analysis by source	Group		Trust	
	Year ended 31 March 2025	Year ended 31 March 2024	**Year ended 31 March 2025**	Year ended 31 March 2024
	£000	£000	**£000**	£000
NHS - Foundation Trusts	395	248	395	248
NHS - NHS England	53,625	44,484	53,625	44,484
NHS - ICBs	264,118	229,208	264,118	229,208
NHS - other	69	96	69	96
Non NHS - private patients	1,299	1,274	1,299	1,274
Non NHS - overseas patients	11	-	11	-
NHS Injury Scheme	199	251	199	251
Non NHS - other	24	22	24	22
Total	**319,740**	275,583	**319,740**	275,583

NHS Injury Scheme income relating to the 2024/25 financial year is subject to a provision for doubtful debts of 24.45% (2023/24: 22.43%) to reflect expected rates of collection.

The Group and Trust overseas patient income for the year amounted to £11k (2023/24 £nil). Cash received amounted to £4k (2023/24 £20k) in respect of current and previous years' income. The amounts written off in respect of current and prior years amounted to £nil (2023/24 £nil).

4. Other operating income

	Note	Group Year ended 31 March 2025 £000	Group Year ended 31 March 2024 £000	Trust Year ended 31 March 2025 £000	Trust Year ended 31 March 2024 £000
Research and development		1,190	1,116	1,190	1,116
Education and training		9,189	11,201	9,189	11,201
Education and training - notional income from apprenticeship fund		856	781	856	781
Received from NHS Charities: Cash donations		473	194	473	194
Received from NHS Charities: Contributions to expenditure		111	86	111	86
Contributions to expenditure - consumables (inventory) donated from DHSC group bodies for COVID response		-	102	-	102
Non-patient care services to other bodies		18,199	14,650	18,279	14,711
Staff recharges		468	365	468	365
Operating leases - Minimum lease receipts	5	105	102	113	110
Car parking		435	309	435	309
Catering		737	720	737	720
Pharmacy sales		83	52	83	52
Staff accommodation rentals		730	676	730	676
Non-clinical services recharged to other bodies		9	4	9	4
Clinical excellence awards		83	49	83	49
Other income generation schemes		77	69	77	69
Other income		803	694	803	694
Total		**33,548**	31,170	**33,636**	31,239

5. Operating lease income and future receipts

Lease receipts recognised as income in year:

	Group Year ended 31 March 2025 £000	Group Year ended 31 March 2024 £000	Trust Year ended 31 March 2025 £000	Trust Year ended 31 March 2024 £000
Minimum lease receipts	105	102	113	110
Total minimum lease payments	**105**	102	**113**	110
Of which:				
Income generated from owned assets	**105**	102	**113**	110
Future minimum lease receipts due:				
Not later than one year	105	100	113	108
Later than one year and not later than five years	105	200	113	216
Total	**210**	300	**226**	324

6. Operating expenses

	Note	Group Year ended 31 March 2025 £000	Group Year ended 31 March 2024 £000	Trust Year ended 31 March 2025 £000	Trust Year ended 31 March 2024 £000
Employee expenses	7.1	220,171	198,516	220,081	198,423
Employee expenses - Non-executive directors		151	128	151	128
Purchase of healthcare from NHS and DHSC bodies		8,645	7,515	8,645	7,515
Purchase of healthcare from non-NHS and non-DHSC bodies		11,671	9,914	17,493	15,168
Supplies and services - clinical (excluding drug costs)		24,322	20,572	24,322	20,572
Supplies and services - clinical utilsation of consumables donated from DHSC for COVID response		-	102	-	102
Supplies and services - general		3,040	2,734	3,040	2,734
Drug costs		28,325	25,559	22,811	20,604
Inventories written down (net, incl. drugs)		65	27	64	27
Consultancy costs		61	119	55	112
Establishment		1,786	2,089	1,786	2,088
Premises - Business rates payable to Local Authorities		1,515	1,409	1,515	1,409
Premises - Other		10,504	9,809	10,504	9,809
Transport (business travel only)		453	433	453	433
Transport (other)		417	552	417	552
Depreciation on property, plant and equipment		11,295	10,341	11,295	10,341
Amortisation on intangible assets		1,123	764	1,123	764
Impairments net of (reversals)	13	22	2,025	22	2,025
Movement in credit loss allowance		(6)	-	(6)	-
Change in provisions discount rate		-	(4)	-	(4)
External audit - statutory audit services*		146	145	140	139
Internal audit costs - (not included in employee expenses)		115	113	115	113
Clinical negligence - NHS Resolution (premium)		7,195	6,233	7,195	6,233
Legal fees		77	133	77	133
Insurance		138	121	138	121
Research and development		61	82	61	82
Training courses and conferences		629	1,322	629	1,321
Education and training - notional expenditure funded from apprenticeship fund		856	781	856	781
Lease - short term lease (<= 12 months)		19	71	19	70
Car parking and security		888	1,381	888	1,381
Losses, ex gratia & special payments		2	6	2	6
Other services		1,106	1,164	1,106	1,164
Other		789	760	785	759
Total		**335,581**	304,916	**335,782**	305,105

*no other remuneration was paid to the auditor, except for the amounts disclosed above

7. Employee expenses and numbers

7.1 Employee expenses

	Group		Trust	
	Year ended 31 March 2025	Year ended 31 March 2024	**Year ended 31 March 2025**	Year ended 31 March 2024
	£000	£000	**£000**	£000
Staff & executive directors	217,322	196,296	217,232	196,203
Research and development staff	1,018	994	1,018	994
Education and training staff	1,574	1,205	1,574	1,205
Redundancy	242	-	242	-
Early retirements	15	21	15	21
Special payments	-	-	-	-
	220,171	198,516	**220,081**	198,423
Salaries and wages	166,121	147,188	166,043	147,106
Social security costs	17,272	15,610	17,263	15,602
Apprenticeship levy	839	755	839	755
Employer contributions to NHS Pension scheme	19,731	17,250	19,731	17,250
Employer contributions paid by NHSE on provider's behalf (24/25 9.4%, 23/24 6.3%)	12,905	7,473	12,905	7,473
Pension cost - other	33	61	30	58
Agency and contract staff	6,459	13,430	6,459	13,430
Termination benefits	478	216	478	216
Less: Staff costs capitalised as part of assets	(3,667)	(3,467)	(3,667)	(3,467)
Employee benefits expense	**220,171**	198,516	**220,081**	198,423

Salaries and wages include the cost of amounts accrued in respect of holiday earned by employees due to their service, but not taken, as required under IAS 19.

The amount of Employer's pension contributions payable in the year ended 31 March 2025 was £32,669k (2023/24: £24,784k), £12,905k (2023/24: £7,473k) of this figure is paid by NHSE on behalf of the Trust. Of this total, an amount of £1,611k (2023/24: £1,532k) was unpaid at the reporting date.

7.2 Retirement benefits

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years".

An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2025, is based on valuation data as 31 March 2023, updated to 31 March 2025 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the statement by the actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

8. Retirements due to ill-health

During 2024/25 there were 3 cases (2023/24: 7 cases) of early retirement from the Trust agreed on grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £519k (2023/24: £527k). The cost of ill-health retirements is borne by the NHS Business Services Authority – Pensions Division. This information has been supplied by NHS Pensions.

9. Salary and pension entitlement of directors and senior managers

9.1 Directors remuneration

	Group		Trust	
	Year ended 31 March 2025	Year ended 31 March 2024	**Year ended 31 March 2025**	Year ended 31 March 2024
	£000	£000	**£000**	£000
Directors remuneration - Salaries and wages	1,044	1,162	1,044	1,162
Employers pension contributions in respect of directors	127	110	127	110
Less: amounts in respect of Director Recharges Salary*	(167)	(203)	(167)	(203)
Less: amounts in respect of Director Recharges Pension*	(24)	(29)	(24)	(29)
	980	1,040	**980**	1,040
	Number	Number	**Number**	Number
The total number of directors to whom retirement benefits were accruing under:				
Defined benefit schemes	**9**	8	**9**	8

*The amounts in respect of Director Recharge Salary and Pensions relates to the share of Director costs of the Joint Board between Dorset County Hospital NHS FT and Dorset Healthcare University NHS FT which commenced during 2023.

Detailed disclosures of the remuneration and pension entitlements of each director are set out on pages 54 to 70 of the Remuneration Report.

10. Finance income

	Group		Trust	
	Year ended 31 March 2025	Year ended 31 March 2024	**Year ended 31 March 2025**	Year ended 31 March 2024
	£000	£000	**£000**	£000
Interest on bank accounts	874	938	856	910
Total	**874**	938	**856**	910

11. Finance expenses

	Group		Trust	
	Year ended 31 March 2025	Year ended 31 March 2024	**Year ended 31 March 2025**	Year ended 31 March 2024
	£000	£000	**£000**	£000
Loans from the Department of Health	97	97	97	97
Interest on lease obligations	655	574	655	574
Interest on the late payment of commercial	1	1	1	1
Total interest expense	753	672	753	672
Unwinding of discount on provisions	2	3	2	3
Total finance expenses	**755**	675	**755**	675

The Trust incurred interest and compensation charges of £879 during 2024/25 (2023/24 £916) under the Late Payment of Commercial Debt (Interest) Act 1998.

12. Gains/(losses) on disposals

	Group		Trust	
	Year ended 31 March 2025	Year ended 31 March 2024	**Year ended 31 March 2025**	Year ended 31 March 2024
	£000	£000	**£000**	£000
Gains on disposal of other property, plant and equipment	6	6	6	6
Gains on disposal of right of use assets	16	2	16	2
Losses on disposal of other property, plant and equipment	(2)	(1)	(2)	(1)
Total gains / (losses) on disposal of assets	**20**	7	**20**	7

13. Impairment of non-current assets

	Group		Trust	
	Year ended 31 March 2025	Year ended 31 March 2024	**Year ended 31 March 2025**	Year ended 31 March 2024
Impairment	**£000**	£000	**£000**	£000
Other	-	596	-	596
Changes in market price*	1,886	7,381	1,886	7,381
Reversal of impairments*	(417)	(594)	(417)	(594)
Total impairments	**1,469**	7,383	**1,469**	7,383

* Resulting from the revaluation of land and buildings as at 31 March 2025.

Total impairments have been charged/(credited) to the following lines in the Statement of Comprehensive Income.

	Group		Trust	
	Year ended 31 March 2025	Year ended 31 March 2024	**Year ended 31 March 2025**	Year ended 31 March 2024
	£000	£000	**£000**	£000
Operating expenses	22	2,025	22	2,025
Revaluation reserve	1,447	5,358	1,447	5,358
	1,469	7,383	**1,469**	7,383

14. Intangible assets

14.1 Intangible assets - 2024/25

	Group and Trust		
	Software licences	Asset under construction	Total
	£000	£000	£000
Cost or valuation at 1 April 2024	**13,685**	**9,806**	**23,491**
Additions - purchased	833	1,648	2,481
Reclassifications	714	(714)	-
Disposals	(875)	-	(875)
Cost or valuation at 31 March 2025	**14,357**	**10,740**	**25,097**
Amortisation at 1 April 2024	**7,691**	**-**	**7,691**
Provided in the year	1,123	-	1,123
Impairments charged to operating expenses	-	-	-
Disposals	(875)	-	(875)
Amortisation at 31 March 2025	**7,939**	**0**	**7,939**
Net book value 31 March 2025	**6,418**	**10,740**	**17,158**
Net book value total at 1 April 2024	**5,994**	**9,806**	**15,800**

14.2 Intangible assets - 2023/24

	Group and Trust		
	Software licences	Asset under construction	Total
	£000	£000	£000
Cost or valuation at 1 April 2023	**12,936**	**6,273**	**19,209**
Additions - purchased	1,031	3,752	4,783
Reclassifications	219	(219)	-
Disposals	(501)	-	(501)
Cost or valuation at 31 March 2024	**13,685**	**9,806**	**23,491**
Amortisation at 1 April 2023	**6,885**	**-**	**6,885**
Provided in the year	764	-	764
Impairments charged to operating expenses	541	-	541
Disposals	(499)	-	(499)
Amortisation at 31 March 2024	**7,691**	**0**	**7,691**
Net book value 31 March 2024	**5,994**	**9,806**	**15,800**
Net book value total at 1 April 2023	**6,051**	**6,273**	**12,324**

Software licences have been assigned asset lives of between 3 and 19 years

15. Property, plant and equipment

The Trust's land and buildings were valued by external valuers as at 31 March 2025 on the basis of fair value, as set out in the accounting policy note 1.6.2. The valuation was undertaken by Avison Young.

15.1 Property, plant and equipment, current year 2024/25

Group	Total £000	Land £000	Buildings exc. dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000
Cost or valuation at 1 April 2024	**192,213**	6,668	112,730	5,179	15,281	38,028	13,667	660
Additions - purchased	**17,894**		4,736	4	11,397	1,446	311	-
Additions - assets purchased from cash donations/grants	**473**	-	-	-	396	77	-	-
Impairments charged to operating expenses	**(24)**	-	(24)	-	-	-	-	-
Impairments charged to revaluation reserve	**(5,118)**	(5)	(5,109)	(4)	-	-	-	-
Reversal of Impairments credited to operating expenses	**(51)**	-	(51)	-	-	-	-	-
Revaluations	**(15)**	-	(15)	-	-	-	-	-
Reclassification	**-**	-	2,344	-	(2,960)	593	23	-
Disposals/derecognition	**(2,176)**	-	(1)	-	-	(1,472)	(701)	(2)
Cost or valuation at 31 March 2025	**203,196**	**6,663**	**114,610**	**5,179**	**24,114**	**38,672**	**13,300**	**658**
Depreciation at 1 April 2024	**31,148**	-	55	-	12	22,377	8,441	263
Provided in the year	**9,594**	-	4,528	140	-	3,271	1,598	57
Impairments charged to operating expenses	**(10)**	-	(10)	-	-	-	-	-
Impairments charged to revaluation reserve	**(3,685)**	-	(3,600)	(85)	-	-	-	-
Reversal of Impairments credited to operating expenses	**(147)**	-	(147)	-	-	-	-	-
Revaluations	**(118)**	-	(63)	(55)	-	-	-	-
Disposals/derecognition	**(2,173)**	-	(1)	-	-	(1,469)	(701)	(2)
Depreciation at 31 March 2025	**34,609**	**-**	**762**	**-**	**12**	**24,179**	**9,338**	**318**

15.2 Property, plant and equipment, current year 2023/24

Group	Total £000	Land £000	Buildings exc. dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000
Cost or valuation at 1 April 2023	**181,765**	6,603	104,579	5,159	17,491	34,870	12,459	604
Additions - purchased	**19,823**	-	8,598	24	7,732	2,014	1,399	56
Additions - assets purchased from cash donations/grants	**194**	-	19	-	89	86	-	-
Impairments charged to operating expenses	**(620)**	-	(620)	-	-	-	-	-
Impairments charged to revaluation reserve	**(8,138)**	-	(8,114)	(24)	-	-	-	-
Reversal of Impairments credited to operating expenses	**34**	-	34	-	-	-	-	-
Revaluations	**48**	65	(37)	20	-	-	-	-
Reclassification	**-**	-	8,271	-	(10,031)	1,509	251	-
Disposals/derecognition	**(893)**	-	-	-	-	(451)	(442)	-
Cost or valuation at 31 March 2024	**192,213**	**6,668**	**112,730**	**5,179**	**15,281**	**38,028**	**13,667**	**660**
Depreciation at 1 April 2023	**27,390**	-	-	-	12	19,763	7,377	238
Provided in the year	**8,563**	-	3,839	134	-	3,063	1,502	25
Impairments charged to operating expenses	**(98)**	-	(102)	-	-	-	4	-
Impairments charged to revaluation reserve	**(3,678)**	-	(3,597)	(81)	-	-	-	-
Reversal of Impairments credited to operating expenses	**(24)**	-	(24)	-	-	-	-	-
Revaluations	**(114)**	-	(61)	(53)	-	-	-	-
Disposals/derecognition	**(891)**	-	-	-	-	(449)	(442)	-
Derecognition - COVID equipment returned	**-**	-	-	-	-	-	-	-
Depreciation at 31 March 2024	**31,148**	**-**	**55**	**-**	**12**	**22,377**	**8,441**	**263**

15.3 Property, plant and equipment financing

	Total	Land	Buildings exc. dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value as at 31 March 2025								
Owned assets	**162,650**	6,663	109,514	5,179	23,706	13,577	3,961	50
Donated assets	**5,937**	-	4,334	-	396	916	1	290
Total at 31 March 2025	**168,587**	**6,663**	**113,848**	**5,179**	**24,102**	**14,493**	**3,962**	**340**
Net book value as at 31 March 2024								
Owned assets	**154,954**	6,668	108,381	5,179	15,169	14,227	5,224	106
Donated assets	**6,111**	-	4,294	-	100	1,424	2	291
Total at 31 March 2024	**161,065**	**6,668**	**112,675**	**5,179**	**15,269**	**15,651**	**5,226**	**397**

16. Right of use assets

16.1 Right of use assets, current year 2024/25

	Group and Trust				
	Total	Property (land and buildings)	Plant & machinery	Transport equipment	Information technology
Group	**£000**	**£000**	**£000**	**£000**	**£000**
Cost or valuation at 1 April 2024	**21,029**	18,288	1,986	359	396
Additions - lease liability	**667**	546	-	121	-
Remeasurements of the lease liability	**951**	871	-	80	-
Impairments charged to operating expenses	**(708)**	(708)	-	-	-
Impairments charged to the revaluation reserve	**(104)**	(104)	-	-	-
Reversal of impairments credited to operating expenses	**(446)**	(446)	-	-	-
Revaluations	**(63)**	(63)	-	-	-
Disposals/derecognition - lease termination	**(226)**	(56)	-	(170)	-
Cost or valuation at 31 March 2025	**21,100**	**18,328**	**1,986**	**390**	**396**
Depreciation at 1 April 2024	**645**	-	467	165	13
Provided in the year - right of use asset	**1,701**	1,243	215	186	57
Impairments charged to operating expenses	**(283)**	(283)	-	-	-
Impairments charged to the revaluation reserve	**(90)**	(90)	-	-	-
Reversal of impairments credited to operating expenses	**(767)**	(767)	-	-	-
Revaluations	**(69)**	(69)	-	-	-
Disposals/derecognition - lease termination	**(204)**	(34)		(170)	-
Depreciation at 31 March 2025	**933**	**-**	**682**	**181**	**70**
Net book value at 31 March 2025	**20,167**	**18,328**	**1,304**	**209**	**326**

16.2 Right of use assets, prior year 2023/24

	Group and Trust				
	Total	**Property (land and buildings)**	**Plant & machinery**	**Transport equipment**	**Information technology**
Group	**£000**	**£000**	**£000**	**£000**	**£000**
Cost or valuation at 1 April 2023	**22,684**	20,107	1,986	200	391
Additions - lease liability	**998**	453	-	148	397
Remeasurements of the lease liability	**1,134**	1,123	-	11	-
Impairments charged to operating expenses	**(2,556)**	(2,556)	-	-	-
Impairments charged to the revaluation reserve	**(967)**	(967)	-	-	-
Reversal of impairments credited to operating expenses	**158**	158	-	-	-
Disposals/derecognition - lease termination	**(422)**	(30)	-	-	(392)
Cost or valuation at 31 March 2024	**21,029**	**18,288**	**1,986**	**359**	**396**
Depreciation at 1 April 2023	**721**	-	252	78	391
Provided in the year - right of use asset	**1,778**	1,462	215	87	14
Impairments charged to operating expenses	**(1,000)**	(1,000)	-	-	-
Impairments charged to the revaluation reserve	**(69)**	(69)	-	-	-
Reversal of impairments credited to operating expenses	**(378)**	(378)	-	-	-
Disposals/derecognition - lease termination	**(407)**	(15)	-	-	(392)
Depreciation at 31 March 2024	**645**	**-**	**467**	**165**	**13**
Net book value at 31 March 2024	**20,384**	**18,288**	**1,519**	**194**	**383**

17. Inventories

Current year 2024/25	Group			
	Drugs	Consumables	Other	Total
	£000	£000	£000	£000
Balance at 1 April	1,447	2,160	171	**3,778**
Additions	28,570	12,041	715	**41,326**
Inventories recognised as an expense in the period	(28,221)	(10,979)	(749)	**(39,949)**
Write-down of inventories recognised as an expense	(65)	-	-	**(65)**
Balance at 31 March	**1,731**	**3,222**	**137**	**5,090**

Current year 2024/25	Trust			
	Drugs	Consumables	Other	Total
	£000	£000	£000	£000
Balance at 1 April	1,213	2,160	171	**3,544**
Additions	23,001	12,041	715	**35,757**
Inventories recognised as an expense in the period	(22,698)	(10,979)	(749)	**(34,426)**
Write-down of inventories recognised as an expense	(65)	-	-	**(65)**
Balance at 31 March	**1,451**	**3,222**	**137**	**4,810**

The Trust does not currently operate a complete inventory management control system and is therefore, not able to separately evaluate any amount arising, from write-downs or losses, for inventories other than drugs.

18. Receivables

18.1 Receivables

	Group		Trust	
	31 March 2025	31 March 2024	**31 March 2025**	31 March 2024
Current	**£000**	£000	**£000**	£000
Contract receivables (IFRS 15): invoiced	2,055	2,369	2,055	2,369
Contract receivables (IFRS 15): not yet invoiced/non-invoiced	13,269	13,437	13,269	13,495
Allowance for impaired contract receivables	(74)	(80)	(74)	(80)
Prepayments	4,576	3,727	4,573	3,724
Interest receivable	107	69	104	67
PDC dividend receivable	69	73	69	73
VAT receivables	552	741	454	667
Clinician pension tax provision	4	8	4	8
Other receivables	933	860	933	860
Total	**21,491**	21,204	**21,387**	21,183
Non-current				
Prepayments	310	209	310	209
Contract receivables (IFRS 15): not yet invoiced/non-invoiced	112	329	112	329
Clinician pension tax provision	169	146	169	146
Total	**591**	684	**591**	684
Grand Total	**22,082**	21,888	**21,978**	21,867

The great majority of trade is with Integrated Care Boards, as commissioners for NHS patient care services. As Integrated Care Boards are funded by central government to buy NHS patient care services, no credit scoring of them is considered necessary.

18.2 Allowance for credit losses (doubtful debts)

Contract receivables and contract assets	Group		Trust	
	31 March 2025	31 March 2024	**31 March 2025**	31 March 2024
	£000	£000	**£000**	£000
Balance at 1 April	80	80	80	80
New allowances arising	40	36	40	36
Reversals of allowances	(46)	(36)	(46)	(36)
Balance at 31 March	**74**	80	**74**	80

19. Cash and cash equivalents

	Group		Trust	
	31 March 2025	31 March 2024	**31 March 2025**	31 March 2024
	£000	£000	**£000**	£000
Balance at 1 April	8,805	18,914	8,609	18,302
Net change in year	16,360	(10,109)	15,801	(9,693)
Balance at 31 March	**25,165**	8,805	**24,410**	8,609
Made up of				
Commercial banks and cash in hand	7	7	7	7
Cash with Government Banking Service	25,158	8,798	24,403	8,602
Cash and cash equivalents	**25,165**	8,805	**24,410**	8,609

20. Trade and other payables

	Group		Trust	
	31 March 2025	31 March 2024	**31 March 2025**	31 March 2024
Current	**£000**	£000	**£000**	£000
Trade payables	18,638	14,660	18,160	14,773
Capital payables	4,578	6,613	4,578	6,613
Accruals	3,872	4,293	3,872	4,293
Other taxes payable	4,438	4,433	4,403	4,395
PDC dividend payable	-	-	-	-
Pension contributions payable	2,683	2,540	2,683	2,540
Total	**34,209**	32,539	**33,696**	32,614

21. Borrowings

	Group Current		Trust Current	
	31 March 2025	31 March 2024	**31 March 2025**	31 March 2024
	£000	£000	**£000**	£000
Loans from Department of Health and Social Care	4,604	4	4,604	4
Lease liabilities	2,072	1,749	2,072	1,749
Total	**6,676**	1,753	**6,676**	1,753

	Non-current		Non-current	
	31 March 2025	31 March 2024	**31 March 2025**	31 March 2024
	£000	£000	**£000**	£000
Loans from Department of Health and Social Care	-	4,600	-	4,600
Lease liabilities	25,496	25,671	25,496	25,671
Total	**25,496**	30,271	**25,496**	30,271

The Trust drew down a capital loan on the 1st August 2011 from the Department of Health against the receipt of future asset sales at an annual interest rate of 2.11%. The loan repayment date has been extended by the Department of Health and Social Care in a letter dated 4th May 2020 to 15th March 2026.

21.1 Reconciliation of liabilities current year 2024/25

	Total	**DHSC loans**	**Lease liabilities**
Group and Trust	**£000**	**£000**	**£000**
At 1 April 2024	**32,024**	4,604	27,420
Cash movements:			
Financing cash flows - principle	**(1,498)**	-	(1,498)
Financing cash flows - interest	**(686)**	(97)	(589)
Non-cash movements:			
Additions	**667**	-	667
Lease liability remeasurements	**951**	-	951
Interest charge arising in year	**752**	97	655
Early termination	**(38)**	-	(38)
At 31 March 2025	**32,172**	4,604	27,568

21.2 Reconciliation of liabilities prior year 2023/24

	Total	**DHSC loans**	**Lease liabilities**
Group and Trust	**£000**	**£000**	**£000**
At 1 April 2023	**31,569**	4,604	26,965
Cash movements:			
Financing cash flows - principle	**(1,656)**	-	(1,656)
Financing cash flows - interest	**(675)**	(97)	(578)
Non-cash movements:			
Additions	**998**	-	998
Lease liability remeasurements	**1,134**	-	1,134
Interest charge arising in year	**671**	97	574
Early termination	**(17)**	-	(17)
At 31 March 2024	**32,024**	4,604	27,420

22. Provisions

	Group and Trust Current	
	31 March 2025	31 March 2024
	£000	£000
Pensions early departure costs	9	14
Pensions injury benefits	15	14
Other legal claims	23	-
Clinician pension tax reimbursement	4	8
Total	**51**	36

	Non-current	
	31 March 2025	31 March 2024
	£000	£000
Pensions early departure costs	16	24
Pensions injury benefits	64	71
Clinician pension tax reimbursement	169	146
Total	**249**	241

22.1 Provisions movement

Group and Trust	**Total** **£000**	**Pensions early departure costs** **£000**	**Pensions Injury benefits** **£000**	**Legal and other claims** **£000**	**Clinician pension tax** **£000**
At 1 April 2024	**277**	38	85	-	154
Change in discount rate	**(2)**	-	-	-	(2)
Arising during the year	**59**	10	8	23	18
Utilised during the year - accruals	**-**	-	-	-	-
Utilised during the year - cash	**(43)**	(23)	(15)	-	(5)
Reversed unused	**(1)**	(1)	-	-	-
Unwinding of discount	**10**	1	1	-	8
At 31 March 2025	**300**	25	79	23	173
Expected timing of cash flows:					
Within one year	**51**	9	15	23	4
Between one and five years	**84**	16	34	-	34
After 5 years	**165**	-	30		135
Total	**300**	25	79	23	173

Provisions that are not expected to become due for several years are shown at a reduced value to take account of inflation.

Provisions shown under the heading 'Pensions early departure costs' have been calculated using figures provided by the NHS Pension Agency. They assume certain life expectancies. Provisions shown under the heading 'Legal claims' relate to public and employer liability claims. The liability claims amounts have been calculated using information provided by NHS Resolution and are based on the best information available at the balance sheet date.

22.2 Clinical negligence liabilities

Group and Trust	**31 March 2025** **£000**	31 March 2024 £000
Amount included in provisions of NHS Resolution in respect of clinical negligence liabilities of the Trust	81,166	82,256

23. Other liabilities

	Group		Trust	
	31 March 2025	31 March 2024	**31 March 2025**	31 March 2024
	£000	£000	**£000**	£000
Deferred income - goods and services	1,669	2,007	1,669	2,007
Total	**1,669**	2,007	**1,669**	2,007

24. Lease Liabilities

24.1 Maturity analysis

	Group and Trust	
	31 March 2025	31 March 2024
	£000	£000
Undiscounted future lease payments		
not later than one year	2,670	2,398
later than one year and not later than five	8,165	7,867
later than five years	25,285	25,825
Total gross future payments	36,120	36,090
Finance charges allocated to future periods	(8,552)	(8,670)
Net lease liabilities	**27,568**	27,420
of which :		
Currenly not yet invoiced/not relating to current year	2,072	1,749
Non-Current	25,496	25,671
	27,568	27,420

24.2 Movement in the carrying value current year 2024/25

	Group and Trust
	Total
	£000
Carrying value at 1 April 2024	**27,420**
Cash movements:	
Financing cash flows - principle	(1,498)
Financing cash flows - interest	(589)
Non-cash movements:	
Lease additions	667
Lease liability remeasurement	951
Interest charge arising in year	655
Termination of lease	(38)
Carrying value at 31 March 2025	**27,568**

24.3 Movement in the carrying value prior year 2023/24

	Group and Trust Total £000
Carrying value at 1 April 2023	**26,965**
Cash movements:	
Finance cash flows - principle	(1,656)
Finance cash flows - interest	(578)
Non-cash movements:	
Lease additions	998
Lease liability remeasurement	1,134
Interest charge arising in year	574
Termination of lease	(17)
Carrying value at 31 March 2024	**27,420**

24.4 Reconciliation of the carry value of lease liabilities current year 2024/25

	Group and Trust Total £000
Carrying value at 1 April 2024	**27,420**
Lease additions	667
Lease liability remeasurement	951
Interest charge arising in year	655
Termination of lease	(38)
Lease payments (cash outflows)	(2,087)
Carrying value at 31 March 2025	**27,568**

24.5 Reconciliation of the carry value of lease liabilities prior year 2023/24

	Group and Trust Total £000
Carrying value at 1 April 2023	**26,965**
Lease additions	998
Lease liability remeasurement	1,134
Interest charge arising in year	574
Termination of lease	(17)
Lease payments (cash outflows)	(2,234)
Carrying value at 31 March 2024	**27,420**

Lease liabilities are included within borrowings in the statements of financial position. A breakdown of borrowings is disclosed in note 21.

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on and index or rate are recognised in operating expenditure.
These payments are disclosed in note 6. Cash outflows in respect of leases recognised on-SOFP are disclosed in the reconciliation above.

25. Contingencies

Contingent liabilities	31 March 2025	31 March 2024
Group and Trust	**£000**	£000
Pensions injury benefits	9	11
Pensions early departures	1	2
Risk pooling*	15	-
Total	**25**	13

*Risk pooling is in respect of employer and public liability incidents for which claims have been made against the Trust. The contingent liabilities have been calculated using information provided by NHS Resolution. Provisions relating to these cases are included in Note 22.

26. Financial instruments

26.1 Financial assets

	Group		Trust	
	31 March 2025	31 March 2024	31 March 2025	31 March 2024
Loans and receivables	**£000**	£000	**£000**	£000
Trade and other receivables with NHS and DH bodies	12,164	15,577	12,164	15,577
Trade and other receivables with other bodies	4,407	1,553	4,404	1,609
Cash and cash equivalents at bank and in hand	25,165	8,805	24,410	8,609
Total at 31 March	**41,736**	25,935	**40,978**	25,795

The financial assets consist of the financial element of trade and other receivables (note 18.1) and cash and cash equivalents at bank and in hand (note 19). Financial assets in the table above are valued at amortised cost.

26.2 Financial liabilities

	Group		Trust	
	31 March 2025	31 March 2024	31 March 2025	31 March 2024
	£000	£000	**£000**	£000
Borrowing excluding finance lease and PFI contract	4,604	4,604	4,604	4,604
Obligations under finance lease	27,568	27,420	27,568	27,420
Trade and other payables with NHS and DH bodies	12,300	7,614	12,300	7,614
Trade and other payables with other bodies	14,408	17,320	13,930	17,059
Provisions under contract	300	277	300	277
Total at 31 March	**59,180**	57,235	**58,702**	56,974

The financial liabilities consist of the financial element of trade and other payables (note 20), plus current and non-current borrowings (note 21) and provisions (note 22.1) excluding legal costs. Financial liabilities in the table above are valued at amortised cost.

Maturity of financial liabilities	Group		Trust	
	31 March 2025	31 March 2024	**31 March 2025**	31 March 2024
	£000	£000	**£000**	£000
Finance leases				
In one year or less	2,670	2,398	2,670	2,398
In more than one year but not more than five years	8,165	7,867	8,165	7,867
In more than five years	25,285	25,825	25,285	25,825
	36,120	36,090	**36,120**	36,090
DHSC loans				
In one year or less	4,697	97	4,697	97
In more than one year but not more than five years	-	4,697	-	4,697
	4,697	4,794	**4,697**	4,794
Trade & Payables: DHSC group bodies				
In one year or less	12,300	7,614	12,300	7,614
	12,300	7,614	**12,300**	7,614
Trade & Payables: other bodies				
In one year or less	14,408	17,320	13,930	17,059
	14,408	17,320	**13,930**	17,059
Provisions				
In one year or less	51	36	51	36
In more than one year but not more than five years	84	86	84	86
In more than five years	165	155	165	155
	300	277	**300**	277
Total				
In one year or less	34,126	27,465	33,648	27,204
In more than one year but not more than five years	8,249	12,650	8,249	12,650
In more than five years	25,450	25,980	25,450	25,980
	67,825	66,095	**67,347**	65,834

The figures above are based on undiscounted future contractual cash flow as per IFRS 7 Financial Instruments.

26.3 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Due to the continuing service provider relationship that the Trust has with Integrated Care Boards and the way those Boards are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the Finance Department, within parameters defined formally within the Trust's Standing Financial Instructions and Policies agreed by the Board of Directors. The Trust's treasury activity is subject to review by the Trust's internal auditors.

26.3.1 Currency risk

The Trust is a UK based organisation with no overseas operations. The vast majority of its income, expenses, assets and liabilities are denominated in sterling, and therefore it has low exposure to currency risk.

26.3.2 Interest rate risk

The Trust's exposure to interest rate risk is limited to the rate of interest it earns on short-term cash deposits placed with the National Loans Fund and its cash balances with the Government Banking Service. All the borrowings of the Trust are at fixed rates of interest.

The Group earned interest of £874k (at an average rate of approximately 4.84%) during 2024/25. An increase in interest rates of 0.5% would increase interest earned by approximately £101k.

26.3.3 Credit risk

The majority of the Trust's trade and other receivables are due from other NHS bodies that are funded by central government. As a result, the Trust has a low credit risk profile. Exposures as at 31 March are disclosed in the Trade and other receivables note.

The Trust has a credit control policy and actively pursues unpaid debts, utilising the services of a debt collection agency for certain older debts. The Trust does not enter into derivative contracts.

26.3.4 Liquidity risk

The Trust's net operating costs are incurred under annual service agreements with local Integrated Care Boards, which are financed from resources voted annually by Parliament with revenue support also available under an agreed borrowing limit. The Trust also largely finances its capital expenditure from internally generated funds, or from facilities made available from Government under an agreed borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

The Trust has a surplus of £13m in the current financial year and has a cash balance of £25.2m. Therefore, there is minimal risk to payables.

27. Events after the reporting period

There have been no significant post balance sheet events requiring disclosure.

28. Related party transactions

Dorset County Hospital NHS Foundation Trust is an independent public benefit corporation as authorised by NHS Improvement in their Terms of Authorisation. None of the Trust's Directors, senior managers, or parties deemed to be related to them, has undertaken any material transactions with Dorset County Hospital NHS Foundation Trust.

The Department of Health and Social Care is regarded as the ultimate parent of the Trust. During the year the Foundation Trust has had a significant number of transactions with entities for which the Department of Health is regarded as the ultimate parent. Central and Local Government and NHS entities, with which the Foundation Trust had transaction totals exceeding £500,000 for the year, are listed in the following table.

	Income in year to 31 March 2025 £000	Expenditure in year to 31 March 2025 £000	Receivables at 31 March 2025 £000	Payables at 31 March 2025 £000
Department of Health and Social Care	20	-	-	4,604
Dorset Healthcare University NHS Foundation Trust	4,015	6,593	870	11,292
HM Revenue and Customs - Tax & NI	-	18,142	-	4,438
NHS Blood and Transplant	23	983	-	17
NHS Devon ICB	543	-	-	-
NHS Dorset ICB	259,353	394	7,803	-
NHS England - Central Specialised Commissioning Hub	5,281	-	-	-
NHS England - Core	9,925	53	419	-
South West Regional Office	34,807	-	249	-
NHS Hampshire and Isle of Wight ICB	2,510	-	23	-
NHS Somerset ICB	3,068	-	307	-
NHS Resolution	-	7,281	-	-
NHS Pension Scheme	-	32,626	-	2,683
Somerset NHS Foundation Trust	1,211	152	397	-
University Hospital Southampton NHS Foundation Trust	704	521	122	222
University Hospitals Dorset NHS Foundation Trust	3,858	3,128	1,748	717
Dorset Council	445	415	275	108
DCH Subco Ltd	87	5,823	-	46

The payables included above in respect of HM Revenue and Customs and NHS Pension Scheme include both employee and employer contributions. The expenditure figures for these organisations are only in respect of employer contributions.

The Trust receives revenue payments and contributions to the cost of non-current assets from the Dorset County Hospital NHS Foundation Trust Charitable Fund, of which the Foundation Trust is the corporate trustee.

Transactions with Dorset County Hospital NHS Foundation Trust Charitable Fund:	**31 March 2025 £000**	31 March 2024 £000
Contributions from the Charity to non-current assets	473	194
Contributions from the Charity to expenditure	71	86

29. Third Party Assets

The Trust did not hold cash and cash equivalents which relate to monies held on behalf of patients (2023/24 £nil).

30. Losses and special payments

Group and Trust	Number of cases		Total value of cases	
	31 March 2025	31 March 2024	**31 March 2025**	31 March 2024
	Number	Number	**£'000**	£'000
Losses;				
Damage to buildings and property due to:				
stores losses	**1**	1	**65**	27
other	**4**	7	**1**	1
Special Payments;				
Ex-gratia payments in respect of:				
loss of personal effects	**8**	14	**1**	5
other	**-**	-	**-**	-
	13	22	**67**	33

31. Limitation on auditor's liability

The limitation on the Trust's auditor's liability is £1.0m (2023/24: £1.0m).

32. Pooled Budget – Equipment for Living Partnership

The Trust, via Dorset ICB, contributes towards a pooled budget arrangement which started on the 1st April 2015. This is hosted by BCP Council to provide equipment for Living Partnership.

Payments are included in note 6 – Operating expenses under heading Purchase of healthcare from NHS and DHSC bodies. The Trust contributed £228k in 2024/25 (£219k 2023/24). This forms part of the NHS Dorset total included in the table below.

The below disclosure is based on month 12 information provided by NHS Dorset and it should be noted that these figures are un-audited.

	Group and Trust	
	Year ended 31 March 2025	Year ended 31 March 2024
Funding	**£000**	£000
BCP Council	1,940	1,562
Dorset Council	1,554	1,239
NHS Dorset	7,056	5,646
Partner Contributions (excluding management costs)	10,550	8,447
Risk Share: Local Authorities	(208)	336
Risk Share: NHS Dorset	(421)	670
Section 256	-	500
Total Funding	**9,921**	9,953
Expenditure		
Integrated Community Equipment Store		
Actual Spend to March	(9,921)	(9,953)
Total Expenditure	**(9,921)**	(9,953)
Total Surplus at 31 March	**-**	-

33. Other Financial Commitments

The Trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

	Group		Trust	
	31 March 2025	31 March 2024	**31 March 2025**	31 March 2024
	£000	£000	**£000**	£000
not later than 1 year	6,009	4,741	6,009	4,741
after 1 year and not later than 5 years	2,881	3,440	2,881	3,440
paid thereafter	203	1,293	203	1,293
Total	**9,093**	9,474	**9,093**	9,474

34. Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements comprise:

	Group		Trust	
	31 March 2025	31 March 2024	**31 March 2025**	31 March 2024
	£000	£000	**£000**	£000
Property, plant and equipment	64,206	727	64,206	727
Intangible assets	168	84	168	84
Total	**64,374**	811	**64,374**	811

Auditor's Annual Report 2024/25

Dorset County Hospital NHS Foundation Trust

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27 June 2025

Contents

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This report is addressed to Dorset County Hospital NHS Foundation Trust (the Trust), as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state, those matters we are required to state to them in an auditors' annual report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Dorset County Hospital NHS Foundation Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

We take no responsibility to any member of staff acting in their individual capacities, or to third parties.

External auditors do not act as a substitute for the audited body's own responsibility for putting in place proper arrangements to ensure that public business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for, and used economically, efficiently and effectively.

01 Executive Summary

Executive Summary

Purpose of the Auditor's Annual Report

This Auditor's Annual Report provides a summary of the findings and key issues arising from our 2024-25 audit of Dorset County Hospital NHS Foundation Trust (the 'Trust'). This report has been prepared in line with the requirements set out in the Code of Audit Practice published by the National Audit Office and is required to be published by the Trust alongside the annual report and accounts.

Our responsibilities

The statutory responsibilities and powers of appointed auditors are set out in the Local Audit and Accountability Act 2014. In line with this we provide conclusions on the following matters:

Accounts - We provide an opinion as to whether the accounts give a true and fair view of the financial position of the Trust and of its income and expenditure during the year. We confirm whether the accounts have been prepared in line with the Group Accounting Manual prepared by the Department of Health and Social Care (DHSC).

Annual report - We assess whether the annual report is consistent with our knowledge of the Trust. We perform testing of certain figures labelled in the remuneration report.

Value for money - We assess the arrangements in place for securing economy, efficiency and effectiveness (value for money) in the Trust's use of resources and provide a summary of our findings in the commentary in this report. We are required to report if we have identified any significant weaknesses as a result of this work.

Other reporting - We may issue other reports where we determine that this is necessary in the public interest under the Local Audit and Accountability Act.

Findings

We have set out below a summary of the conclusions that we provided in respect of our responsibilities:

Accounts	We issued an unqualified opinion on the Trust's accounts on 27 June 2025. This means that we believe the accounts give a true and fair view of the financial performance and position of the Trust. We have provided further details of the key risks we identified and our response on page 10.
Annual report	We did not identify any significant inconsistencies between the content of the annual report and our knowledge of the Trust. We confirmed that the annual report has been prepared in line with the NHS Group Accounting Manual (GAM) and the Foundation Trust Annual Reporting Manual (the ARM).
Value for money	We are required to report if we identify any matters that indicate the Trust does not have sufficient arrangements to achieve value for money. We have nothing to report in this regard.
Other reporting	We did not consider it necessary to issue any other reports in the public interest.

02
Audit of the Financial Statements

Audit of the financial statements

KPMG provides an independent opinion on whether the Trust's financial statements:

- Give a true and fair view of the state of the Trust's affairs as at 31 March 2025 and of its income and expenditure for the year then ended;
- Have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State in February 2025 as being relevant to NHS Foundation Trusts and included in the Department of Health and Social Care Group Accounting Manual 2024/25; and
- Have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Audit opinion on the financial statements

We have issued an unqualified opinion on the Trust's financial statements on 27 June 2025.

The full opinion is included in the Trust's Annual Report and Accounts for 2024/25 which can be obtained from the Trust's website.

Further information on our audit of the financial statements is set out overleaf.

Audit of the financial statements

The table below summarises the key risks that we identified to our audit opinion as part of our risk assessment and how we responded to these through our audit.

Risk	Procedures undertaken	Findings
Fraudulent expenditure recognition Auditing standards suggest for public sector entities a rebuttable assumption that there is a risk expenditure is recognised inappropriately. We recognised this risk over the Trust's operating expenditure balance excluding costs associated with payroll and deprecation.	• We evaluated the design and implementation of controls to verify if expenditure accruals have been completely recorded, including the year on year of accruals performed by management. • We inspected a sample of expenditure transactions and cash payments, in the period after 31 March 2025, to determine whether expenditure has been recognised in the correct accounting period and whether accruals are complete; • We inspected journals posted as part of the year end close procedures that decrease the level of expenditure (e.g. through accruals) recorded in order to critically assess whether there was an appropriate basis for posting the journal and the value can be agreed to supporting evidence; and • We performed a retrospective review of prior year accruals to assess the completeness with which accruals had been recorded at 31 March 2024 and consider the impact on our assessment of the accruals at 31 March 2025. We also compared the items that were accrued at 31 March 2024 to those accrued at 31 March 2025 to assess whether any items of expenditure not accrued for as at 31 March 2025 have been done so appropriately and challenge management where the movement is not in line with our understanding.	• We sampled a number of expenditure transaction and cash payments in the period following 31 March 2025, and did not identify any inappropriate entries. • We performed a retrospective review of accruals (both through consideration of prior year accruals and through comparison to current year accruals), and did not identify any inappropriate entries. • We did not identify any material misstatements relating to this risk.

Audit of the financial statements (cont.)

Risk	Procedures undertaken	Findings
Management override of controls We are required by auditing standards to recognise the risk that management may use their authority to override the usual control environment.	• Assessed accounting estimates for biases by evaluating whether judgements and decisions in making accounting estimates, even if individually reasonable, indicate a possible bias. • In line with our methodology, evaluated the design and implementation of controls over journal entries and post closing adjustments. • Assessed the appropriateness of changes, compared to the prior year, to the methods and underlying assumptions used to prepare accounting estimates. • Assessed the business rationale and the appropriateness of the accounting for significant transactions that are outside the Trust's normal course of business, or are otherwise unusual. • Identified journal entries and other adjustments with characteristics that indicate that they may be inappropriate or unauthorised and therefore may have been used to manipulate the financial statements (which we refer to as 'high-risk journals and other adjustments'), and performed procedures to test the appropriateness of these entries and adjustments.	• We identified a number of journal entries and other adjustments which met our high risk criteria. These included unusual entries to cash and borrowings as well as journal entries which were posted to accruals in the last quarter of the year. Our review and examination of supporting documents did not identify any instances of management override of controls, with the journals being fully supported by documentation. • We raised a control recommendation in relation to the journal's authorisation control in place at the Trust. • We did not identify any material misstatements in relation to this significant risk.

03 Value for Money

Value for Money

Introduction

We are required to consider whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources or 'value for money'. We consider whether there are sufficient arrangements in place for the Trust for the following criteria, as defined by the National Audit Office (NAO) in their Code of Audit Practice:

- Financial sustainability: How the Trust plans and manages its resources to ensure it can continue to deliver its services.
- Governance: How the Trust ensures that it makes informed decisions and properly manages its risks.
- Improving economy, efficiency and effectiveness: How the Trust uses information about its costs and performance to improve the way it manages and delivers its services

Approach

We undertake risk assessment procedures in order to assess whether there are any risks that value for money is not being achieved. This is prepared by considering the findings from other regulators and auditors, records from the organisation and performing procedures to assess the design of key systems at the organisation that give assurance over value for money.

Where a significant risk is identified we perform further procedures in order to consider whether there are significant weaknesses in the processes in place to achieve value for money.

We are required to report a summary of the work undertaken and the conclusions reached against each of the aforementioned reporting criteria in this Auditor's Annual Report. We do this as part of our commentary on VFM arrangements over the following pages.

We also make recommendations where we identify weaknesses in arrangements or other matters that require attention from the Trust.

Summary of findings

	Financial sustainability	Governance	Improving economy, efficiency and effectiveness
Commentary page reference	12-13	14	15
Identified risks of significant weakness?	Yes	No	No
Actual significant weakness identified?	No	No	No
2023-24 Findings	No significant weakness identified	No significant weakness identified	No significant weakness identified
Direction of travel	⇔	⇔	⇔

Value for Money

NATIONAL CONTEXT

Following the general election in July 2024 the Labour government commissioned reviews in order to determine the causes of challenges within the sector and where priorities were for improvement. A 10 year plan is currently being developed to set out the strategy for transforming health care services in the future.

Operational performance across the sector has continued to be significantly below constitutional standards, continuing a trend that began during the Covid-19 pandemic. In March 2025 25% of patients attending A&E waited more than the four hour target and 60% of patients awaiting planned care had a wait of more than 18 weeks. While mental health performance improved year on year in a number of areas the backlog for treatment nationally has grown by a further 11% year on year, with 1.7 million referred patients awaiting their second contact.

During the year a revised timetable was announced for the New Hospital Programme, the national capital project to build 40 new hospitals. For a number of hospitals this has meant delays to the timetable for their construction deferred to the 2030s.

Financial performance

Local NHS systems continued to face challenging financial targets in 2024-25. Budgets across the 42 integrated care systems in England had a combined £500 million deficit compared to the funding that was available at the beginning of 2024-25. By February 2025 (the latest national data available when this report was drafted) the forecast performance of all systems was a £604 million overspend against the agreed figures.

Each year NHS entities are delegated efficiency targets through funding allocations and contracting guidance. Across England there was a £539 million shortfall in the identified efficiencies compared to those required based on the agreed levels of funding delegated to systems.

Structures

Significant changes to the structure of the health system have been announced, to be implemented between 2025 and 2027. ICBs have been set running cost targets, with many expected to pursue mergers or large restructurings in order to achieve these. Providers are expected to reverse 50% of their corporate cost growth since Covid-19. During 2025-26 all NHS entities will therefore need to reassess their structures, which can impact on management bandwidth, stability of controls and morale.

LOCAL CONTEXT

The Trust provides acute hospital services from its main site in Dorchester, serving a population of nearly 300,000 with over 3,500 staff. The Trust is a member of Dorset ICS ('Our Dorset').

During 2023/24 the Trust established a federated model with Dorset Healthcare University NHS Foundation Trust ('DHU'), which included the appointment of a Joint Chair, Chief Executive and other Executive Director and has seen a new joint strategy 'Working together, improving lives' approved in August 2024.

Financial performance

The Trust has delivered an adjusted financial surplus of £13.0 million during the year. This was achieved through a focus on cost improvement programmes ('CIP'), with the Trust delivering £9.6 million of cost savings compared to a planned target of £14.3 million and receipt of £13.0 million of additional funding from the ICB and NHS England. The funding supported additional activity delivered in the year linked to the number of escalation beds open across the Trust, as well additional funding to support the structural deficit in the Trust.

Delivery of the financial plan remains a key challenge for the Trust. The Trust recognises being part of an ICS with a challenging financial position, with the system reporting a current year deficit of £12.0 million and an underlying deficit of over £172.2 million.

The 2025/26 Trust and ICS plan was approved by the Board on 30 April 2025, with the Trust forecasting to deliver a £9.8 million deficit, with the overall system forecasting a breakeven position. The plans include challenging cost improvement targets of c. 8.5% for the Trust, which is greater than the CIP delivered in the current year.

Maternity CQC Inspection

The Trust have continued to implement the action plan agreed as part of the CQC inspection of Maternity Services in June 2023, with appropriate oversight by the Quality Committee. All 11 actions have now been addressed as required by the Section 29A notice.

Financial Sustainability

How the Trust plans and manages its resources to ensure it can continue to deliver its services.

We have considered the following in our work:

- How the Trust ensures that it identifies all the significant financial pressures that are relevant to its short and medium-term plans and builds these into them;
- How the Trust plans to bridge its funding gaps and identifies achievable savings;
- How the Trust plans finances to support the sustainable delivery of services in accordance with strategic and statutory priorities;
- How the Trust ensures that its financial plan is consistent with other plans such as workforce, capital, investment, and other operational planning which may include working with other local public bodies as part of a wider system; and
- How the Trust identifies and manages risks to financial resilience, e.g. unplanned changes in demand, including challenge of the assumptions underlying its plans

Summary of arrangements

We have **not identified a significant weakness** in the Trust's arrangements in relation to financial sustainability.

Delivery against 2024-25 financial plan

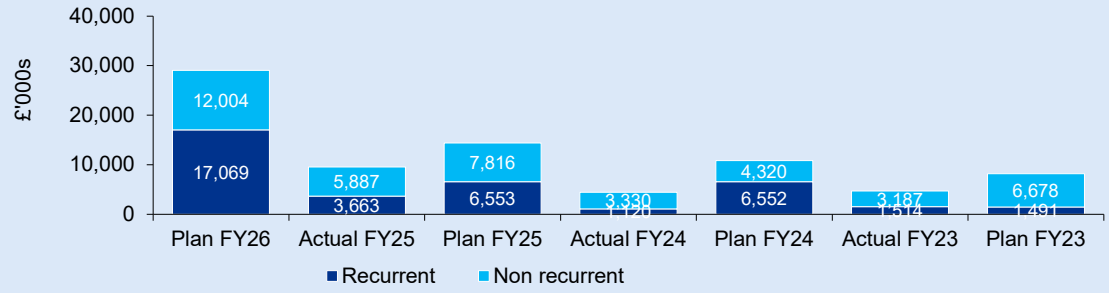
The original Trust financial plan for 2024/25 was a breakeven plan, which formed part of a wider ICS breakeven budget. The budgets were prepared based on appropriate local and national planning assumptions and were approved at both a Trust and ICS level prior to submission. However, during the period, risks within the budget crystalised, such as pressures arising due to the number of escalation beds in operation at the Trust, which had not been funded. These pressures resulted in the Trust reporting a deficit position of £11.8 million at month 9. The Trust responded to this position by working closely with partners across the system to review the level of funding in place and consider system wide initiatives, including an independent review of the deficit across the system and underlying drivers of the DCH financial position conducted by NHS England.

The Trust was able to mitigate the reported month 9 deficit and achieved a £13.0 million surplus at the year end, with the main driver for this improved performance being the partial delivery of Cost Improvement Programmes ('CIPs') and receipt of additional funding in relation to the structural deficit identified through the review conducted by NHS England in January 2025. This resulted in an additional £13 million of funding being received by the Trust.

To support the delivery of the financial position, the Trust planned delivery of £14.4 million of CIPs, with £6.5 million as recurrent savings and £7.8 million non-recurrent savings. The Trust failed to achieve the required savings, with £3.7 million of recurrent and £5.9 million of non-recurrent CIPs delivered in year.

The Trust have failed to achieve initial CIP plans in recent years, as noted in the below graph, however the delivery of CIPs remains a significant focus in the Trust's financial plans. The significant level of CIP in 2025/26 will require additional focus from the Trust, with £4.5 million planned CIP unidentified in the submitted plan.

CIP Delivery: Plan vs Actual / Recurrent vs Non-Recurrent



Financial Sustainability

The Trust has submitted a 2025/26 plan with a total CIP delivery target of £29.1 million, split between recurrent savings of £17.1 million and non-recurrent of £12.0 million. Alongside this, the Trust continues to work with the ICB and NHS England to obtain additional funding in relation to the structural at the Trust.

Capital Spend

As part of the 2024/25 plan, the Trust identified £30.0 million of capital spend, largely relating to the New Hospital Programme. The delivery of plans are monitored through the Finance and Performance Committee in Common. The Trust delivered total capital spend of £22.5 million during the year, with the performance against plan being largely driven by delays in the New Hospital Programme and delays in backlog maintenance. The additional capital spend is expected to be spent in 2025/26 with the Trust having submitted a total capital plan of £52.1 million.

The Trust is in Phase One of the New Hospital Programme with construction work having already started in 2024/25. The progress and monitoring of this project is routinely reported to both the Finance and Performance Committee in Common and the Trust's Board.

Planning process for 2024-25

The Trust has worked with ICS partner organisations to develop plans for 2025/26 in line with the national guidance, with planning initiatives, including but not limited to: planning workshops, recurring Director of Finance meetings, challenge and confirm sessions and system development meetings. In particular, the Trust has ensured all relevant stakeholders including the Board, Finance and Performance Committee in Common and Senior Leadership Group throughout the process, with necessary background and detail included within such updates. Prior to submission, management obtained approval from the Trust Board on 27 March 2025, with minutes evidencing sufficient challenge and scrutiny on all relevant aspects of the draft plan.

The final Trust and ICS plans were submitted on 30 April 2025 with the Trust submitted a breakeven plan and the wider ICS also forecasting an in year breakeven position.

Key financial and performance metrics:	2024-25	2023-24
Planned performance (adjusted financial performance)	Breakeven	Breakeven
Actual performance (adjusted financial performance)	£13.0 million surplus	£47k deficit
Planned CIP - Recurrent - Non-recurrent	Planned CIP of £14.4 million: — £6.5 million recurrent — £7.8 million non-recurrent	Planned CIP of £10.8 million: — £6.5 million recurrent — £4.3 million non-recurrent
Actual CIP - Recurrent - Non-recurrent	Achieved CIP of £9.5 million: — £3.7 million recurrent — £5.9 million non-recurrent	Achieved CIP of £4.4 million: — £1.1 million recurrent — £3.3 million non-recurrent
Year-end cash position	£25.2 million	£8.8 million

Governance

How the Trust ensures that it makes informed decisions and properly manages its risks.

We have considered the following in our work:

- how the Trust monitors and assesses risk and how the body gains assurance over the effective operation of internal controls, including arrangements to prevent and detect fraud;
- how the Trust ensures effective processes and systems are in place to ensure budgetary control; to communicate relevant, accurate and timely management information (including non-financial information where appropriate); supports its statutory financial reporting requirements; and ensures corrective action is taken where needed, including in relation to significant partnerships;
- how the Trust ensures it makes properly informed decisions, supported by appropriate evidence and allowing for challenge and transparency; and
- how the body monitors and ensures appropriate standards, such as meeting legislative/regulatory requirements and standards in terms of management or Board members' behaviour

Summary of arrangements

We have **not identified a significant weakness** in the Trust's arrangements in relation to governance.

Risk Management Process

The Trust has defined processes in place to monitor and assess risk, with key documents including the Board Assurance Framework (BAF) to manage strategic risks and the Trust Risk Register, which contains key operational risks. The Trust utilise a 5/5 scoring matrix to score operational risks, with key risks including areas such as staffing levels in certain areas of the Trust and physical health care provisions in inpatient services. Risks scoring 15+ are reported to relevant Committee's, alongside the Board Assurance Framework strategic risks that are owned by that Committee. The Committees also receive wider risk reporting, such as new risks and changes in risks, to support the discussions over the areas within their remit. This ensures the relevant risks are considered alongside the Board Assurance Framework.

Governance framework

The Trust has a clear governance framework, and since the approval of the federated model with Dorset County Hospital NHS Foundation Trust and appointment of joint Executive roles, has worked to align this framework. During the current year, this included establishing three 'Committees in Common' between the two Trusts; People and Culture Committee in Common, Finance and Performance Committee in Common and the Strategy, Transformation and Partnerships Committee in Common. The Trust are also working to revise the Risk Appetite statements and Risk Strategy in 2025/26 to align the documents between the two organisations.

CQC Inspection

The latest CQC inspection for the Trust was carried out in June 2023, resulting in a "Requires Improvement" rating in relation to maternity services and a Section 29(a) notice under the Health and Social Care Act 2006. During the year, the Trust has continued to address the concerns raised by the CQC, including providing regular updates to each meeting of the Quality Committee. The Trust addressed all elements of the action plan and are awaiting reinspection from the CQC to confirm they are closed.

	2025	2024
Control deficiencies reported in the Annual Governance Statement	None	None
Head of Internal Audit Opinion	Moderate assurance that there is a sound system of internal control.	Moderate assurance that there is a sound system of internal control.
Oversight Framework segmentation	3 – Mandated Support required to address specific issues.	3 – Mandated Support required to address specific issues.
Care Quality Commission rating	Good – November 2018	Good – November 2018

Improving economy, efficiency and effectiveness

How the Trust uses information about its costs and performance to improve the way it manages and delivers its services

We have considered the following in our work:

- how financial and performance information has been used to assess performance to identify areas for improvement;
- how the Trust ensures effective processes and systems are in place in order to develop their cost saving efficiency saving program;
- how the Trust evaluates the services it provides to assess performance and identify areas for improvement;
- how the Trust ensures it delivers its role within significant partnerships and engages with stakeholders it has identified, in order to assess whether it is meeting its objectives; and
- where the Trust commissions or procures services, how it assesses whether it is realising the expected benefits.

Summary of arrangements

We have **not identified a significant weakness** in the Trust's arrangements in relation to improving economy, efficiency and effectiveness.

Partnership Working

As a member of 'Our Dorset', members of the Board and leadership team are integrated within the governance of the system. This includes Chief Financial Officer and Chief Operating Officer involvement in system decisions through the Operations and Finance Reference Group and Chief Executive Involvement in the System Leadership Team. This ensures the Trust is integrated into key system decisions and relevant Executives feed back to the Trust via Board, Committee and operational/clinical meetings.

System working is embedded as business as usual to enact the appropriate actions and change. This is underpinned by the Dorset Health System Collaborative Agreement, which in its agreement principles states that all providers agree to work within the aggregate of organisational control totals.

Overall, the ICS reported a 2024/25 performance of a £12 million deficit. All providers in the ICS broke even (or better), with the deficit being attributable to the ICB. However, given the underlying deficit of £172.2 million, there is pressure across the system for all parties to contribute to improve the position. The Trust take an active role in both 'Our Dorset Provider Collaborative' meetings and 'System Recovery Group', where parties discuss system performance, and progress against actions to recover the financial position.

We note that alongside financial planning, the Trust also has a number of roles in system wide working for clinical projects including Rheumatology and Urology.

Given the scale of the underlying deficit within the ICS, effective partnership working remains a key priority for the Trust and ICS partner organisations to deliver system wide efficiency and transformation. The Trust should continue to engage in the system working groups and collaborations to progress the system wide plans.

Monitoring of Performance of Services

The Trust has a performance management framework in place to set the structure of performance management. This details the format of reporting, outlining roles and responsibilities for each level. The main element of performance reporting is the integrated performance report which provides the Finance and Performance Committee, and subsequently the Board, with key operational performance indicators on a monthly basis. This report highlights performance in different domains in line with the Trust's strategy and highlights key areas for improvement within each domain.

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