NHS Equality Delivery System 2

EDS2 Report and Action Plan 2025

Dorset County Hospital

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Introduction to the Equality Delivery System for the NHS

The EDS Reporting Template

Implementation of the Equality Delivery System (EDS) is a requirement on both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS in accordance EDS guidance documents. The documents can be found at: www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/eds/

The EDS is an improvement tool for patients, staff and leaders of the NHS. It supports NHS organisations in England - in active conversations with patients, public, staff, staff networks, community groups and trade unions - to review and develop their approach in addressing health inequalities through three domains: Services, Workforce and Leadership. It is driven by data, evidence, engagement and insight.

The EDS Report is a template which is designed to give an overview of the organisation's most recent EDS implementation and grade. Once completed, the report should be submitted via england.eandhi@nhs.net and published on the organisation's website.

NHS Equality Delivery System (EDS)

Name of Organisation		**Dorset County Hospital**		**Organisation Board Sponsor/Lead**	
				Rachel Wharton, Chief Medical Officer; Nicola Plumb, Joint Chief People Officer	
Name of Integrated Care System		NHS Dorset			

EDS Lead	Jo Howarth Director of Nursing Emma Hoyle Deputy Director of Nursing (Domain 1) Emma Hallett, Deputy Chief People Officer Jan Wagner Equity, Diversity, Inclusion & Belonging Lead (Domain 2 and 3)		**At what level has this been completed?**	
				***List organisations**
EDS engagement date(s)	July – Dec 2025		**Individual organisation**	Dorset County Hospital
			Partnership* (two or more organisations)	Not for this reporting cycle
			Integrated Care System-wide*	Not for this reporting cycle

Date completed	January 2026	**Month and year published**	January 2026 TBC

Date authorised	People and Culture Committee in Common – January 2026	**Revision date**	NA

Completed actions from previous year	
Action/activity	**Related equality objectives**
Continued progress with engagement with forums and carers to patients with a Learning Disability via the Patient and Public Engagement and Learning Disabilities Team. Liaison with the Weymouth and Portland PCN LD Lead on response to those with lower-level need/support to improve uptake of appointments	Reduce DNA/Was Not Brought rates amongst those with LD
Training and Education on Protected Characteristics and Inclusion Health Groups with targeted staff groups. Expansion of data capture and reporting of protected characteristics to inform digital/data improvements and reporting mechanisms to identify inequalities. Development of a Health Inequalities dashboard and refinement and use of digital flags.	Improve Ethnicity and Protected Characteristic recording
Engagement with Inclusion Health Groups (LD, Prison Health, Migrants) to triangulate data analysis with lived experience and to determine further opportunities to deliver services differently. Establishment of the Ocean Team in Maternity (Continuity of Carer), implementation of community-based clinics for Paediatric Dietetics aligned to populations of greatest need; analysis of AHP led clinics and community engagement with the 'Shaping the future of Physiotherapy Services' strategy via the Your Voice group	Reduce DNA rates; improve wider determinants of health (Nutrition); Social Values Programme (Anchor Institution)
Full implementation of the WorkInConfidence reporting system, offering transparent anonymised statistics about cases of incivility, implementing a Sexual Misconduct Policy with a Zero-Tolerance approach, updating Bullying & Harassment Policy to a Zero-Tolerance approach.	Improve staff confidence in reporting bullying, harassment and sexual misconduct; reduce under-reporting of incidents; ensure fair, consistent and timely responses across all protected characteristic groups.
Set up Task and Finish Group to ensure incidents of harassment, bullying or abuse are reported and staff are supported	Ensure equitable access to support for staff experiencing bullying, harassment or abuse; reduce disproportionate negative experiences for protected groups;

	strengthen organisational learning from incidents.
Senior management team and Board to engage with all staff networks – sponsors understand their role and commitment and including it as essential objective.	Strengthen inclusive leadership and accountability; ensure diverse staff voices inform decision-making; improve representation, visibility and trust across staff networks.
Review and revise existing Equality Impact Assessment framework to ensure EIAs are fully embedded as a decision-making tool for processes impacting staff and patients. Full adoption of the NQB EQIA templates into Transformation and Cost Improvement Programme workbooks and establishment of an EQIA panel	Embed equality considerations into organisational decision-making; prevent unintended discriminatory impact on staff and patients; improve consistency and quality of equality risk assessment.
Design and implement mandatory EDIB questions for every interview	Promote fair and inclusive recruitment practices; reduce bias in selection processes; support a more diverse and representative workforce.

EDS Rating and Score Card

The Rating and Score Card supporting guidance document has a full explanation of the new rating procedure.

Undeveloped activity – **organisations score out of 0** for each outcome	Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**
Developing activity – **organisations score out of 1** for each outcome	Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**
Achieving activity – **organisations score out of 2** for each outcome	Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**
Excelling activity – **organisations score out of 3** for each outcome	Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

Domain 1: Commissioned or provided services

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	**Reducing DNA Rates - CORE20 & LD** DNA rates continue to fluctuate by speciality and by inclusion health group. Work is underway to deliver an expanded community offer for Physiotherapy and Dietetics Services and to explore opportunities to locate specialist equipment into community-based clinic settings where appropriate (Ophthalmology/Urology). Analysis demonstrates a higher level of DNA rates at Weymouth Community Hospital than at DCH and work is ongoing to determine if this is dependent on the type of clinic (e.g. Nurse or AHP led versus consultant clinics). Work with Primary Care and the emerging Neighbourhood Teams will be instrumental in delivering further improvements in levels of access with particular emphasis on Paediatrics and Older People. **Access barriers identified** -The biggest inequality in access at DCH is in DNA rates by deprivation, the Core20 are twice as likely to miss appointments. The majority of the Core20 live in Weymouth and Portland. Two thirds of the specialties only held clinics in Dorchester, which suggests people may assume the appointment is in Dorchester. MSK variation in waiting lists is predominantly due to poor accessibility of Charlton Down and other rural areas due to infrequent bus times. Pelvic health and Respiratory DNA rates are higher due to clinics being held at Charlton Down and the challenges of travelling a long journey from rural areas. **Actions to improve access** - Some scope to reduce inequality through expanding clinics in Weymouth and Portland for some specialties. Benefit in scheduling appointments for the Core20 in the afternoon at Weymouth and Portland clinics. Community Learning Difficulty Team (CLDT) and dieticians facilitated home visit to	Average: Achieving activity (2)	Director of Nursing

		improving access. Ensuring copies of appointment letters were available within the PCN so local follow-up could occur. Regular attendance of DCH Staff at the Weymouth and Portland Social Prescribing and Carer Co-ordinator Meetings. New services expanding local access: Paediatric dietetic clinics opened in Blandford and Sturminster Newton; Portland clinic starting Jan 2026. Increased clinic capacity in Weymouth paediatric dietetic service (two lists on Friday mornings). Adult dietetic clinics opened in Bridport and Blandford; Portland clinic planned. Pulmonary Rehabilitation improved attendance and completion rate for W&P supported by patient focus groups. Trial clinics at Bridport and Blandford where highest DNA rates occur. *Rating: achieving activity (2)* **Reducing DNA Rates - Prison Health** **Access barriers identified -** High rates of missed hospital appointments in the prison estate due to security and transport constraints. Prison residents are not informed of outpatient appointments for security reasons, which limits their ability to prepare and engage. High levels of long-term conditions, disability, and mobility issues among an older prisoner population further restrict access. Nutritional inadequacies (low fibre/protein, and insufficient provision on two days each week) impact health, wellbeing, and ability to attend. **Access disparities quantified -** 37 face-to-face outpatient appointments per month for The Verne population. • DNA rate at The Verne recorded at 7.8% with an additional 3% same-day patient cancellations. • Nationally DCH has low DNA rate for prison population attendance **Access-improving actions -** Collaboration with The Verne to improve appointment planning and align with escort availability. DCH teams have identified opportunities for virtual MDTs and virtual follow-up appointments. Currently considering co-locating ophthalmology		

		equipment within the prison. Exploration of dedicated AHP clinics (e.g., Dietetics) supported through service-level agreements. Dietetic placement established to better understand barriers and strengthen links between teams. *Rating: achieving activity (2)* **Ethnicity and Protected Characteristics Recording** Ensuring that our data is right means ensuring our systems are fit for purpose and user-friendly for those inputting data. This indicates the service is working to ensure systems are accessible and functional for use. Use of digital tools suggest improved access and usability of systems e.g. BadgerNet is the most comprehensive, and since implementation, data completeness has improved Maternity systems significantly. Evidence of work underway to improve access and standardisation of systems across services can be seen via the collaboration across Dorset and Somerset to procure a single Electronic Health Recor and will supersede current systems and standardise the way in which Ethnicity is recorded. To support accessibility for service users, especially those unwilling to give information verbally will be attended to with the roll out of guide cards to all reception desks, outpatient clinics and departments where patient information is recorded or validated. *Rating: developing activity (1.5)* **Digital Inclusion** DCH have worked closely with system colleagues on this element. Eligibility for the digital intervention was determined using clinically validated risk group criteria, aligned with the evidence base. This included consideration of ethnicity, as certain ethnic groups have a higher associated risk of hypertension. Where this increased risk applied, individuals from these groups were prioritised for the intervention. Patient identification followed these risk-based criteria. In total, 368,631 patients in Dorset were identified as eligible, (59% of the		

		adult population), and segmented into three distinct clinical risk groups. Data sharing and eligibility information were available for over 90% of the Dorset population, and patients registered across all Primary Care Networks were able to receive the offer. The intervention was therefore available across the entire Dorset population. Importantly, data on eligibility criteria could be viewed through an age, sex, and ethnicity lens, enabling proactive identification of patient groups experiencing health inequalities and ensuring targeted outreach where needed. *Rating: achieving activity 2*		
	1B: Individual patients (service users) health needs are met	**Reducing DNA rates in identified populations – CORE20 & LD** There is evidence of targeted work with individuals with varying levels of Learning Disability to drive improvements in the Did Not Attend/Was Not Brought' rates. Closer collaboration and improved data sharing with the W&P PCN LD Lead will be instrumental in ensuring an individualised approach is adopted. Further evidence is required to understand what is driving a higher DNA rate at Weymouth Community Hospital than at DCH. Analysis of clinic type, patient demographic (age, gender). **Meeting needs through targeted service design** -Identifying that most of our dietetic referrals are coming from W&P and Blandford and so opened clinics locally to better meet population needs. W&P patients have more home visit dietetic slot for those most at need. Pulmonary Rehabilitation improved attendance supported by patient focus groups and volunteers. **Addressing needs of people with Learning Disabilities (LD)** - CLDT continued to follow up DNA/WNB with marginal improvement from 9.6% to 8.9%. Reasons for DNAs listed in detail—indicating individual assessment of need (communication, organisation, health, transport, letters missing, chaotic lifestyles). Proactive follow-up has meant awareness of concern and risk; joint working allowed home visits by dieticians. Meeting with PCN LD Lead	Average: Developing activity 1.5	Director of Nursing

		and Patient Experience Team to determine ways that individuals could be better supported to respond to appointments. DCH LD Practitioner and Engagement Manager met service users to collect feedback and demonstrate appointment and surgery videos to improve understanding and confidence. **Population health and inequality-focused work** - Pan-Dorset strategy focusing on food poverty, BFI status, working with food banks, and children's hubs. Task and Finish group to address loss of gluten-free prescriptions and support those most at need. Work of Integrated Neighbourhood Teams will be instrumental for personalised holistic care. *Rating: achieving activity (2)* **Reducing DNA rates – Prison Health** Scoping of service needs undertaken and high and complex needs recognised. There is a high prevalence of cardiovascular disease, respiratory illness, infectious disease, mental health disorders, and multimorbidity. This is within a significant ageing population with long-term conditions and mobility issues. Currently there is a dedicated 24-hour care unit in place, with plans for a palliative care suite. **Service responses -** Work is underway to improve coordination of outpatient appointments. In addition, there is a proposed virtual MDTs to support management of complex co-morbidities. Current review in place to support potential expansion of specialist equipment and AHP clinics on-site to better meet needs. **Targeted insight to health service** input to The Verne including progress with work to improve coordination of outpatient appointments, proposed virtual MDTs to support management of complex co-morbidities and potential expansion of specialist equipment and AHP clinics on site to better met needs. Specific input from dietetic services include menu review identified nutritional deficits and impacts of staffing limitation and engagement with prisoners through a focus group captured service user views. In addition, good existing initiatives		

		(vitamin D supplementation, allotments) noted, with further work planned to support recommendations. *Rating: developing activity (1.5)* **Ethnicity and Protected Characteristics Recording** Better data completeness supports more accurate care planning and meeting individual needs. Use of digital tools such as Badgernet has encouraged data completeness and since implementation of this tool there has been significant improvement. A review of current PAS Patient Flags is underway to standardise and refine the current list and ensure consistency and specificity with population groups, this shows steps to ensure specific health and communication needs are identified. Protected characteristics recorded include: • Age (100%) • Disability (some recorded through risk/flags) • Pregnancy and maternity (recorded in DPR and BadgerNet) Accurate recording supports recognition of health needs for these groups. Use of reliable demographic data helps tailor services to health needs associated with ethnicity and a further upload from the DiiS is planned, which will update 24k patient records and improve overall percentage ethnicity recorded. *Rating: developing activity (1.5)* **Digital Inclusion** Required level of activity is taking place – Data on patients who agreed to take up the offer of home blood pressure monitoring was reviewed for the period October 2021 to November 2025, covering 17,166 patients in total. The offer was available and taken up across all Primary Care Networks in Dorset, ensuring system-wide reach. Analysis was conducted from a whole-population perspective and through an age, sex, and ethnicity lens. Quantitative data showed uptake across a broad age range (18 years to over 80) and a relatively equal distribution between sexes (see Figure 3). However,		

		ethnicity-specific uptake data was not available, and we recommend that this be captured in future to strengthen equality monitoring. The digital offer was implemented at scale using a risk-based model informed by whole population data. The approach applied appropriate weighting for risk factors associated with protected characteristics such as ethnicity, age and sex, and was supported by engagement with patients, community groups, and the public during the design phase. *Rating: achieving activity (2)*		
	1C: When patients (service users) use the service, they are free from harm	**Reducing DNA Rates - CORE20 & LD** There is evidence of risk identification and follow-up e.g. proactive follow up for parent and child with LD, the services worked together so that the dieticians could do home visits. Recognition required that system failures out of healthcare's control can lead to DNAs such as traffic, error in reading letter, letter lost in post. This demonstrates monitoring of contributory factors that could cause harm through missed care. Attendance made to different access opportunities for appointment information such as via NHS app and virtual appointment offer. **Risk identification and follow-up**- Child Learning Development Team follow up on DNA/WNB ensured awareness of concern and risk. Proactive follow-up for mum and son with LD—services worked together so the dieticians could do home visits (Prevents harm from missed essential care). **Mitigation actions to reduce harm** - Ensuring copies of appointment letters are available in the PCN for follow-up, appointment and surgery videos shown to improve understanding, confidence and engagement, weekly DCH Carer Café which support extended to those with LD not just attending hospital, Integrated Neighbourhood Teams (for personalised and holistic care). Monitoring inequalities that may lead to harm - Higher DNA rate for minority ethnic patients but noted	Average: Achieving activity (2)	Director of Nursing

		inequality reducing, longer RTT for mixed-race patients (21 weeks vs 17 weeks), no inequality in waits for diagnostic tests. These demonstrate active identification of harm risks and actions underway to reduce them. *Rating: achieving activity (2)* **Reducing DNA rates – Prison Health** The various risks identified for the prison health relate to delayed access to treatment and screening leading to increased clinical risk (including cancer), security and transport issues contributing to missed appointments, lack of appointment communication to residents limiting preparation and follow-up and nutritional inadequacy affecting wellbeing and recovery. There is clear evidence to mitigate and reduce harm in progress such as improved appointment coordination with prison officers, exploration of virtual appointments to bypass transport/security risks, consideration of risk-based decision-making around use of cuffs for older or mobility-restricted prisoners, menu review and planned implementation of nutritional recommendations and a proposal for onsite ophthalmology equipment to reduce the need for external transfers. *Rating: achieving activity (2)* **Ethnicity and Protected Characteristics Recording** Use of PAS flags contribute to preventing harm by alerting staff accordingly. Use of flags for disability and other risks. Some [disability information] can be recorded in risk and register tables including use of Flags. Review of PAS flags actively in place. Guide cards have been developed and tested with people with Lived Experience to reduce risk of miscommunication or distress by offering private, accessible methods to disclose information. The Accessible Information Standards Group have developed and tested this approach to ensure communication needs are met reduces risk of harm from misunderstanding. Identifying and mitigating system		

		risks contributes to safer care recognises the limitations in current systems and actions to address them (e.g., EHR collaboration). *Rating: developing activity (1.5)* **Digital Inclusion** Data for the 17,166 patients who took up the digital intervention shows a measurable reduction in clinical risk, with individuals moving from higher-risk groups to lower-risk categories. This demonstrates that by improving blood pressure management and reducing the risk of poor outcomes, the digital intervention supports patient safety and contributes to harm reduction. These outcomes can be reviewed from an age perspective, confirming effectiveness across different age groups. However, no data is currently available on outcomes by sex or ethnicity, and we recommend that this be addressed going forward to strengthen equality monitoring and ensure comprehensive assessment of impact across protected characteristics. Data was available for all patients who used the service, and evidence suggests the intervention reduces clinical risk. While this supports the principle of being free from harm, further work is needed to incorporate analysis by sex and ethnicity to fully demonstrate equity in outcomes. *Rating: achieving activity (2)*		
	1D: Patients (service users) report positive experiences of the service	**Reducing DNA Rates - CORE20 & LD** User voice and engagement has demonstrated via feedback change is positive**.** **Focus on co-production and user engagement -** particularly in pulmonary rehabilitation and the patient focus groups in place and being developed. Large number of service users met with to collect feedback**.** There is clear evidence of targeted support via healthcare **and** VSCE targeted support and community follow-up for individual	Average: Achieving activity 2	Director of Nursing

		with LD who suffered a bereavement at the hospital. There is evidence of expansion in clinic activity where referrals are the highest e.g. Weymouth and Portland, Blandford and Sturminster Newton. Co-production and user engagement. **Improving understanding and confidence -** Demonstrated 'Attending an Outpatient Appointment' and 'Attending for Surgery' videos. **Community-based support improving patient experience -** Weekly DCH Carer Cafés in the HIVE and the support extends to all with LD. Better links with family hubs and food banks. **Responsive service changes based on experience feedback -** Clinics expanded where referrals highest (W&P, Blandford, Sturminster Newton). Dietetic lists in Weymouth always fully utilised review planned to understand impact on access and experience. These actions show that user experience is actively sought, heard, and used to shape services. *Rating: achieving activity (2.5)* **Reducing DNA rates – Prison Health** **User voice and engagement** has demonstrated via feedback change is positive. Focus on co-production particularly in pulmonary rehabilitation and the patient focus groups in place. This also applies to prison health where there is a focus group undertaken with prisoners to understand their experiences of catering and service frustrations. This group provides insights that directly inform improvement recommendations. Strengthened working relationships between DCH teams, students, and The Verne. **Experience-informed improvements** include nutritional recommendations developed collaboratively, plans for future student involvement to revisit the site and assess progress/barriers and exploration of virtual care expected to reduce stress associated with escorted external appointments.		

		Enhancing dignity - Proposed review of flight-risk assessments aims to reduce unnecessary cuffing, particularly for older, frail, or disabled prisoners. *Rating: achieving activity (2)* **Ethnicity and Protected Characteristics Recording** Efforts to ensure sensitive, respectful interactions take place can be evidenced from staff feeding back that they understand why this information is needed and are confident to ask questions. Positive feedback from patients who have accessed and used the guide cards feeling that their privacy was being respected. Co-production of the cards with service users (people with lived experience) to ensure a positive and acceptable service processes. Improvements in data completeness (e.g., ethnicity recording rising from 78% to 85.8% through bulk update), thus supporting more personalised care and therefore better experience. *Rating: achieving activity (2)* **Digital Inclusion** Evidence from patients engaging with the digital offer, alongside the outcomes identified in section 1B, demonstrates positive experiences. This aligns with academic evidence suggesting that, for long-term conditions such as hypertension, which is largely asymptomatic, many patients prefer managing their condition at home, as this fits with their preferred way of receiving care2. To understand the acceptability of the offer, a range of patient feedback was gathered from individuals of different ages and sexes, including both working-age adults and retired people. A survey of 1,501 people in Dorset with hypertension found that 797 respondents monitored their own blood pressure at home. Feedback indicated that patients valued the ability to check their own blood pressure and felt more in control of their health. The survey also captured data across a wide range of protected characteristics,		

		including age, sex, ethnicity, marital/civil partnership status, sexual orientation, pregnancy, disability, religion or belief, gender reassignment, as well as information on vulnerable groups such as prisoners, homeless individuals, care home residents, and those living in traveller vehicles. Patient experience data was collected at scale and included representation across multiple protected characteristics. *Rating: achieving activity (2)* NB All scores have been ratified by ICS EDS Moderation Panel 09/12/2025		
Domain 1: Commissioned or provided services overall rating			7.5	

Domain 2: Workforce health and well-being

Domain	Outcome	Data Sources	Evidence	Rating	Owner (Dept/Lead)
Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	2024 National Staff Survey Stakeholder engagement carried out mid 2025	The Trust provides a range of support to staff to help manage physical and mental health conditions, including obesity, diabetes, asthma, COPD and mental health. This includes access to Occupational Health services, which provide clinical advice, assessment and support for staff with long-term conditions, including advice on reasonable adjustments and referral to Access to Work where appropriate. In addition, staff have access to the Employee Assistance Programme (Vivup), which offers confidential counselling, advice and information on a wide range of issues affecting health and wellbeing, as well as signposting to specialist support where required. Further information and support is available via the 80 Health and Wellbeing Coaches, the Health and Wellbeing Folders (situated in	**Achieving activity (2)** The Trust has an established and accessible support offer to help staff manage long-term physical and mental health conditions while at work. This includes, health and wellbeing Coaches, Occupational Health provision, access to confidential independent support through the Employee Assistance Programme, and a range of wellbeing resources and pathways available via the intranet and wider Trust provision. Staff Survey results and stakeholder feedback indicate that staff largely understand where to access support and that many experience positive	Joint Chief People Officer

			every ward and department) and the Trust intranet, including Trust-wide vaccination programmes, menopause support, and signposting to support related to domestic abuse, LGBTQ+ inclusion, and health and wellbeing for men and women. These routes provide staff with clear access to support and advice to help them manage both physical and mental health conditions while at work. NHS Staff Survey results indicate a generally positive perception of managerial and organisational support for health and wellbeing. In response to NSS Question 9d, 75% of staff agreed that their immediate manager takes a positive interest in their health and wellbeing, representing a 3% increase compared to both 2020 and the previous reporting year. For NSS Question 11a, 61% of staff agreed that the organisation takes positive action on health and wellbeing, reflecting a 2% improvement compared to the previous year. Stakeholder feedback collected in mid-2025 further supports this assessment. In response to the	managerial and organisational interest in health and wellbeing. While further development is required to strengthen the proactive and preventative use of workforce data and to better identify and address disproportionate impacts by protected characteristic, the current evidence demonstrates that appropriate support is available and can be accessed by staff when needed. **To reach Excelling:** The organisation strengthens the proactive and preventative use of workforce and health insight, including routine monitoring by protected characteristic, and uses sickness absence and Occupational Health data to identify inequalities and implement targeted interventions. This includes clearer escalation	

			question 'Do you know where to go to find information that would support you to manage obesity, diabetes, asthma, COPD and mental health conditions?', 67% of respondents indicated that they did. While stakeholders noted that much of the current offer focuses on access to information, signposting and support on request, this reflects an established and accessible support framework rather than an absence of provision. Taken together, this evidence demonstrates that staff are able to access appropriate support to help manage long-term physical and mental health conditions while at work, supported by Occupational Health, independent support services and organisational wellbeing provision.	routes and measurable improvement in the experience and outcomes of staff with long-term health conditions.	
	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	2024 National Staff Survey NSS combined Q14b & Q14c 'In the last 12 months how many times	The Trust has taken steps to strengthen its approach to preventing and responding to bullying, harassment, abuse and sexual misconduct. This includes signing the Sexual Safety Charter, implementing a Sexual Misconduct Policy, and introducing a new staff	**Achieving activity (2)** The Trust has established a clear organisational framework to prevent and respond to bullying, harassment, abuse and sexual misconduct. This	Joint Chief People Officer

		have you personally experienced harassment, bullying or abuse at work from managers & other colleagues' NSS Q16c 1-7 'On what grounds have you experienced discrimination?' Stakeholder engagement carried out mid 2025	reporting system with the option to submit concerns anonymously. In addition, the Trust's Dignity and Respect at Work Policy sets out a clear zero-tolerance position, stating that "the Trust will not tolerate bullying, harassment or discrimination in any form." This provides a clear organisational standard for expected behaviours and reinforces leadership commitment to addressing unacceptable conduct. Sexual Safety training has been made mandatory for staff, reinforcing the Trust's zero-tolerance stance and supporting awareness, prevention and appropriate response to sexual misconduct. NHS Staff Survey data indicates that experiences of bullying, harassment and abuse remain a significant issue for a proportion of staff. In the 2024 survey, 28% of staff reported experiencing harassment, bullying or abuse from managers or colleagues. This represents a reduction of 2% compared to earlier reporting	includes a stated zero-tolerance position within the Dignity and Respect at Work Policy, alongside defined reporting routes, policies, mandatory Sexual Safety training, and processes to support staff and address concerns when they arise. Evidence demonstrates that staff are able to raise concerns through multiple routes and that the organisation takes action to support individuals who experience bullying, harassment or abuse. Recent NHS Staff Survey data shows a reduction in reported experiences compared to previous years and remains slightly below the national NHS average, indicating early signs of improvement alongside continued challenge. While stakeholder feedback and workforce data confirm that bullying,	

			periods and remains slightly below the national NHS average. Analysis of discrimination data (NSS Q16c) highlights ongoing inequalities in lived experience. Discrimination on the basis of ethnicity was reported most frequently (53%), representing an increase compared to the previous year, followed by 'other' grounds (26%) and gender (21%). This demonstrates that experiences of bullying, harassment and discrimination are not evenly distributed across the workforce. Stakeholder feedback collected in mid-2025 reinforces this picture. In response to the question 'When at work, staff are free from abuse, harassment, bullying and physical violence from any source?', 22% of respondents rated the organisation at level 0 and 44% at level 1 (out of a maximum of 3). Stakeholders recognised that the organisation acts to support staff who have experienced abuse and takes action where incidents occur, but noted that a stronger, more visible zero-tolerance approach and more	harassment and discrimination are still experienced by a proportion of staff, and that impact is not evenly distributed across protected characteristics, the Trust has the necessary leadership commitment, governance arrangements and mechanisms in place to respond to concerns and take action. On this basis, activity within this outcome is assessed as achieving. **To reach Excelling:** To progress towards excelling, the Trust will further strengthen the consistent and visible application of its zero-tolerance approach, improve staff confidence in reporting processes, and make more systematic use of workforce and staff survey data by protected characteristic to prevent	

			consistent preventative action are required. While a new reporting system is in place, low levels of use to date are not interpreted as an absence of bullying or harassment. Instead, this highlights the need to continue building staff confidence in reporting processes and to demonstrate consistently that concerns are addressed fairly, transparently and without detriment.	harm, address disproportionate impact and demonstrate sustained improvement in staff experience. The anti-racism work currently underway will assist with this.	
	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	2024 NSS Q11d 'In the last three months have you ever come to work despite not feeling well enough to perform your duties?' 2024 NSS Q11c 'During the last 12 months have you felt	Staff at Dorset County Hospital have access to multiple sources of independent support and advice when experiencing stress, bullying, harassment or physical violence, all of which operate outside of line management structures. These include the Freedom to Speak Up Guardian, who provides confidential advice and support, as well as recognised Trade Union representatives (BMA, HCSA, RCN and Unison), who are available to offer independent guidance and representation. In addition, the Trust's four staff networks provide peer-led support through regular	**Achieving activity (2)** Recognising that while workplace stress remains a challenge, staff have access to well-established, trusted and independent sources of support outside of line management structures. **To reach Excelling:** The organisation Facilitates pooling union representatives with partner organisations,	Joint Chief People Officer

		unwell as a result of work-related stress?' NSS Q13a – Q13c 'In the last 12 months how many times have you personally experienced physical violence at work from...? Patients / service users, their relatives or other members of the public, Managers, Other colleagues.' The stakeholder survey carried out mid 2025 Q7 'Staff have access to independent support and	meetings and network activities, offering safe spaces for staff to raise concerns and seek advice. Independent emotional and practical support is further available through the Employee Assistance Programme (Vivup), which operates 24/7 and provides confidential counselling, advice and signposting via an external provider. Equality impact assessments are routinely applied when developing or amending policies and procedures relating to bullying, harassment, abuse and physical violence, supporting consistent and equitable application of processes. NHS Staff Survey data indicates that workplace stress and exposure to challenging behaviours remain significant issues for some staff groups. 57% of staff reported attending work despite not feeling well enough to perform their duties, and 45% reported feeling unwell as a result of work-related stress in the previous 12 months, both showing a small year-on-year increase. Reports of physical violence remain relatively low but are	to encourage independence and impartiality. Relevant staff networks are … "provided protected time **to support and guide staff who have suffered abuse, harassment, bullying and physical violence from any source**." Appropriate resourcing to be in place.	

		advice when suffering from stress, abuse, bullying harassment and physical violence from any source'	present across different sources, including patients, colleagues and managers. Despite these pressures, stakeholder feedback gathered in mid-2025 demonstrates strong confidence in the availability and independence of support mechanisms. In response to the question 'Staff have access to independent support and advice when suffering from stress, abuse, bullying, harassment and physical violence from any source', 89% of stakeholders rated the organisation at level 2, reflecting embedded Freedom to Speak Up arrangements, active and accessible staff networks, independent trade union support, and support routes outside of line management.		
	2D: Staff recommend the organisation as a place to work and receive treatment	NSS Q25c I would recommend my organisation as a place to work NSS Q25d If a friend or relative needed	NHS Staff Survey data indicates that overall staff advocacy for Dorset County Hospital remains mixed and has declined compared to earlier years. In response to NSS Question 25c, 68% of staff reported that they would recommend the organisation	**Developing activity (1)** Although a majority of staff would recommend the organisation as a place to work and receive care, overall levels of staff advocacy remain below the thresholds associated	Joint Chief People Officer

		treatment I would be happy with the standard of care provided by this organisation.	as a place to work. This represents a small increase of 2% compared to 2023, but a decrease of 4% compared to 2020. In response to NSS Question 25d, 68% of staff stated that they would be happy with the standard of care provided by the organisation if a friend or relative needed treatment. This reflects a decrease of 4% compared to 2023 and a more significant decrease of 12% compared to 2020. While these results indicate some recent stabilisation, they suggest that staff confidence and advocacy have not yet recovered to pre-pandemic levels. At present, analysis focuses primarily on overall Trust-level results, with limited systematic comparison of experiences across different protected characteristics.	with achieving or excelling performance. In addition, there is currently limited routine analysis of recommendation rates by protected characteristic, which restricts understanding of whether staff experiences are equitable across different groups. To reach Achieving: The organisation routinely analyses staff recommendation and experience data by protected characteristic, including sexual orientation, and uses this insight to address any identified disparities. Overall staff recommendation rates increase to **above 70%,** demonstrating improved and more equitable staff experience.	
Domain 2: Workforce health and well-being overall rating				7	

Domain 3: Inclusive leadership

Domain	Outcome	Data Sources	Evidence	Rating	Owner (Dept/Lead)
Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	Staff Networks The stakeholder survey carried out mid 2025 Q2 Ongoing engagement with staff networks.	Evidence from staff networks and stakeholder feedback indicates that visible and routine engagement between Board members, senior leaders and staff networks is currently limited. As part of the stakeholder survey conducted in mid-2025 (Q2), 77% of respondents rated the organisation at level 1 or below for leadership engagement with staff networks. Only one of four staff networks reported experiencing at least annual or twice-yearly engagement with Board members or senior leaders. No networks reported meeting with Board members or senior leaders three or more times per year. In addition, staff networks reported no recall of Board or senior leader engagement in religious, cultural or local events and celebrations.	**Developing activity (1)** While the Trust has established governance structures, executive accountability and strategic oversight for equality and health inequalities, evidence from staff networks indicates that regular, visible and relational engagement by Board members and senior leaders is not yet embedded in practice. Further development is required to ensure leadership commitment is consistently experienced by staff.	Trust Board

			This feedback suggests that, while some individual engagement occurs, it is not yet consistent, visible or routine across all networks and leadership roles. Alongside this, the Trust has established governance mechanisms to support equality, diversity and inclusion. The Board receives and approves WRES, WDES, Gender Pay Gap and Staff Survey reports, providing oversight of progress and challenges. Executive leads for EDI and health inequalities are clearly defined through the Joint Chief People Officer and Director of Nursing roles. EDI-related matters are discussed through the EDI Delivery Group, the Joint Inclusion & Belonging Reference Group, the People & Culture Committee in Common and the Trust Board. EDI priorities are embedded within the Trust's Joint EDI Strategy. However, these governance arrangements are not yet consistently translated into visible, relational leadership behaviours experienced by staff networks.	To achieve Achieving/Excelling: **All** board members and senior leaders routinely and visibly engage with **all** staff networks, meeting them **three or more times per year.** All senior leaders actively participate in **religious, cultural and local events** and celebrations. An already good example was the Diwali event late in 2025 in Damers Restaurant. All Board members and **line managers** complete Conscious Inclusion and Inclusive Leadership training. Each Board member and executive leader holds	

				clear personal accountability for an EDI-related workstream.	
	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed		The Trust Board and the People and Culture Committee in Common (PCCiC) include key EDI frameworks within their annual workplans, including WRES, WDES, Gender Pay Gap and the Equality Delivery System (EDS 2022). These frameworks are discussed at defined points linked to statutory reporting, compliance and implementation cycles. The annual EDI report and the recent review of the Trust's EDI Strategic Plan have been fully discussed at PCCiC, providing the Committee with oversight of progress, risks and areas requiring further development. While this demonstrates structured governance and compliance oversight, equality and health inequalities are not yet consistently embedded as standing considerations across all Board and Committee papers. The use of equality	**Achieving activity (2)** While equality and health inequalities are considered through defined reporting cycles and governance forums, they are not yet embedded as routine, standing elements of Board and Committee decision-making. Further development is required to ensure consistent identification, assessment and management of equality and health inequalities risks across all organisational activity.	Trust Board

			and health inequalities impact assessments to explicitly identify, assess and mitigate risks within decision-making is not yet applied systematically across all projects, policies and programmes.		
	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	EDIB dashboard (18/12/25) Dorset Census 2021	Current senior leadership composition (AfC Band 8C and above) There are currently 34 individuals in AfC Band 8C and above roles at Dorset County Hospital. Ethnicity: – Non-White: 1 individual (approx. 3%) Disability: – Declared disability: 4 individuals (approx. 12%) **Population benchmarks – Dorset** (local population served): – Ethnic minority (non-White): approximately 6% (Census 2021) – Disabled people (long-term condition impacting daily activities): approximately 20% (Census 2021) **Population benchmarks – UK** (national context):	**Developing activity (1)** To reach Achieving: Increased representation at AfC Band 8C and above across protected characteristics, reflecting both the local population served and the wider labour market, supported by measurable progress through recruitment, promotion and succession planning.	Trust Board

			– Ethnic minority (non-White): approximately 18% (Census 2021, England & Wales) – Disabled people: approximately 25% (Family Resources Survey / UK disability estimates) Interpretation and methodology Local Dorset population data (Census 2021) is used as the primary benchmark to reflect the population served by the Trust. National UK population estimates are included to provide wider context and to illustrate that Dorset has a lower level of population diversity than the national average. This highlights that, even when compared against a less diverse local population, senior leadership representation at AfC Band 8C and above remains disproportionately low for some protected characteristics. It is also recognised that some characteristics, particularly disability and ethnicity, may be underreported within workforce data due to disclosure factors.		

			Based on the available data, those holding roles at AfC Band 8C and above are not yet reflective of the population served. This remains the case when compared both to the local Dorset population and to wider UK population benchmarks. The Trust therefore rates this outcome as Developing (1), recognising the need for sustained and targeted action to improve senior leadership diversity over time.		
		Domain 3: Inclusive leadership overall rating		4	

Third-party involvement in Domain 3 rating and review	
Trade Union Rep(s): Not within this reporting cycle.	**Independent Evaluator(s)/Peer Reviewer(s):** Not within this reporting cycle.

EDS Organisation Rating (overall rating): **18.5 – Developing**
Organisation name(s): Dorset County Hospital
Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped** Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing** Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving** Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

EDS Action Plan	
EDS Lead	**Year(s) active**
Jan Wagner, Equity, Diversity, Inclusion & Belonging Lead	Joint Inclusion & Belonging Strategy (2024-2026) Action plan
EDS Sponsor	**Authorisation date**
Nicola Plumb (Joint Chief People Officer)	January 2026

Domain	Outcome	Objective	Action	Completion date
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	Increase availability of clinic locations to include areas of deprivation	Continue to establish clinics in areas that are showing higher DNA rates, thus bringing services closer to the patients. Continue to explore relocation of equipment to prison services to facilitate clinics locally.	Q4 26/27
	1B: Individual patients (service users) health needs are met	Accurate and complete data will inform and direct services accordingly.	Systemwide roll out of EHR 26/27. Increase local access to specialist clinics where needed. Work alongside Integrated Neighbourhood Team programme to facilitate.	Q4 26/27

	1C: When patients (service users) use the service, they are free from harm	The Trust has oversight of all patient safety incidents and HSIB reports through the Patient Safety Committee, these reports will consider the impact of culture, ethnicity and language alongside harm prevention.	Maintain ‘golden thread’ of ethnicity and protected characteristics, health inequalities, CORE20 through Patient Safety Committee and ensure assurance, monitoring and reporting any trends for action.	Q2 26/27
	1D: Patients (service users) report positive experiences of the service	Ensure that the patient feedback is reviewed and actioned appropriately to improve services	Promote and continue co-production work across all areas	Q2 26/27

Domain	Outcome	Objective	Action	Completion date
Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	To ensure staff have accessible, practical and equitable support to manage long-term physical and mental health conditions (including obesity, diabetes, asthma, COPD and mental health), and to reduce avoidable negative impacts of the working environment, with appropriate escalation and support routes where needed. Dignity and respect will underpin our civility agenda.	(Actions come from Joint Inclusion & Belonging Strategy – Action plan) Action 31: Occupational Health to support staff who have a disability and/or long-term health condition and require reasonable adjustments, including promotion of Access to Work. Action 33: Monitor the application of relevant policies and procedures (including Health and Wellbeing and return to work after long-term absence) to identify and address any disproportionate impacts on staff with protected characteristics.	2026/2027

	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	To reduce bullying, harassment, abuse and physical violence experienced by staff, and to ensure a consistently applied zero-tolerance approach that prevents harm, addresses closed cultures, and supports staff to report concerns with confidence.	(JIBS AP – Joint Inclusion & Belonging Strategy – Action plan) JIBS Action 1: Update and implement the Bullying and Harassment Policy to explicitly reflect a zero-tolerance approach, with clear expectations, consequences and leadership accountability. JIBS Action 2: Promote the Trust's staff reporting system, including anonymous reporting options, to increase confidence and accessibility for raising concerns. JIBS Action 4: Use reporting, Datix and workforce data to identify themes, hotspots and patterns related to bullying, harassment, abuse and violence, and take targeted preventative action. JIBS Action 7: Implement and embed the Respect and Resolution Policy to support early intervention, resolution and cultural change. Anti-Racism Framework (Phase 1–2): Strengthen organisational capability to identify, challenge and prevent racist behaviour and closed cultures, using workforce data,	2026/2027

			reporting insights and leadership accountability. These actions collectively strengthen prevention, reporting confidence and leadership accountability, with a specific focus on reducing disproportionate impact on staff from ethnic minority backgrounds.	

	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	To ensure staff have consistent access to trusted, independent advice and support outside of line management structures when experiencing stress, bullying, harassment, abuse or violence, and to strengthen confidence in these routes across all staff groups.	(JIBS AP – Joint Inclusion & Belonging Strategy – Action plan) JIBS Action 4: Use reporting, Datix and workforce data to identify themes, patterns and barriers related to access to support, including Freedom to Speak Up, trade unions and staff networks. JIBS Action 7: Embed the Respect and Resolution Policy to support early, informal resolution and ensure staff are signposted to appropriate independent support routes. Anti-Racism Framework (Phase 2): Strengthen transparency and reporting of themes emerging from Freedom to Speak Up, disciplinary processes and workforce data, to build trust and confidence in independent support mechanisms. Enabling action (local, non-duplicative): Improve visibility and clarity of independent support routes (Freedom to Speak Up, trade unions, staff networks, EAP) through coordinated communications and engagement with staff networks.	2026/2027

	2D: Staff recommend the organisation as a place to work and receive treatment	To improve staff confidence and advocacy by addressing key drivers of staff experience, including bullying, harassment and discrimination, leadership behaviours, and access to support, with a focus on reducing inequalities in experience across protected characteristics.	(JIBS AP – Joint Inclusion & Belonging Strategy – Action plan) JIBS Action 1, 3, 4 and 7: Reduce bullying, harassment and discrimination through a zero-tolerance approach, improved reporting confidence, hotspot analysis and early resolution, addressing key factors that negatively impact staff experience. JIBS Actions 38, 41 and 43: Strengthen inclusive leadership behaviours through mandatory training, clear EDIB objectives for senior leaders, and regular engagement with staff networks. Anti-Racism Framework (Phase 1–2): Address racial disparities in staff experience through targeted actions, leadership accountability and use of workforce and staff survey data to inform improvement. Enabling action (within existing reporting cycles): Analyse staff survey and experience data by protected characteristic and use findings to inform priority actions within existing governance and delivery structures.	2026/2027

Domain	Outcome	Objective	Action	Completion date
Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	To ensure Board members and senior leaders demonstrate visible, consistent and accountable commitment to equality, diversity, inclusion and health inequalities through leadership behaviours, engagement with staff networks, and ownership of EDIB priorities.	(JIBS AP – Joint Inclusion & Belonging Strategy – Action plan) JIBS Action 38: Deliver Conscious Inclusion and Inclusive Leadership training for all line managers to strengthen inclusive leadership capability and behaviours. JIBS Action 41: Embed EDIB objectives within senior leader performance objectives to reinforce accountability for equality, diversity, inclusion and health inequalities. JIBS Action 43: Strengthen routine engagement between Board members, senior leaders and staff networks to support dialogue, visibility and shared ownership of inclusion priorities. Anti-Racism Framework (Phase 1–2): Increase senior leader visibility and accountability in addressing racial inequalities through leadership behaviours, engagement and communications.	2026/2027

	3B:Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	To ensure equality and health inequalities impacts and risks are routinely identified, considered and managed through Board and Committee decision-making, supported by consistent use of impact assessments and governance oversight.	(JIBS AP – Joint Inclusion & Belonging Strategy – Action plan) JIBS Action 37: Fully embed the Equality Impact Assessment (EIA) framework across the organisation to support identification, mitigation and management of equality and health inequalities risks in projects, policies and decision-making. JIBS Action 4: Use workforce, reporting and staff survey data to identify equality and health inequalities risks and themes, and ensure these are escalated through appropriate governance forums. While JIBS Action 4 primarily focuses on identifying and addressing hotspots related to bullying, harassment and inappropriate behaviours, the strengthened use of workforce data, staff reporting insights and thematic analysis also provides an early warning mechanism for wider equality-related risks. This enables senior leaders to identify patterns of disproportionate impact, escalate concerns appropriately, and take timely, preventative action as part of inclusive leadership and governance. Anti-Racism Framework (Phase 2):	2026/2027

			Strengthen Board and senior leadership oversight of racial inequalities through routine review of workforce data, risk assessments and mitigating actions. (EDI Dashboard)	

	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	To ensure effective levers are in place to manage performance, monitor progress and address inequality and health inequalities across the workforce, including improving representation and fairness in senior leadership recruitment and progression.	(JIBS AP – Joint Inclusion & Belonging Strategy – Action plan) JIBS Action 16: Ensure diverse interview panels and inclusive recruitment practices are applied consistently across recruitment, including use of inclusive job descriptions and structured interview questions. JIBS Action 19: Review workforce composition and staffing levels to ensure they are reflective of local, regional and national labour markets, using workforce data to inform planning and monitoring. JIBS Action 20: Review recruitment and appointment processes for Board and senior leadership roles to identify and address potential barriers to representation. Anti-Racism Framework (Phase 2): Strengthen monitoring and accountability for senior workforce representation through routine analysis of recruitment, progression and workforce data, with findings escalated through governance structures.	2026/2027