Dorset County Hospital
NHS Foundation Trust

Minutes of a meeting of the Council of Governors
of Dorset County Hospital (DCH) NHS Foundation Trust
held on the 17 November 2025 at 2.00 pm – 4.30 pm
in Trust HQ Board Room and via MS Teams

Present:		
David Clayton-Smith	DCS	Joint Trust Chair
Becky Aldridge	BA	Appointed Governor- Dorset Mental Health Forum
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
Jan Wagnar	JW	Staff Governor
Lynn Taylor	LT	Public Governor
Midhun Paul	MP	Staff Governor
Max Deighton	MD	Staff Governor
Laura Kerr	LK	Appointed Governor- People First
In Attendance:		
Sarah Anton	SA	Joint Governor and Membership Manager (minutes)
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
Eiri Jones	EJ	Joint Non-Executive Director
Nicola Plumb	NP	Joint Chief People Officer
Frances West	FW	Joint Non-executive Director
Adam Savin	AS	Director of Operational Planning and Performance
Glenn Ford	GF	Trust Member (observing)
Rachel Wharton	RW	Chief Medical Officer
David Underwood	DU	Joint Non-Executive Director
Apologies:		
Anita Thomas	AT	Chief Operating Officer
Paul Kent	PK	Appointed Governor (Friends of DCH)

CoG25/034	**Formalities**	**Action**
	The Chair declared the meeting open and quorate. DCS welcomed BA to her first DCH Council of Governor (CoG) as Appointed Governor to represent the Dorset MH Forum	
CoG25/035	**Conflicts of Interest**	
	There were no conflicts of interest declared in the business to be transacted on the agenda.	

CoG25/036	**Minutes of the Meeting held on the 18.08.2025**	
	KH flagged there were errors in the minutes. DU flagged that the minutes of the 18.08.2025 did not capture his attendance.	
	Resolved: that the minutes of the meeting held on the 18.08.2025 be approved.	
CoG25/037	**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.	
CoG25/038	**Chairs Update**	
	In addition to the previously circulated report DCS highlighted the following- • Both AMMs were successful despite their different formats; DCS expressed his appreciation for everyone's support. • Introductory meeting held with Tim Harry, the new Chair of Dorset Mental Health Forum. • Significant recruitment of consultants into DCH reported as very positive. • Ministerial visit from Karen Smith (Health and Social Care Minister) and local MP Lloyd Hatton; discussions covered the new hospital building and DHC's Foundation Trust status. • Regular visits continued across both trusts, including the new Allenhurst Road development, which is progressing well. • Governor induction at Dorset HealthCare took place, including explanation of federation arrangements to new governors. • DCS highlighted some joint working activities such as the Executive team appraisal summary submitted to NHS England; non-executive appraisals completed; overall rating "good" with some known gaps. • Ongoing system-level meetings with Sue Doheny, Interim Southwest Regional Director, and participation in bimonthly chairs' meetings across University Hospitals Dorset (UHD) and the Integrated Care Board (ICB). Noted the ICB is facing substantial organisational and financial challenges, including unfunded requirements for 50% reductions. • Continued involvement in informal national group of Chairs from joint trusts as an opportunity to share best practice and developments. • Creative Health strategy progressing, with multi-partner involvement; recognised for its therapeutic value in neighbourhood health and within the hospital. • Updated on building works: visible structural progress, including second-floor development for A&E and ICU; expected pre-Christmas installation of the helipad; some delays but within manageable programme tolerance.	

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AC expressed interest in visiting the site; arrangements may be made depending on construction schedules. DCS assured the CoG that the programme is progressing largely as planned.

RW added that the MPs visit was a valuable opportunity to discuss DCH's role as a District General Hospital, especially its importance to Weymouth and Portland, which interested Lloyd Hatton. The visit allowed the team to ensure their perspectives were heard, and for RW was a first and very useful experience.

MB added that the building site remained strictly off-limits for safety reasons, even for the minister, due to active construction work such as concrete pouring. The group instead viewed progress from a safe platform and captured photographs.

DCS updated that the trust received confirmation of its first anniversary as a Veteran Aware Trust, recognising the organisation's strong commitment to supporting the armed forces community, with thanks expressed to everyone involved in achieving and maintaining this standard.

FW commented as the NED to represent the Veterans and praised the thorough, well-coordinated work behind the Veterans Aware accreditation, noting that the work reflected far more than simply meeting basic requirements, it highlighted the significant effort to integrate services and felt the recognition was highly deserved.

DCS introduced the concept of an Advanced Foundation Trust (AFT) and explained that the government's 10-year plan aims to shift accountability and decision-making closer to local populations, reducing central control and empowering communities. An AFT model will allow selected foundation trusts greater independence over how money is spent and how services are shaped to meet local needs. DHC was named as one of eight trusts nationally, invited to begin the AFT process. The implications for system partners such as UHD and DCH are not yet fully clear. Achieving AFT status would enable eligibility to hold an Integrated Healthcare Organisation (IHO) contract, aligning with the wider Dorset strategy. DCS addressed concerns about references that Governors will no longer be required as part of the new AFTs and stated that as legislation is not yet drafted, further discussion will follow.

MB emphasised that DHC reaching the starting point for AFT consideration was only possible because of the strong partnership between DHC and DCH, noting that neither organisation would have been eligible alone. The focus must remain on how the model supports population health while balancing this work with other priorities. MB also highlighted the significant value of the CoG within the foundation trust model and, although future legislation is outside local control, he stressed the importance of ensuring that patient and community voices remained central.

KH reflected that when Foundation Trusts (FTs) were first introduced, they were intended to give organisations greater independence and control, however this never fully materialised in practice. KH questioned

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how the new AFT model will differ and what will make it more effective this time. DCS explained that early FTs did initially gain greater financial freedom, particularly over their balance sheets, but this autonomy was quickly rolled back. The new AFT model is an attempt to restore some of that delegated authority, though this time it will be governed by strict criteria to ensure it is applied responsibly.

KH noted that if the current CoG structure changes, meaningful public engagement must still be maintained and emphasised that true engagement cannot be achieved through digital tools alone, as valuable insights come from governors' outreach work in local communities, including speaking with people who are not currently patients or visitors. KH welcomed the commitment expressed by MB in exploring future models that continued strong public and governor involvement, even if the formal CoG structure is altered.

DCS added that as we move toward neighbourhood care and closer partnership working with the voluntary sector, it's important to strengthen our connections—not just with Trust members but more broadly. The CoG plays a valuable role in supporting these links. We may need to consider an advisory group or another collaborative approach to ensure this partnership working is effective.

BA added that she understood message of the 10- year health plan was to focus on strengthening engagement and bringing lived experience into core decision-making at the highest levels of the organisation. The opportunities to develop engagement infrastructure beyond the existing CoG were seen as exciting, offering the potential for far more meaningful involvement.

KH shared an email from the National Lead Governors Association and will be attending an online meeting for lead governors and invited colleagues to share anything they wanted raised at the upcoming discussion.

LT questioned why Governors might be removed when their roles are unpaid and cost the system nothing aside from basic administration and highlighted that Governors handle important responsibilities—such as overseeing NED recruitment and salaries—which would otherwise require paid staff.

JC noted that Healthwatch is also being disbanded—despite its key role in representing patient voices and gathering valuable community feedback. JC was concerned that both governors and Healthwatch, two well-established channels for patient input, are being removed at a time when the government is emphasising the importance of patient experience.

JPL identified several transition risks linked to the 10-year plan's move to digital patient feedback. They noted that establishing effective digital feedback loops will take time, creating delays. JPL also highlighted financial-oversight risks for organisations in deficit, as well as the risk of reduced motivation and participation within the CoGs if members potentially affecting quoracy and decision-making.

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	DCS suggested that while national changes are still unfolding, it may be necessary for the local system to create its own ways of maintaining strong connections with patients and communities, including functions previously supported by Healthwatch. He noted that shared best practice will emerge, and local solutions can fill any gaps. DD explained that Healthwatch's statutory role will transfer to the Integrated Care Board (ICB), so it will not disappear entirely. DD emphasised that providers must ensure patient and community input is embedded in every stage of service design, planning, and delivery, and noted that patient experience will play an increasingly important role in how providers are evaluated, suggesting there is important nuance in understanding the changes. DCS noted that the executive team has significant work ahead to plan and prepare for the upcoming changes, ensuring the right processes and structures are put in place, and stressed the need for close collaboration over the coming period to make the new arrangements effective. LK raised concern that relying mainly on digital methods for patient feedback risked excluding whole groups, such as people with learning disabilities, older people, and those who are homeless, who are often digitally excluded. LK stressed the importance of ensuring these voices are not lost and emphasised the vital role of Governors and representatives in continuing to advocate for these groups during the transition. MB apologised for the way the national announcement was handled, acknowledging that it felt discouraging given the time and commitment Governors volunteer. MB expressed gratitude for governors' continued dedication and emphasised the importance of the voices they represent. MB clarified that any changes cannot happen without a change in legislation, which is unlikely to progress in the immediate months. MB suggested sessions in the new year to work with Governors on shaping future arrangements together, potentially drawing on co-production expertise from local partners such as Dorset NH Forum. KH commented that DHC being part of the first wave gives us a real opportunity to shape what the future should look like. Since nothing is defined yet, we can lead the way, design the model we believe works best, and create a blueprint that others can follow. This puts us at the forefront of making it happen.	
	Resolved: that the Chairs Update be received for information.	
CoG25/039	**Trust Executive Update**	
	Matthew Bryant, Chief Executive Officer, highlighted the following- • The DCH remained very busy, with high activity levels affecting patient experience and contributing to staff pressures; governors on walkarounds may have observed this.	

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	- Continued work with Dorset Council on improving timely discharge as part of the Future Care project. - Resident Doctor strikes are ongoing; plans are in place to maintain activity and deliver services safely, and these are working effectively so far. - Concerns about the forthcoming flu season and encouragement for all eligible individuals to get vaccinated and to promote uptake. Staff vaccination uptake is progressing well. - DCH and broader Dorset system continue to face significant financial pressures, with concerns about the outlook for next year. - Partnership with University Hospitals Dorset (UHD) continues; the estates and facilities shared service will not proceed, but development of a shared procurement function is progressing. Clinical collaboration with UHD remains important. - The ICB cluster now covers Dorset, Somerset and Wiltshire, with full transition to the new Integrated Care Partnership expected by April 2026. The NHS Southwest regional team will take on more regulatory responsibilities. - Rob Whiteman has been appointed as Chair of the cluster; recognition given to Patricia Miller for her contribution. Jonathan Higman appointed Cluster Chief Executive, with wider structural appointments underway. NHS England has announced voluntary redundancy arrangements for ICB staff. - Committees continue to meet as Committees in Common, except for the two organisation-specific Audit Committees. Board in Common arrangements began in October and the first meeting was positive. - CQC maternity review showed improvement from ‘Requires Improvement’ to ‘Good’ for safety and leadership, reflecting significant work by the maternity team. - The hospital continues to maintain an active research programme, including securing significant funding for a new specialist retinal scanner, improving both research capacity and ophthalmology services. Dawn Dawson, Chief Nursing Officer updated the following- - Bloodstream infections had remained a key area of focus, with all cases reviewed through the Patient Safety Incident Response Framework (PSIRF) process to maximise learning. - Face-to-face training had been increased for all colleagues, and several quality improvement (QI) programmes were underway. - Staff flu vaccination uptake had been progressing well; although the slide showed 47%, the most recent figure was 52.1%, placing the organisation among the top performers. - Flu had begun circulating earlier than usual, making vaccination particularly important for staff, patients and the wider community. - The organisation had been awarded pilot status for Martha’s Rule, providing a “call for concern” line for patients or relatives. The pilot had begun in the Emergency Department in October.	

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- Maternity services had achieved an overall rating of Good, which had also raised the Trust's overall rating to Good.
- CQC staff feedback had highlighted that maternity staff were kind, caring and compassionate, and well-led by a senior team that embodied the organisation's cultures and values.
- CQC patient feedback had indicated that people felt safe, were able to raise concerns and were well cared for by compassionate staff throughout their stay.
- DD concluded by emphasising the importance of these staff and patient experience findings.

Rachel Wharton, Chief Medical Officer updated the following-

- Before moving into the update on industrial action, it was noted that the organisation was halfway through the 13th round of action.
- Alongside this, staff were updated on the government's 10-point plan aimed at addressing issues affecting resident doctors, including wellbeing, payroll discrepancies and more structured regional rotations.
- The organisation had been working through this plan successfully, with board support and input from a senior resident peer representative who worked closely with the presenter and reported into the Board.
- It was highlighted that DCH was doing everything possible to support resident doctors, in line with its commitment to support all staff.
- The paediatric ophthalmology service had recently been reinstated after several months' suspension due to a vacancy.
- This reinstatement meant that children in the West of the county could once again access eye care closer to home.
- The model of a visiting consultant supported by DCH teams was seen as an important template for future joint working with UHD to maintain services that might otherwise be difficult to sustain locally.
- he SHMI (standardised hospital mortality indicator) had been reported as sitting at 1.0 and was expected to drop just below 1.
- This meant that the number of deaths occurring within 30 days of admission, or while in the trust, was exactly as expected, which was regarded as reassuring.
- Appreciation was expressed to all staff across the trust for their contribution to this outcome.
- Specific recognition was given to the coding team for their work in helping the organisation understand the patient population accurately.
- RW concluded by confirming they were happy to take questions.

KH asked how many Resident Doctors took part in the recent industrial strike action. RW answered that it was 40% of doctors which is a reduction from last time.

SB referred to a BBC news report that references the rise of *C. auris* in some hospitals and asked if this is something we should be concerned

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	with? DD confirmed that she will investigate the report and get back to SB. Adam Savin, Director of Operational Planning and Performance reported that- • Urgent and emergency care saw sharp demand increases, with nearly 1,900 more A&E attendances than planned between April–September 2025, many from walk-ins as the ambulance service was overwhelmed. • These attendances drove 551 extra admissions, adding pressure and reducing September ED performance, though early October data shows recovery of the four-hour standard. • October attendances were even higher (≈600 above plan), meaning cumulative additional attendances will exceed 2,000. • Hospital flow improved: numbers not meeting criteria to reside stayed stable, but proportion fell, and September 2025 recorded the lowest "no reason to reside" figures in two years. • Bed use remained efficient and below planned numbers, but occupancy stayed high due to demand. • Elective care performed strongly in September, with improving indicators. Referrals rose 4% as planned, and the waiting list is now on or slightly ahead of plan. • Long-wait targets were met, including 52-week waits, except for 24 children and young people—still greatly reduced from nearly 60 earlier in the year. • Cancer pathways faced pressures, especially the 28-day diagnosis standard, but October performance showed recovery across the 62-day, 31-day and 28-day standards. • Breast pathway issues affecting 28-day performance have been fully resolved. The Trust remains among the strongest performers in Wessex. • Diagnostics waiting lists grew during the year, partly due to higher inpatient activity. A recovery plan with NHSE and mutual aid from UHD is underway; October performance improved to 70%. • The Trust will not meet this year's diagnostic standard, but the year-end trajectory of 76% has been agreed. Work is underway to ensure sustainable future improvement. • Planning for next year continues, with services preparing integrated activity, workforce and finance business plans for ICB submission. BA asked whether the increase in A&E presentations included a rise in mental health (MH) -related attendances, and if any percentage breakdown by age or mental health category was available. AS explained that MH presentations generally experienced longer delays in A&E. AS could not confirm today the exact percentages and whether the proportion of MH attendances had increased and agreed to take this away as an action. AS clarified that the main rise in attendances had come from physical-health walk-ins but acknowledged that MH patients often waited longer. These waits were monitored separately and reported to committees, and further information could be provided.	**DD** **AS**

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LK asked whether there was any understanding of the causes behind the spikes in A&E attendances, and whether any data showed a relationship between those spikes and GP service activity, and queried whether increases in A&E attendances coincided with decreases in GP appointments, or whether both rose together as part of a general increase in demand for healthcare services.

AS explained that extensive analysis of emergency demand had been undertaken, including patients registered GP practices, demographics and acuity, and all indicators pointed to a broad-based uplift across all categories rather than growth concentrated in any specific area. There had been no notable increase from out-of-county attendances, nor a demographic shift. NHS England and the ICB had agreed with the Trust that population growth was the most likely driver.

Nicola Plumb, Joint Executive Director of People & Culture updated-

- Sickness absence had been creeping up and was approaching levels seen in neighbouring trusts, such as UHD at around 4.7%.
- Short-term sickness linked to increased emergency demand and concerns about flu had contributed to the rise.
- Overall staff availability had reduced year on year, in line with reductions in whole-time equivalent staffing, meaning fewer staff were managing increased demand.
- Temporary staffing usage had risen in the same period, and work was underway to reduce this for the remainder of the year.
- Workforce and operational teams had been working together on medium- and longer-term workforce changes to ensure sustainable staffing.
- Turnover had continued to fall while the vacancy rate had risen, suggesting people were staying, and reflecting fewer posts being offered across providers due to financial pressures and operational planning requirements.
- Appraisal and mandatory training rates were being monitored, and the staff survey response rate stood at 36 percent with a push underway to increase it, including divisional reviews at the senior leadership team meeting.
- Team members had been supporting services with low survey response rates to encourage participation.
- Staff flu vaccination uptake had reached 52 percent, which was particularly important given the rise in sickness absence.
- The Inspire Awards had opened, with 24 nominations submitted so far, forming a new quarterly recognition approach preferred by staff over an annual ceremony.
- The second meeting of the joint Cultural Inclusion Group had taken place, bringing together diverse colleagues to strengthen the staff voice and support collaborative work across communities and staff networks.
- Work was underway to progress the ambition of becoming a truly anti-racist organisation in partnership with Dorset Healthcare.

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- These cultural and inclusion initiatives were described as essential to supporting staff wellbeing and experience, alongside the operational and performance pressures the organisation faced.

KH asked what has been done to repair staff morale and rebuild trust following the decision not to proceed with the SubCo proposal. How has the Trust addressed the ongoing impact and restored relationships?

NP answered rebuilding trust was essential and confirmed that the grievance process with Unison had been completed after a period when industrial action was considered. Senior leaders had held positive discussions with Unison to clarify expectations and strengthen relationships, and this work was being extended to other staff-side groups. Engagement with affected staff was continuing.

CH added although the shared services proposal had ended, work had continued to find better long-term arrangements. Procurement had moved to a hosted-service model supported by unions, with UHD chosen as the host because most spending and staff were already based there. For estates and facilities, it was acknowledged that keeping three separate functions was not sustainable, so colleagues were still exploring a more effective, system-wide approach for the future.

MD asked what assurance Non-Executive Directors (NEDs) receive about the governance and operations of services like One Dorset Pathology given concerns about structural changes made without consultation and that the Southern Counties Pathology business case is being reviewed by an executive-only board. Are there plans to ensure robust assurance when the Southern Counties Pathology proposal is delivered.

RW explained that if the Southern Counties Pathology network proceeds, its final leadership structure would include equal representation from all seven partner organisations, with DCH guaranteed one-seventh of the board.

MB added that if any staff governors wanted a further discussion, a separate meeting could be arranged with the relevant directors. MB also confirmed that NEDs were being kept fully involved and had clear visibility of the pathology work, and that the Southern Counties Pathology business case was expected to come to the Board in December 2026.

DU confirmed as a NED they had been fully briefed on the Southern Counties Pathology case during the previous week and continued to be involved in further discussions, which may go to the Board in December 2025 or possibly early in the new year. DU reiterated that NEDs had been fully informed and had a good understanding of the key issues.

Chris Hearn, Joint Director of Finance highlighted –

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	• Month 6 financial headlines showed continued pressure across the trust, reflected in the financial position. • The trust had a planned deficit of £9.8m for the year, with an 8.7% cost improvement requirement (£29.1m). • Most efficiencies were back-loaded into the second half of the year as plans were not fully developed at year-end. • At month 6, performance was broadly on plan, though the in-year deficit stood at £16.9m, leaving a significant recovery requirement for the remainder of the year. • Operational pressures were high, and the trust continued balancing safe services with productivity and value for money. • Agency expenditure was £0.5m below plan, reflecting strong controls; bank spend was £2.2m above plan, driven by gaps and sickness across clinical and corporate areas. • Additional costs were incurred due to the Yeovil maternity closure (£355k), expected to be offset by income from Somerset. • Industrial action had financial implications with no national funding to cover costs. • Efficiency delivery to date was £5.6m, in line with plan, though most savings remained in the second half of the year. • The halting of the subsidiary company created a gap in planned efficiency savings; discussions with NHS England were ongoing regarding mitigations. • Capital schemes were progressing, including the new hospital programme, the new chemotherapy unit, and investments in backlog maintenance and digital infrastructure. • Cash remained a key financial risk, with a month-6 balance of £17m and significant savings still required; a system-wide cash mitigation approach was being developed. • Medium-term planning was underway, with requirements to submit a three-year revenue plan and five-year capital plan by year-end. • The Dorset system faced an underlying deficit exceeding £100m, contributing to a highly challenging outlook for next year. • National financial pressures were recognised as part of the broader context affecting all NHS organisations.	
	Resolved: The Trust Executive Update be received for assurance.	
CoG25/040	**NED Update, Feedback and Accountability Session including update from the committee chairs**	
	Eiri Jones, Non-Executive Director (NED) stated it had been a privilege to serve as NED and Deputy Chair, including on joint work with Dorset Healthcare. EJ explained that she had stepped in to chair the Joint Quality Committee during CL's absence and continued as a member of People and Culture Committees in Common. EJ had chaired a stage of the recent grievance process, which had been conducted respectfully and, in her view, helped support to rebuild trust. She and another NED had been involved in pathology discussions and were available for further conversations with Governors. EJ had undertaken consultant interviews and valued seeing strong interest in joining DCH. As maternity board safety champion, EJ had continued regular visits to	

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	maternity and neonatal areas, noting strong teamwork, leadership and positive feedback from staff and service users. Joint work with Dorset Healthcare had continued, including a focus on improving pathways for elderly patients, supported by walkabouts and service visits. She had also carried out unannounced "secret shopper" visits and praised the quality of care. EJ reported she participated fully in committee and board activity, observing UHD's board for shared learning, and attended national events that provided useful insights, including discussions with senior NHS leaders. She had contributed to Quality Impact Assessment (QIA) meetings where capacity allowed and maintained regular contact with executives to stay informed and provide support during what she described as the most challenging period she had seen in her long career. EJ thanked board colleagues and Governors for their support and invited questions. **Governor observations reports of the Board Committees** Carol Manton, Public Governor noted that the Quality Committee in Common had been embedding over several months. Claire Lehman chaired the meetings. A review had been carried out to consider changes in format and alignment between DCH and DHC which included the introduction of an informal session alongside the formal meeting. This had allowed more detailed discussion and made the formal agenda more manageable. The September 2025 papers had exceeded 300 pages, and it was acknowledged that NED members continued to manage this significant workload. CM described the debates within the committee as high quality, with strong and frequent challenge, and thanked the Chair and NEDs for their work. Alan Clark, Public Governor reflected that he had been impressed by the volume of work handled by the People and Culture Committees in Common and noted it operated very effectively. Strong and constructive questioning was noted from EJ and Margaret Blankson. AC praised Frances West for keeping the committee to time while still allowing full discussion, ensuring nothing felt rushed. AC confirmed that it had been a pleasure to observe the committee in action. Jean-Pierre Lambert, Public Governor stated that the Finance Committees in Common continued to progress well and that the combined DCH–DHC discussions were stimulating, with strong contributions from new members and effective leadership from DU. JPL noted that financial challenges were significant, particularly in the third and fourth quarters, partly due to the decision not to proceed with the SubCo. JPL explained that NEDs had been more involved than usual in operational matters because of current pressures and that new performance reporting formats were being introduced, allowing future comparison across both trusts. JPL concluded that a substantial amount of work had been achieved and that the finance team faced considerable demands, including medium- and long-term forecasting and ongoing recovery planning. Kathryn Harrison, Public Governor explained that she had only been able to attend the second half of the Strategy and Transformation & Partnership (STP) Committee due to timing changes and invited other	

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	Governors to step into observe. KH said the part she observed appeared well run but felt the committee covered an extremely wide range of topics, which raised questions about whether each item could receive sufficient consideration. KH reflected that some matters discussed also appeared in other meetings, prompting concerns about duplication. KH questioned whether the committee was still needed in its current form now that the organisational strategy had been developed and implemented. They suggested that much of the remaining work might be more appropriately treated as business as usual rather than handled separately as strategy. KH remarked on the volume of papers, noting that this had long been a concern and querying whether such lengthy documentation was necessary. BA added that in her view, the STP Committee in Common had an important role because it focused not only on the strategy but also on the transformational work required to deliver new ways of working across the partnership. KH raised the previous discussion about the NEDs presenting the committee assurance reports in this section of the meeting rather than the reports being included in the information pack. DCS confirmed that the reports had already been presented at Board, and this would be a duplication. MP reported that the extraordinary Audit committee in June had been held to sign off the accounts, this was run smoothly and that he had noted no issues. MP commented again on the daunting volume of papers for this type of committee, which made it difficult to read everything in detail. They added that they were experimenting with artificial intelligence (AI) tools to help summarise large documents and intended to test some of these committee papers as examples, noting that another NED colleague was already using similar tools.	
	Resolved: That the NED Update, Feedback and Accountability Session including update from the committee chairs be received for Assurance	
CoG25/041	**Report from the Membership Development Committee**	
	KH reported that the last meeting on 4 September 2025 had focused mainly on planning for the Annual Members' Meeting (AMM), which had since taken place and now felt some time ago. The committee had worked through its usual items, including engagement events, the activity tracker and the demographics report, which rarely changed. A smaller follow-up discussion had been held to revise the membership leaflet, and Governors had been invited to contribute to the leaflet. A draft had been expected but was not yet ready, with the DCH Comms team due to bring it to the membership committee on 2 December. JPL noted that the next community engagement event had been arranged for the following day with the blind and partially sighted community and explained that the Patient Experience team had supported in supplying the leaflets in large print. AC added that the public engagement is a pleasure to take part in.	

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	DCS commended JPL for his comprehensive reports of the feedback that is captured from the public engagement activities. KH concluded it was important not to lose the type of community engagement work the committee was doing when considering any future changes to the Council of Governors or its structures. They stressed that such engagement brought in perspectives that could not be gained solely through hospital-based activity or digital methods, and that relying only on those approaches would exclude valuable insight from parts of the community.	
CoG25/042	**Resolved: that the Report from the Membership Development Committee received for information.**	
CoG25/043	**Governor Matters**	
	Judy Crabb – what impact will be shutting 30 beds have on patients? AS responded that the Future Care programme was designed to reduce occupied bed use by cutting admissions and shortening length of stay, with 15 beds closed temporarily for the stroke ward reconfiguration. Partners have agreed these will be the only closures this year, and decisions about closures next year will depend on demand modelling and completion of the stroke work. MP asked if 15 beds close does this increase waiting times or cause cancellations? AS responded the beds closed during the stroke ward building work, which led to an increase in bed occupancy from 95% to 97% in this year's operating plan. Despite running at this higher occupancy, emergency department wait times have improved compared with last year, and there has been no negative impact on performance. Lynn Taylor asked should there be an app to help people find their way around the hospital site? Due to CH no longer present at the meeting DD responded that there was work happening nationally on this and we will get back to Lynn with a full response. Jean-Pierre Lambert- 1. Management of Long stay Alzheimer Patients 2. Proportion of current NRTR that are Alzheimer patients. 3. What is the annual cost attributed for this including security guards? 4. Alzheimer's patients into community-based settings? (Anita has asked where these figures are from and happy to meet with Jean-Pierre outside the meeting) Jo Howarth is coming back to JPL on his questions. Anne Link – asked if there can be a letter of thanks from the Council of Governors to Hannah Robinson Simon Bishop- Are meals in the canteen subsidised? RW answered that yes, the meals are subsidised for staff but is unsure of the exact reduction amount.	**SA** **JHo** **KH**

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	Resolved: that Governor Matters be received for Information.	
CoG25/044	**Joint Code of Conduct for Governors**	
	JH explained that the Joint Code of Conduct is being presented for approval today and builds on earlier work carried out during the Constitution review. The team compared the Dorset HealthCare Code of Conduct with the Dorset County Governors' Code and aligned them into a single, clearer, more detailed, and strengthened joint version. This updated Code is now ready for approval here and will also be taken to the Dorset HealthCare meeting later this week for approval. JH invited any comments or questions. JPL raised the point in paragraph 19 about periods of absence and availability of Governors and asked who monitored this. JH confirmed that the Corporate Team monitor this in an attendance log, and we will append it to future CoG information packs. Due to the new Code of Conduct this attendance will be monitored closely and will be more firmly followed up. SB raised two points that the new Code of Conduct did not mention the press and that the process for Governors to resign is not through the Director of Corporate affairs rather than the Trust Chair. JH raised that there is also now a SOP for removal of a Governor which outlines where conversation would happen and with who, this will be shared with SB. BA confirmed that the press is covered in paragraph 37. BA raised that the policies that are mentioned in the new Code of Conduct are very important, JH confirmed that the links to the relevant policies will be embedded into the document.	SA SA SA
	Resolved: Joint Code of conduct for Governors is approved.	
CoG25/045	**Terms of Reference (ToR) for Nominations and Remuneration Committee (NRC)** **Terms of Reference (ToR) for Membership Committee**	
	JH introduced the item and explained that new ToR would usually be taken through the relevant committees first, however the NRC ToR has not been taken to NRC first due to the irregular meeting of the committee and has therefore been bought straight to CoG today. KH raised the proposal that in these new ToR there are only two public governors required to be members, and she felt this was not enough and there should be four Public Governor as this increased the likely hood of having at least some members available for the meetings.	

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	JPL added that more voices to add to the NRC discussions are useful and if short notice is given for NRC members to take part in NED interview, wider membership is helpful. JH confirmed that quoracy for the NRC is three members. JH confirmed that she is content to add two more Governor to the membership taking the total number of members to six. JH moved on to present the ToR for the Membership Committee and explained that the team have aligned and streamlined the ToR. KH confirmed that all Governors are members of the Membership Committee, this was amended due to align with what DHC currently do at Membership Committee.	
	Resolved: Terms of Reference for Nominations and Committee be approved. **That the Terms of Reference for Membership Committee be approved.**	
CoG25/046	**Any other Business**	
	AC raised that recently that when he has visited ED there are patients on trolleys in the corridor and asked how often this is happening. RW confirmed that this is recorded as data that is reported regionally and nationally. This does not go unnoticed, and we strive to avoid this wherever possible.	
CoG25/047	**Date and Time of Next Meeting** The next meeting of the Dorset County Hospital NHS Foundation Trust Council of Governors will take place on 9 March 2026.	

Signed by Chair …………………………………….. Date …………………………………..

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