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**	
	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 ……..